TIPS FOR MEDICAL GROUP PRACTICES TO UNDERSTAND AND USE THE 2012 QUALITY AND RESOURCE USE REPORT (QRUR) DRILL-DOWN REPORTS

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BACKGROUND AND PURPOSE OF THE "DRILL-DOWN" REPORTS

The 2012 Quality and Resource Use Report (QRUR) drill-down reports supplement the information provided in the QRURs, so that medical group practices have a better sense of their patient population, their patients' use of healthcare services, and awareness of the other providers involved in their patients' care. This report's primary sources of information are the 2012 Medicare Part A and Part B claims submitted by all providers who treated beneficiaries attributed to a medical group practice, even if the providers were not affiliated with the group.

Specifically, these drill-down reports build on the information in the QRUR and present:

1. Information about the Medicare beneficiaries attributed to your medical group practice
2. Information about the physician and non-physician eligible professionals billing under the group's TIN
3. Data on the hospital admissions for attributed beneficiaries

This tips sheet suggests ways your medical group can use data from the drill-down reports to improve quality of care, streamline resource use, and identify care coordination opportunities for your beneficiaries. Tables 1 and 3 provide data your medical group can use to improve care coordination for patients attributed to your group practice. Table 2 gives data to support your group's practice management systems.

TABLE 1: Medicare Fee-for-Service (FFS) Beneficiaries Attributed to the Medical Group Practice, Selected Characteristics, 2012

Table 1 provides information about the Medicare beneficiaries attributed to your medical group practice. Your medical group practice can use these data as a starting point for examining systematic ways to improve and maintain delivery of high quality and efficient care to beneficiaries. The table is divided into sections that describe patient characteristics, specific Medicare claims data, the percentage of cost sources for each patient, and whether or not the patient had one or more of 4 chronic conditions requiring more integrative care. These data can be downloaded in MS Excel, so you can perform data analysis and focus on groups of patients—such as those in the 4 chronic condition subgroups—whose care delivery process you may want to examine more closely, to see if there is potential to improve quality of care. For example, you can use the Excel file to filter or sort the data to identify groups of patients with a particular chronic condition or a set of conditions, or patients who have a high ratio of evaluation and management services outside of your medical group practice, or patients with the highest HCC risk score, among other data. The tips below highlight other ways in which you can use the data in Table 1 to improve care for patients attributed to your medical group.

1. **How can my medical group use the listing of patients attributed to our group practice?**

   You can use the data to confirm that your group furnished services to these patients. Check the information in the column titled "Date of Last Claim for Professional Services Filed by TIN" to make sure that CMS captured this information correctly. The HIC number will allow your group to match the listed beneficiary with your practice management system's records.

2. **How can we learn about the services other healthcare professionals gave to the patients attributed to our medical group practice?**

   The breakdown of costs by category in Table 1 shows a range of service types and providers. Your group can use this information (as well as the information about the hospitals admitting your attributed beneficiaries shown in Table 3) to learn general information about the relative costs of different types of services used by specific patients. By reviewing your own records and the records of hospitalizations, you can determine, for specific patients, which services you provided, which services were provided by consultants who reported to you, and which hospital-based services were administered by providers outside of your group. If you discover unexpected patterns of service use for specific patients attributed to your practice, you may wish to ask other providers for additional medical records to aid efforts in coordinating care. This also presents an opportunity for your providers to talk to these patients to better understand their full range of health care needs and the additional services they receive.

3. **How can we use data in the "Number of Primary Care Services Provided by TIN" and "Percent of Primary Care Services Billed by TIN" columns?**

   Sort the data in the "Percent of Primary Care Services Billed by TIN" column in ascending order to identify the patients attributed to your medical group practice who got most of their services outside of your medical group practice. This will allow you

to see which services were received outside of your group practice and why, in some cases, a high percentage of evaluation and management services were provided outside of your medical group.

4. How can we use the data in the "Date of Last Hospital Admission" column?

Compare values in the "Date of Last Hospital Admission" column with values in the "Date of Last Claim for Professional Service Filed by TIN" column to identify patients who did not have a visit with any provider in your medical group practice following inpatient care. This allows you to examine why the patients attributed to your medical group did not receive follow-up care.

