2013 QRUR Interpretation and Quality Improvement Guide

In the fall of 2014, the Centers for Medicare and Medicaid Services (CMS) disseminated Quality and Resource Use Reports (QRURs) to organizations who met certain criteria for providing services to Medicare patients in 2013. This guide intends to help organizations learn how to use their QRUR, and act on the data to improve quality and cost of care.

This guide supplements resources located on the CMS website that are dedicated to helping organizations interpret their 2013 QRUR including:

- Tips to Understand and Use the 2013 Quality and Resource Use Report (QRUR) and QRUR Supplementary Exhibits [PDF, 230KB] - This document provides tips on how physicians and groups of physicians can use the QRUR and supplementary exhibits to understand their performance and to improve quality of care, streamline resource use, and identify care coordination opportunities for one's beneficiaries.
- Questions & Answers About the 2013 Quality and Resource Use Reports [PDF, 242KB] - This document presents frequently asked questions (FAQs), and answers, that physicians and groups of physicians may have about the 2013 QRURs and the value modifier (VM).
- Detailed Methodology for the 2013 Quality and Resource Use Reports and 2015 Value-Based Payment Modifier [PDF, 912KB] - This document provides details of the technical methodology used to produce the 2013 QRURs.

This guide is divided into three sections. The first section briefly describes the purpose of the 2013 Quality and Resource Use Reports (QRURs). The second section provides a methodology to read and interpret the findings of the report for your organization. Finally, the last section describes some action steps that organizations might take to improve scores on cost and quality measures in order to improve scores on the value modifier for future years.

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SECTION 1: QRUR BASICS

What is a QRUR?

2013 Quality Resource and Use Reports (QRURs) contain information on the quality of care provided to Medicare fee-for-service (FFS) beneficiaries that organizations treated in 2013, as well as the resources used to provide that care. In September 2014, CMS provided these reports to all groups and physician solo practitioners nationwide who met two criteria: (a) at least one physician billed under the tax ID number (TIN) in 2013, and (b) the TIN had at least one eligible case for at least one of the quality or cost measures included in the QRUR.

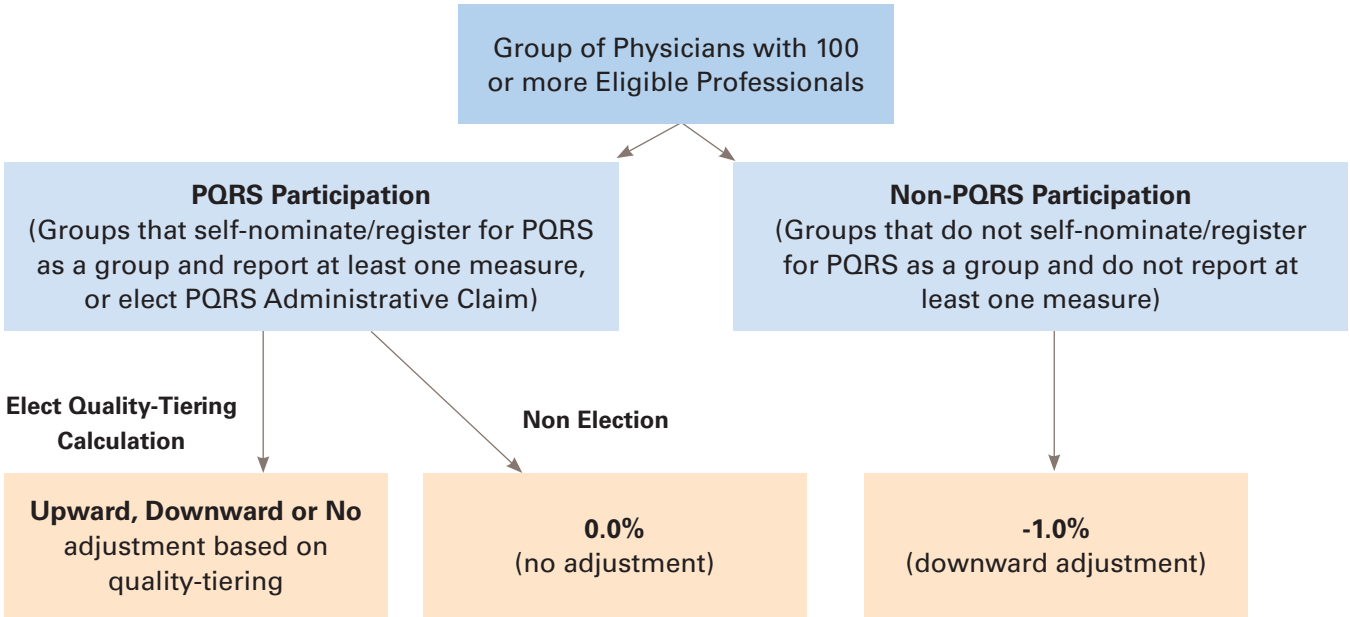
Why is your QRUR Important?

