Learning Forum Friday

2016 Quality Resource and Use Report (QRUR) Review

Questions and Answers

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November 3, 2017

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Questions and Answers

Question 1:	**How can the QRUR be used to help the practice meet its goal and what tables you should look at?** (received prior to the WebEx) Hopefully our review of the QRUR answered your question. Please refer to the slides of the presentation to see how the information on the cover page and the identified exhibits and tables will assist you and are going to be important. I encourage you to download the report and look at it.
Question 2:	**If an informal review of the PQRS was denied and a decrease for 2018 was received but the one percent reduction is pending, do I stand a chance of the decision being reversed for?** (received prior to the WebEx) There's always a possibility of anything, however, the QRURs are comprised of two different areas that we know —quality and cost. So, with the denial of the informal review and you're receiving that negative two percent, you probably will still be subjected to the 1% negative adjustment on the value modifier based on the cost. Something must have happened with the PQRS where you didn't participate or you had an issue with a vendor. It never hurts to request an informal review, but make sure that when you request one, that you submit everything necessary, because you don't get a second chance at an informal review; once you file the review and a determination is made, that determination is final.
Question 3:	**Could you please review your suggestions on how to lower the cost for Medicare beneficiaries?** Some suggestions on what you might want to ask yourself that might help you to reduce costs to the beneficiaries would include: • How can you work with or educate the patient? • Are there guidelines you can give the patient for when to call the office versus going straight to the hospital? • How can you work with the patient's PCP, family members and/or other care givers? • Can you refer the patient to an urgent care center instead of the hospital if our office is closed? • Would the patient benefit from a Chronic Care Management Program? • Is your practice participating in the CMS Transitions of Care Program? Example: You have a patient that has diabetes and every time his sugar increases or gets high, he goes straight to the emergency room. What are any guidelines you could give that patient in advance, such as, "Before you go to the hospital or

	present to the ER, give us (or your primary care physician) a call and let's see what we can do to get your sugar down before you head that direction."
Question 4:	**Are specialty benchmarks determined by peers in that specialty or are primary care providers included?** The term "peer group" refers to the comparison group used to determine comparative Benchmarks for scoring purposes in this report. With the exception of the All-Cause Hospital Readmission measure that the Centers for Medicare & Medicaid Services (CMS) calculates from Medicare claims, the peer group for all quality measures is defined as all Medicare-enrolled Taxpayer Identification Numbers (TINs) that had at least 20 eligible cases for a given measure in calendar year 2016. The peer group for the All-Cause Hospital Readmission measure is defined as all Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program with at least one eligible case and all non-Shared Savings Program TINs nationwide with 10 or more Eligible Professionals that had at least 200 eligible cases. For all cost measures except Medicare Spending Per Beneficiary, the peer group is defined as all TINs nationwide that had at least 20 eligible cases for the measure in calendar year 2016. For the Medicare Spending per Beneficiary measure, the peer group is defined as all TINs nationwide with at least 125 eligible episodes.
Question 5:	**Who has access to the QRUR?** Anyone in your office can request a copy of the QRUR by using/establishing an EIDM account. CMS does not automatically send the reports; you must register for an account and request the report. Many large organizations assign an individual within their administration with the responsibility of monitoring the QRUR and other feedback reports. If you are that individual in your organization, it is very important that you share the information you receive with all of the clinicians and staff in your practice. It takes a team effort to decrease costs and improve patient outcomes. Everyone, from the person greeting the patient at the door to the clinician seeing the patient, is part of the care each patient receives. Everyone in your office should be aware of what the feedback is that is found in these reports.
Question 6:	**How do I download the slides?** The slides can be downloaded from www.HSAG.com/LFF. You will also find slides from previous webinars that you might find helpful if you were unable to attend those events. For example, if you are interested in establishing your own EIDM account, there are slides that walk you through that process.

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Question 7:	**If I didn't download the modifier, do I need to do something different for PQRS because I will be reporting then?** The value modifier and peak adjustments effectively end with the 2018 reporting period. Your 2017 reporting period will be 2019. Utilize the QRUR to maximize any incentives that that you could potentially get for 2019 by reviewing the quality measures and being strategic in the quality measures that you choose to report. Make sure you are at least obtaining the benchmark for them because the performance on quality measures is the largest portion of your score. It is important to review your list of patients that have been admitted into the hospital and then be proactive in reducing additional admissions for those patients going forward. Review the data made available through the reports from the year prior and then flag those patients as hospital frequent flyers. Once those frequent flyers have been identified, you can implement care management plans to reduce admissions.
Question 8:	**How is TIN size determined?** The number of practices and individuals identified in the Provider Enrollment Chain and Ownership System (PECOS) are used to determine your practice size, as well as the number of EPs that submitted claimed to Medicare under the 2016 period. It is critical that you make sure that PECOS is up-to-date, that you add and remove providers as soon as they join or leave your practice.
Question 9:	**Can you talk about the field testing, and provide recommendations on how to view and respond to the survey?** Recently CMS sent out emails regarding the field testing to TINs that come for the measures. You can participate in the field testing by going through your EIDM account under the value modified section and selecting the option to participate.
Question 10:	**Why would information about diabetes show up on my QRUR if I am a pain management specialist?** If a patient is coming to you to control the pain that he or she is having that is associated with their diabetes instead of going to their primary care physician (PCP), that patient may show up under you rather than the PCP. You may need to educate the patient and remind him/her that they need to see their PCP. Or, you may have to reach out to their PCP to let them know what is happening.
Question 11:	**Do you have any suggestions on how to improve on this section? It seems like we have no control.** Review the list of patients in Table 2 of your report. Discuss the feedback with your staff and then create a list of topics to talk with patients and families to improve those issues. Find ways to increase patient and family engagement.

This material was prepared by Health Services Advisory Group, the Medicare Quality Improvement Organization for Arizona, California, Florida, Ohio, and the U.S. Virgin Islands, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. QN-11SOW-D.1-11212017-01