Costs, MIPS and QRUR

Oregon MACRA Playbook Conference

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Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

HealthInsight

Disclosure

David Smith and Ryan Brown have no real or apparent conflicts of interest to report.

David

Objectives

Understand:

- How to use Quality and Resource Use Reports (QRUR) to as a proxy for cost performance in MIPS
- Other tools for evaluating costs
- Which tools are available for preparing to decrease costs
- Ideas for overarching strategy to improve or decrease costs

David

Agenda

- History of costs – Ryan
- Introduce suggested model for costs in MIPS – David
- Utility of the QRUR – Ryan
- Share sample of QRUR – Ryan
- Connecting QRUR to MIPS costs – David/Ryan

David

Why Costs?

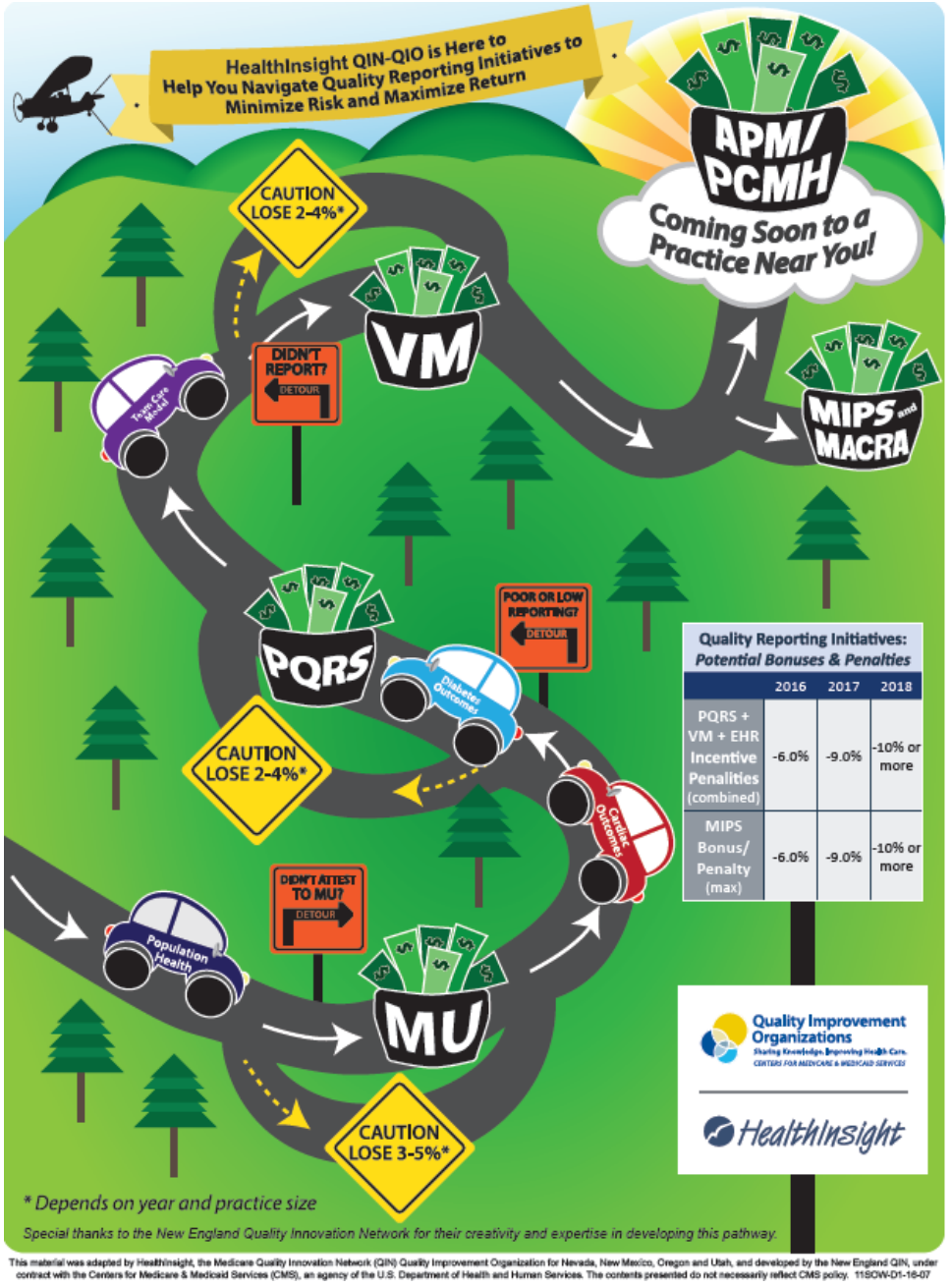
- History of Costs
- History for Clinic reimbursement costs:
  - VM Modifier applied to
    - 2013 – Groups of 100+
    - 2014 – Groups of 10+
    - 2015 – Groups of 1 or 1+
    - 2016 – Groups of 1 or 1+, may include PAs and NPs*
- For years, hospitals have had cost/quality performance objectives that affected reimbursement.

David

*https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

Where Are We Today?

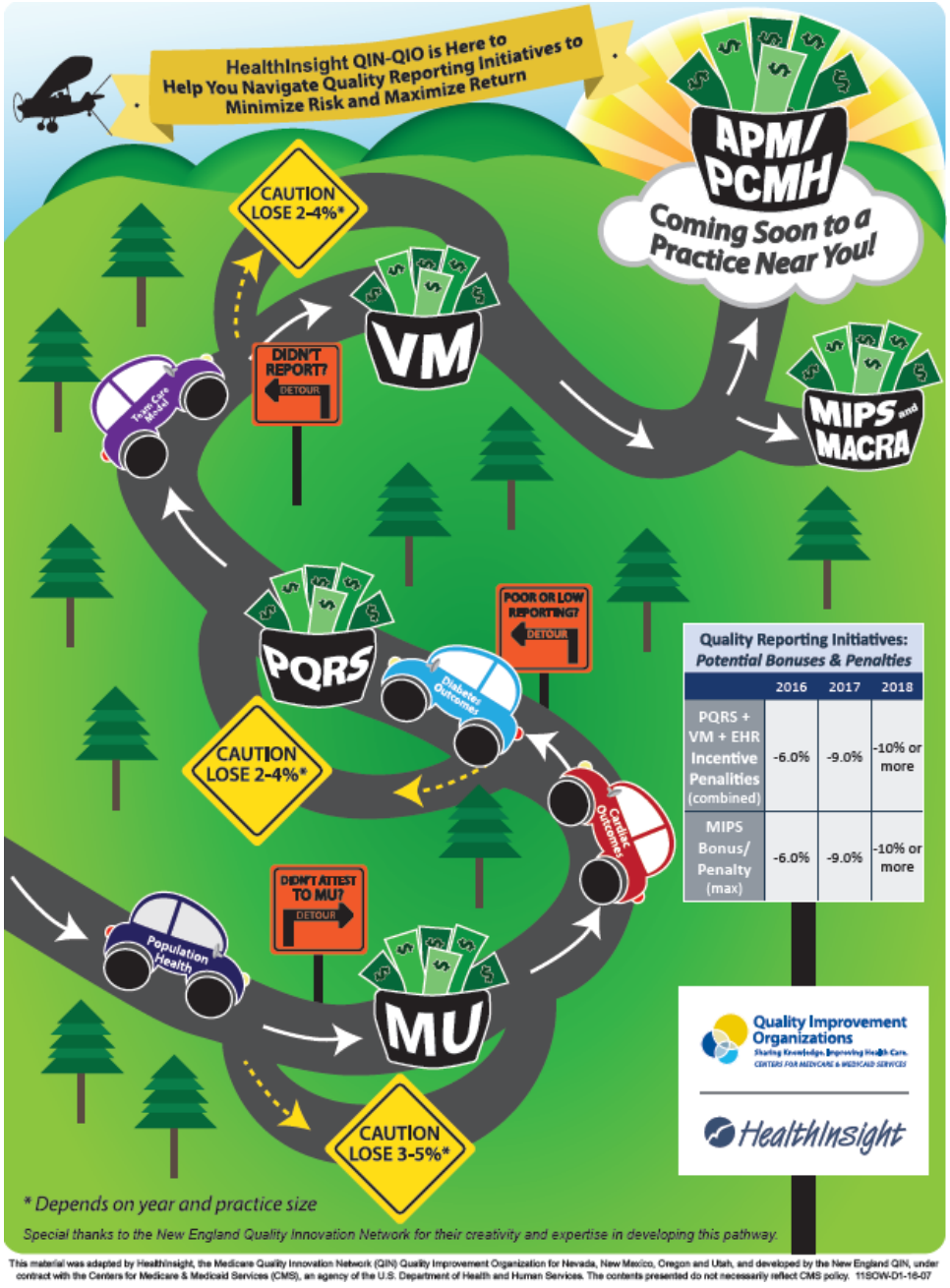
A look back on our road to MACRA/QPP …



Where Are We Going?

