Tips to Understand and Use the 2015 Supplemental Quality and Resource Use Reports (QRURs)

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The 2015 Supplemental Quality and Resource Use Reports (QRURs) provide information to medical group practices and solo practices on their resource utilization for the management of episodes of care ("episodes") for their Medicare fee-for-service (FFS) patients. The 2015 Supplemental QRURs are for informational purposes only and provide actionable and transparent information on resource use to assist medical group practices and solo practices, as identified by their Medicare-enrolled tax identification number (TIN), to improve their practice efficiency.[1] Payments presented in the 2015 Supplemental QRURs reflect Medicare allowed amounts, which include both Medicare trust fund payments and beneficiary deductible and coinsurance. Payments are referred to throughout the reports as "cost to Medicare" or "cost." This report is limited to 23 major episode types and an additional 44 episode subtypes, resulting in 67 total reported episode types. The *Detailed Methods of the 2015 Medical Group Practice Supplemental QRURs* (abbreviated as "*Detailed Methods*") and the *Episode Definition* files provide the methodology for each episode type.[2]

The 2015 Supplemental QRURs have four exhibits and three drill down tables that allow TINs to identify patients, eligible professionals (EPs), and facilities that are high in cost and to investigate sources of excess cost in comparison to the national average. In addition to the exhibits and drill down tables, the reports include three appendices that provide definitions for terms, service categories used in Exhibits 3 and 4, and service categories used in the drill down tables. These appendices provide a simple reference for key definitions in the reports. The purpose of this document is to describe the reported data and to help TINs identify care coordination opportunities and streamline resource use.[3] The following sections detail how your TIN can use the information reported in each exhibit and drill down table.

EXHIBIT 1: SUMMARY OF ALL EPISODE TYPES

Exhibit 1 provides a graphical depiction of the percent difference between your TIN's average cost to Medicare and national average cost to Medicare for each episode type, for comparison purposes. This percentage is calculated separately for each episode subtype.[4]

[1] The phrase "TIN" is used throughout this document to refer to medical group practices or solo practices.
[2] The *Detailed Methods, 2015 Supplemental QRURs* document and *Episode Definition (2015)* files are located under the Downloads section of this CMS webpage (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Episode-Costs-and-Medicare-Episode-Grouper.html).
[3] All results should be interpreted with caution for episode types with fewer than ten episodes attributed to your TIN.
[4] A detailed explanation of major episode type and subtypes are included in Section 1.2 of the *Detailed Methods* document.

Negative percentages indicate that your TIN's average attributed episode cost to Medicare is *lower* than the national average; *positive* percentages indicate that your TIN's average attributed episode cost to Medicare is *higher* than the national average. Lower average episode cost to Medicare indicates better performance on the episodes presented in this report.

Medical group practices and solo practices are encouraged to use Exhibit 1 to compare the cost to Medicare of their episodes to the national average. All payment data reflect allowed charges, which include Medicare Part A and Part B payments as well as beneficiary deductibles and coinsurance, and are risk-adjusted and payment standardized. A detailed description of risk adjustment and calculation of episode cost are provided in Section 4 of the *Detailed Methods* document.

EXHIBIT 2: FREQUENCY AND COST TO MEDICARE FOR ALL EPISODE TYPES

Exhibit 2 shows the number, frequency, and cost to Medicare of all episode types attributed to your TIN and compares those statistics to the national average. Exhibit 2 provides more detailed episode subtype level information and provides the underlying data used in the graphical depictions in Exhibit 1. As mentioned in the previous section, all costs shown in Exhibit 1 and 2 are risk-adjusted and payment standardized costs. If your TIN's average risk-adjusted costs to Medicare are *higher* than the national average risk-adjusted costs to Medicare for an episode type, then the episodes attributed to the TIN cost *more* than expected given the patient population. Conversely, if your TIN's average risk-adjusted costs to Medicare are *lower* than the average national risk-adjusted costs to Medicare, then the episodes cost *less* than expected given the patient population. Your TIN can use the information in this exhibit to determine which episode types and practice areas require more attention and analysis for improvement.

EXHIBIT 3: EPISODE TYPE SUMMARY

Exhibit 3 shows the risk score, costs to Medicare broken down by episode components and service categories (e.g., inpatient hospital and post-acute care services), and the top five billing hospitals, skilled nursing facilities, home health agencies, and eligible professionals within and outside of your TIN for a given episode type. To improve the clarity and actionability of the reports, a separate version of Exhibit 3 is created for each individual episode type and subtype. There are four sections of Exhibit 3 to allow your TIN to examine the cost to Medicare of episodes of a given type, and the following discusses each section in turn.

