Tips for Medical Group Practices to Understand and Use the 2012 Supplemental Quality and Resource Use Reports (QRURs)

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The 2012 Supplemental Quality and Resource Use Reports (QRURs) supply actionable and transparent information that can support medical group practices in efforts to gauge and improve the efficiency of medical care provided to patients with certain medical conditions. The reports are designed to assist medical group practices in identifying opportunities for coordination and efficiency improvements. To achieve this goal, the 2012 Supplemental QRURs provide information on medical group practices' health care service resource use for common episodes of care ("episodes") that occurred during 2012.[1] Episodes include the costs of services occurring across settings over a defined period of time and encompass the relevant diagnoses, treatments, and aftercare (including post-acute care) for a clinical condition. The 2012 Supplemental QRURs are for informational purposes only and include episodes comprising a range of medical situations including acute hospital events, major treatment procedures, and chronic conditions. The *Detailed Methods of the 2012 Medical Group Practice Supplemental QRURs* (also, "*Detailed Methods*") provides the methodology for the episode-based cost measures.[2]

The 2012 Supplemental QRURs have four exhibits and three Drill Down tables that allow medical group practices 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. The purpose of this document is to help medical group practices interpret the reported data to identify care coordination opportunities and streamline resource use. The following sections detail how medical group practices can use the information reported in each exhibit and Drill Down Table in turn.

EXHIBIT 1: PERCENT COST DIFFERENCE FROM NATIONAL AVERAGE FOR YOUR GROUP'S ATTRIBUTED EPISODES

Exhibit 1 displays the average cost for each episode type attributed to your medical group practice compared to episodes in the national benchmark population. Medical group practices

[1] In this document and in the 2012 Supplemental QRURs, the terms "cost," "spending," and "resource use" are used interchangeably and all denote Medicare FFS paid claims. "Group costs" refer to services/costs during an attributed episode that are provided or ordered by eligible professionals (EPs) billing Medicare under a single Tax Identification Number (TIN).

[2] The Detailed Methods documentation can be found on the CMS webpage.

are encouraged to use Exhibit 1 to compare the cost 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 deductible and coinsurance, and are payment standardized. The reports also include several versions of some episode conditions (i.e., "subtypes") based on acuity or other clinical detail. As a result, Exhibit 1 gives the episode subtype composition to enable meaningful comparison between your medical group practice and the national benchmark population.

The costs shown in Exhibit 1 are risk-adjusted costs. A detailed description of risk adjustment is provided in Section 4 of the *Detailed Methods* documentation. If your medical group practice's average risk-adjusted costs are *higher* than the national average risk-adjusted costs for an episode type, then the episodes attributed to your medical group practice cost *more* than expected given the patient population. Conversely, if your medical group practice's average risk-adjusted costs are *lower* than the average national risk-adjusted costs, then the episodes cost *less* than expected given the patient population.

Exhibit 1 includes a graphical depiction of the percent cost difference from the national average for your medical group practice's attributed episodes. This percentage is calculated separately for each episode subtype. *Negative* percentages indicate that your medical group practice's average attributed episode cost is *lower* than the national average; *positive* percentages indicate that your medical group practice's average attributed episode cost is *higher* than the national average.

EXHIBIT 2: SERVICE CATEGORY BREAKDOWN FOR YOUR GROUP'S ATTRIBUTED EPISODES

Exhibit 2 presents the average utilization, percentage of beneficiaries receiving the service, and the average non-risk-adjusted cost of episodes by service categories (e.g., inpatient hospital facility services and post-acute care). The list of service categories is detailed in Appendix A of the 2012 Supplemental QRURs and described in Section 6.1 and 6.2 of the *Detailed Methods* documentation. Medical groups can use Exhibit 2 to identify high-cost services by assessing the average utilization and average cost for specific service categories for each episode type. Based on suggestions from medical group practices who received the 2011 Supplemental QRURs, the average non-risk-adjusted costs for each service category includes all episodes, instead of episodes with any service use in each category. Thus, medical group practices can identify which services are influencing the total average cost within an episode type. Medical group practices can also compare their service category utilization and cost to the national average by looking at the percent difference in average non-risk-adjusted cost. The percent cost ordered by other groups allows the attributed medical group practice to consider their relative influence on each service category and promote care coordination.

EXHIBIT 3

Exhibit 3 is reserved for future use and is shown as a blank page.

EXHIBIT 4: TOP FIVE BILLING HOSPITALS, SNFS, HHAS, AND EPS WITHIN AND OUTSIDE YOUR MEDICAL GROUP PRACTICE

Exhibit 4 lists the top five billing hospitals, skilled nursing facilities (SNFs), home health agencies (HHAs), and eligible professionals (EPs) within and outside of your medical group practice that are involved in the care of the attributed episode. The top five billing hospitals, SNFs, and HHAs overall are listed based on the cumulative cost of all episodes attributed to your medical group. The top five EPs are listed for each major episode type based on the cumulative cost of all attributed episodes within that episode type. If there is only one EP billing outside the medical group practice for an episode type, the EP's name is suppressed for privacy reasons and denoted with an asterisk (*). Each EP's specialty was determined using the most frequently appearing specialty code submitted by the EP on the carrier claims (also known as physician/supplier Part B claims) grouped to the episode. Medical group practices can combine this data with the episode specific information provided in the Drill Down Tables to pinpoint facilities and EPs that may be adversely affecting the average cost.

