QUALIS HEALTH
PRACTICE INNOVATION NETWORK

2014 QRUR Interpretation and Quality Improvement Guide

December 2015

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

QUALIS HEALTH

It's challenging to stay abreast of noteworthy changes taking place in the healthcare industry, especially as payers transition from fee-for-service payments to value-based reimbursement models.

In September 2015, Centers for Medicare and Medicaid Services (CMS) disseminated annual Quality and Resource Use Reports (QRURs) to organizations that provided services to Medicare fee-for-service (FFS) patients in 2014. The annual 2014 QRUR is the final summary report used to calculate the Value Modifier (VM) and the resulting payment adjustment for physicians for Medicare claims in 2016. It's a critical component to understanding value-based payment.

This guide educates organizations about how to interpret their annual QRUR reports and act on the data to improve quality and lower the cost of care.

Additional resources are located on the CMS website to help organizations interpret their 2014 QRUR including:

- Understanding Your QRUR
- Sample QRUR
- Detailed Methodology for the 2016 Value Modifier and the 2014 Quality and Resource Use Report
  This document provides details of the technical methodology used to produce the 2014 QRURs.

This guide is divided into three sections. The first section briefly describes the purpose of the 2014 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 increase the value modifier for future years.

SECTION 1: QRUR BASICS

What is a QRUR?

Quality Resource and Use Reports (QRURs) contain information about the quality and cost of care provided to Medicare fee-for-service (FFS) beneficiaries treated in 2014. In September 2015, 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 2014, and (b) the TIN had at least one eligible case for at least one of the quality or cost measures included in the QRUR. The 2014 Annual QRURs are also available for groups and solo practitioners that participated in the Medicare Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care Initiative in 2014.

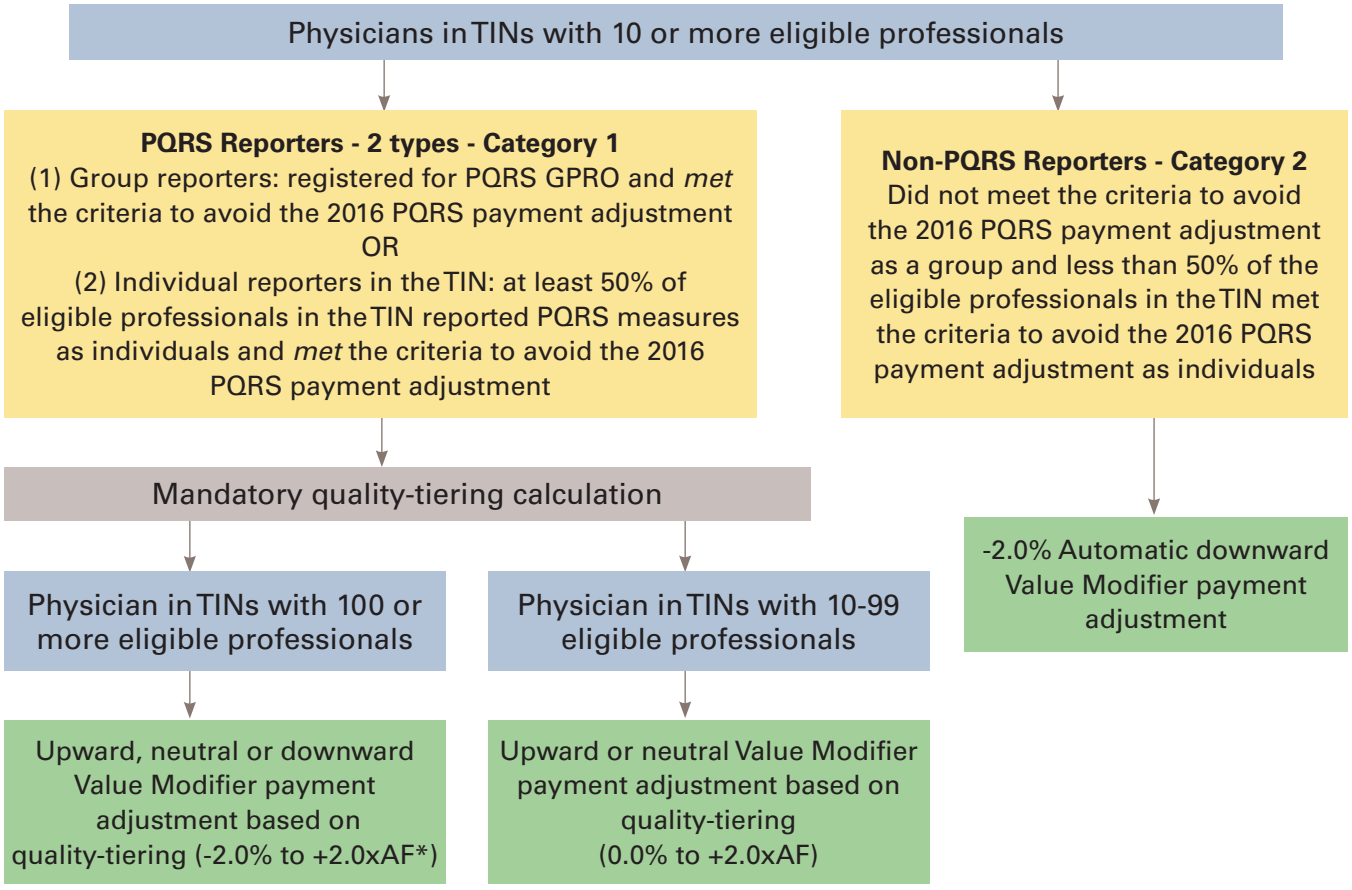
Why is your Annual QRUR Important?

