What You Need to Know About CMS’ Quality and Resource Use Report

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Maryland Family Medicine Summit
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Learning Objectives

• Describe the purpose of CMS’ Quality Resource and Use Report.
• Interpret the quality and cost information provided in the QRUR.
• Describe the importance of the QRUR on payment and care delivery.
Medicare’s Shift to Value-based Payment

• Physician Quality Reporting System (PQRS)

• Value-based Payment Modifier (VM)—per claim adjustment that is applied at the group level to physicians billing under the TIN

• Assesses the quality of care furnished and the cost of that care, based on what is reported in PQRS and claims data
What is the Quality and Resource Use Report (QRUR)?

• Illustrates the quality and cost of care you provide to your Medicare patients
• Shows how you will fare under the Value-based Payment Modifier Program
• Will be able to use the QRUR to see how they compare with other TINs caring for other Medicare beneficiaries
Who Receives a QRUR?

• Provided to all solo physician and physician groups who provided services in 2015
• Had at least one eligible case for the quality or cost measures
• Reported by Tax Identification Number (TIN)—how CMS identifies a practice and its patients
• Information in the QRUR is presented at the TIN level
Types of QRURs

**Mid-Year QRUR**
- Released April 2016
- Designed to be for informational purposes only
- Information about performance only on cost and quality measures that the Centers for Medicare & Medicaid Services (CMS) calculates from Medicare claims
- Performance period: (7/1/14 - 6/30/15)
- PQRS data not included
- Will not impact Medicare Fee Schedule (MPFS) payments
- Not intended to predict future value-based performance

**Annual QRUR**
- Distributed in late summer/early fall 2016
- Serve as the final summary report on quality and cost performance
- Performance period: calendar year 2015
- Claims data & PQRS data
- Includes actionable Quality and Cost data
- Reports your value modifier for 2017
- Used to adjust MPFS payments to physicians
- Contains supplemental QRUR
Supplemental QRURs

• Released with Annual QRUR
• Information on the management of their Medicare fee-for-service (FFS) beneficiaries
• Based on episodes of care
• Informational purposes only
• Complement the per capita cost and quality information provided by the annual QRURs
• Information is not incorporated in the 2016 VBM
What’s in the Annual QRUR?

• Performance data during calendar year 2015
• Includes all quality and cost measures used in calculating the 2017 value-modifier
• Quality and Cost Composite Scores that determines the TIN’s 2017 value-modifier adjustments
• TINs quality and cost tier designation
• Benchmarks to compare your performance to that of your peers
• Detailed supplementary information
QRUR Performance Highlights

Quality Composite Score

Cost Composite Score

Average of Cost and Quality Composites
Quality Tiering

- **High performance**: composite score greater than 1.0 standard deviation above the mean for quality or greater than 1.0 standard deviation below the mean for cost.
  - eligible for a VM bonus payment

- **Average performance**: composite score between 0 and 1.0 standard deviation from the mean for quality and between 0 and -1.0 standard deviation from the mean for cost.
  - receives no payment changes under Medicare

- **Low performance**: composite score of more than 1.0 standard deviation below the mean for quality or more than 1.0 standard deviation above the mean for cost.
  - may result in a VM penalty
Quality Tiering Methodology

- How Medicare determines your payment adjustment based on quality and cost performance
- Group will not receive a payment adjustment due to average quality and cost performance
Benchmarking and Risk Adjustment

• CMS uses benchmarks to compare your quality and cost measures against your peers

• Benchmark for each individual quality and cost measure is the weighted mean of all eligible groups

• Risk-adjusts quality outcome measures and cost data; standardizing cost data to account for geographic variation and specialty

• 20 eligible patients per measure to count towards the VM
Quality Composite Score

• Quality measures reported through PQRS in 2014

• Hospital admissions for Ambulatory Care-Sensitive Conditions (ACSC) measures (Acute Conditions Composite and Chronic Conditions Composite)

• 30-day All-Cause Hospital Readmissions

• Medicare Spending Per Beneficiary (MSPB)

