Frequently Asked Questions (FAQs) Regarding the 2012 Supplemental Quality and Resource Use Reports (QRURs)

Revised August 2014

The 2012 Supplemental Quality and Resource Use Reports (QRURs) provide information to medical group practices on their resource utilization for the management of episodes of care ("episodes") for their Medicare fee-for-service (FFS) patients. An episode is defined as the set of services provided to diagnose, treat, manage, and follow-up a clinical condition. The 2012 Supplemental QRURs are for informational purposes only and provide actionable and transparent information on resource use to assist medical group practices in improving their practice efficiency. The *Detailed Methods of the 2012 Medical Group Practice Supplemental QRURs* (also, "*Detailed Methods*") provides the methodology for the episode-based cost measures.[1] The following sections provide answers to frequently asked questions about the reports.[2]

ABOUT THE 2012 SUPPLEMENTAL QRURS

1. Which medical group practices can receive a 2012 Supplemental QRUR?

The 2012 Supplemental QRURs are being made available to medical group practices that meet the following requirements:

(1) The group consists of at least 100 eligible professionals (EPs);

(2) The group did not participate in multiple accountable care organizations (ACOs); and

(3) The group did not participate in more than one of the following initiatives in program year (PY) 2012: the Medicare Shared Savings Program (MSSP), the Pioneer Accountable Care Organization (ACO) Model, or the Comprehensive Primary Care Initiative (CPCI).

Medical group practices are identified by a single Tax Identification Number (TIN), and EPs are identified by their individual National Provider Identifiers (NPIs).

[1] The *Detailed Methods* documentation can be found on this CMS webpage.

[2] 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. How can medical group practices access their reports?

Information on how to access the 2012 Supplemental QRURs can be found on the CMS Episode Grouper webpage.[3] Medical group practices are advised to use Internet Explorer 8 or 9, Google Chrome, or Mozilla Firefox to view the 2012 Supplemental QRUR Drill Down Tables. Users viewing the 2012 Supplemental QRUR Drill Down Tables in Internet Explorer 10 may experience some difficulty due to a software compatibility issue.

3. How can medical group practices use the data in the reports?

Medical group practices can use the data reported in the 2012 Supplemental QRURs to identify potential sources of excess cost in comparison to national benchmarks and consider opportunities to reduce redundancy and waste and improve care coordination. These observations are potentially a rich source of data for the group's performance improvement activities. Medical group practices can consider the drivers of high-cost versus low-cost episodes, such as identifying practice patterns that affect costs. For example, examining low-cost episodes may identify ways to replicate efficient care patterns. Separate documentation, the *Tips for Medical Group Practices to Understand and Use the 2012 Supplemental QRURs,* provides additional suggestions.[4]

4. Will the 2012 Supplemental QRURs be used in calculating the value-based payment modifier?

No. The 2012 Supplemental QRURs solely complement the per capita cost and quality information provided in the 2012 QRURs by providing information on the medical group practice's Medicare FFS health care service utilization and costs for common episodes of care. The episode information in the 2012 Supplemental QRURs is not used in calculating the Medicare Physician Fee Schedule Value-based Payment Modifier (VM).

The Centers for Medicare & Medicaid Services (CMS) is gaining experience with episode grouping. The Supplemental QRURs are currently for informational purposes only and have not yet been proposed to be part of the VM. CMS will provide further information on plans for their use in future rulemaking.

5. How is CMS preparing the episode modeling analysis for transition to ICD-10?

The current version of the episode grouper is undergoing continual developments to create the next version. On April 1, 2014, the Protecting Access to Medicare Act of 2014

[3] Information on how to access the reports can be found on the CMS webpage.
[4] The *Tips for Medical Group Practices to Understand and Use the 2012 Supplemental QRURs* can be found on the CMS webpage.

(PAMA) (Pub. L. No. 113-93) was enacted, which stated that the Secretary may not adopt ICD-10 prior to October 1, 2015. Accordingly, the U.S. Department of Health and Human Services expects to release an interim final rule that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The rule will also require HIPAA-covered entities to continue to use ICD-9-CM through September 30, 2015.