The Annual QRUR provides comparative quality and cost data and allows providers to benchmark their performance against their peers. Measures reflected in the QRUR are risk-adjusted, geographically standardized, and are intended to promote systems-based care.

How does the Annual QRUR affect the Value Modifier and future Medicare payments?

For physicians in groups (as identified by their TIN) with 10 or more eligible professionals (EPs), the annual 2014 QRUR is the final summary report used to calculate the Value Modifier (VM) and the resulting payment adjustment for physicians for Medicare claims in 2016. For TINs with nine or fewer EPs, the annual QRUR is for informational purposes only and will not affect 2016 Medicare payments. You can read more about the value modifier here.

The following diagram illustrates the way information in the annual QRUR will affect 2016 Physician Fee Service Medicare payments.



* *The precise size of the reward for higher-performing TINS will vary from year to year, based on an adjustment factor (AF) derived from actuarial estimates of projected billings. The AF for the year 2016 Value Modifier will be posted here.*

How is the Value Modifier Calculated?

The VM is derived from a *quality composite score* and a c*ost composite score*.

- The *quality composite score* summarizes a TIN's performance on quality care for Medicare FFS beneficiaries for as many as six, equally weighted quality domains: (1) Effective Clinical Care, (2) Person and Caregiver Centered Experience and Outcomes, (3) Community/Population Health, (4) Patient Safety, (5) Communication and Care Coordination, and (6) Efficiency and Cost Reduction.

- The *cost composite score* summarizes a TIN's performance regarding resource use for its attributed FFS 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, coronary artery disease [CAD], chronic obstructive pulmonary disease [COPD], and heart failure).

What is 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, as compared to a national mean. Quality tiering could result in an upward, neutral, or downward payment adjustment in 2016 for groups of 100 or more EPs, and an upward or neutral payment adjustment for groups of 10–99 EPs.

Quality-tiering payment adjustment for TINs with 10–99 EPs

	Low quality	Average quality	High quality
Low cost	0%	+1%	+2%
Average cost	0%	0%	+1%
High cost	0%	0%	0%