• CAHPS (if applicable)
Quality Composite Score

Exhibit 5: Your TIN’s Performance in 2014, by Quality Domain

<table>
<thead>
<tr>
<th>Quality Domain</th>
<th>Number of Quality Measures Included in Composite Score</th>
<th>Standardized Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardized Quality Composite Score</td>
<td>17</td>
<td>-0.54* (Average)</td>
</tr>
<tr>
<td>Average Quality Composite Score</td>
<td>17</td>
<td>-0.15</td>
</tr>
<tr>
<td>Clinical Process/Effectiveness</td>
<td>11</td>
<td>-0.15</td>
</tr>
<tr>
<td>Patient and Family Engagement</td>
<td>0</td>
<td>--</td>
</tr>
<tr>
<td>Population/Public Health</td>
<td>0</td>
<td>--</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>2</td>
<td>-0.29</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>4</td>
<td>0.00</td>
</tr>
<tr>
<td>Efficient Use of Health Care Resources</td>
<td>0</td>
<td>--</td>
</tr>
</tbody>
</table>
### Quality Measure Performance

**Exhibit 6: Clinical Process/ Effectiveness**

<table>
<thead>
<tr>
<th>PQRS Measure Number and Name</th>
<th>Your Performance</th>
<th>Peer Group Performance</th>
<th>Contribution to Your Domain Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Eligible Cases</td>
<td>Performance Rate</td>
<td>Benchmark Rate</td>
</tr>
<tr>
<td><strong>Bone, Joint, and Muscle Disorders</strong></td>
<td></td>
<td></td>
<td>Average Range</td>
</tr>
<tr>
<td>Osteoporosis Management in Women ≥ 67 Who Had a Fracture</td>
<td>58</td>
<td>12.07%</td>
<td>14.54%</td>
</tr>
<tr>
<td><strong>Chronic Obstructive Pulmonary Disease (COPD)</strong></td>
<td></td>
<td></td>
<td>Average Range</td>
</tr>
<tr>
<td>Use of Spirometry Testing to Diagnose Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>160</td>
<td>28.75%</td>
<td>31.35%</td>
</tr>
<tr>
<td>Dilated Eye Exam for Beneficiaries ≤ 75 with Diabetes</td>
<td>684</td>
<td>49.12%</td>
<td>54.05%</td>
</tr>
<tr>
<td>Hba1c Testing for Beneficiaries ≤ 75 with Diabetes</td>
<td>684</td>
<td>85.23%</td>
<td>87.65%</td>
</tr>
<tr>
<td>Nephropathy Screening Test or Evidence of Existing Nephropathy for Beneficiaries ≤ 75 with Diabetes</td>
<td>684</td>
<td>86.84%</td>
<td>76.31%</td>
</tr>
<tr>
<td>Lipid Profile for Beneficiaries ≤ 75 with Diabetes</td>
<td>684</td>
<td>79.82%</td>
<td>82.30%</td>
</tr>
<tr>
<td><strong>Diabetes Mellitus</strong></td>
<td></td>
<td></td>
<td>Average Range</td>
</tr>
<tr>
<td>Lipid Profile for Beneficiaries with Ischemic Vascular Disease (IVD)</td>
<td>871</td>
<td>77.84%</td>
<td>78.45%</td>
</tr>
<tr>
<td>Adherence to Statin Therapy for Beneficiaries with Coronary Artery Disease (CAD)</td>
<td>69</td>
<td>57.97%</td>
<td>67.86%</td>
</tr>
</tbody>
</table>
Cost Composite Score

• Derived from Medicare FFS information for patients assigned to your group

• Per capita costs for all assigned beneficiaries

• Per capita costs for beneficiaries with specific conditions (diabetes, coronary artery disease, chronic obstructive pulmonary disease or heart failure)

• Per episode cost for the Medicare spending per beneficiary

• Standardized and risk-adjusted to account for differences in geography, medical history, specialty

• Based on 2015 costs
Patient Attribution Methodology

• Five cost measures and three claims-based quality outcome measures
• Used two-step approach similar to Accountable Care Organizations under the Medicare Shared Savings Program
• Plurality of primary care services provided by a physician
• Supplementary Exhibits include assigned patients
Cost Composite Score