INFORMATION INCLUDED IN THE 2012 SUPPLEMENTAL QRURS

6. What episodes are included in the 2012 Supplemental QRURs?

The 2012 Supplemental QRURs report on 26 episodes that include condition and procedural episode types. Condition episodes can further be categorized into chronic condition episodes, which represent care for a patient's ongoing disease, and acute condition episodes, which are characterized by a shorter duration and may be a severe exacerbation of a chronic condition. The reports include several versions of some episode conditions (i.e., "subtypes") based on acuity or other clinical detail. 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 condition and procedural episode subtype as well as the method used to produce the episode.

Table 1: Episodes and Their Subtypes Reported in the 2012 Supplemental QRURs

Episode Name (Subtypes Indented)[5]	**Episode Type**	**Method**
1. Acute chronic obstructive pulmonary disease (COPD)/asthma, inpatient exacerbation	Acute condition	A
2. Acute coronary syndrome (ACS) (*all*) 3. ACS with coronary artery bypass graft (CABG) 4. ACS with percutaneous coronary intervention (PCI) 5. ACS without PCI or CABG	Acute condition	A
6. Cellulitis	Acute condition	B
7. Gastrointestinal (GI) hemorrhage	Acute condition	B
8. Kidney/urinary tract infection	Acute condition	B
9. Pneumonia (*all*) 10. Pneumonia without inpatient hospitalization 11. Pneumonia with inpatient hospitalization	Acute condition	A
12. Chronic atrial fibrillation/flutter	Chronic condition	A
13. Chronic congestive heart failure (CHF)	Chronic condition	A
14. COPD/asthma	Chronic condition	A
15. Ischemic heart disease (IHD) (*all*) 16. IHD without ACS 17. IHD with ACS	Chronic condition	A

[5] The 2012 Supplemental QRURs first list all condition episodes alphabetically and then list all procedural episodes alphabetically. For clarity, the *Detailed Methods* and *FAQ* documents lists all acute condition episodes alphabetically, then lists chronic condition episodes alphabetically, and finally lists procedural episodes alphabetically.

Table 1 (cont.): Episodes and Their Subtypes Reported in the 2012 Supplemental QRURs

Episode Name (Subtypes Indented)[5]	**Episode Type**	**Method**
18. Bilateral cataract removal with lens implant	Procedural	A
19. CABG (*all*) 20. CABG without ACS	Procedural	A
21. Hip replacement/revision	Procedural	B
22. Knee replacement/revision	Procedural	B
23. Lumbar spine fusion/refusion	Procedural	B
24. PCI (*all*) 25. PCI without ACS	Procedural	A
26. Permanent pacemaker system replacement/insertion	Procedural	A

7. 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.[6] Therefore, CMS is applying episode grouping algorithms specially designed for constructing episodes of care in the Medicare population. A preliminary grouping algorithm was employed for a small number of episodes in the 2011 Supplemental QRURs, and the 2012 Supplemental QRURs report the same episodes as well as additional episodes, using two methodologies. Method A is used for 20 episodes, and Method B is used for 6 episodes. Method A was developed by the Center for Medicare and Medicaid Innovation (CMMI) (under contract HHSM-500-2011-00012I, HHSM-500-T0008). A prototype of Method A was employed for select episodes in the 2011 Supplemental QRURs. Method B was developed by CMS in partnership with Acumen, LLC ("Acumen") (under contract GS-10F-0133S, HHSM-500-2011-00098G). 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.[7] 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* documentation.

[6] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3003, 124 Stat. 366 (2010).
[7] 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.

8. 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 medical group practice that is attributed the episode. Payments that are eligible for grouping include any allowed charges from Medicare FFS Part A and Part B payments. Allowed charges are comprised of 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 2012 Supplemental QRURs.

9. What is the size of the national sample?

Approximately 8.8 million Medicare FFS beneficiaries met the enrollment criteria and had attributable episodes in PY 2012 (as specified in the *Detailed Methods* documentation).