You will likely see a growing interest in **risk sharing models:**

- -MSSPs
- -Bundled Payments
- -PCP+

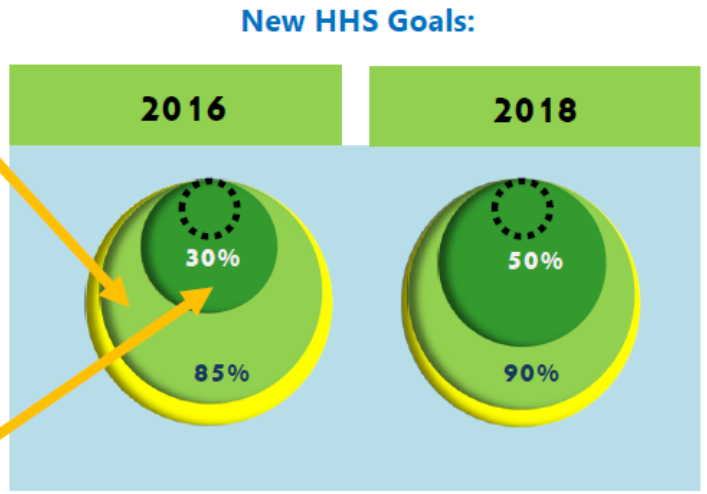


Goals – From HHS

MACRA moves us closer to meeting these goals…

The new Merit-based Incentive Payment System helps to link **fee-for-service payments** to quality and value.

The law also provides incentives for **participation in Alternative Payment Models** in general and bonus payments to those in the most highly advanced APMs



All Medicare fee-for-service (FFS) payments (Categories 1-4)

Medicare **FFS** payments **linked to quality and value** (Categories 2-4)

Medicare payments linked to quality and value **via APMs** (Categories 3-4)

Medicare Payments to those in the most highly advanced APMs under MACRA

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf

Why Look at the QRUR? — David

- Current look at Cost equation includes
  - Cost Per Beneficiary
  - Total Per Capita Costs
  - Episode Groups

- Which are in …
  - The QRUR

David

Points to Consider

- Current equation for Cost points is still not final.
- Comment Period is over for Episode Groups.
- We have our own ideas on how this equation might look.

- Next: QRUR explanation, what to look for, from Ryan Brown.
- Finally, David will review possible strategies.

David

About Quality and Resource Use Reports (QRUR)

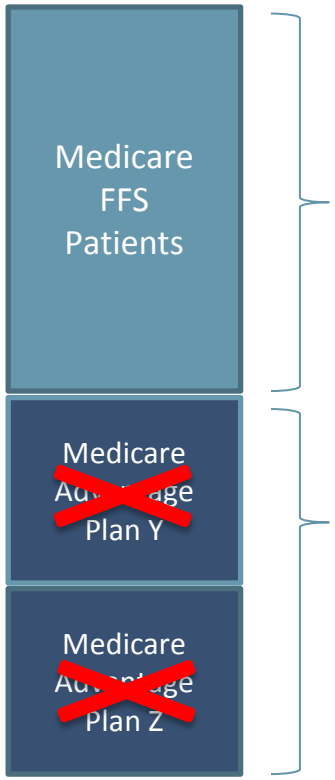
Points we will examine:

1. What data are used to generate the QRUR?
2. Who has a QRUR report & how does one obtain said report?
3. How to read select outputs

Poll question: Have you downloaded your QRUR?

- ❑ Yes
- ❑ I’m not sure
- ❑ No
- ❑ No, but I would like help getting this report

Where Do the Data Come From?



These data are used to populate the report:

1. Medicare enrollment data
2. Medicare Part A & B claims data (Not part D)
3. Other data: PQRS*, HCC risk scores, Standardized Payment, PECOS…

Data from Medicare Advantage plan patients **are not** used to generate QRUR data**

*Some methods of PQRS reporting may include advantage plan patients

**For 2014 VM, GPRO PQRS data is omitted

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2014QRUR-2016VM-DetailedMethodology.pdf

How Is the QRUR Organized?

The report is organized by **Tax Identification Number** (TIN) – normally, this is the group of providers that deliver care in your setting.

- For **most organizations**, this grouping is sensible.
  But for some, this level of aggregation may be less ideal for QI opportunity identification.

- You also may have >1 TIN for the group.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2014QRUR-2016VM-DetailedMethodology.pdf

What Is Included in the QRUR Report?

The QRUR report contains

1. Quality Data – from Claims and PQRS submission
2. Cost Data
3. Benchmark Data
4. A Value Modifier (VM) score, **depending on eligibility**
   (Note: From 2015 on, most providers are subject to the VM.)

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2014QRUR-2016VM-DetailedMethodology.pdf

Who Doesn't Have a QRUR?

1. Organizations that don't bill Medicare Part B patients
2. Certain groups that are excluded from some Medicare Part B related programs, including FQHCs & RHCs

Note: CMS has a way of accommodating specialists into this report. Thus, it is worthwhile downloading these reports if they are available.

Primer on specialist calculations:
http://tinyurl.com/h4frto7

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2014QRUR-2016VM-DetailedMethodology.pdf

Questions?

I would like to download our TINs QRUR—Where do I start?

The next few slides will outline how to obtain your QRUR report.

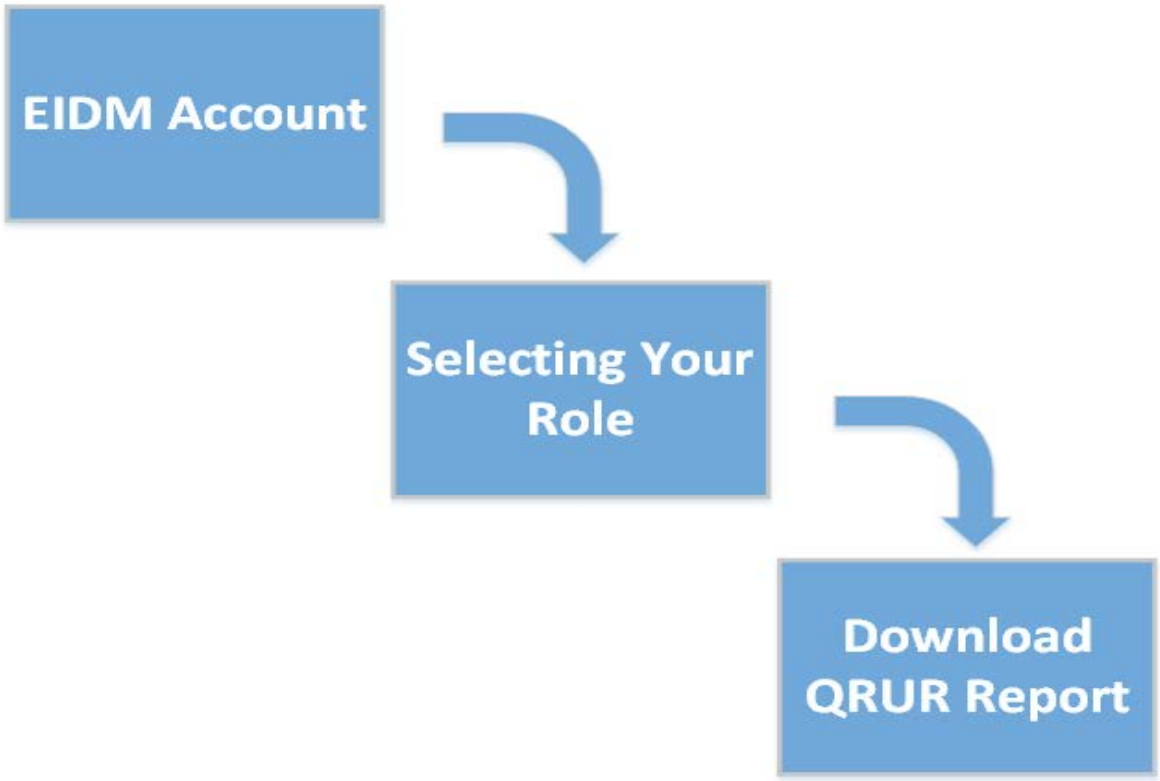
This is brief overview; more detail can be found on the CMS website:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html

The Path to Downloading QRUR

The goal of these next slides is to outline one path to downloading your QRUR.

Along the way, we will discuss some common decision points.



What Is an EIDM?

CMS created the Enterprise Identity Management (EIDM) website to provide users with a means to apply for, obtain approval for and receive a ***single User ID*** they can use to access one or more CMS applications.

EIDM portal: https://Portal.cms.gov

Question: Is There an EIDM Account Already Associated with Your TIN?

- If someone in your organization **has access** to your TIN's QRUR information, contact that person for the reports.