DRILL DOWN TABLES: EPISODES ATTRIBUTED TO YOUR MEDICAL GROUP PRACTICE

The Drill Down Tables provide more detailed episode-specific information. The information provided in the Drill Down Tables supplement the episode-level information 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 medical group is included in the Drill Down Tables.

The Drill Down Tables can be downloaded into a spreadsheet so medical group practices 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 evaluation and management (E&M) visits or use of a particular hospital. Table 1 provides information used for attribution of episodes to your medical group practice. Tables 2 and 3 present a breakdown of episode costs from claims billed, ordered, or referred by EPs within and outside your medical group practice, respectively. Tables 2 and 3 also list the number of EPs who are involved in treating the episode and the name of the hospitals, SNFs, and HHAs where care was provided.

Table 1: Attribution and Total Cost Information

Drill Down Table 1 contains information on attribution and total costs for each episode. Table 1 presents the apparent lead EP identified for the episode along with the EP's specialty as well as data on total physician fee schedule (PFS) costs, PFS cost and percentage billed by the group practice, total E&M visits, and E&M visits and percentage billed by the group. Table 1 also provides total actual costs (non-risk-adjusted and non-payment-standardized) for medical groups to match against their own records.

1) How can medical group practices use the listing of attributed beneficiaries?

Medical group 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 medical group practices with identifying information to match with their management system records. In addition, medical group practices 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 an apparent lead eligible professional (EP) help a medical group practice manage care for attributed beneficiaries?

The "apparent lead EP" is provided for informational purposes. By identifying an apparent lead EP, along with the EP's specialty, medical group practices can pinpoint potential areas of high cost care and opportunities for improved care coordination. Only EPs of clinically appropriate specialties for that episode type are eligible to be identified. More information about the identification of apparent lead EP can be found in Section 5.2 in the *Detailed Methods* documentation.

3) What services are included in the physician fee schedule (PFS) cost and evaluation and management (E&M) visits shown in Table 1?

For condition episodes, the total PFS schedule costs and total E&M visits presented in Table 1 come from services that are used for episode attribution. For example, acute condition episodes can be attributed based on the plurality of IP E&M visits during the trigger IP stay, so the total PFS cost and total E&M visits columns in Table 1 shows the costs of those IP E&M visits. Similarly, chronic condition episodes can be attributed based on the plurality of outpatient E&M visits, so the information in Table 1 reports on outpatient E&M visits during the entire episode. However, procedural episodes are attributed based on the performance of the triggering procedure, not based on PFS costs or E&M visits; thus, the data presented in Table 1 for procedural episodes is for informational purposes only and is based on the total PFS cost and total E&M visits during the entire episode. See Section 5 in the *Detailed Methods* documentation for more information on the attribution methodology.

4) How can medical group practices use the data in the "Risk Score Percentile in Episode Subtype Nationally" column?

The risk score percentile in the episode subtype nationally documents how the complexity of the beneficiary's health is used to account for anticipated use of resources. A higher risk score indicates that the patient is more complex relative to other beneficiaries with that episode subtype. The risk score is used to calculate risk-adjusted costs, which account for relative case mix differences.

Table 2: Breakdown of Episode Costs from Claims Billed, Ordered, or Referred by EPs Within Your Medical Group Practice

Table 2 provides the cost breakdown by service category and details the number of EPs within your medical group practice that provided care for the specific episode. If applicable, Table 2 also provides the names of the first two hospitals where your medical group practice provided care for the attributed patients in the specific episode. Similarly, Table 2 includes the names of the first two SNFs and/or HHAs where your medical group practice referred or ordered care in the attributed episode. Section 6.2 and Appendix F of the *Detailed Methods* documentation specify the methodology used to identify costs billed or ordered outside your medical group practice.

1) How can medical group practices use the "Number of EPs within Your Medical Group Practice Treating the Episode" column and the data on the first two hospitals, skilled nursing facilities (SNFs), or home health agencies (HHAs) within your medical group that provide care to the attributed beneficiary?

Table 2 provides the number of EPs and the first two hospitals and SNFs and/or HHAs within your medical group to provide care to the attributed beneficiary. This column provides medical group practices another measure, in addition to percentage of PFS costs and E&M visits, to gauge their involvement in any specific episode. Medical group practices could sort the data to examine their performance on the episodes in which they were the most involved. In addition, medical group practices can use this data to identify potential differences in care among providers within their medical group practice.

2) How can medical group practices use the data on the breakdown of episode costs from claims billed, ordered, or referred to by eligible professionals (EPs) within the medical group practice, by service category, to improve care for the patients they manage?

Medical group practices can use the data on the breakdown of episode costs to identify trends in service use among attributed patients. Some patterns of use may show opportunities for your medical group practice to improve care coordination and management. For example, if your medical group 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 the group practice to further engage this patient in care management and coordination. Patients who had substantial costs in post-acute care may be at risk of frailty or re-hospitalization and, therefore, may also benefit from closer monitoring. Medical group practices 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 Episode Costs from Claims Billed or Ordered by EPs or Facilities Outside Your Medical Group Practice

Table 3 provides information similar to the information in Table 2 but shows costs based on claims billed or ordered by EPs or facilities *outside* your medical group practice. If applicable, Table 3 also provides the names of the first two hospitals, SNFs, and HHAs outside your medical group practice that billed for care provided for the attributed episode. Medical group practices can use Table 3 in similar ways to Table 2 to identify opportunities for improvement in care coordination and management.