The QRURs provide comparative quality and cost data for quality improvement purposes. The report previews some of the quality and cost measures that are used in the value modifier, allowing physicians to benchmark performance. The Medicare Physician Feedback Program serves as the foundation for the value modifier which will be used to determine whether organizations get a bonus, penalty or neutral payment for Medicare services provided. Measures reflected in the QRUR are risk-adjusted, geographically standardized, and should promote systems-based care.

How does your QRUR impact the Value Modifier?

The VM is derived from a quality composite score and a cost composite score. The quality composite score summarizes a TIN's performance on quality care for Medicare beneficiaries for as many as six, equally weighted quality domains: (1) Clinical Process/Effectiveness, (2) Patient and Family Engagement, (3) Population/Public Health, (4) Patient Safety, (5) Care Coordination, and (6) Efficient Use of Healthcare Resources. The cost composite score summarizes a TIN's performance regarding resource use for its attributed Medicare beneficiaries, across two equally weighted cost domains: Per Capita Costs for All Attributed Beneficiaries and Per Capita Costs for Beneficiaries with Specific Conditions (diabetes, CAD, COPD, and heart failure).

Overview of How CMS Calculated the Value Modifier for CY 2015



How is the Value Modifier Calculated?

The value modifier is calculated at taxpayer identification number (TIN) level. The attribution method focuses on the delivery of primary services. Beneficiaries are assigned to the provider group where they received the plurality of their primary care services from primary care physicians during the year. If a beneficiary received no primary care services from a primary care provider, the beneficiary is assigned to the group where he or she received the plurality of his or her primary care services from either specialists or non-physician providers.

Quality of Care Domains: CMS aligned the quality measures reported by the groups of physicians, in addition to the three PQRS administrative claims-based outcome measures, with the six national priorities related to clinical care, patient experience, population/community health, patient safety, care coordination, and efficiency established in the National Quality Strategy. Then each of the quality measures was classified into one of these six domains. Next, CMS weighted each domain equally to form a quality of care composite. Measures within each domain were weighted equally so that physician groups had equal incentive to improve care delivery on all measures

If a domain did not contain quality measures, the remaining domains were equally weighted to form the quality of care composite. For example, if only three domains contained quality information, each domain was weighted at 33.3 percent to form the quality composite while the remaining three domains were not included.