5. How should we interpret and use the HCC risk score?

The HCC risk score is derived from prior year Medicare claims data for each patient and gives an estimate of the relative burden of illness for that patient as reflected by those claims. Use this column to identify high and low risk patients in your practice. The HCC risk score percentile is based on Medicare fee-for-service (FFS) beneficiaries nationwide, with 1 being low and 100 being high (83, for example, means that 83 percent of beneficiaries nationwide had relatively lower burden of illness). Higher scores tend to be associated with more severe illness (most often, multiple chronic conditions.) As a result, these patients are at risk for having conditions that would benefit from more intensive efforts by your practice at managing their chronic illness, including closer monitoring of the patient's condition, actively coordinating care, and supporting patients' self-management. Such efforts have been shown to cut costly worsening of illness and improve patients' quality of life. You may also seek opportunities for more coordinated care for patients with low risk scores who, in the prior year, had a high percentage of total costs in unexpected categories of services (such as emergency services).

You can sort data by HCC risk score percentile, in descending order, to see the high- and low-risk patients in your practice. Once you identify a risk population, you can examine the cost category percentages to see if there are opportunities for more coordinated care for your selected patients.

6. How can we use the data in the "Percent of Total Costs, by Category of Services, All Providers" columns to improve care for the patients we manage?

This section gives a breakdown of costs for your patient for the year. Use these columns to identify trends in service use among patients attributed to your group practice. Some patterns of use may show opportunities for you to improve care coordination. For example, if your practice gave a low percentage of all primary care services for a patient with substantial costs devoted to procedures, ancillary or hospital services, there may be opportunities for you to further engage this patient in care management and coordination. Similarly, patients who have a high proportion of total costs for emergency services may benefit from outreach to improve their use of primary care for urgent concerns, as well as additional efforts at care coordination. Patients who had substantial prior year costs in post-acute care may be at risk of frailty or re-hospitalization and, therefore, may also benefit from closer monitoring. You can sort data in descending order in each column to identify high percentages in use of specific service categories for your patients.

7. How can we use the information on the 4 chronic condition subgroups to improve how we care for our patients?

These 4 subgroups reflect widespread chronic conditions among Medicare beneficiaries, conditions for which improved management has been shown to improve patient outcomes as well as efficiency of care. The QRURs give general information regarding the patterns of utilization for patients with these chronic conditions who are attributed to your group practice. The drill-down reports show which specific patients were in each of these groups. Therefore, you can use this information to identify individual patients with these conditions who may benefit from improved chronic illness management. For example, a higher hospital admission rate for a patient with congestive heart failure represents an opportunity to re-examine how your practice manages such patients. You may decide to update or change patients' preventive care, patient self-management support, patient monitoring or the medical treatment plan for your patient. These patients may also benefit from greater efforts at care coordination across providers.

In general, it may be helpful to sort the data in the column labeled "Chronic Condition Subgroup," and the associated sub-columns (Diabetes, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease [COPD], and Heart Failure), to identify beneficiaries with one or more of the 4 conditions. For each condition, use the data in the "Percent of Total Costs, by Category of Services Provided, All Providers" to see whether a specific patient's pattern of utilization suggests an opportunity for improved care.

TABLE 3: Attributed Beneficiaries' Hospital Admissions for any Cause, 2012

Table 3 gives details about the medical group's attributed patients' hospitalizations in 2012, by individual patient. Data is broken down by patient and the admitting hospital, along with the principal diagnosis associated with the admission.

Note: Hospitalizations with a primary diagnosis of alcohol and substance abuse are **not** included in this table.

Table 3 also shows whether the hospital admission was the result of an emergency department evaluation, whether it was the result of an ambulatory care sensitive condition (ACSC), or whether it was a readmission within 30 days of a prior admission. The table also indicates the date of discharge and the subsequent care environment. You can use these data as a starting point, along with your group's medical records, to examine systematic ways to improve or maintain the delivery of high quality and efficient care to patients attributed to your practice. You can also link the data in Table 3 with data in Table 1 to understand the overall scope of services that a patient admitted to the hospital has been receiving. Furthermore, you can study this combination to see how to better align and coordinate these services, how information may have been shared across the continuum of care, and how a patient may become better engaged in his care—all of which might have worked to prevent the hospitalization.

1. **How can the data in the "Admitting Hospital" column help our group care for patients attributed to our practice?**

   These data allow you to determine which hospitals are providing inpatient services to your patients. Examine the hospital data, together with the principal diagnosis on admission data, for possible linkages. These steps present opportunities for better care coordination and management of care transitions for your patients.