- If you are **unsure** whether someone has access to the QRUR report, contact the QualityNet Help Desk to verify this person:
  - Call 866-288-8912 or email gnetsupport@hcquis.org
  - They will ask for your name, number and TIN

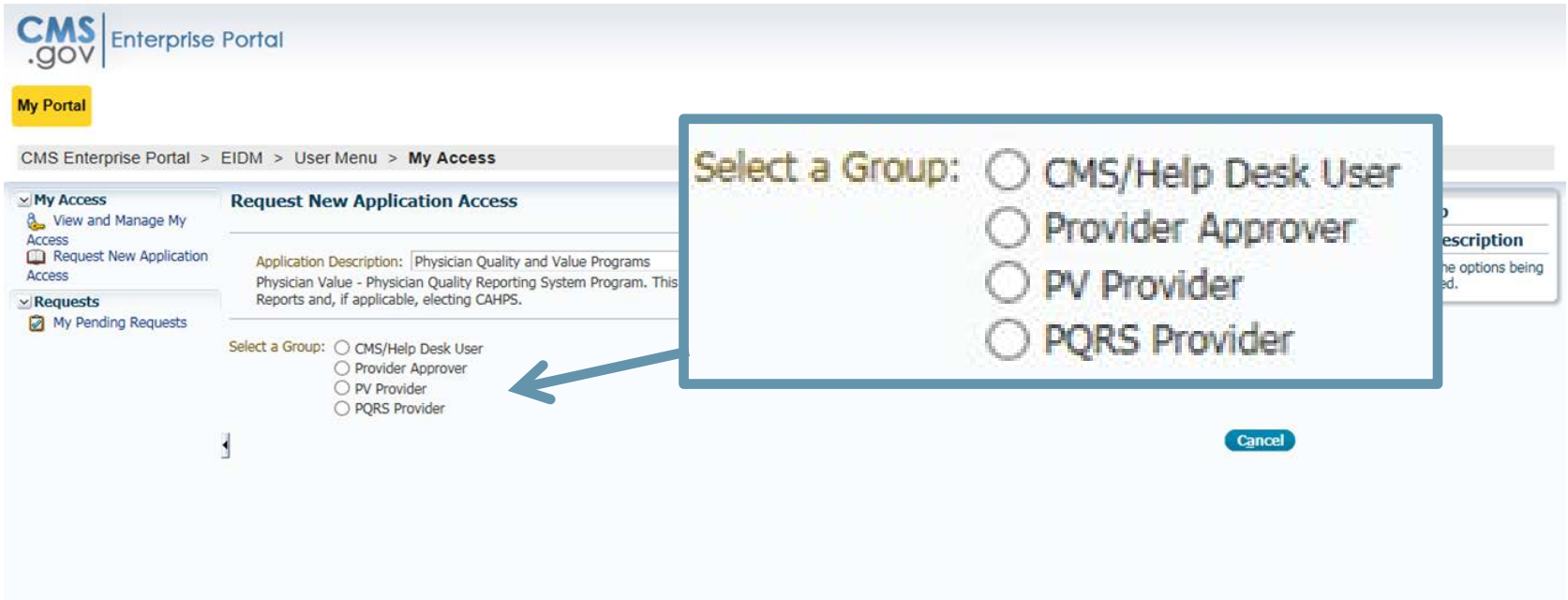
- If **no one** has established access to your TIN's reports, follow the outlined steps to establish and EIDM account and download the reports.

What Do You Need for an EIDM Account?

Information to have on hand before you start:

- ✓ Designated person to represent the TIN(s)
- ✓ Full ---Name
- ✓ Email Address
- ✓ Social Security Number
- ✓ Date of Birth
- ✓ Home Address
- ✓ Primary Phone Number
- ✓ Your Role
- ✓ NPI (if a clinician)

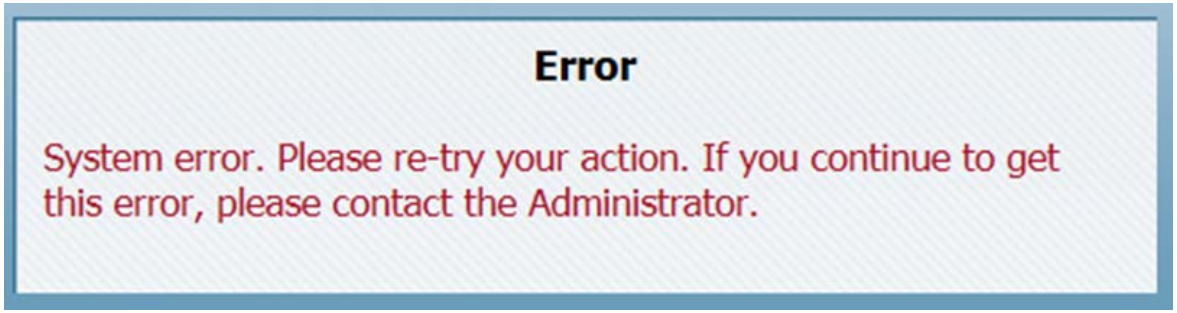
Choosing the Correct Account Type



Help Lines

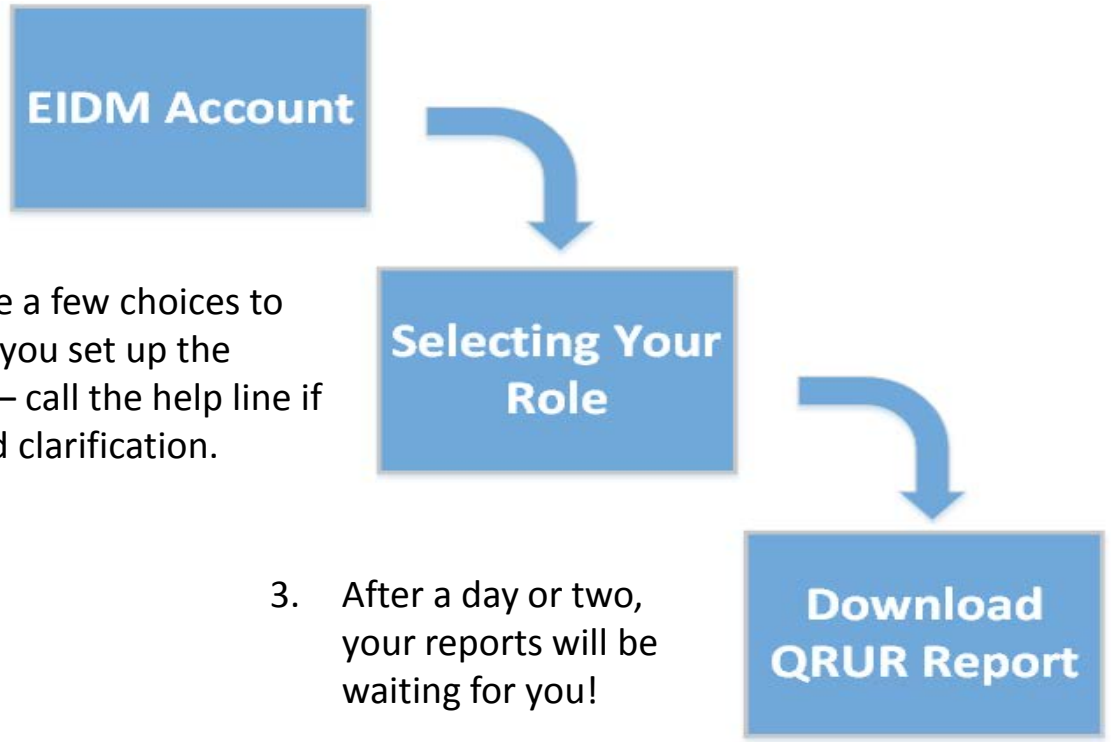
Questions related to account set up can be directed to these contacts:

For QRUR and VM questions or to provide feedback on the content and format of the QRUR, contact the **Physician Value Help Desk**:	For PQRS and EIDM questions, contact the **QualityNet Help Desk**:
Phone: 1-888-734-6433 (select option 3) Monday – Friday: 8:00 am – 8:00 pm EST Email: pvhelpdesk@cms.hhs.gov	Phone: 1-866-288-8912 (TTY 1-877-715-6222) Monday – Friday: 8:00 am – 8:00 pm EST Email: qnetsupport@hcqis.org



EIDM Set-up in Review

1. Make sure you have the right information to set up the account.



2. There are a few choices to make as you set up the account – call the help line if you need clarification.

3. After a day or two, your reports will be waiting for you!

What If I Want Help Doing This?

