Frequently Asked Questions (FAQs) Regarding the 2014 Supplemental Quality and Resource Use Reports (QRURs)

September 2015

The 2014 Supplemental Quality and Resource Use Reports (QRURs) provide information to medical group practices and solo practices, as identified by their Medicare-enrolled tax identification number (TIN), on their resource utilization for the management of episodes of care ("episodes") for their Medicare fee-for-service (FFS) patients.[1] The 2014 Supplemental QRURs are for informational purposes only. The *Detailed Methods of the 2014 Supplemental QRURs* (abbreviated as "*Detailed Methods*") provides the methodology for constructing the episodes presented in the reports.[2] The following sections provide answers to frequently asked questions about the reports.[3]

ABOUT THE 2014 SUPPLEMENTAL QRURS

1. What is an episode?

An episode is a group of services that may be used within a resource use measure. It includes the cost of services provided to diagnose, treat, manage, and follow-up on a specified clinical condition, with adjustments made to account for differences in patient case-mix. Episodes assist TINs with improving their practice efficiency and care coordination by including clinically related costs from multiple settings.

2. Which medical group practices and solo practices can receive a 2014 Supplemental QRUR?

The 2014 Supplemental QRURs are available to all medical group practices and solo practices that have at least one attributed episode. Medical group practices and solo practices are identified by a single TIN, and EPs are identified by their individual National Provider Identifier (NPI). If a TIN did not have any attributed episodes, they will receive a one-page report.

3. How can medical group practices and solo practices, as identified by their Medicare-enrolled tax identification number (TIN), access their reports?

Information on how to access the 2014 Supplemental QRURs can be found on the CMS Episode Grouper webpage.[4] TINs are advised to use Internet Explorer 10 or 11, Google Chrome, or Mozilla Firefox to view the 2014 Supplemental QRUR drill down tables.

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[1] The phrase "TIN" is used throughout this document to refer to medical group practices or solo practices.
[2] The *Detailed Methods, 2014 Supplemental QRURs* is located under the Downloads section of this CMS webpage.
[3] In this document and in the 2014 Supplemental QRURs, the terms "cost," "spending," and "resource use" are used interchangeably, and all denote Medicare FFS paid claims.
[4] Information on how to access the reports can be found in the *Instructions for Medical Group Practices and Solo Practices to Access Their 2014 Supplemental QRURs* document, located under the Downloads section of this CMS webpage.

4. How can TINs use the data in the reports?

TINs can use the data reported in the 2014 Supplemental QRURs to identify potential sources of excess cost in comparison to national averages and consider opportunities to reduce redundancy and improve care coordination. These observations are a rich source of data that may help inform the group's performance improvement activities. Medical group practices and solo practices can consider the drivers of high-cost and low-cost episodes by identifying practice patterns that affect costs. For example, examining low-cost episodes may illuminate ways to replicate efficient care patterns. The *Tips to Understand and Use the 2014 Supplemental QRURs* document provides additional suggestions.[5]

5. Will the episodes reported in the 2014 Supplemental QRURs be used in calculating the Value-based Payment Modifier?

No. The 2014 Supplemental QRURs solely complement the per capita cost and quality information provided in the 2014 QRURs by providing information on the TIN's Medicare FFS health care service utilization and costs for common episodes of care. The episode information in the 2014 Supplemental QRURs is not used in calculating the Medicare Physician Fee Schedule Value-based Payment Modifier (VM).

6. How do the 2014 Supplemental QRURs account for differences in Medicare payment rates for medical services when calculating episode costs?

The episode cost presented in the 2014 Supplemental QRURs are payment standardized and do not include geographic differences in rates paid within Medicare payment systems.[6] CMS' payment standardization algorithm eliminates geographic differences and special program payments unrelated to resource use, such as disproportionate share hospital (DSH) payments, except where explicitly noted. For an overview of payment standardization, please see the *Basics of Payment Standardization* document available through the QualityNet webpage.[7] For a detailed description of the methodology applied to each setting, please see the *CMS Price Standardization Methodology* document that is also available through the QualityNet webpage.