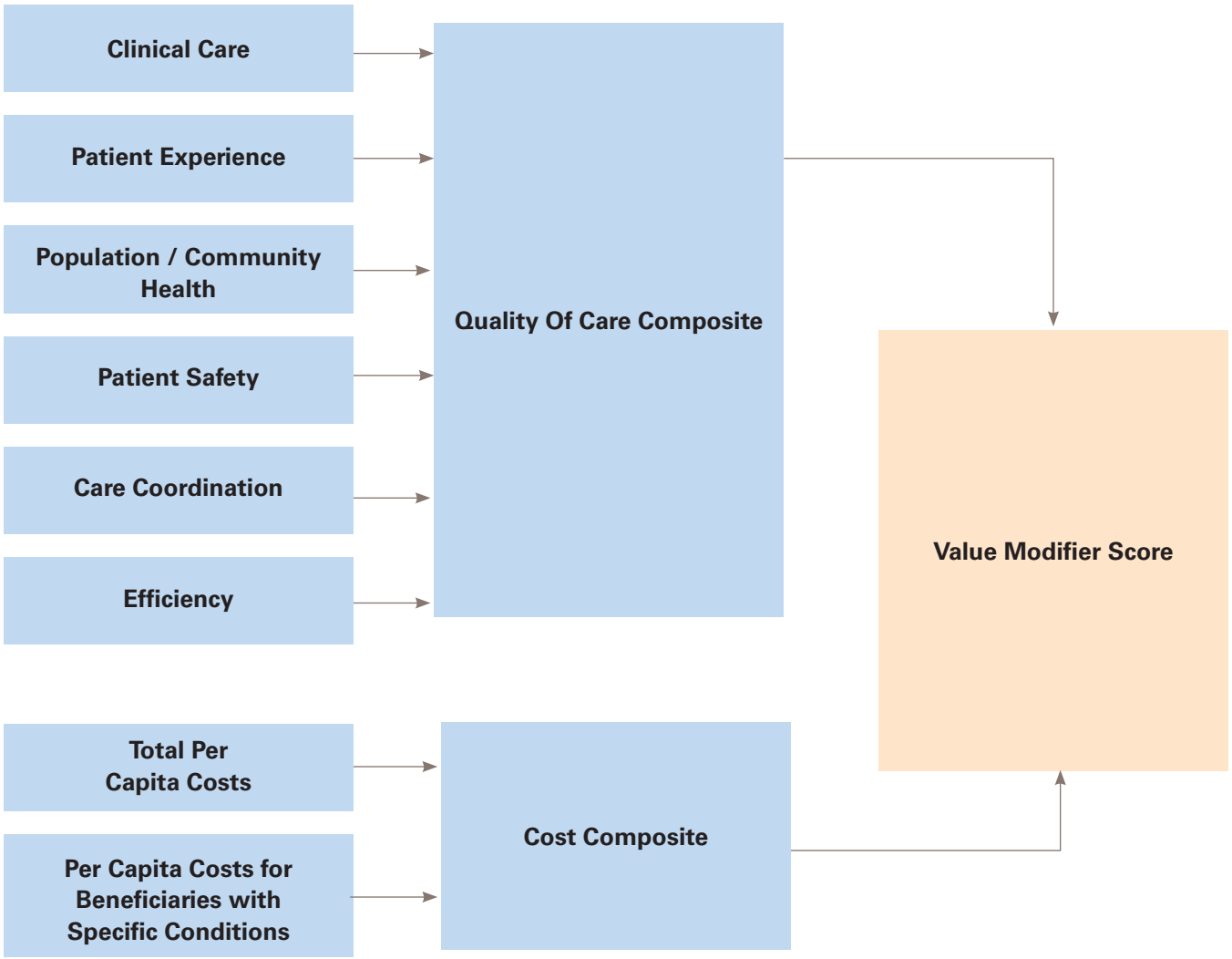
Cost Domains:

The total per capita cost measures in the QRURs include all 2013 Medicare fee-for-service Part A (hospital insurance) and Part B (medical insurance) payments to all providers who treated beneficiaries attributed to a given TIN, whether or not those providers themselves were associated with the TIN. These Medicare costs include those associated with inpatient, outpatient, skilled nursing facility, home health, hospice, durable medical equipment, and non-institutional provider/supplier services. Payments for Part D outpatient prescription drugs are not included. To the extent that Medicare claims include such information, the total per capita cost measures include payments to providers from Medicare, beneficiaries (copayments and deductibles), and third-party private payers.

The QRURs also include condition-specific per capita cost measures for Medicare beneficiaries who had at least one of the following four chronic health conditions: diabetes, coronary artery disease, chronic obstructive pulmonary disease, or heart failure. The four conditions are not mutually exclusive—CMS counted beneficiaries with more than one of these conditions within each relevant condition. Also, the condition-specific total per capita cost measures include all costs of care, not just those associated with treating the condition.

Quality Tiering

Quality tiering is the analysis used to determine the type of adjustment (upward, downward or neutral) and the range of adjustment based on performance on quality and cost measures. Quality tiering determined if a group practice's 2013 performance was statistically better, the same, or worse than the national mean.



For the 2015 value modifier, group practices with 100 or more EPs could voluntarily choose to participate in quality tiering under the value modifier. Quality tiering could result in an upward, neutral, or downward payment adjustment in 2015 for groups of 100 or more EPs. Those who did not choose quality tiering would have a neutral value modifier, which would have no impact on their payments under the MPFS.