If you would like 1:1 help pulling these reports, look to your local community partners for assistance:

- CMS Help Lines
- Quality Improvement Organization (QIO)

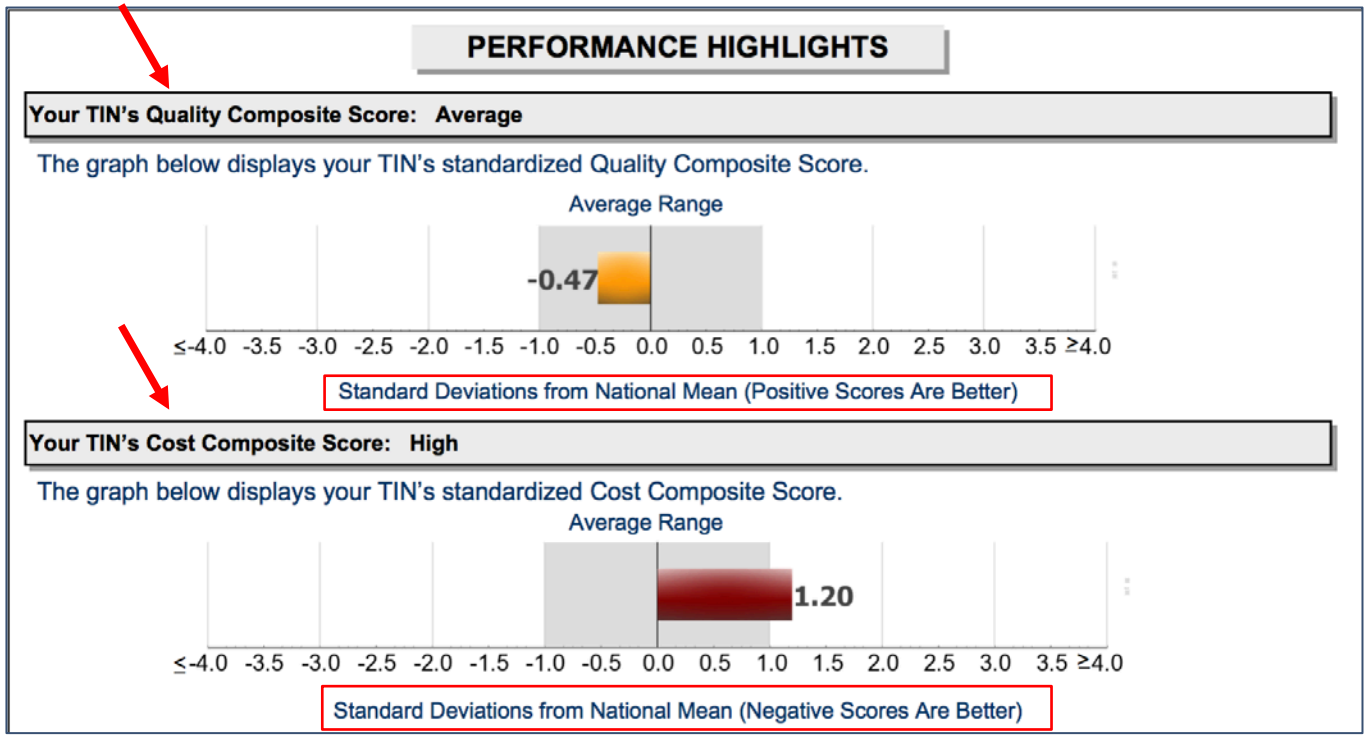
Questions?

QRUR Basics

In this section, we will review the basic QRUR outputs and discuss their connection to:

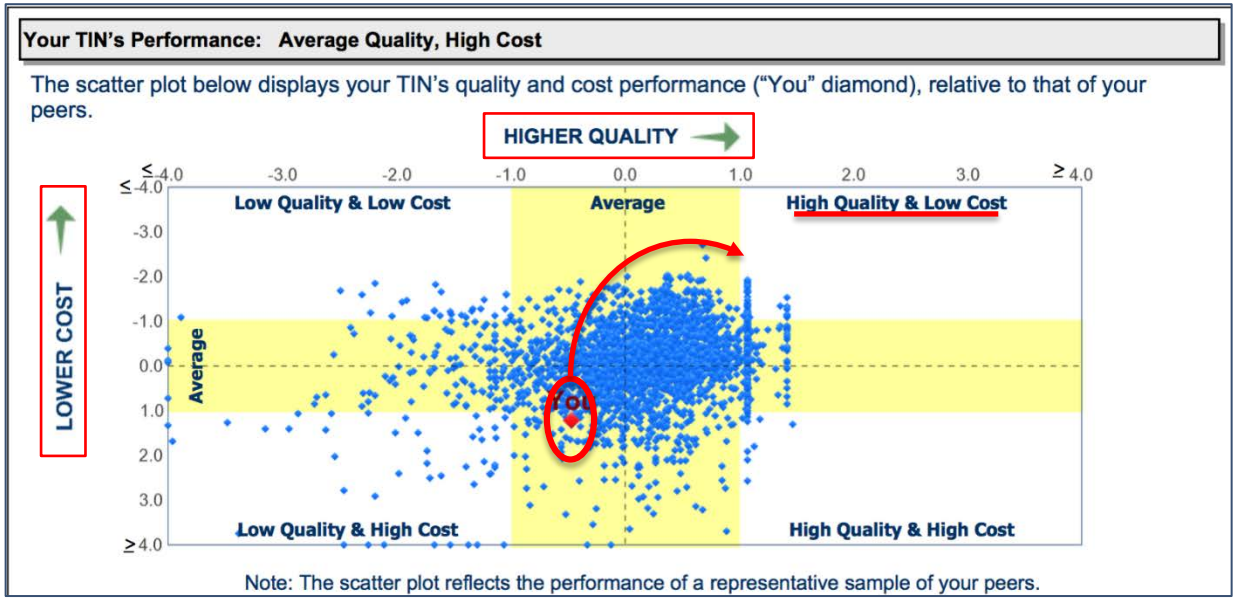
1. Annual Wellness Visit (AWV)
2. Chronic Care Management (CCM)
3. Transitions of Care (TOC)

Looking at the Performance Highlights



Key Takeaway:
This is how you compare to your peers on cost and quality (Medicare Part B)

The Scatter Plot



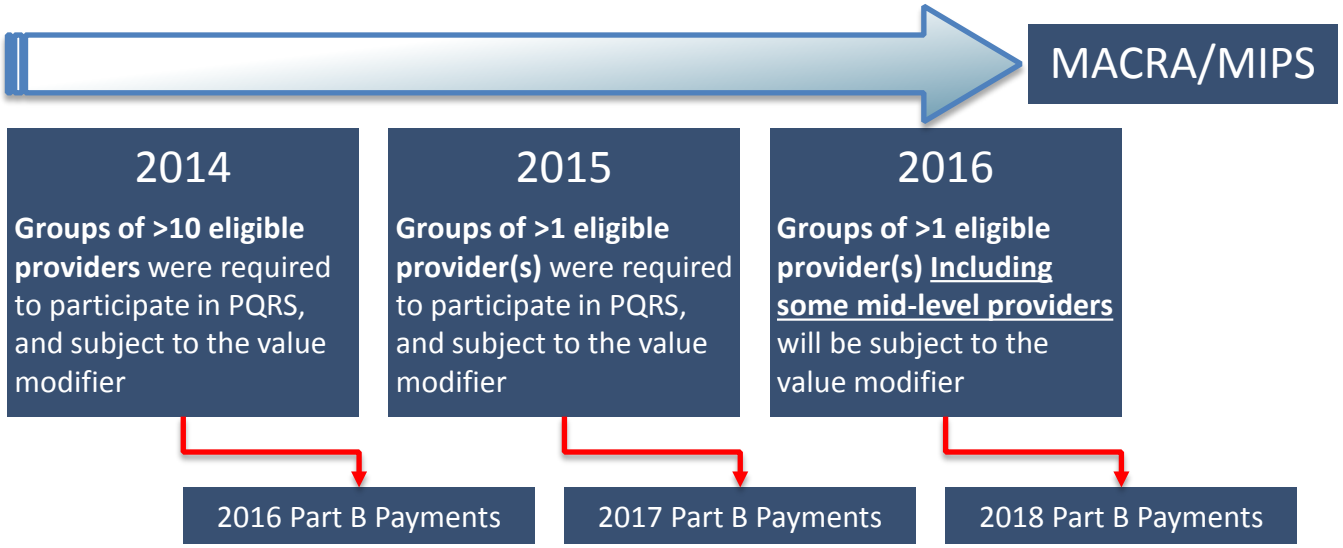
If CMS has sufficient data, your TIN will have a data point on this scatter plot.
Where are you, and where do you want to be?

High-Risk Bonus Adjustment and Value Modifier

The mechanics and application of the High-Risk Bonus Adjustment and Value Modifier are not the focus of this talk.

- We will review the basics of the Value Modifier program.
- Specific questions about calculation, adjustments and application are beyond the scope of this talk. However, links are provided to help answer specific questions.