Exhibit 3.A: Your Episode Type Summary

Exhibit 3.A presents summary cost to Medicare information about all episodes attributed to your TIN that are of the same episode type. If your TIN's average non-risk-adjusted, payment standardized episode cost is *lower* than your TIN's average risk-adjusted episode cost, then your TIN's patient population is *more complex* relative to other patients with the same episode type. The complexity of your TIN's patient population for this episode type is also reflected in the average beneficiary risk score percentile.

Exhibit 3.B: Average Cost to Medicare for Episode Components

Exhibit 3.B provides the average non-risk-adjusted, payment standardized cost to Medicare of each episode component for your TIN and for the national average: "treatment" and "clinically associated services". This information can be further investigated by looking at Exhibits 4.A - 4.C, which provides detailed cost breakdown by service categories for the entire episode, for the "treatment" service component, and the "clinically associated services" component.

Treatment services comprise the medical care occurring during the initial care directly related to managing the illness, and clinically associated services are all services not classified as treatment services. If your TIN has a *high* fraction of episode costs in the "treatment" category, then most of the care in the episode occurred on days managed by your TIN. If your TIN has a *high* fraction of episode costs in the "clinically associated services" category, then other TINs provided most of the care for the patient's episode. Your TIN can use this information to identify episode types that would benefit from increased care coordination with providers outside of your TIN. More information on the "treatment" and "clinically associated services" components can be found in Section 6.3.2 of the *Detailed Methods* document.

Exhibit 3.C: Average Cost to Medicare for Select Service Categories in Episode

Exhibit 3.C presents the average non-risk-adjusted, payment standardized cost to Medicare of select service categories for your TIN and for the national average. This information provided in Exhibit 3.C includes the cost to Medicare of services provided in the inpatient (IP) hospital setting for IP stays that triggered the episode and for all other IP stays. The exhibit also provides the cost to Medicare of physician services during hospitalization, outpatient evaluation and management (E&M) services, major procedures, and the cost to Medicare for post-acute care (e.g., SNF and HH). Medical group practices and solo practices can view which service category has the highest cost to Medicare for the given episode type and investigate further in Exhibit 4.A.

Exhibit 3.D: Top Five Highest Average-Billing Providers Treating Episode

Exhibit 3.D lists the top five billing hospitals, skilled nursing facilities (SNFs), home health agencies (HHAs), and eligible professionals (EPs) within and outside of your TIN that are involved in the care of the attributed episode. Medical group practices and solo practices can combine these data with the episode specific information provided in the drill down tables to pinpoint facilities and EPs with whom they may wish to better coordinate care, in order to improve the average cost per episode.

EXHIBIT 4: EPISODE TYPE SERVICE CATEGORY COST TO MEDICARE BREAKDOWN

Exhibit 4 summarizes the cost to Medicare, by service category, of episodes of a given episode type attributed to your TIN for the entire episode and for the treatment and clinically associated services components of the episode. All costs are payment standardized but not risk-adjusted because risk adjustment is performed at the entire episode level. Just like Exhibit 3, a separate version of Exhibit 4 is created for each individual episode type and subtype. Exhibit 4.A presents a breakdown of the total cost to Medicare for the episode, Exhibit 4.B presents a breakdown of the cost to Medicare for the treatment component of the episode, and Exhibit 4.C presents a breakdown of the cost to Medicare for the clinically associated services component of the episode.

Medical group practices and solo practices can use Exhibit 4 to identify high-cost services by assessing the average utilization and average cost to Medicare for specific service categories for each episode type. In addition, your TIN can identify which services are influencing the total average cost to Medicare within an episode type and compare their service category utilization and cost to the national average by looking at the percent difference in average non-risk-adjusted cost to Medicare. The percent cost ordered by other groups allows your TIN to consider your relative influence on each service category and promote care coordination. The list of service categories is detailed in Appendix 2 of the reports and Appendix C of the *Detailed Methods* document.

DRILL DOWN TABLES: EPISODES ATTRIBUTED TO YOUR MEDICAL GROUP PRACTICE

The drill down tables provide information for each individual episode attributed to your TIN, including the episode type, the beneficiary's risk score, the episode start date, and physician and non-physician costs to Medicare by service category. The information provided in the drill down tables supplements the episode-level statistics provided in Exhibits 1 through 4. These tables are intended to increase the actionability of reports and provide beneficiary-specific

information. Every episode that is attributed to your TIN is included in the drill down tables. The drill down tables are created for each individual episode type and subtype.

The drill down tables can be downloaded into a spreadsheet so your TIN can perform data analysis and identify opportunities to improve care coordination and efficiency. For example, the spreadsheet can be filtered or sorted to identify groups of patients that are most involved in the use of a specific service, such as E&M visits or use of a particular hospital. Unless otherwise noted, all costs are actual Medicare payment amounts (non-payment standardized and non-risk adjusted) to allow your TIN to compare this data to your own records. The following sections provide an overview of each of the three drill down tables.