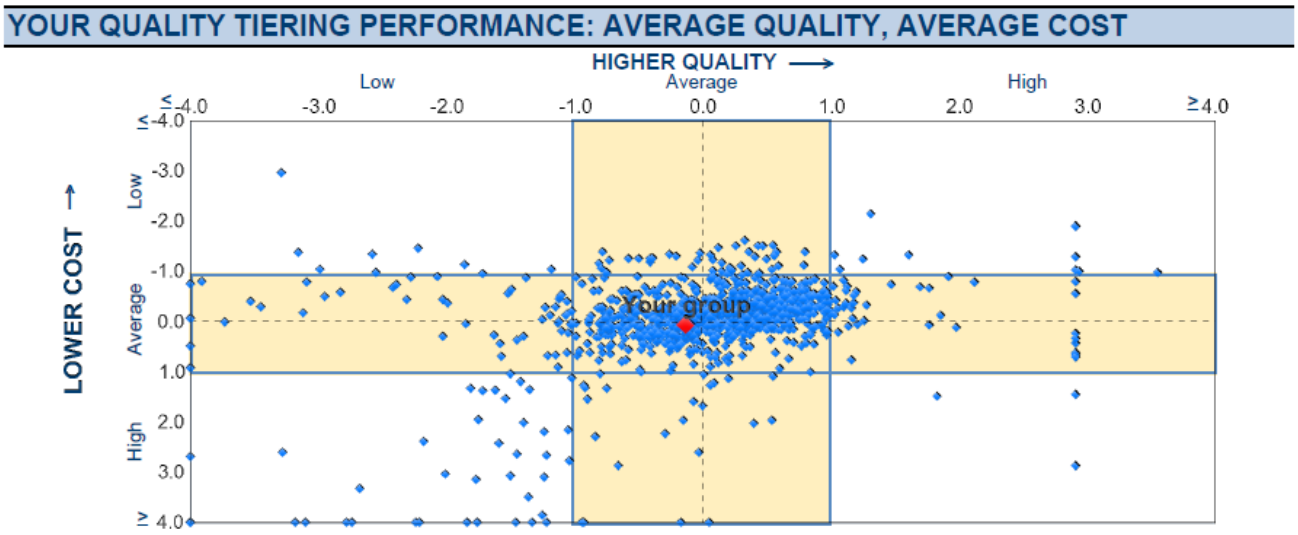
Quality/Cost	Low Cost	Average Cost	High Cost
High Quality	+2.0x*	+1.0x*	+0.0%
Medium Quality	+1.0x*	+0.0%	-0.5%
Low Quality	+0.0%	-0.5%	-1.0%

Since the total sum of downward adjustments is unknown at this time, CMS cannot determine specific upward payment amount percentage. Rather, as shown in the table above, CMS will give groups that provide high quality and low cost care the highest upward adjustment. The value of "x" will depend on the total sum of negative adjustments in a given year. In addition, to ensure that the value modifier encourages physicians to care for the severely ill and beneficiaries with complicated cases, CMS will provide an additional upward payment adjustment for groups of physicians furnishing services to high-risk beneficiaries.

SECTION 2: HOW TO READ YOUR QRUR

The QRUR can seem daunting to understand since there are so many tables with complicated calculations displayed. Here we describe one methodology for reading and interpreting your report to make it more understandable and actionable.

1. Look first at page three. This page shows how you compare to other groups on cost and quality measures. In order to be eligible for a bonus, you must be above a 1.0 for quality or below a -1.0 for cost. The bottom part of the page shows your average beneficiary risk percentile and your adjustment factor. This is the big picture of the report.



2. Next, look on page 7, Exhibit 4. The top line (Standardized Quality Composite Score) is the same value we just saw for quality on page 3. That number shows how your Average Quality Composite Score compares to other groups. The Average Quality Composite Score is calculated as an average of each of the domains on that table (Clinical Process/Effectiveness, Patient and Family Engagement, etc.) Not all groups will have scores for all domains—this depends on which measures you chose to report for the performance year. Note also how many measures were used to calculate the standardized score for each domain. The number of measures is not equal across all domains. Since all domains are weighted equally, individual measures within the domains with fewer measures have a larger impact on the total score. The following pages show the measures that comprise each domain.

Quality Domain	Number of Quality Indicators	Standardized Score
Standardized Quality Composite Score	**16**	**-0.13(Average)**
Average Domain Score	16	-0.36
Clinical Process/Effectiveness	11	-0.80
Population/Public Health	1	-0.13
Patient Safety	1	-0.22
Care Coordination	3	-0.31

3. For all of the measures on Exhibit 5 (multiple pages), the first column you should look at is your performance rate. You should determine whether your performance meets the quality goals you set for your group and the performance you see in internal quality reports. The next column you should look at is the one that is second from the right, the Standardized Score. These are the values that are averaged to make your total domain score (if you are familiar with statistics, your standardized score is the z-score for the measure). For this column, 0.00 is average, larger than 1.00 puts you into bonus territory, and less than -1.00 puts you into penalty territory. You should pay special attention to improvement opportunities where you have a negative standardized score, as these are the measures where you are most under-performing your peers. Make a list of all the measures where you have a negative standardized score.