Value Modifier – Will I See It?



The Value Modifier applied to many providers. The impact on your payments can be negative, neutral or positive. There are resources to help you understand how CMS applied the Value Modifier to your TIN.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Timeline.html

Value Modifier, Continued

Do you have questions about your Value Modifier?

- How it was calculated
- How it applies to my situation
- Can I contest the findings?

CMS has resources and call lines to answer these questions.

Value Modifier Resources from CMS

2014 VM Resources:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html

2015 VM Resources:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html

2016 VM Resources:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2016-QRUR.html

How Many Eligible Providers Are in the TIN?

Exhibit 1

Eligible Professionals in Your TIN	Number Identified in PECOS	Percentage Identified in PECOS	Number Identified in Claims	Percentage Identified in Claims
All eligible professionals	9	100.00%	8	100.00%
Physicians	8	88.89%	6	75.00%
Non-physicians	1	11.11%	2	25.00%

Note: To determine the size of your TIN for purposes of the Value Modifier, CMS uses the lower of the number of eligible professionals identified in PECOS as having re-assigned their billing rights to your TIN, and the number of eligible professionals identified in the claims data for the performance period.

CMS Calculates this 1 of 2 ways – via PECOS or Claims data.

Per the description under Exhibit 1,CMS chooses the lower of the two reported numbers.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2014QRUR-2016VM-DetailedMethodology.pdf

Attribution – They Are Our Patients, Right?

Exhibits 2 & 3

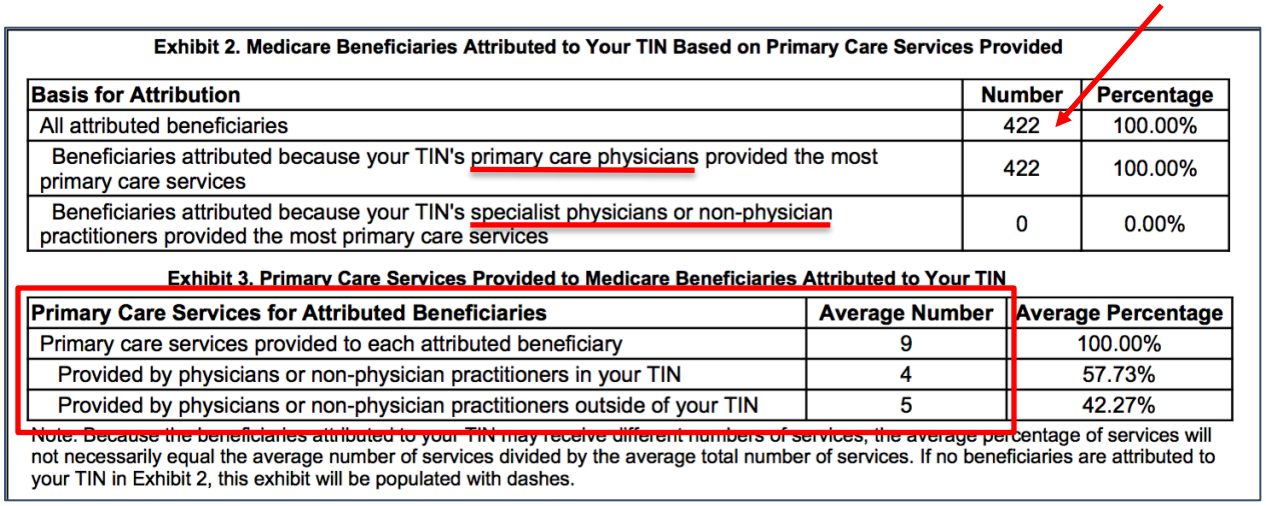


Exhibit 2. Medicare Beneficiaries Attributed to Your TIN Based on Primary Care Services Provided

Basis for Attribution	Number	Percentage
All attributed beneficiaries	422	100.00%
Beneficiaries attributed because your TIN's primary care physicians provided the most primary care services	422	100.00%
Beneficiaries attributed because your TIN's specialist physicians or non-physician practitioners provided the most primary care services	0	0.00%

Exhibit 3. Primary Care Services Provided to Medicare Beneficiaries Attributed to Your TIN

Primary Care Services for Attributed Beneficiaries	Average Number	Average Percentage
Primary care services provided to each attributed beneficiary	9	100.00%
Provided by physicians or non-physician practitioners in your TIN	4	57.73%
Provided by physicians or non-physician practitioners outside of your TIN	5	42.27%

Note: Because the beneficiaries attributed to your TIN may receive different numbers of services, the average percentage of services will not necessarily equal the average number of services divided by the average total number of services. If no beneficiaries are attributed to your TIN in Exhibit 2, this exhibit will be populated with dashes.

Are your patients seeking primary care outside your clinic?

Exhibit 4 – Hospital Episodes

Exhibit 4

Hospital Episodes and Beneficiaries	Number
Total episodes of hospital care attributed to your TIN	67
Unique Medicare beneficiaries associated with attributed episodes of care	64

You will see Exhibit 4 right after the attribution table. Note this shows a specific grouping of hospitalizations and should mirror the data from Exhibit 10.

Note – this looks at a specific grouping of patients:
The **Medicare Spending Per Beneficiary (MSPB)**

"MSPB Measure assesses the cost to Medicare of services performed by TINs during an MSPB episode, which comprises the period immediately prior to, during, and following a patient's hospital stay." —CMS

Quick Overview of the Quality Domain

Although it is not a central part of this talk, Quality is a component in the QRUR and is a potential input in designing a Chronic Care Management program.

The following seven slides are a brief overview on cost. More information can be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2014QRUR-2016VM-DetailedMethodology.pdf

Quality – How Do We Compare?

Exhibit 5

Exhibit 5. Your TIN's Performance in 2014, by Quality Domain

Quality Domain	Number of Quality Measures Included in Composite Score	Standardized Performance Score (Quality Tier Designation)
Quality Composite Score	**9**	**0.79 (Average)**
Effective Clinical Care	3	1.40
Person and Caregiver-Centered Experience and Outcomes	0	—
Community/Population Health	3	1.58
Patient Safety	1	0.57
Communication and Care Coordination	2	0.53
Efficiency and Cost Reduction	0	—

Note the number of quality measures reported, and the Standardized Score. The description below this output speaks to the specifics of what measures are used for Quality Tier designation.

Performance on Quality Measures

Exhibit 6

Measure Reference	Measure Name	Your TIN's Eligible Cases	Your TIN's Performance Rate	Benchmark	Benchmark -1 Standard Deviation	Benchmark +1 Standard Deviation	Standardized Score	Included In Domain Score?
2 (CMS163v2)	Diabetes Mellitus (DM): Low Density Lipoprotein (LDL-C) Control	7	71.43%	52.81%	31.95%	73.67%	0.89	No
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	1	100.00%	35.02%	4.82%	65.22%	2.15	No
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	2	100.00%	75.01%	38.23%	100.00%	0.68	No
51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	1	100.00%	84.18%	62.27%	100.00%	0.72	No
111 (GPRO Prev-8, CMS127 v2)	Preventive Care and Screening: Pneumococcal Vaccination for Older Adults	170	100.00%	45.42%	14.41%	76.42%	1.76	Yes
113 (GPRO Prev-6, CMS130 v2)	Preventive Care and Screening: Colorectal Cancer Screening	72	100.00%	46.48%	15.80%	77.16%	1.74	Yes