Quality-tiering payment adjustment for TINs with 100 or more EPs

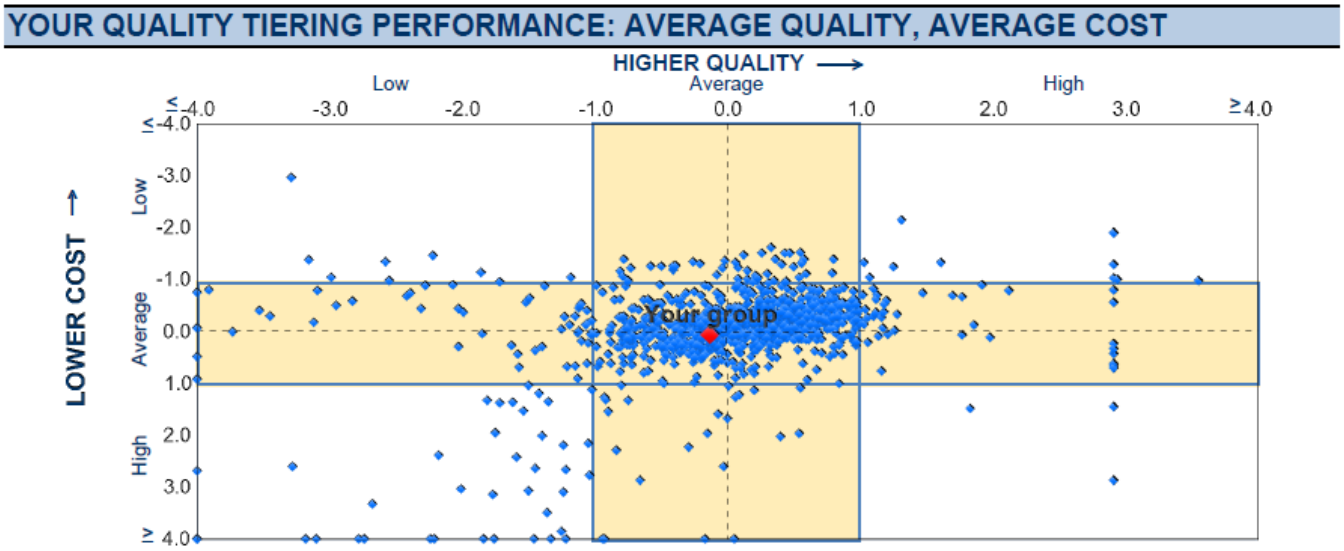
	Low quality	Average quality	High quality
Low cost	0%	+1%	+2%
Average cost	-1%	0%	+1%
High cost	-2%	-1%	0%

SECTION 2: HOW TO INTERPRET YOUR QRUR

The QRUR can seem daunting. The following is one suggested methodology for reading and interpreting the report to make it more understandable and actionable.

In the sample scatter plot below, the TIN has a **quality composite score of -0.13** and a **cost composite score of 0.28**.

A TIN comparison chart allows for comparing to other organizations.



Additionally, on this same page is your TIN's value modifier and payment adjustment. The TIN in this sample (highlighted in blue) has average cost and quality scores and will receive a neutral payment adjustment.

Your TIN's Value Modifier: Neutral Adjustment

The highlighted payment adjustment will be applied to payments under the Medicare Physician Fee Schedule for physicians billing under in your TIN in 2016.

	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0 x AF	+2.0 x AF
Average Cost	-1.0%	**0.0%**	+1.0 x AF
High Cost	-2.0%	-1.0%	0.0%

Note: Quality and Cost Composite Scores that could not be calculated due to insufficient data are categorized as "Average" for the purposes of determining the Value Modifier payment adjustment under quality tiering. The displayed payment adjustment includes the high-risk bonus adjustment, if applicable. The precise size of the reward for higher performing TINs will vary from year to year, based on an adjustment factor (AF) derived from actuarial estimates of projected billings. The AF for the 2016 Value Modifier will be posted at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.

Exhibit 5, provides more details about your TIN's quality composite score. The sample table below, found in Exhibit 5, lists quality tier designations for each of the six quality domains. **Please note that all sample tables in this guide contain fictitious data.**

Exhibit 5

Quality Domain	Number of Quality Measures Included in Composite Score	Standardized Performance Score (Quality Tier Designation)
Quality Composite Score	16	-0.13
Effective Clinical Care	11	-0.80
Person and Caregiver-Centered Experience and Outcomes	0	---
Community/Population Health	1	-0.13
Patient Safety	1	-0.22
Communication and Care Coordination	1	-0.31
Efficiency and Cost Reduction	0	---

Exhibit 6 details your TIN's performance on specific quality measures, broken down by quality domain. It contains many tables. Following is a sample table for the Effective Clinical Care domain.