PQRS Measure Number and Name	Your Performance		Peer Group Performance			Contribution to Your Domain Score	
	Eligible Cases	Performance Rate	Benchmark Rate	Average Range: Benchmark –1 Standard Deviation	Average Range: Benchmark +1 Standard Deviation	Standardized Score	Included In Domain Score
Bone, Joint, and Muscle Disorders							
- Osteoporosis Management in Women ≥ 67 Who Had a Fracture	53	9.43%	14.54%	7.87%	21.20%	-0.77	Yes
Chronic Obstructive Pulmonary Disease (COPD)							
- Use of Spirometry Testing to Diagnose Chronic Obstructive Pulmonary Disease (COPD)	167	32.34%	31.35%	17.24%	45.45%	0.07	Yes

- Special note: All measures within each domain are weighted equally when generating the domain score, regardless of the number of eligible cases (assuming that there is a minimum of 20 eligible cases). That means that improving performance on measures with few eligible cases by one or two individuals may have an outsized impact on your total score.

4. Now look at Exhibit 7. This is similar to Exhibit 4 only for the cost component of the modifier. Again, the Standardized Cost Composite Score is what goes into the modifier on page 3.That shows how your Average Cost Composite Score compares to your peers. In this instance, negative standardized scores indicate lower costs (better performance) and positive scores indicate higher costs (worse performance).

Cost Categories	Your Medical Group Practice's Performance			Performance of All 1,032 Groups with at Least 100 Eligible Professionals		
	Number of Eligible Cases	Per Capita Costs Before Risk Adjustment	Per Capita Costs After Risk Adjustment	Benchmark Per Capita Costs (Risk-Adjusted)	Average Range	
					Benchmark –1 Standard Deviation	Benchmark +1 Standard Deviation
Per Capita Costs for All Attributed Beneficiaries (Domain Score = + 0.41)						
All Beneficiaries	1,351	$19,135	$10,898	$10,265	$8,722	$11,808
Per Capita Costs for Beneficiaries with Specific Conditions (Domain Score = - 0.03)						
Diabetes	373	$25,396	$14,732	$14,788	$12,379	$17,198
COPD	139	$36,685	$24,396	$24,153	$19,840	$28,466
Coronary Artery Disease	418	$26,036	$17,750	$17,265	$14,415	$20,115
Heart Failure	227	$34,857	$24,467	$26,013	$21,237	$30,788

5. Now look at Exhibit 8 and the Standardized Score column. Make a list of all the measures where you have a positive standardized score to set a target for improvement.

Cost Domain	Standardized Score
Standardized Cost Composite Score	**0.04(Average)**
Average Domain Score	0.19
Per Capita Costs for *All* Attributed Beneficiaries	0.41
Per Capita Costs for Beneficiaries *with Specific Conditions*	-0.03

6. Look at Exhibit 10. First notice the right-most column. Numbers that are not in parentheses are where your group is spending more per capita than your peer groups. These per capita costs have two key components: per user costs and percent of population who are users. So you probably want to look at overall costs, but also the two columns of the percentage of beneficiaries using services in this category. There may be instances where your costs are high because more of your patients are being hospitalized than one would expect based on their risk profile or because more of them are receiving imaging and outpatient laboratory tests. This is an opportunity to evaluate whether you are providing the proper levels of care—enough good care to keep people out of the hospital while avoiding unnecessary care that drives up costs.