2. **How can we identify preventable hospital admissions using the data provided in this table?**

   This table has 3 key categories: ACSC admissions, admissions via the emergency department (ED), and 30-day readmissions. Each category represents an opportunity for you to identify and take another look at patients with potentially preventable admissions.

   a. **Ambulatory Care Sensitive Condition (ACSC) Admissions:** Effective coordinated care has been shown to cut resource use for patients with conditions in this category, including asthma, chronic obstructive lung disease, congestive heart failure, diabetes mellitus, and hypertension. Therefore, this is an important group of patients on which to focus. Use the column "ACSC Admission" to identify patients attributed to your group practice who were admitted for one of the diagnoses in this category. For this group of patients, improved access to care, care coordination, appropriate preventive services, patient self-management support, and proactive monitoring of patient conditions may lead to fewer instances of worsening illness, and therefore, less emergency care and fewer hospital admissions.

   b. **Admission via the Emergency Department (ED)**: Sort the column "Admissions via the ED" to identify patients that needed non-elective hospital

services. Moreover, from the column in Table 1, "Percent of Total Costs, by Category of Services Provided, All Providers," you can calculate the percentage of the overall costs that came from emergency department use. Patients who disproportionately use the ED in their medical care are a subset that may benefit from more intensive primary care, including improved access for urgent concerns, as well as better care coordination. Sort the column "Admissions via the ED" to identify patients that needed non-elective hospital services.

c. **Readmissions**: Filter the data in the column titled "Followed by All-Cause Readmissions within 30 Days" to focus on patients readmitted, for unplanned causes, to the hospital within 30 days of discharge. You can use this to study how your care pathways and collaboration with the hospital might be improved to identify and follow-up with patients discharged from the hospital, in order to cut down on readmissions.

3. How can we use data in the "Principal Diagnosis" column?

Sorting data in the "Principal Diagnosis" column allows you to more closely examine the conditions that are drivers of your patients' care. This exercise may be particularly beneficial for primary care practices that treat a broad range of diseases. If you see that certain diagnoses seem to appear frequently, you may find it useful to pay further attention to how your group manages that set of patients.

4. How can we use the information on hospital discharge status to improve the care that we provide?

Discharge information highlights which patients were discharged to post-acute care last year. If, for example, you notice patterns of adverse outcomes (such as a 30-day readmission following discharge) attributed to a post-acute care provider, this might represent an opportunity to refer to your medical records for this particular provider and contact them to see if there are ways to improve communication and data sharing. Better collaboration and care coordination efforts with post-acute care providers may prevent complications for this patient or others that you share. Sort or filter data in the column "Discharge Status," in the Discharge Disposition section, to find patients discharged to home, home care, skilled nursing facilities and other post-acute care facilities.

TABLE 2: Physicians and Non-Physician Eligible Professionals Billing Under the Medical Group Practice TIN, Selected Characteristics, 2012

Table 2 provides information about the eligible professionals who billed under the medical group practice's TIN. This table lists the eligible professional national provider identifier (NPI) number and name, physician or non-physician eligible professional attribution, specialty designation, and the date of the last claim this eligible professional billed under the TIN. In an effort to be transparent, we disclose this information for your review and understanding.

1. **What should we do if an eligible professional listed in the report no longer belongs to our group?**

   Only providers who billed for specific services under your group's TIN are listed—by date of service. If this information appears inaccurate, review your practice management system's setup, make sure the provider in question has been inactivated, or let the medical group charge entry staff know the proper charge entry procedures. Moreover, you should contact your Medicare Administrative Contractor (MAC) to find out how you can correct the claims, if you believe a provider was paid erroneously.

2. **What should we do if some of the specialties for the eligible professionals in our group are listed incorrectly in the table?**

   Providers whose specialty is listed incorrectly should update their record on the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) at https://pecos.cms.hhs.gov/pecos/login.do.

FEEDBACK FOR CMS

1. **What other pieces of information would you like to know about your beneficiaries and the care that they get from other Medicare providers?**

   You and other providers in your practice can contact CMS at pvhelpdesk@cms.hhs.gov to share your thoughts about the content and format of these reports. Our goal is to improve the reports based on the feedback that we receive.

2. **Would you like to share some other ways you have used these data?**

   We are interested in learning how you and your colleagues have used the report data in ways not mentioned in this tips sheet. Share your tips at pvhelpdesk@cms.hhs.gov.