Tips to Understand and Use the 2014 Supplemental Quality and Resource Use Reports (QRURs)

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The 2014 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 2014 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), in improving their practice efficiency.[1] This report is limited to 26 major episode types and an additional 38 episode subtypes, resulting in 64 total reported episode types. The *Detailed Methods of the 2014 Medical Group Practice Supplemental QRURs* (abbreviated as "*Detailed Methods*") and the *Episode Definition* files provide the methodology for each episode type.[2]

The 2014 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. 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 TINs can use the information reported in each exhibit and drill down table.

EXHIBIT 1: SUMMARY OF ALL EPISODES

Exhibit 1 provides a graphical depiction of the percent difference between a TIN's average cost and national average cost for each episode type for comparison purposes. This percentage is calculated separately for each episode subtype.[4] *Negative* percentages indicate that the TIN's average attributed episode cost is *lower* than the national average; *positive* percentages indicate that your TIN's average attributed episode cost is *higher* than the national average. Lower average episode cost 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 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

[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* document and *Episode Definition (2014)* files are located under the Downloads section of this CMS webpage.
[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 2.1 of the *Detailed Methods* document.

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: EPISODE FREQUENCY AND COST

Exhibit 2 shows the number, frequency, and cost of all episode types attributed to a 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 the TIN's average risk-adjusted costs are *higher* than the national average risk-adjusted costs for an episode type, then the episodes attributed to the TIN cost *more* than expected given the patient population. Conversely, if the TIN'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. The TIN can use the information in this exhibit to determine which episode types require more attention and analysis for improvement.

EXHIBIT 3: EPISODE SUMMARY

Exhibit 3 shows the risk score, costs broken down by episode components and service categories (e.g., IP 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 the 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 the TIN to examine the cost performance of episodes of a given type, and the following discusses each section in turn.

Exhibit 3.A: Your Episode Summary

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

Exhibit 3.B: Average Cost for Episode Components

Exhibit 3.B provides the average non-risk-adjusted, payment standardized cost of each episode component for the TIN and for the national average: "treatment" and "indirect" services. This information can be further investigated by looking at Exhibit 4.A - 4.C, which provides

detailed cost breakdown by service categories for the entire episode, for the "treatment" services, and the "indirect" services.

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

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

Exhibit 3.C presents the average non-risk-adjusted, payment standardized cost of select service categories for the TIN and for the national average. This information provided in Exhibit 3.C includes cost 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 of physician services during hospitalization, outpatient evaluation and management (E&M) services, major procedures, and the cost for post-acute care (e.g., SNF and HH). Medical group practices and solo practices can view which service category is highest 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 the 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 that may be adversely affecting the average cost.

EXHIBIT 4: EPISODE SERVICE CATEGORY COST BREAKDOWN

Exhibit 4 summarizes the cost performance, by service category, of episodes of a given episode type attributed to the TIN for the entire episode and for the treatment and indirect 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.

Medical group practices and solo practices can use Exhibit 4 to identify high-cost services by assessing the average utilization and average cost for specific service categories for

each episode type. In addition, the TIN can identify which services are influencing the total average cost 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. The percent cost ordered by other groups allows the attributed TIN to consider their relative influence on each service category and promote care coordination. The list of service categories is detailed in 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 the TIN, including the episode type, the beneficiary's risk score, the episode start date, and physician and non-physician costs 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 the TIN is included in the drill down tables. The drill down tables are created for each individual episode type and subtype, just as Exhibit 3 and 4 are.

The drill down tables can be downloaded into a spreadsheet so TINs 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 TINs to compare this data to their own records. The following sections provide an overview of each of the three drill down tables.

Table 1: Episode-Level Information

Table 1 provides an overview of each individual episode to assist the 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 TINs 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 TINs with identifying information to match with their management system records. In addition, TINs 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, TINs can pinpoint potential areas of high cost care and opportunities for improved care coordination. 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 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 the 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 the 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 the 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.

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 TINs another measure, in addition to E&M visits and PFS costs, to gauge their involvement in any given episode. Medical group practices or solo practices could sort the data to examine their performance on the episodes in which they were the most involved. In addition, TINs can use these data to identify potential differences in care among providers.

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

Table 2 provides detailed information on physician costs billed by the TIN and other TINs for episodes of a given type that were attributed to the TIN. All costs are actual Medicare payment amounts (non-payment standardized and non-risk adjusted) to allow TINs to compare these data to their own records. Appendix Table C.4 of the *Detailed Methods* document specifies the methodology used to identify physician costs billed by the 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 the TIN to improve care coordination and management. For example, if the 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 the TIN 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 or solo 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 Non-Physician Costs

Table 3 provides detailed information on non-physician costs for episodes of a given type that were attributed to the TIN. Just as in Drill Down Table 2, all costs are actual Medicare payment amounts (non-payment standardized and non-risk adjusted). Medical group practices or solo practices 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.