Table 1: Episode-Level Summary Information

Table 1 provides an overview of each individual episode to assist your TIN in identifying specific episodes, lead EPs, or hospital or post-acute care providers that treated the episode. Table 1 includes the beneficiary's risk score, summary information about the lead EP and the number of E&M visits and Physician Fee Schedule (PFS) costs during the episode, and lists the providers, hospitals, SNFs, and HH Agencies that provided care for the beneficiary. This section includes a few directed questions and answers to help make it easier for your TIN to understand how to use the data presented in Table 1.

1) How can TINs use the listing of attributed beneficiaries?

Medical group practices or solo practices can use the data presented in this table to determine the episodes with their highest involvement and confirm that they provided the specified services to the beneficiaries listed. The health insurance claim (HIC) number, date of birth, and gender data of the beneficiaries provide your TIN with identifying information to match with your management system records. In addition, your TIN can use the episode start date to understand the period of the patient's care included in the episode.

2) How can the identification of a lead eligible professional (EP) help a TIN manage care for attributed beneficiaries?

The "lead EP" is provided for informational purposes. By identifying lead EP(s), along with the EP's specialty, your TIN can pinpoint potential areas of high cost care and opportunities for improved care coordination. Your TIN can also use the lead EP to help recognize which members of your practice are managing your attributed episodes, which can allow you to provide more targeted feedback to professionals in your practice. More information about the identification of lead EP(s) can be found in Section 5.2 in the *Detailed Methods* document.

3) What services are included in the E&M visits and PFS costs shown in Table 1?

Table 1 includes data on total E&M visits and total PFS costs to Medicare during the episode. All E&M visits billed by EPs that are grouped to the episode are included in the count of E&M visits. The total count of E&M visits as well as the count billed by your TIN and by the lead EP(s) are presented in Table 1. All services billed on carrier claims (also known as Physician/Supplier Part B claims (PB)) by EPs that are grouped to the episode are included in summing the total PFS costs. The total PFS costs is displayed along with the PFS costs billed by your TIN and by the lead EP(s).

The data in Table 1 on E&M visits and PFS costs are for informational purposes only and are not used for attributing episodes to your TIN. See Section 5 in the *Detailed Methods* document for more information on the attribution methodology.

4) How can TINs use the data in the "Risk Score Percentile" column?

The risk score percentile is a relative measure of the beneficiary's predicted episode spending. A higher risk score percentile indicates that the beneficiary was predicted to have relatively higher costs for this episode type or subtype. Your TIN can use this number to understand the medical complexity of the beneficiary as compared to the medical complexity of all other beneficiaries nationally who have an episode of the same type.

5) How can TINs use the data on the first two hospitals, skilled nursing facilities (SNFs), or home health agencies (HHAs) that provide care to the attributed beneficiary?

Table 1 provides the first two hospitals and SNFs and/or HHAs providing care to the attributed beneficiary. This column provides your TIN another measure, in addition to E&M visits and PFS costs, to gauge your involvement in any given episode. Your TIN could sort the data to examine your performance on the episodes in which you were the most involved. In addition, your TIN can use these data to identify potential differences in care among providers.

Table 2: Breakdown of Physician Costs to Medicare Billed By Your TIN and Other TINs

Table 2 provides detailed information on physician costs to Medicare billed by your TIN and other TINs for episodes of a given type that were attributed to your TIN. All costs are actual Medicare payment amounts (non-payment standardized and non-risk adjusted) to allow you to compare these data to your TIN's own records. Appendix Table C.4 of the *Detailed Methods* document specifies the methodology used to identify physician costs billed by your TIN and by other TINs.

Medical group practices or solo practices can use the data on the breakdown of physician cost by service category to improve care for the patients they manage and to identify trends in service use among attributed patients. Some patterns of use may show opportunities for your

TIN to improve care coordination and management. For example, if your TIN 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 your TIN to further engage this patient in care management and coordination. Patients who had substantial costs to Medicare in post-acute care may be at risk of frailty or re-hospitalization and, therefore, may also benefit from closer monitoring. Your TIN can sort data in descending order in each column to identify high percentages in use of specific service categories for attributed patients.

Table 3: Breakdown of Non-Physician Costs to Medicare

Table 3 provides detailed information on non-physician costs to Medicare for episodes of a given type that were attributed to your TIN. Just as in Drill Down Table 2, all costs are actual Medicare payment amounts (non-payment standardized and non-risk adjusted). Your TIN can use Table 3 in similar ways to Table 2 to recognize patterns in care delivery for non-physician costs and identify opportunities for improvement in care coordination and management.