CMS Calculates Metrics Via Claims

Exhibit 6–CCC–B

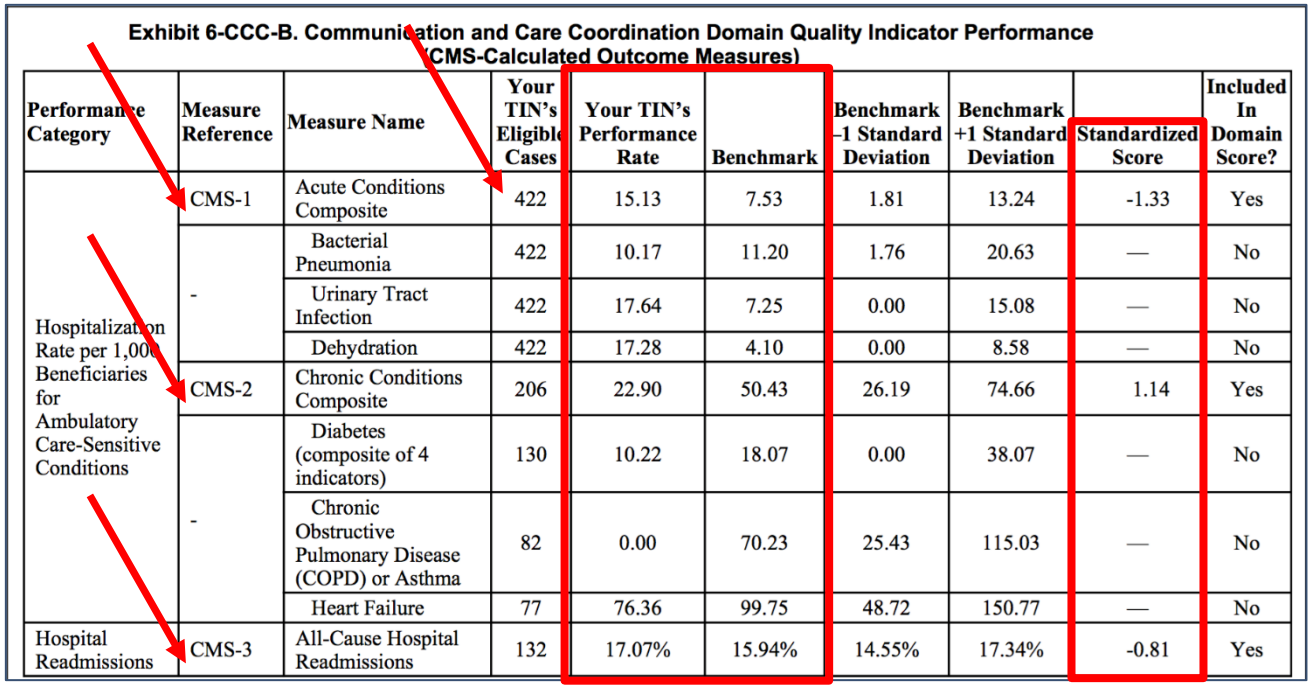


Exhibit 6-CCC-B. Communication and Care Coordination Domain Quality Indicator Performance (CMS-Calculated Outcome Measures)

Performance Category	Measure Reference	Measure Name	Your TIN's Eligible Cases	Your TIN's Performance Rate	Benchmark	Benchmark -1 Standard Deviation	Benchmark +1 Standard Deviation	Standardized Score	Included In Domain Score?
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care-Sensitive Conditions	CMS-1	Acute Conditions Composite	422	15.13	7.53	1.81	13.24	-1.33	Yes
	-	Bacterial Pneumonia	422	10.17	11.20	1.76	20.63	—	No
		Urinary Tract Infection	422	17.64	7.25	0.00	15.08	—	No
		Dehydration	422	17.28	4.10	0.00	8.58	—	No
	CMS-2	Chronic Conditions Composite	206	22.90	50.43	26.19	74.66	1.14	Yes
	-	Diabetes (composite of 4 indicators)	130	10.22	18.07	0.00	38.07	—	No
		Chronic Obstructive Pulmonary Disease (COPD) or Asthma	82	0.00	70.23	25.43	115.03	—	No
		Heart Failure	77	76.36	99.75	48.72	150.77	—	No
Hospital Readmissions	CMS-3	All-Cause Hospital Readmissions	132	17.07%	15.94%	14.55%	17.34%	-0.81	Yes

Question:
What Is the "Scale" for These Rates?

Exhibit 6–CCC–B

Exhibit 6-CCC-B. Communication and Care Coordination Domain Quality Indicator Performance (CMS-Calculated Outcome Measures)

Performance Category	Measure Reference	Measure Name	Your TIN's Eligible Cases	Your TIN's Performance Rate	Benchmark	Benchmark –1 Standard Deviation	Benchmark +1 Standard Deviation	Standardized Score	Included In Domain Score?
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care-Sensitive Conditions	CMS-1	Acute Conditions Composite	422	15.13	7.53	1.81	13.24	-1.33	Yes
	-	Bacterial Pneumonia	422	10.17	11.20	1.76	20.63	—	No
		Urinary Tract Infection	422	17.64	7.25	0.00	15.08	—	No
		Dehydration	422	17.28	4.10	0.00	8.58	—	No
	CMS-2	Chronic Conditions Composite	206	22.90	50.43	26.19	74.66	1.14	Yes
	-	Diabetes (composite of 4 indicators)	130	10.22	18.07	0.00	38.07	—	No
		Chronic Obstructive Pulmonary Disease (COPD) or Asthma	82	0.00	70.23	25.43	115.03	—	No
		Heart Failure	77	76.36	99.75	48.72	150.77	—	No
Hospital Readmissions	CMS-3	All-Cause Hospital Readmissions	132	17.07%	15.94%	14.55%	17.34%	-0.81	Yes

What Is the "Scale" for These Rates?

Answer:

1. Hospital Admissions for Ambulatory Care-Sensitive Conditions (ACSCs): Acute Conditions Composite. This is the risk-adjusted rate of hospital admissions among Medicare beneficiaries for three acute ACSCs—bacterial pneumonia, urinary tract infection, and dehydration—that are potentially avoidable with appropriate primary and preventive care. This measure is computed at the TIN level.

2. Hospital Admissions for ACSCs: Chronic Conditions Composite. This is the risk adjusted rate of hospital admissions among Medicare beneficiaries for three chronic ACSCs— diabetes, chronic obstructive pulmonary disease (COPD), and heart failure—that are potentially avoidable with appropriate primary and preventive care. This measure is computed at the TIN level. 3

3. 30-Day All-Cause Hospital Readmissions. This is the risk-adjusted rate of unplanned hospital readmissions for any cause within 30 days after discharge from an acute care or critical access hospital. This measure is computed at the TIN level.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2014QRUR-2016VM-DetailedMethodology.pdf

Hospitals – Where Are Your Patients Going?

Exhibit 7

Exhibit 7. Hospitals Admitting Medicare Beneficiaries Attributed to Your TIN Based on Primary Care Services Provided

Hospital Name	Hospital CMS Certification Number	Hospital Location	Number of Stays	Percentage of All stays
Total			220	**100.00%**
Redacted Hospital A	90210	Salt Lake City	80	36.36%
Redacted Hospital B	20006	SALT LAKE CITY, UT	40	18.18%
Redacted Hospital C	84103	Salt Lake City	30	13.64%
Redacted Hospital D	84107	Salt Lake City	20	9.09%
Redacted Hospital E	84403	Salt Lake City	20	9.09%
Redacted Hospital F	84106	Salt Lake City	20	9.09%

Hospital Accounting for Episodes of Care

Exhibit 8

Hospital Name	Hospital CMS Certification Number	Hospital Location	Number of MSPB Episodes	Percentage of All MSPB Episodes
Total			**67**	**100.00%**
Redacted Hospital A	867-5309	SALT LAKE CITY, UT	67	100.00%

Note – this table corresponds with a row from Exhibit 10 – this is a specific grouping of patients – MSPB

"MSPB Measure assesses the cost to Medicare of services performed by TINs during an MSPB episode, which comprises the period immediately prior to, during, and following a patient's hospital stay." - CMS

Questions?

Cost Domain

The next four slides will review key outputs related to cost.

Note: the majority of information in the QRUR is dedicated to cost.

Your TIN's Performance – by Cost Domain

Exhibit 9

Cost Domain	Number of Cost Measures Included in Composite Score	Standardized Performance Score (Cost Tier Designation)
Cost Composite Score	**6**	**1.20 (High)**
Per Capita Costs for All Attributed Beneficiaries	2	1.50
Per Capita Costs for Beneficiaries with Specific Conditions	4	1.59

When you are looking at your cost standardized performance score, lower is better. The description for this exhibit tells you how to read the output.

How Much Are These conditions costing per patient?

Exhibit 10

Exhibit 10. Per Capita or Per Episode Costs for Your TIN's Attributed Medicare Beneficiaries

Cost Domain	Cost Measure	Your TIN's Eligible Cases or Episodes	Your TIN's Per Capita or Per Episode Costs	Benchmark	Benchmark – 1 Standard Deviation	Benchmark + 1 Standard Deviation	Standardized Score	Included in Domain Score?
Per Capita Costs for All Attributed Beneficiaries	Per Capita Costs for All Attributed Beneficiaries	342	$16,843	$11,142	$8,292	$13,993	2.00	Yes
	Medicare Spending per Beneficiary	67	$22,061	$20,476	$18,878	$22,074	0.99	Yes
Per Capita Costs for Beneficiaries with Specific Conditions	Diabetes	103	$22,652	$16,150	$11,774	$20,525	1.49	Yes
	Chronic Obstructive Pulmonary Disease (COPD)	41	$32,988	$25,263	$17,938	$32,588	1.05	Yes
	Coronary Artery Disease (CAD)	72	$30,448	$18,570	$13,470	$23,670	2.33	Yes
	Heart Failure	50	$41,147	$28,474	$20,044	$36,904	1.50	Yes

Thinking larger: Do you see trends in your patients? Does this help paint a picture for what you could target with a Chronic Care Managment program?