Service Category	Your Medical Group Practice			Mean for All 1,032 Groups with at Least 100 Eligible Professionals		Amount by Which Your Group's Costs Were Higher or (Lower) than Peer Group Mean
	Your Medicare Patients Using Any Service in This Category		Risk-Adjusted Per Capita Costs	Medicare Patients Using Any Service in This Category	Risk-Adjusted Per Capita Costs	
	Number	Percentage				
All Services	**1,351**	**100.0%**	**$10,898**	**100.0%**	**$10,265**	**$633**
Evaluation and Management (E&M) Services in All Non-Emergency Settings						
All E&M Services Provided by YOUR Group	**1,351**	**100.0%**	**$357**	**100.0%**	**$541**	**($184)**
Primary Care Physicians	313	23.2%	$62	78.6%	$338	($276)
Medical Specialists	1,234	91.3%	$254	32.3%	$106	$148
Surgeons	0	0.0%	$0	22.4%	$42	($42)
Other Eligible Professionals	399	29.5%	$41	27.2%	$54	($14)
All E&M Services Provided by OTHER Groups	**1,053**	**77.9%**	**$310**	**81.0%**	**$622**	**($312)**
Primary Care Physicians	285	21.1%	$62	24.6%	$88	($26)
Medical Specialists, Surgeons, and Other Eligible Professionals	1,024	75.8%	$248	78.9%	$534	($286)

7. Lastly, look through the exhibits that we skipped in case there is anything else that jumps out for your organization to address.

   - Special note: Double check Supplementary Exhibit 1 to make sure all of the providers for whom data was used to generate this report are actually part of your group. Also confirm that their specialties are correct. Group specialist mix is included in the cost adjustment methodologies in future years.

Frequently Asked Questions

1. How are beneficiaries attributed to my practice?

Beneficiaries are assigned to the provider group where they received the plurality of their primary care services from primary care physicians during the year. If a beneficiary received no primary care services from a primary care provider, the beneficiary is assigned to the group where he or she received the plurality of his or her primary care services from either specialists or non-physician providers. Beneficiaries are not attributed to any medical group if:

- They were enrolled in only Part A or only Part B for any portion of the year
- They were enrolled in Part C for any portion of the year
- They resided outside the United States for any portion of the year
- They had no allowable Medicare charges for primary care services for the year

2. How is the cost data risk-adjusted?

Patient risk is assessed using the standard CMS risk-adjustment methodology using Hierarchical Condition Categories (HCCs). This method includes pulling diagnosis codes from claims for up to one year prior to the event in question and determining predicted patient costs based on those diagnoses.

SECTION 3: QUALITY AND COST IMPROVEMENT STRATEGIES

Next we will look at ways to improve quality and reduce cost in order to improve value modifier scores. In addition, we provide a brief description of support needed for each item so you can identify processes or resources needed for improvement.

Quality/Cost Domain	Quality Improvement Strategies	Support Needed

Clinical Process/Effectiveness	• Decide who should run quality improvement reports and how often and in what capacity they should be shared with care teams.
	• Run lists by care team of patients diagnosed with DM, IVD, and depression to identify care gaps.
	• Run lists by race/ethnicity and language to identify care gaps.
	• Provide regular reports to care teams on progress with priority measures.
	• Provide care team members with dedicated time to work the reports.
	• Run lists by care team of women ≥ 67 who had a fracture to manage osteoporosis.
	• Run lists by care team of women 50-74 years old who need a breast cancer screening.
	  • Assign care team members to work these reports
	  • Provide care team members with dedicated time to work the reports.
	  • Decide how often these lists should be run and who should follow up with making sure patients have been notified of gaps
		• Staff should be trained in how to collect demographic data in order to get the most accurate and complete results possible.
		• Patients need to be attributed to care teams so reports can reflect teams' patients accurately. Through the Safety Net Medical Home Initiative, Qualis Health has published an Empanelment Implementation Guide that describes a methodology for patient attribution.
		• Problem list policies should detail who can update diagnoses in the patient chart.
		• Data and clinical definitions should be made for priority diagnoses so that reports reflect all patients being diagnosed with these conditions.
		• Clinic policies should include guidelines for schedule of reports and patient outreach.

Patient and Family Engagement	The AHRQ Guide to Patient and Family Engagement in Hospital Quality and Safety lists four steps to improving patient engagement: • Step 1: Identify opportunities for patient and family engagement efforts at your hospital. • Step 2: Get commitment from and the support of hospital leadership. • Step 3: Form a multidisciplinary team that includes patients and families to plan implementation of the Guide strategies • Step 4: Implement and evaluate the Guide strategies.	• Leadership must make patient engagement a priority and proactively seek ways to involve patients in quality improvement efforts. • Create forums for patients to begin participating in quality improvement efforts – you might start with an "experience" issue such as customer service before moving to clinical care.

