Frequently Asked Questions Regarding the 2011 Supplemental Quality and Resource Use Reports (QRURs)

August 2013

Acumen, LLC
500 Airport Blvd., Suite 365
Burlingame, CA 94010

[This page is intentionally left blank.]

PROVIDING FEEDBACK

1. How can groups provide feedback on the Supplemental QRURs?

Comments can be provided through the QRUR episodes web portal discussion board for the 2011 groups or by emailing QRUREpisodes@AcumenLLC.com. Comments you provide can only be seen by your medical group practice, Centers for Medicare & Medicaid Services (CMS), and CMS-designated contractors (Acumen). When sending comments and questions, do not post or email any person-level identifiers or other confidential information such as beneficiary health insurance claim number or social security number. If there is a particular episode that you are providing feedback on or using as an example, please share the episode number.

2. When is the cutoff for providing feedback?

Please provide all comments by **September 16, 2013**. We would like to receive feedback no later than this date so that it is possible to consider it during development of the next iteration of reports (which will use 2012 data).

3. Will the CMS Episode Grouper software be publicly available?

The current plan is to make the CMS Episode Grouper publicly available on the CMS Episode Grouper website in the future (located at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Episode-Costs-and-Medicare-Episode-Grouper.html). More details will be forthcoming.

ACTIONABILITY OF THE REPORTS

1. How do groups use the data and act on the information in the reports?

This is Medicare's first attempt to develop episode-based costs for pneumonia and cardio-related episodes of care to supplement the existing total per capita cost information in the annual QRURs. The data are intended to complement medical groups' systematic efforts to improve the efficiency of medical care furnished to the Medicare fee-for-service patients. This information is meant to open discussion for further analysis by the medical group. The data include group-specific information on volume for certain episodes, actual and relative episode costs, and utilization of specific service types and the costs of these services. The data also include the national mean costs for each episode to help groups identify potential factors contributing to episode costs above and below the national mean.

Groups, for example, can examine the drivers of their high- and low-cost episodes to determine where opportunities lie for improvement. For the high-cost episodes, groups can review patient information (using their chart or a discussion with the suggested lead eligible

professional (EP), for example) and see whether the care was appropriately delivered or whether there were gaps/redundancies that unexpectedly drove up the costs. Likewise, groups could examine why the low-cost episodes are low and whether appropriate care was furnished.

2. Is this the same information that organizations will receive for 2012 that we will need to use to elect quality tiering for the Value Based Modifier - or will that report also contain quality data?

No, this episode information is completely separate from the Value Based Modifier. The 2012 QRURs that will be made available on **September 16, 2013** will provide the group's quality of care composite and cost composite based on your 2012 performance on quality measures and total per capita costs and total per capita costs measures for beneficiaries with four chronic conditions (chronic obstructive pulmonary disease, heart failure, coronary artery disease, and diabetes). It is this information on your performance on the quality of care and cost composites for performance year 2012 that should be used to inform your decision about electing quality tiering for the 2015 Value Based Modifier.

3. What is the role of the episode groupers beyond CY 2015? Can you explain how episodes will be incorporated into the Value Based Modifier in 2016 and beyond?

We are gaining experience with the CMS Episode Grouper. The output from the Episode Grouper is being used for informational purposes only and not proposed to be part of the Value Based Modifier. Please stay tuned to future physician fee schedule (PFS) rules for further information on CMS' plans for 2017 and beyond.

INFORMATION INCLUDED IN THE SUPPLEMENTAL QRURS

1. Why are episode costs only shown as payment-standardized?

All costs were payment-standardized to eliminate geographic differences in rates paid within Medicare payment systems. Payment standardization assigns a standardized payment for each service so that the price Medicare paid for a service is identical across all geographic regions. We have focused on payment-standardized costs instead of non-standardized costs because comparisons of episode costs are made from benchmarks derived from a national sample. Payment standardization allows a medical group to assess why it has higher or lower costs than the national average for reasons not due to geographic payment differences. Reporting non-standardized costs would highlight regional variation in payment rules instead of differences in efficiency of care.

2. Why were specific choices made in the Supplemental QRURs? For example, why do the reports benchmark the top 20%?

CMS has flexibility in how we present the data from the CMS Episode Grouper in the 2011 Supplemental QRURs. The choice of examining the top 20% of episodes in Exhibit 2 of the Supplemental QRURs, for example, was selected because it is a common cut point for a group to be able to get a sense of its highest cost episodes. Additional or alternative cut points could have been chosen. We tried to balance the goal of presenting enough usable information at a high level (i.e., Exhibits 1, 2, and 3) while ensuring that the initial supplemental reports are a manageable length for clarity. We welcome feedback on what information would be most useful for the groups.