Exhibit 6

Measure Reference	Measure Name	Your TIN's Eligible Cases	Your TIN's Performance Rate	Benchmark	Benchmark -1 Standard Deviation	Benchmark +1 Standard Deviation	Standardized Score	Included in Domain Score?
111	Preventive Care and Screening: Pneumococcal Vaccination for Older Adults	774	89.78%	45.42%	14.41%	76.42%	1.43	Yes
-	Diabetes Mellitus (DM): Composite (All or Nothing Scoring)	867	55.09%	25.50%	12.96%	37.43%	2.36	Yes
204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	389	58.55%	70.56%	46.12%	95.00%	-0.49	Yes
236	Hypertension (HTN): Controlling High Blood Pressure	437	82.43%	73.99%	54.77%	93.22%	0.44	Yes
-	Coronary Artery Disease (CAD): Composite (All or Nothing Screening)	328	43.01%	68.09%	53.61%	82.56%	-1.73	Yes

First look at 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. Next, look at your 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). 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.

Note that this table also includes your TIN's eligible cases for each measure listed. 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.

In Exhibit 9, you will find cost information. The cost domain information is similar to that presented in Exhibit 5, but for costs instead of quality. The Standardized Cost Composite Score shows how your Average Cost Composite Score compares to your peers.

Exhibit 9

Cost Domain	Number of Cost Measures Included in Composite Score	Standardized Performance Score (Cost Tier Designation)
Cost Composite Score	**6**	**0.28 (Average)**
Per Capita Costs for All Attributed Beneficiaries	2	-0.54
Per Capita Costs for Beneficiaries with Specific Conditions	4	0.85

Exhibit 10 provides more detail about costs, broken down by costs for all beneficiaries and for those with specific conditions.

Exhibit 10

Cost Domain	Cost Measures	Your TIN's Eligible Cases or Episodes	Your TIN's Per Capita or Per Episode Costs	Benchmark	Benchmark -1 Standard Deviation	Benchmark +1 Standard Deviation	Standardized Score	Included in Domain Score?
Per Capita Costs for All Attributed Beneficiaries	Per Capita Costs for All Attributed Beneficiaries	8,076	$9,998	$10,907	$8,066	$13,749	0.32	Yes
	Medicare Spending per Beneficiary	1,597	$22,712	$20,475	$18,877	$22,073	-1.40	Yes
Per Capita Costs for Beneficiaries with Specific Conditions	Diabetes	2,465	9,329	$15,826	$11,466	$20,185	1.49	Yes
	Chronic Obstructive Pulmonary Disease (COPD	947	$12,760	$24,854	$17,524	$32,185	1.65	Yes
	Coronary Artery Disease (CAD)	932	$15,020	$18,234	$13,132	$23,336	0.63	Yes
	Heart Failure	1,206	$32,836	$28,033	$19,606	$36,460	-0.57	Yes

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
Effective Clinical Care	• 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 for patients with selected diagnoses. You may want to focus on patients with one of the conditions identified by CMS in its cost composite score: diabetes, CAD, COPD or heat failure. Alternatively, you might select a condition that corresponds to a measure for which your practice received a standardized score of less than zero. • 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. • Decide how often these lists should be run and who should follow-up to make sure patients have been notified of the 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 forpatient 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.

Quality/Cost Domain	Quality Improvement Strategies	Support Needed
Person- and Caregiver-Centered Experience and Outcomes	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.
Community / Population 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.

Quality/Cost Domain	Quality Improvement Strategies	Support Needed

Patient Safety	• Have your coders study the measure specifications to make sure they are documenting and billing in alignment with the measures of interest. Make sure you receive credit for the care you provide.
	• 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
Communication and Care Coordination	• 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.
Efficiency and Cost Reduction	• 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.).	• 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.

For more information, please contact:

Kelley Carnwath, MPH, CPHIT
Quality Improvement Principal, Qualis Health
(206) 288-2574
KelleyC@qualishealth.org

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

QUALIS HEALTH

This material was prepared by Qualis Health, the Medicare Quality Innovation Network - Quality Improvement Organization (QIN-QIO) for Idaho and Washington, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. ID/WA-HITC-QH-2048-12-15