Quality/Cost Domain	Quality Improvement Strategies	Support Needed
Population/ Public Health	• Make sure that appropriate workflows are in place and reviewed regularly to ensure that preventive services such as tobacco screening and cessation counseling, depression screening and referrals, and BMI screening and follow up are in place.	• Quality Improvement teams should regularly monitor priority public health measures in order to make sure that standard workflows are in place and information is being documented and billed appropriately. Consider resources such as the US Preventive Services Task Force to monitor changes in evidence-based guidelines. • Leadership must support staff time dedicated to working reports and recalling patients as necessary.

Patient Safety	• Have your coders study the measure specifications to make sure they are documenting and billing in alignment with the measures of interest. You don't want to provide the care but not get credit for it.
	• Create a drug formulary to minimize the occurrence of prescriptions for high-risk medications.
	• Establish clinical decision support (CDS) to help avoid use of high risk medications in the elderly.
	• Review medications on the list available on the NCQA website.
	• Regular follow up with patients on Warfarin
	  • For patients with INRs outside the therapeutic range, consider shorter retest intervals
	  • Consider patient self-testing
	• Run list of patients on Warfarin by race/ethnicity/language to identify care gaps.
		• EHR super user should be responsible for making sure CDS is up-to-date and functioning properly.
		• Care team should review patients receiving high risk medications and look for alternative medications.
		• Consider policies for when to use specific types of medication.
		• Consider workflows for avoiding inappropriate antibiotic use; reducing polypharmacy; working with pharmacists to track and intervene with drug-drug/ drug-patient, drug-bug mismatches; reducing/eliminating antipsychotics for dementia patients without psychosis.

Quality/Cost Domain	Quality Improvement Strategies	Support Needed
Care Coordination	• Identify diagnosis codes for mental illness that need follow up within 7 or 30 days. • Establish system to flag high-risk patients and document follow-up. • Identify highest risk patients for readmissions and provide with care management. For example, use history of prior admissions/ readmissions as an important indicator. • Work with your hospitals so that your group is informed when patients are admitted and discharged. This may help with some of the necessary care coordination tasks such as follow-up after hospitalization for mental illness and readmission reductions.	• Problem list policy helps make sure that the problem list is updated appropriately. • Care managers responsible for highest risk patients should make sure that patients get support they need to be seen. • A strong relationship with nearby hospitals helps maintain communication mechanisms when patients transition care. Take a field trip to local emergency departments (EDs) and hospitals; establish warm handovers at transitions.
Efficient Use of Healthcare Resources	• Make sure that processes are in place to eliminate unnecessary orders or tests, such as monitoring the use of imaging studies for low back pain.	• A system should be in place to make sure orders are regularly monitored to determine that they are necessary and appropriate. The Choosing Wisely initiative is a helpful resource to help providers ensure the right care is delivered at the right time. • Create and/or use already validated protocols to triage and appropriately refer patients to correct level of care. • Establish 24/7 capability to answer patient calls and questions.

Quality/Cost Domain	Quality Improvement Strategies	Support Needed
Cost Measures	• Use data to profile the cost of care by physician. Average your patient costs by provider from Supplementary Exhibit 2 to see who your high-cost providers are. Keep in mind that their data are risk-adjusted and cost standardized, which should account for differences in patient populations. You may also want to see which physicians with hospitalized patients (Supplementary Exhibit 3) have the highest readmission rates. • Make sure your coders are coding diagnoses robustly; Medicare risk-adjusts the cost measures, so you want to make sure that Medicare has an accurate picture of patient complexity. • Identify your high-cost patients from Supplementary Exhibit 2. See if you can improve the quality of preventive care that is provided and assess whether there are non-inpatient services that may be of use (skilled nursing care, adult family homes, mental health treatment, hospice care, etc.). • Note: In the future, There will be an additional cost measure (Spending per hospital patient with Medicare, see Exhibit 13). Patients will be assigned to your practice if you provide the plurality of Part B services during the inpatient stay. The costs include all Part A and Part B payments 3 days before, during, and 30 days after hospitalization. Look at Supplementary Exhibit 4 and track the data by provider to see where there may be opportunities to improve particularly post-acute referral patterns.	• Strong relationships and communication among billers, quality improvement champions, data analysts and physician champions help ensure that the correct information about evidence based care provided is being captured in patient charts and billed appropriately. • Create protocols to answer patient questions 24/7 and educate patients about appropriate use of high cost, high risk services such as hospital and ED. • Encourage all patients to have advanced directives and work with local palliative and hospice providers to develop an approach to end-of-life conversations.

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