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

There are multiple areas in a medical group practice's 2012 Supplemental QRURs where data may be not applicable (marked with an "n/a"), suppressed (denoted with an asterisk [*]), or reported as blank. The following explanation details when an "n/a," asterisk, or blank cell appears in the 2012 Supplemental QRURs and how medical group practices should interpret each section:

- **Exhibit 1**: Percent Cost Difference from National Average for Your Group's Attributed Episodes
    - In the columns titled "Your Group's Subtype Frequency" and "National Subtype Frequency," an "n/a" appears for all major episode types that are not further stratified (i.e., into subtypes) in the reports. A blank cell, in contrast, indicates that the medical group practice does not have any episodes of a particular type or subtype.
    - In the columns titled "Your Group's Average Risk-Adjusted Cost" and "National Average Risk-Adjusted Cost," a blank cell appears when the medical group practice has zero episodes of the major episode type. A blank cell appears in the column titled "Your Group's Average Risk-Adjusted Cost" when the medical group practice is attributed episodes in the major episode type but does not have any of a particular subtype.
- **Exhibit 2**: Service Category Breakdown for Your Group's Attributed Episodes
    - In the columns titled "Average Utilization" and "% Beneficiaries Receiving Service" under episodes attributed to the medical group practice and all episodes nationally, an "n/a" occurs for the "All Services" category because the columns are not relevant at the cumulative service level.

- In the column titled "% Difference in Average Non-Risk-Adjusted Cost from National Average," a blank cell appears if the national average non-risk-adjusted cost for the specific service category and episode type is $0.
- For all columns, a blank cell indicates that the medical group practice does not have any episodes in the major episode type.

- **Exhibit 3**
  - Exhibit 3 reports as a blank section that is reserved for future use.
- **Exhibit 4:** Top Five Billing Hospitals, Skilled Nursing Facility (SNFs), Home Health Agencies (HHAs), and EPs Within and Outside Your Medical Group Practice Treating Episode
  - A blank cell appears if there are fewer than five total hospitals, SNFs, HHAs, or EPs within or outside a medical group practice treating their attributed episodes.
  - An asterisk (*) indicates that the medical group practice has only one EP outside the medical group 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.
- **Drill Down Tables**
  - In Table 1, an asterisk (*) appears in the column titled "Apparent Lead EP" to indicate that no apparent lead EP within the TIN was attributed the episode.
  - In Table 2 and 3, a blank cell may appear in the columns for hospital, SNFs, or HHAs billing first and second if there are not any of the respective facilities billing first or second within the group or outside the group.
  - In Table 3, an asterisk (*) in the column titled "Top Billing EP Outside Your Medical Group Practice Treating Episode" indicates that only one EP was billing outside of the group, and the EP's name is suppressed for privacy reasons.

EPISODE CLINICAL LOGIC

11. 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.

12. Are procedural and acute condition episode costs included in the episode costs of the underlying chronic condition?

Yes. Several of the procedural and acute condition episodes represent treatments and acute exacerbations, respectively, of the condition episodes reported in the 2012 Supplemental QRURs. The costs of a procedural or acute condition episode may therefore be included in the total costs for the underlying chronic condition, reflecting a patient-centric approach that

considers all aspects of care. Method A included the cost of a patient's procedural episode in his or her clinically-associated condition episode if the procedure was a treatment for that condition. For example, the costs from a patient's percutaneous coronary intervention (PCI) episode for the treatment of acute coronary syndrome (ACS) would be included in the cost of the ACS for which it was performed. Similarly, Method A incorporated the cost of care for an acute condition into the episode costs for the chronic underlying condition. For example, the costs from an acute exacerbation of ischemic heart disease (IHD) in the form of an ACS would be included in the costs of the IHD episode. However, group attribution and apparent lead EP identification rules for the episodes vary, so clinically-associated episodes may be attributed to different groups and/or have different EPs identified as apparent lead EP within a group.

RISK ADJUSTMENT

13. What data does the risk adjustment methodology use?

Method A and B only use information found on Medicare claims and enrollment files to risk-adjust episode costs and do not use data from clinical registries. Both methods use health and non-health explanatory variables when calculating the predicted cost of an episode. Method A's health variables include: (i) indicators for 54 Condition Categories (CCs); (ii) indicators for 58 typical conditions; and (iii) indicators for 81 complications.[8,9] Method B uses several health variables that include: (i) indicators for 70 Hierarchical Condition Categories (HCC) and 11 HCC interactions to adjust or health severity; (ii) indicators for whether a patient recently required care in a long-term care facility; and (iii) an indicator of an Medicare-Severity Diagnosis-Related Group (MS-DRG) of admission to adjust for case-mix. In addition to the preceding health variables, Method A uses age, sex, and Medicare enrollment type as non-health explanatory variables while Method B only uses age and enrollment type.