[5] The *Tips to Understand and Use the 2014 Supplemental QRURs* can be found on the CMS webpage.
[6] The 2014 Supplemental QRUR drill down tables are an exception since they provide actual Medicare payment amounts (non-payment standardized and non-risk adjusted) to allow TINs to compare beneficiary-specific data to their own records.
[7] The payment standardization methodology documents are located under the Measure Development section on this QualityNet webpage.

7. Where can TINs submit comments and questions about the 2014 Supplemental QRURs?

To submit written comments and suggestions on the Supplemental QRURs, please send an email to pvhelpdesk@cms.hhs.gov. Please be sure not to include any personally identifiable information. If there is a question about the TIN's report or a specific beneficiary's episode, a call can be set up to discuss over the phone.

INFORMATION INCLUDED IN THE 2014 SUPPLEMENTAL QRURS

8. What episodes are included in the 2014 Supplemental QRURs?

The 2014 Supplemental QRURs report on 9 major acute condition episode types and 17 major procedural episode types. For some major episode types, the reports also include episode subtypes to provide additional clinical detail and to improve the actionability of the reports. There are 38 episode subtypes, resulting in 64 total reported episode types in the 2014 Supplemental QRURs. Two grouping methods, Method A and Method B, are used to construct the episodes, and the two methods are discussed in the following section. Table 1 lists each major condition episode type and subtype, and Table 2 lists each major procedural episode type and subtype. Both tables also specify the method used to produce the episode.

Table 1: Condition Major Episode Types and Subtypes

#	**Condition Episode Name *(Subtypes listed in italics)***	**Method**
1	Acute Myocardial Infarction (AMI) (All)	A
2	*AMI without PCI/CABG*	A
3	*AMI with PCI*	A
4	*AMI with CABG*	A
5	Asthma/Chronic Obstructive Pulmonary Disease (COPD), Acute Exacerbation	A
6	Atrial Fibrillation (AFib)/Flutter, Acute Exacerbation	A
7	Cellulitis (All)	B
8	*Cellulitis in Diabetics*	B
9	*Cellulitis in Patients with Wound, Non-Diabetic*	B
10	*Cellulitis in Obese Patients, Non-Diabetic without Wound*	B
11	*Cellulitis in All Other Patients*	B
12	Gastrointestinal (GI) Hemorrhage (All)	B
13	*GI Hemorrhage, Upper and Lower*	B
14	*GI Hemorrhage, Upper*	B
15	*GI Hemorrhage, Lower*	B
16	*GI Hemorrhage, Undefined*	B
17	Heart Failure, Acute Exacerbation	A
18	Ischemic Stroke	A
19	Kidney and Urinary Tract Infection (UTI)	B
20	Pneumonia, Inpatient (IP)-Based	A

Table 2: Procedural Major Episode Types and Subtypes

#	**Procedural Episode Name *(Subtypes listed in italics)***	**Method**
21	Aortic Aneurysm Procedure (All)	B
22	*Abdominal Aortic Aneurysm Procedure*	B
23	*Thoracic Aortic Aneurysm Procedure*	B
24	Aortic/Mitral Valve Surgery (All)	A
25	*Both Aortic and Mitral Valve Surgery*	A
26	*Aortic or Mitral Valve Surgery*	A
27	Carotid Endarterectomy	A
28	Cholecystectomy and Common Duct Exploration (All)	B

#	Procedural Episode Name *(Subtypes listed in italics)*	Method
29	*Cholecystectomy*	B
30	*Surgical Biliary Tract Procedure*	B
31	Colonoscopy (All)	B
32	*Colonoscopy with Invasive Procedure*	B
33	*Colonoscopy without Invasive Procedure*	B
34	Coronary Artery Bypass Graft (CABG)	A
35	Hip/Femur Fracture or Dislocation Treatment, IP-Based	A
36	Hip Replacement or Repair (All)	B
37	*Hip Arthroplasty*	B
38	*Hip Arthroscopy and Hip Joint Repair*	B
39	Knee Arthroplasty	B
40	Knee Joint Repair (All)	B
41	*Meniscus Repair*	B
42	*Knee Ligament Repair*	B
43	Lens and Cataract Procedures (All)	B
44	*Cataract Surgery*	B
45	*Discission*	B
46	*Intraocular Lens (IOL) Removal/Repositioning or Secondary IOL Insertion*	B
47	Mastectomy for Breast Cancer (All)	A
48	*Lumpectomy or Partial Mastectomy without Reconstruction*	A
49	*Lumpectomy or Partial Mastectomy with Reconstruction*	A
50	*Simple or Modified Radical Mastectomy without Reconstruction*	A
51	*Simple or Modified Radical Mastectomy with Reconstruction*	A
52	Pacemaker (All)	A
53	*Pacemaker Placement, IP-Based*	A
54	*Pacemaker Placement, Outpatient (OP)-Based*	A
55	*Pulse Generator Replacement*	A
56	Percutaneous Coronary Intervention (PCI) (All)	A
57	*PCI, IP-Based*	A
58	*PCI, OP-Based*	A
59	Prostatectomy for Prostate Cancer	A
60	Spinal Fusion (All)	B
61	*Lumbar and/or Thoracic Spinal Fusion*	B
62	*Cervical Spinal Fusion*	B
63	*Long-Segment Spinal Fusion for Deformity*	B
64	Transurethral Resection of the Prostate (TURP) for Benign Prostatic Hyperplasia	B