Starting small: Could depression affect cost?*

*Ciechanowski PS, Katon WJ, Russo JE. Depression and Diabetes: Impact of Depressive Symptoms on Adherence, Function, and Costs. *Arch Intern Med.*2000;160(21):3278-3285. doi:10.1001/archinte.160.21.3278.

Exhibits 11 and 12
Give a More Detailed Cost Breakdown

Exhibit 11

Exhibit 11. Differences between Your TIN's Per Capita Costs and Mean Per Capita Costs among TINs with these Measures, by Category of Service: Per Capita Costs for All Attributed Beneficiaries and Beneficiaries with Specific Conditions

Service Category	Amount by Which Your TIN's Costs Were Higher/(Lower) than Benchmark:Per Capita Costs for All Attributed Beneficiaries	Amount by Which Your TIN's Costs Were Higher/(Lower) than Benchmark:Per Capita Costs for Beneficiaries with Diabetes	Amount by Which Your TIN's Costs Were Higher/(Lower) than Benchmark:Per Capita Costs for Beneficiaries with Chronic Obstructive Pulmonary Disease	Amount by Which Your TIN's Costs Were Higher/(Lower) than Benchmark:Per Capita Costs for Beneficiaries with Coronary Artery Disease	Amount by Which Your TIN's Costs Were Higher/(Lower) than Benchmark:Per Capita Costs for Beneficiaries with Heart Failure
Evaluation & Management Services Billed by Eligible Professionals in Your TIN*	($96)	($132)	($172)	($94)	($199)
Evaluation & Management Services Billed by Eligible Professionals in Other TINs*	($3)	$15	$85	$94	$218
Major Procedures Billed by Eligible Professionals in Your TIN*	($20)	($18)	($23)	($28)	($27)
Major Procedures Billed by Eligible Professionals in Other TINs*	($33)	($47)	($128)	($118)	($155)
Ambulatory/Minor Procedures Billed by Eligible Professionals in Your TIN*	($42)	($43)	($34)	($46)	($40)
Ambulatory/Minor Procedures Billed by Eligible Professionals in Other TINs*	($43)	($132)	($65)	$2	$267
Ancillary Services	($264)	($553)	($790)	($275)	$120
Hospital Inpatient Services	$1,996	$2,859	$4,553	$4,248	$2,104
Emergency Services Not Included in a Hospital Admission	$162	$60	$94	$248	$102
Post-Acute Services	$4,187	$5,004	$3,649	$7,623	$9,246
Hospice	$623	$430	$388	$813	$976
All Other Services**	($767)	($939)	$170	($590)	$61

These tables drill down on costs – you may or may not see these on your reports.

Exhibits 11 and 12
Give a More Detailed Cost Breakdown

Exhibit 12

Service Category	Amount by Which Your TIN's Costs Were Higher/(Lower) than the Benchmark: Medicare Spending per Beneficiary Measure
Evaluation & Management Services*	$103
Major Procedures and Anesthesia*	($138)
Ambulatory/Minor Procedures*	($79)
Ancillary Services	($47)
Hospital Inpatient Services	($2,148)
Emergency Services Not Included in a Hospital Admission	($20)
Post-Acute Services	$4,322
Hospice	($131)
All Other Services**	($272)

These tables drill down on costs – you may or may not see these on your QRUR report, depending on how much data CMS collected.

Note – This table is looking at the MSPB population.

The Supplementary Exhibits

So far, we have reviewed the 2014 QRUR report format.

Note that the 2014, 2015 and future 2016 reports are very similar, and have drill-down data in the “supplementary exhibits.”

These are available with the QRUR report and will help you better understand the outputs we just discussed.

The next three slides review one example of a supplementary exhibit.

Supplementary Exhibit 5: Per Capita Costs, by Categories of Service… All Beneficiaries Measure

Supplementary Exhibit 5. Per Capita Costs, by Categories of Service, for the Per Capita Costs for All Attributed Beneficiaries Measure

Service Category	Number of Your TIN's Attributed Beneficiaries Using any Service in this Category	Percentage of Your TIN's Attributed Beneficiaries Using any Service in this Category	Per Capita Costs for Your TIN's Attributed Beneficiaries	Benchmark Percentage of Beneficiaries Using Any Service in This Category	Benchmark Per Capita Costs	Amount by Which Your TIN's Costs Were Higher or (Lower) Compared to the Benchmark
ALL SERVICES	342	100.00%	$16,843	100.00%	$11,142	$5,701
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	342	100.00%	$2,583	100.00%	$3,065	($482)
Evaluation & Management Services Billed by Eligible Professionals	342	100.00%	$1,060	100.00%	$1,159	($99)
Billed by Your TIN	342	100.00%	$388	99.99%	$484	($96)
Primary Care Physicians	342	100.00%	$377	67.95%	$365	$12
Medical Specialists	0	0.00%	$0	20.70%	$55	($55)
Surgeons	0	0.00%	$0	9.12%	$22	($22)
Other Eligible Professionals	7	2.05%	$11	10.44%	$41	($30)
Billed by Other TINs	305	89.18%	$672	84.18%	$675	($3)

You can look at utilization and distribution, as well as how your costs compare to your peers.

Supplementary Exhibit 5: Per Capita Costs, by Categories of Service… All Beneficiaries Measure

Supplementary Exhibit 5. Per Capita Costs, by Categories of Service, for the Per Capita Costs for All Attributed Beneficiaries Measure

Service Category	Number of Your TIN's Attributed Beneficiaries Using any Service in this Category	Percentage of Your TIN's Attributed Beneficiaries Using any Service in this Category	Per Capita Costs for Your TIN's Attributed Beneficiaries	Benchmark Percentage of Beneficiaries Using Any Service in This Category	Benchmark Per Capita Costs	Amount by Which Your TIN's Costs Were Higher or (Lower) Compared to the Benchmark
ALL SERVICES	342	100.00%	$16,843	100.00%	$11,142	$5,701
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Surgeons	0	0.00%	$0	9.12%	$22	($22)
Other Eligible Professionals	7	2.05%	$11	10.44%	$41	($30)
Billed by Other TINs	305	89.18%	$672	84.18%	$675	($3)

You can look at utilization and distribution, as well as how your costs compare to your peers.

Supplementary Exhibit 5:
Per Capita Costs, by Categories of Service…
All Beneficiaries Measure

Durable Medical Equipment and Supplies	121	35.38%	$384	26.86%	$299	$85
Hospital Inpatient Services	98	28.65%	$5,028	20.87%	$3,032	$1,996
Inpatient Hospital Facility Services	89	26.02%	$4,353	17.16%	$2,600	$1,753
Eligible Professional Services During Hospitalization	97	28.36%	$675	20.64%	$432	$243
Billed by Your TIN	21	6.14%	$27	4.82%	$67	($40)
Primary Care Physicians	21	6.14%	$27	3.31%	$32	($5)
Medical Specialists	0	0.00%	$0	1.26%	$16	($16)
Surgeons	0	0.00%	$0	0.45%	$15	($15)
Other Eligible Professionals	0	0.00%	$0	0.36%	$4	($4)
Billed by Other TINs	92	26.90%	$647	20.26%	$364	$283
Primary Care Physicians	58	16.96%	$163	13.03%	$82	$81
Medical Specialists, Surgeons, and Other Eligible Professionals	90	26.32%	$484	19.56%	$282	$202
Emergency Services Not Included in a Hospital Admission	136	39.77%	$472	32.21%	$309	$162
Emergency Evaluation & Management Services	135	39.47%	$363	31.79%	$264	$99
Procedures	64	18.71%	$77	11.24%	$26	$51
Laboratory, Pathology, and Other Tests	73	21.35%	$4	12.04%	$2	$2
Imaging Services	101	29.53%	$28	21.26%	$18	$11
Post-Acute Services	91	26.61%	$5,950	14.71%	$1,763	$4,187
Home Health	76	22.22%	$1,603	10.56%	$558	$1,045
Skilled Nursing Facility	52	15.20%	$3,583	6.70%	$924	$2,659
Inpatient Rehabilitation or Long-Term Care Hospital	11	3.22%	$764	1.29%	$281	$483
Hospice	17	4.97%	$775	0.80%	$152	$623
All Other Services	267	78.07%	$899	75.27%	$1,420	($521)

Look to the gray boxes – where are we spending more?

The QRUR Helps You Find Patterns—Putting the Pieces Together

Quality:

- What data are we submitting?
- What data is CMS calculating?

Cost:

- How much is CMS spending on this care?
- How does this compare to our peers?
- What about our sub-populations?
- Are there areas that disproportionally affect cost?

Partners:

- Where are our patients going?

Patients:

- Who are the patients? What can we learn about their utilization?

Questions?