Exhibit 9: Your TIN’s Performance in 2014, by Cost Domain

<table>
<thead>
<tr>
<th>Cost Domain</th>
<th>Number of Cost Measures Included in Composite Score</th>
<th>Standardized Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardized Cost Composite Score</td>
<td>5</td>
<td>0.65* (Average)</td>
</tr>
<tr>
<td>Average Cost Composite Score</td>
<td>5</td>
<td>1.35</td>
</tr>
<tr>
<td>Per Capita Costs for All Attributed Beneficiaries</td>
<td>1</td>
<td>1.47</td>
</tr>
<tr>
<td>Per Capita Costs for Beneficiaries with Specific Conditions</td>
<td>4</td>
<td>1.23</td>
</tr>
</tbody>
</table>
### Per Capita Cost

**Exhibit 10: Per Capita Costs for Your Attributed Medicare Beneficiaries 2015**

<table>
<thead>
<tr>
<th>Cost Categories</th>
<th>Eligible Cases</th>
<th>Per Capita Costs</th>
<th>Peer Group Performance</th>
<th>Contribution to Your Domain Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Benchmark Per Capita Costs</td>
<td>Average Range</td>
</tr>
<tr>
<td>Per Capita Costs for All Attributed Beneficiaries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Beneficiaries</td>
<td>4,404</td>
<td>$12,378</td>
<td>$10,086</td>
<td>$8,525</td>
</tr>
<tr>
<td>Per Capita Costs for Beneficiaries with Specific Conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>1,359</td>
<td>$18,724</td>
<td>$14,441</td>
<td>$11,944</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>575</td>
<td>$28,222</td>
<td>$23,717</td>
<td>$19,242</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>1,792</td>
<td>$20,905</td>
<td>$17,183</td>
<td>$14,193</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>911</td>
<td>$30,833</td>
<td>$25,993</td>
<td>$20,943</td>
</tr>
</tbody>
</table>

*Note: Per capita costs are based on payments for Medicare Parts A and B claims submitted by all providers (including medical professionals, hospitals, and post-acute care facilities) for Medicare beneficiaries attributed to a physician group. Outpatient prescription drug costs are not included.*
Why are Hospital-based Costs Included?

• CMS seeks to align incentives and encourage care coordination across settings

• Based on the assumption that the TIN providing the plurality of services to beneficiaries over the course of performance period or during a hospital episode are well positioned for influence
How to Access your QRUR

• Obtain a **Enterprise Identity Management (EIDM)** system account.

• Once you have the necessary EIDM account, proceed to the **CMS portal**
  • select “Login to CMS Secure Portal,” and log in.

• When accessing your QRUR for the first time, choose the “PV-PQRS” tab at the top of the screen and then select the “QRUR-Reports” option from the dropdown menu.

• Select the year (e.g., 2014) from the “Select a Year” dropdown menu and the QRUR report you want from the “Select a Report” dropdown menu.
What You Do in 2016 in Important!

• Report satisfactorily for 2016 program year will avoid 2018 PQRS negative payment adjustment

• 2016 data determines 2018 payment adjustments
  ▪ Reporting -&gt; 2018 PQRS penalty
  ▪ Performance -&gt; 2018 + or – Value Modifier adjustment

• Use the QRUR to your advantage
  ▪ Generate reports to monitor your performance
  ▪ Compare your performance to the VM quality benchmarks
Resources from the AAFP

- **Quality Use and Resource Report** webpage
- **What You Need to Know About Medicare’s Quality and Resource Use Report**, *Family Practice Management*
- **QRUR 101**, *AAFP News*
- **MACRA Readiness: Preparing for MIPS**, webpage
- FMX sessions
- Subject Matter Experts
Resources

- **CMS QRUR Page**
- **CMS Help Desk**
  - For issues with obtaining EIDM account and accessing QRURs, call 888-288-8912.
  - For assistance with interpreting QRURs and requesting an informal review of your data, contact the QRUR Help Desk at 888-734-6433 (select option 3) or pvhelpdesk@cms.hhs.gov.
- **CMS Guide for Obtaining a New EIDM Account**
- **Sample 2014 QRUR**
- **CMS Document on Detailed Attribution Methodology for Total Per Capita Cost Measures**
- **Information on PTAN**
- **Value-Based Payment Modifier**
Contact Information

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