3. How are CMS and Acumen preparing the episode modeling analysis for transition to ICD-10?

The initial version of the CMS Episode Grouper is undergoing multiple changes to create the next version of the grouper. Starting in Program Year (PY) 2014, future QRURs will present episode data that will use a version of the grouper that uses the International Classification of Diseases (ICD) Tenth Revision (ICD-10) codes instead of ICD-9 codes.

EPISODE CLINICAL LOGIC

1. Can patients have more than one episode open at a time?

Yes. Patients may have multiple conditions that are concurrent. The CMS Episode Grouper allows multiple episodes to be open at a time and may split costs of services between open episodes. Acute myocardial infarction (AMI), percutaneous coronary intervention (PCI) without AMI, and coronary artery bypass graft (CABG) without AMI episodes will automatically open an episode of coronary artery disease (CAD). Therefore, if the patient has a PCI, they also will have a CAD episode open at the same time, and the Supplemental QRURs analyze those episodes separately to observe the costs of the chronic ongoing condition and the costs of the acute episode or treatment episode.

2. Are procedural and acute episode costs included in total costs for the underlying chronic condition?

Yes. Episode costs for a patient with a CAD episode that has an AMI with a PCI performed will reflect the total costs of care for that chronic condition, including costs from the acute exacerbation (AMI) and the procedure (PCI). Similarly, episode costs for an AMI with PCI will include some of the costs of the PCI, reflecting the total cost of care for that acute condition. However, group attribution and suggested lead EP identification rules for the episodes vary, so in

this case, the CAD, AMI, and PCI may all be attributed to different groups and/or have different EPs identified as suggested lead EP within a group.

3. Why are costs for PCI without AMI episodes less variable than costs for other episode types?

PCI without AMI and CABG without AMI both have relatively lower levels of variability in costs compared to the other episode types in the 2011 Supplemental QRURs. These procedure-based episodes represent more specific courses of care than chronic or acute episodes. In addition, chronic and acute episodes include all costs of care related to the condition, which may include costs from acute exacerbations and treatments. For example, a CAD episode may include costs from both an AMI and a PCI. Therefore, it is expected that episode costs for PCI without AMI and CABG without AMI would be less variable than the costs of other episodes types in the 2011 Supplemental QRURs.

MEDICAL GROUP ATTRIBUTION

1. What is the degree of granularity of the medical group attribution method?

Attribution is done at the group level. Please refer to Appendix A.1 and A.2 in the 2011 Supplemental QRUR User's Guide for more information about the group attribution methodology and granularity of the suggested lead EP identification methodology, respectively. We developed the attribution rules by considering how to best encourage care coordination. The group attribution methodology varied by episode type to most sensibly reflect who holds accountability based on type of care delivered. For example, acute medical conditions such as AMI were attributed to medical groups if they had at least 35 percent of evaluation and management (E&M) visits or at least 35 percent of professional costs billed, as this reflected that group's close involvement in patient care. However, procedures such as PCI without AMI episodes were attributed to the group that included the EP/surgeon(s) responsible for the procedure that triggered the episode. This more closely reflects the accountability assumed by the performing surgeon for procedures and surgeries. The suggested lead EP identification methodology also varied by episode type. For example, suggested lead EPs were identified for AMI episodes using E&M visits during the trigger inpatient stay, while suggested lead EPs were identified for PCI without AMI episodes using the performing surgeon for the procedure.

IDENTIFICATION OF SUGGESTED LEAD EP

1. Currently, the measurement profiles are at the group level. Will this expand to the individual physician level within a group, and when?

In the 2011 Supplemental QRURs, a suggested lead eligible professional was identified for each episode for informational purposes. At this time, there is no plan to expand the episode analyses to the individual physician level.

RISK ADJUSTMENT

1. What data does the risk adjustment methodology use?

The risk adjustment approach uses Medicare fee-for-service claims in the year prior to the episode. All aspects of the CMS Episode Grouper, including the risk adjustment approach, use only information found on Medicare claims and enrollment files and do not use data from clinical registries.

2. What is the relationship between the adjustment and the complexity of the patient when risk adjusting?

More complex patients have their episode costs adjusted downward. If a group's average risk-adjusted costs are lower than its non-risk-adjusted costs, its 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.

3. Was a risk score calculated for our attributed beneficiaries within each of our categories or was a national risk score calculated?

The CMS Episode Grouper risk-adjustment methodology calculated risk-adjusted costs for each major episode type separately. Within each major episode type, the methodology calculated risk-adjusted costs for each episode based on the patient's demographics, Medicare beneficiary type, and health status.

4. Why are service category costs not risk-adjusted in the 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 in the reports.