9. Why are there two episode grouping methods?

Section 3003 of the Affordable Care Act (ACA) of 2010 requires that the Secretary of the Department of Health and Human Services (HHS) develop an episode grouper to improve care efficiency and quality.[8] Therefore, CMS is applying episode grouping algorithms specially designed for constructing episodes of care in the Medicare population. The 2014 Supplemental QRURs use expanded versions of the methodologies used in the 2011 and 2012 reports. Method A is used for 28 episode types, and Method B is used for 36 episode types. Method A was

[8] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3003, 124 Stat. 366 (2010).

developed by the Center for Medicare and Medicaid Innovation (CMMI) to fulfill requirements of the Affordable Care Act. A prototype of Method A was employed for select episodes in the 2011 Supplemental QRURs, and a refined version of Method A was also used in the 2012 Supplemental QRURs. Method B was developed by the Center for Medicare (CM) to complement those efforts and provide a more robust measure set in the Supplemental QRUR Reports. Method B is adapted from clinical measures that first were discussed in the FY 2015 Inpatient Prospective Payment System (IPPS) Proposed Rule and align with the Medicare Spending Per Beneficiary (MSPB) Measure.[9] Method B's episodes are presented in the Supplemental QRURs to accompany Method A's episodes. Both methods implement clinical logic to parse and allocate medical services to one or more episodes, although some methodological differences exist. More information about the two methods can be found in the *Detailed Methods* document.

10. What Medicare costs are included in an episode?

Episodes can include payments made to any providers who treated the beneficiary, regardless of whether those providers were associated with the TIN that is attributed the episode. All payments included in an episode are taken from claims that are grouped to the episode according to clinical logic that defines relatedness based on service and/or diagnosis codes on the claims.[10] All payment data shown in the 2014 Supplemental QRURs reflect allowed amounts from Medicare FFS Part A and Part B payments, which include both Medicare trust fund payments and beneficiary deductible and coinsurance. Episode costs may reflect payments associated with inpatient or outpatient hospital, skilled nursing facility, home health, hospice, and/or durable medical equipment services, along with the costs of all evaluation and management services, procedures, and other Medicare-covered services. Payments for Part D outpatient prescription drugs are not included in the episodes in the 2014 Supplemental QRURs.

11. What is the size of the national comparison population?

Approximately 5.6 million Medicare FFS beneficiaries meet the enrollment criteria and have attributable episodes in PY 2014 (as specified in the *Detailed Methods* document).

[9] The FY 2015 IPPS Proposed Rule titled "Medicare Program; Hospital IPPS for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record (EHR) Incentive Program" can be found on this CMS webpage.
[10] Question 15 in this document contains more information on grouping claims to episodes.

12. How are the "treatment" and "indirect" components defined in Exhibit 3 and 4?

The 2014 Supplemental QRURs present episode costs broken into "treatment" and "indirect" components. Broadly, treatment costs are all costs grouped to the episode and billed on days in which the managing provider within your TIN provided care for the beneficiary, and indirect costs are all costs grouped to the episode and billed on days in which the managing provider did not provide care for the beneficiary. Specifically, treatment costs are all IP, OP, PB, and DME costs grouped to the episode on days where the attributed NPI billed for the beneficiary. This includes costs during the trigger event and some costs after the trigger event in the episode. For IP hospital episodes, all costs during the triggering IP stay are included in the treatment category. All grouped costs billed on days before the trigger event (e.g., pre-operative examinations) are included as treatment costs. Indirect costs are those grouped costs not defined as treatment costs. This includes costs on days where the attributed NPI did not bill for the episode and costs billed after the trigger event or triggering IP stay.