Connecting QRUR to MIPS - David

- Possible Equation Components
  - 3 variables
- Comment Period may yield difference in scoring methodology to be used.
- Report to be provided in 2018 for 2017 data, utilize this report to course correct.
- Consider local resources:
  - Q Corp Total Cost of Care reports
  - EDIE/PreManage connectivity shows ED utilization hospitalization information

David

Three Areas to Be Scored

1. Medicare spending per beneficiary (MSPB)
   - Clinicians who do not see patients in the hospital will not be attributed to any episodes and not scored on this measure.
   - Clinicians must be attributed to at least 35 cases to be scored on this measure.
   - Episodes will be attributed to the clinician who provided the plurality of Medicare Part B services to a beneficiary during an index admission.
2. Total per capita costs
   - Based on total costs/beneficiary.
3. Condition and treatment episode based measures on 10 measures.
   - Based on episode group measures assigned to the provider
     - Each measure will be scored based on deciled averages, similar to quality reporting per final rule, 1 POINT per decile (3rd decile in costs gets you 3 points on an episode group measure, 8th decile gets you 8 points).

David

Medicare Spending Per Beneficiary

Per QRUR:

- Evaluate resources
- Consider working on controlling resources external to your organization.

David

Total Per Capita Costs

Per QRUR:

The Per Capita Costs for All Attributed Beneficiaries measure is a payment-standardized…

annualized…

risk-adjusted… (AWV…helps)

specialty-adjusted …

measure that evaluates the overall efficiency of care provided to beneficiaries attributed to solo practitioners and groups, as identified by their Medicare Taxpayer Identification Number (TIN).

David

Cost Scores Are Risk Adjusted—What Is Risk Adjustment?

- Patients with more complications are typically more expensive.
- If they are not diagnosed and coded properly, and end up costing a lot of money, Medicare has no idea why.
- Diagnose and code patients accurately to reflect costs.
- This will result in what's called a "risk adjustment," which gives you a better score for cost categories on patients/services that cost more money.
- For more information, find out more about "RAF" scores.

David

Episode Group Measures: Sample Projection Based on Final Rule

Table 25—Example of Using Benchmarks for One Sample Measure To Assign Points

Decile	Average cost	Possible points
Benchmark Decile 1	$100,000 or more	1.0-1.9
Benchmark Decile 2	$75,893-$99,999	2.0-2.9
Benchmark Decile 3	$69,003-$75,892	3.0-3.9
Benchmark Decile 4	$56,009-$69,002	4.0-4.9
Benchmark Decile 5	$50,300-$56,008	5.0-5.9
Benchmark Decile 6	$34,544-$50,299	6.0-6.9
Benchmark Decile 7	$27,900-$34,543	7.0-7.9
Benchmark Decile 8	$21,656-$27,899	8.0-8.9
Benchmark Decile 9	$15,001-$21,655	9.0-9.9
Benchmark Decile 10	$1,000-$15,000	10

Note: The numbers provided in this table are for illustrative purposes only.

David

Coming Report

- Report to show/share methodology as well as actual data from 2017
- Standards still emerging, to be finalized soon.
- Expecting three components

David

Strategies

Annual Wellness Visit (AWV)

- Opportunity to correctly and accurately diagnose and update conditions.

Transitional Care Management (TCM)

- Opportunities to decrease readmissions.

Chronic Care Management (CCM) Visits

- Opportunity to maintain adherence to care plans, and reduce admissions/readmission. Help patient control conditions.

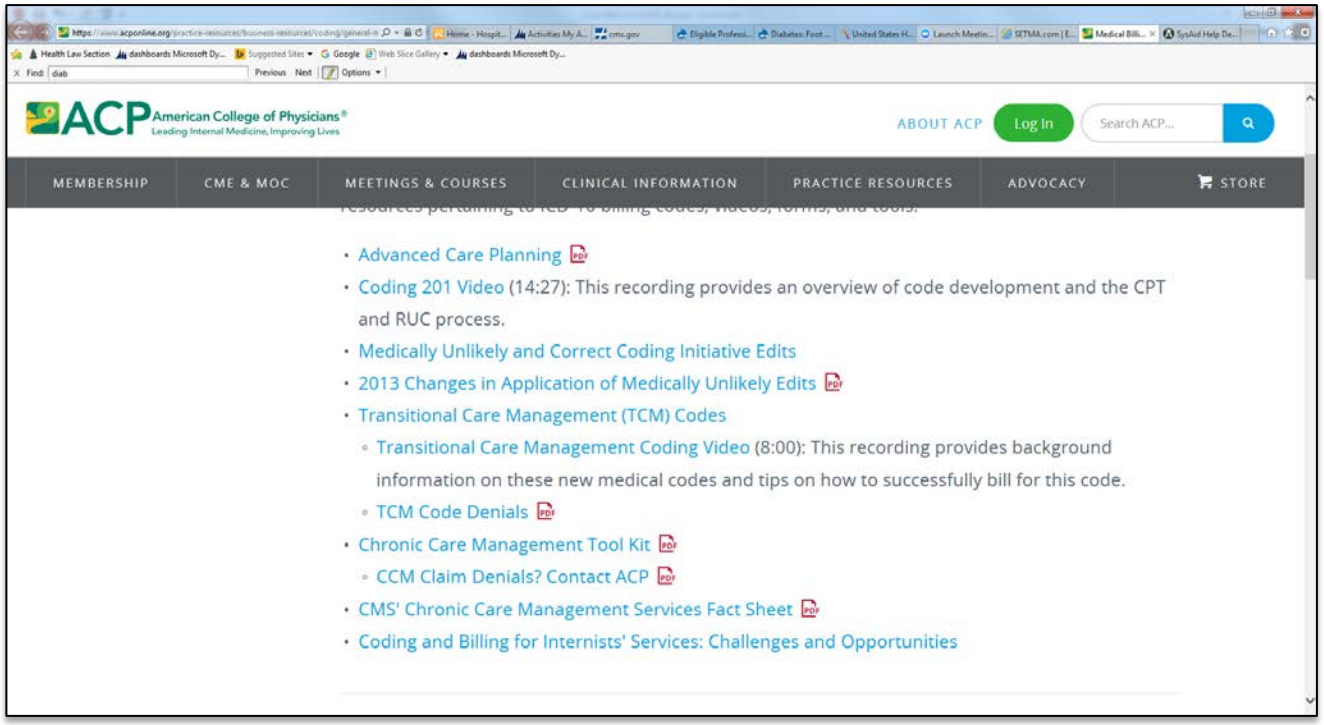
Self-Management – community resources

- Opportunity for patient to get resources to understand and live better with health conditions.

David

Resources for Billing TCM/AWV/CCM

- ACPONLINE.ORG



Annual Wellness Visit

- How many of you are doing annual wellness visits, or working with primary care providers who are doing them?
- Among the specialists, how many of you are familiar with the annual wellness visit?

- Improves diagnosis accuracy.
- Majority of visit can be done through support staff.

David

Chronic Care Management

How many are not providing this service?

- Get paid for telephone visits
- Process requires use of certified EHR
- Patient Portal
- Care Plans to be shared
- Access after hours

David

TCM Visits

- For patients discharged from hospitals and nursing homes.
- Call patient within 48 hours.
- Visit within 7–14 days.
- Includes medication reconciliation and adherence to care plan concepts for documentation/review.
- EDIE/PreManage offers solution.

David

PreManage

"…

- *Real-Time Notifications* Knowing when your most complex patients have ED visits, or are admitted or discharged from inpatient care is critical. With PreManage, Real-Time Notifications with actionable information are delivered according to the criteria you specify, and sent directly to the locations you specify. All without having to be asked.
- *Patient Risk Identification* Identifying who your patients at the greatest risk of readmission are can be tricky. The PreManage system intuitively and automatically identifies those patients most at risk, so that you can proactively work with these patients to reduce the likelihood of readmission. Better for you, and better for your patients. …"

http://collectivemedicaltech.com/what-we-do-2/premanage/

David

Pre-Manage

- PreManage works because of EDIE
- EDIE connects all hospitals to ED utilization for all Oregon hospitals.
- Work with your local CCO to get access.
- CCOs like to grant access in the communities, as it benefits not only Medicaid patients, but Medicare as well.

David

Cost-Saving Improvement Activities

Many of the Improvement Activities, including but not limited to:

- Self-Management
- Million Hearts
- State PCPCH Program
- Behavioral Health Home Initiative

David

Resources

- Outside of QRUR
- Total Cost of Care Reports from Q-Corp.
- PreManage (EDIE tool) for real time information on ED visits and hospitalizations.
- Improvement Activities that support reduced costs.

David

Total Cost of Care

- Q Corp has provided reports to most clinics in the state.
- Provides medians and benchmarks for providers within commercial, state and federal payer programs.

David

Questions?

Call or email HealthInsight

- 503-382-3954 (David Smith)
- qpp@healthinsight.org

David

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