Methods A and B calculate the predicted cost of an episode using information available at the start of the episode for acute condition and procedural episodes. For acute condition and procedural episodes, Method A calculates the predicted cost of an episode using information available 180 days before the start of the episode. For chronic condition episodes, Method A separates the episode into 90-day "periods" and uses the 180 days prior to the start of each episode period to calculate the predicted cost for the following period. Using information available at the start of the episode precludes risk-adjusted costs from being affected by changes

[8] CMS's Condition Categories (CCs) or Hierarchical Condition Categories (HCCs) are the building blocks for risk-adjustment in several CMS programs. More information about the CMS CCs and HCCs can be found on the following CMS webpage.

[9] To prevent collinearity, Method A uses only fifty-four CCs. None of the diagnosis codes used to generate these fifty-four CCs overlap with the diagnosis codes used to build the severity indicators.

occurring consequential to the treatment patterns during the episode; information about the beneficiary known at the start of the episode, however, will become less and less relevant to the episode the longer the episode is open. Therefore, since the chronic condition episodes constructed by Method A could last an indefinite period of time, as chronic episodes are assumed to be ongoing, they are risk-adjusted each quarter using updated information from the 180 days before the start of the period. Method B uses the MS-DRG of the trigger inpatient stay as a severity indicator to align with the risk adjustment approach of the MSPB cost measures. Section 4.2 of the *Detailed Methods* documentation provides additional detail on what data is used to risk-adjust episode costs. Nationally, average risk-adjusted costs are equal to average non-risk-adjusted costs at the major episode level because risk adjustment is performed at the major episode level. Average risk-adjusted costs will not be equal to average non-risk adjusted costs for the subtypes.

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

The 2012 Supplemental QRURs truncate actual payment-standardized episode costs and predicted episode costs. First, high-cost episodes, based on *actual payment-standardized costs*, above the 99th percentile of all episodes within the episode type are assigned the value of the 99th percentile. This method of truncation is also known as Winsorization. In addition, low *predicted* episode costs, based on costs estimated by the risk adjustment model, that fall below the 0.5th percentile of all episodes within the episode type are set to the value at the 0.5th percentile. Truncating predicted costs at the 0.5th percentile is consistent with the methodology used to calculate the MSPB cost measures. Section 4.2 of the *Detailed Methods* documentation further describes how episode costs were truncated and risk-adjusted.

15. What is the relationship between risk adjustment and the complexity of the patient?

Patients that are more complex have their episode costs adjusted downward due to risk adjustment. If a medical group practice's average risk-adjusted costs are lower than its non-risk-adjusted costs, the medical group practice's patient population is more complex than average. Conversely, if a group's average risk-adjusted costs are higher than its non-risk-adjusted costs, its patient population is less complex than average.

16. How are beneficiary risk scores calculated?

A beneficiary's risk score percentile nationally is calculated by comparing the beneficiary's predicted cost, using either Method A or B's risk adjustment model, to the predicted cost 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 2012 Supplemental QRURs provide beneficiary risk score percentiles in the Drill Down Tables as a relative measure of the beneficiary's predicted health care spending based on the risk adjustment models described above.

17. Why are service category costs not risk-adjusted in the 2012 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

18. Will the measurement profiles expand from the group level to the individual physician level within a group?

At this time, there is no plan to expand the episode analyses to the individual physician level. Attribution is performed at the medical group practice level. Refer to Section 5.1 and 5.2 in the *Detailed Methods* documentation for more information about the group attribution methodology and granularity of the apparent lead EP identification methodology, respectively. An apparent lead EP was identified for each episode for informational purposes only.

19. What happens to transfer patients?

Method A allows episodes to be triggered for beneficiaries who transfer between short-term acute inpatient (IP) hospitals during the trigger IP stay. Attribution of these episodes is based on the IP hospital in which the trigger code occurred. Under Method B, hospitalizations that include a transfer between short-term acute IP hospitals during the trigger IP stay cannot trigger an episode, though payments for such a hospitalization would be captured in an episode if the transfer hospitalization occurred during the post-discharge window of a qualifying index admission. The handling of transfers under Method B maintains consistency with the MSPB measure.