13. What does an "n/a," asterisk, or blank cell in the reports mean?

There are multiple areas in a TIN's 2014 Supplemental QRUR where data may be not applicable (marked with an "n/a"), suppressed (denoted with an asterisk (*)), or reported as blank. The following details when an "n/a," asterisk, or blank cell would appear in the 2014 Supplemental QRURs and how TINs should interpret each section:

- **Exhibit 1**: Summary of All Episodes
    - Episode types that are not listed indicate that the TIN does not have any episodes in that episode type.
- **Exhibit 2**: Episode Frequency and Cost
    - In the columns titled "Average Utilization" and "% Beneficiaries Receiving Service" under episodes attributed to the TIN and episodes nationally, an "n/a" occurs for the "All Services" category because the columns are not relevant at the cumulative service level.
    - For all columns, a blank cell appears if the TIN does not have any episodes in the episode type.
- **Exhibit 3**: Episode Summary
    - Blank cells in Exhibit 3.D indicate that a TIN has fewer than five total hospitals, SNFs, HHAs, or EPs within or outside a TIN treating their attributed episodes.
    - An asterisk (*) indicates that the TIN has only one EP outside the TIN treating the specific episode type. The name of the EP is excluded to protect the EP's privacy. This particular use of an asterisk is not noted on the report itself.
- **Exhibit 4:** Episode Service Category Cost Breakdown

- A blank cell appears in the "% Difference" column if there is no national cost for that service category.
- In the columns titled "Average Utilization – Your TIN" and "Average Utilization – National" under episodes attributed to the TIN and episodes nationally, an "N/A" occurs for the "All Services", "Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)", "Ancillary Services", "Hospital Inpatient Services", "Emergency Room Services", "Post-Acute Services", and "All Other Services" categories because the columns are not relevant at the cumulative service level.

- **Drill Down Tables**
  - In Table 1, a blank cell may appear in the columns for hospital, SNFs, or HHAs billing first and second if none of the respective facilities is billing first or second within the group or outside the group.
  - In Table 2, no blank cells or special characters will appear. Some cost categories may have $0 cost paid.
  - In Table 3, no blank cells or special characters will appear. Some cost categories may have $0 cost paid.

EPISODE CLINICAL LOGIC

14. How are costs grouped to episodes?

Method A and Method B both group claims to episodes based on clinical logic and timing. Although each method performs this differently, both methods use input from clinicians to create rules that determine which diagnosis or service codes on claims should be used to assign a claim to an episode. The total episode cost is the sum of the payments for all grouped services that occur during the specified episode time window. A full explanation of each method's grouping algorithm is available in Section 2 of the *Detailed Methods* and in the *Episode Definition* files specific for each major episode type.

15. Can beneficiaries have more than one episode open at a time?

Yes. Both Method A and B grouping algorithms allow beneficiaries to have multiple episodes of different types open simultaneously. Both methods allocate the full cost of relevant services to each open episode. It is possible for one claim to be allocated to multiple open episodes for a beneficiary, with the full cost of the claim included in all episodes that the claim is assigned to.

RISK ADJUSTMENT

16. What data does the risk adjustment methodology use?

Method A and B use information found on Medicare claims and enrollment files to risk-adjust episode costs. The risk adjustment methodology uses health and non-health explanatory variables when calculating the predicted cost of an episode. The health variables include: (i) indicators for 70 Hierarchical Condition Categories (HCC) and 11 HCC interactions to adjust for health severity; (ii) indicators for whether a patient recently required care in a long-term care facility; (iii) an indicator of Medicare-Severity Diagnosis-Related Group (MS-DRG) of admission to adjust for case-mix; and (iv) interaction indicators between the episode sub-type, whether the patient enters care through the emergency room, and the laterality of the procedure (if applicable). The non-health variables are age and Medicare enrollment type.[11]

The risk adjustment methodology calculates the predicted cost of an episode using information available at the start of the episode for acute condition and procedural episodes. For both acute condition and procedural episodes, risk adjustment calculates the predicted cost of an episode using information available 90 days before the trigger date of the episode. Using information available at the start of the episode precludes risk-adjusted costs from adjusting for changes occurring consequential to the treatment patterns during the episode. Risk adjustment uses the MS-DRG of the trigger inpatient stay as a severity indicator for some episode types to align with the risk adjustment approach of the MSPB Measure. Section 4.4 of the *Detailed Methods* documentation provides additional detail on what data are used to risk-adjust episode costs. Nationally, average risk-adjusted costs are equal to average non-risk-adjusted costs at the episode level because risk adjustment is performed at the episode level. Average risk-adjusted costs are not equal to average non-risk adjusted costs for the subtypes.

17. How does the risk adjustment methodology calculate predicted cost of an episode?

An episode's predicted cost is calculated using a linear regression that incorporates the health and non-health explanatory variables listed above. A separate regression is performed for for each episode sub-type.

18. How does risk adjustment account for outlier episode costs?

The 2014 Supplemental QRURs truncate actual payment-standardized episode costs prior to risk-adjustment. High-cost episodes, based on *actual payment-standardized costs*, above the

[11] A full list of variables used in the risk adjustment model is available in Appendix B in the *Detailed Methods*, which is available for download from this CMS webpage.

99th percentile of all episodes within the episode type are assigned the value of the 99th percentile. In addition, low-cost episodes, again based on *actual payment-standardized costs*, below the 1st percentile of all episodes within the episode type are set to the value at the 1st percentile. This method of truncation is also known as Winsorization. Section 4.3 of the *Detailed Methods* documentation further describes how episode costs were truncated. Predicted episode costs are not truncated.

19. What is the relationship between a TIN's average risk-adjusted costs and its average non-risk-adjusted costs?

Patients that are more complex have their episode costs adjusted downward due to risk adjustment. If a TIN's average risk-adjusted costs are *lower* than its non-risk-adjusted costs, the TIN's patient population is *more complex* than average. Conversely, if a TIN's average risk-adjusted costs are *higher* than its non-risk-adjusted costs, its patient population is *less complex* than average. The complexity of the patient population is shown as the beneficiary risk score.

20. How are beneficiary risk scores calculated?

A beneficiary's risk score percentile is calculated by comparing the beneficiary's predicted cost as calculated by the risk adjustment model to the distribution of predicted costs for all episodes of the same subtype nationally. A *higher* risk score percentile indicates that based on his or her risk factors, the beneficiary was predicted to have relatively *high* health care costs for the episode compared to other episodes of the same subtype nationally. The 2014 Supplemental QRURs provide beneficiary risk score percentiles in Exhibit 3 and the drill down tables as a relative measure of the beneficiary's predicted health care spending based on the risk adjustment models described above.

21. Why are service category costs not risk-adjusted in the 2014 Supplemental QRURs?

Risk adjustment is performed at the episode level rather than the service category/claim level. Therefore, costs for service categories are not risk-adjusted when reported separately in the reports.

MEDICAL GROUP ATTRIBUTION

22. How are episodes attributed to TINs?

Acute condition episodes are attributed to all TINs that bill at least 30 percent of IP Evaluation and Management (E&M) visits during the initial treatment, or "trigger event," that opened the episode. It is possible for more than one TIN to be attributed a single episode using this rule. If an acute condition episode has no IP E&M claims during the episode, then that episode is not attributed to any TIN.

Procedural episodes are attributed to all TINs that bill a PB claim with a trigger code during the trigger event of the episode. If more than one TIN bills the surgical claim during the trigger event, the episode is attributed to each of the TINs. If co-surgeons bill the surgical claim, the episode is attributed to each surgeon's TIN. If only an assistant surgeon bills the surgical claim, the episode is attributed to the assistant surgeon's TIN. If an episode does not have a concurrent PB claim with a trigger code for the episode, then that episode is not attributed to any TIN.

23. What happens to transfer patients?

Episodes that have transfers between short-term acute IP hospitals on the same day as the trigger date are excluded from reporting in the 2014 Supplemental QRURs. Patients with other transfers or IP transfers not on the trigger date of an episode are still included in reporting.