

Quality and Resource Use Reports

Why the QRUR matters.

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In a world increasingly filled with acronyms, no industry seems to have more than health care. Even the most informed provider can easily get lost in the fog of health care's alphabet soup. In addition to deciphering their meaning, the challenge lies in determining which acronyms represent a short-lived phenomenon (remember EECF? It was once the "next big thing" in cardiology) versus those that have become a permanent part of our vocabulary (such as STEMI).

One acronym that all providers should have an intimate knowledge of is QRUR, or quality and resource use reports. The nation's single-largest payor, the Centers for Medicare & Medicaid Services (CMS), is rapidly increasing the correlation between QRURs and how providers will be paid in the future. This necessitates not only an understanding of what the QRUR is, but how it will be utilized.

"Volume to value" is now a commonly used phrase to describe the transformation of the health care payment model from a fee-for-service environment to one in which physicians and hospitals are rewarded for their ability to deliver high-quality and low-cost care. This transition has become a cornerstone of the Affordable Care Act and is a key component that is helping to fund insurance expansion. The recently released projections from CMS on the nation's cost of health care are staggering; cost estimates will soar to \$5.4 trillion by 2024. For 2014 to 2024, health spending is projected to grow at an average rate of 5.8% per year, and the health share of gross domestic product is expected to increase from 17.4% in 2013 to 19.6% by 2024,¹ which most economists consider to be an unsustainable trajectory.

Given these projections, CMS is aggressively implementing mechanisms to incentivize different behaviors and treatment patterns. Good examples are meaningful use with penalties that kick in for those providers who did not attest and the Physician Quality Reporting System (PQRS), which has penalties for those who did not successfully report quality measures. A more recent addition is the

value-based modifier (VBM), another program the government is using to try to reduce costs while improving care. All of these programs combined could result in as much as a 4% bonus on your Medicare reimbursements or a 9% penalty. Considering the high percentage of Medicare patients that cardiologists treat, that degree of reward or penalty can equate to a significant financial impact to the average program. Of course, this is all current payment policy until the Medicare Access and CHIP Reauthorization Act (MACRA) begins in 2019 (based on a prior performance period), and the rules will change again.²

WHAT IS A QRUR?

Through its efforts to increase data transparency around cost and quality of care, CMS began rolling out the QRURs to give physicians the opportunity to see their data prior to being placed on a public website. CMS is now distributing QRURs to physicians and physician groups to provide information about their performance on the quality and cost of care delivered to Medicare fee-for-service patients. In September 2014, CMS first released QRURs for all groups and physician solo practitioners nationwide who met two criteria³:

- At least one physician billed under the tax identification number (TIN) in 2013, and
- The TIN had at least one eligible case for at least one of the quality or cost measures included in the QRUR.

The quality information contained in the QRUR is drawn from claims data, registry data, electronic health records, and a web tool reported via PQRS (it is important to note that group practices or solo practitioners participating in the Medicare Shared Savings Program, the Pioneer ACO Model, and the Comprehensive Primary Care Initiative, are currently exempt from the QRUR program).

There are two types of QRURs. The mid-year report provides a preview to physicians and physician groups on their quality and cost performance for informational purposes.

The mid-year QRUR can offer important strategic insights into how CMS may calculate future VBM incentives and penalties. CMS believes the mid-year reports offer an opportunity for physicians and physician groups to assess performance and adjust, if necessary, where improvement is needed.

Conversely, the annual QRUR provides information about performance on quality and cost during the previous calendar year. The most recent annual QRUR became available in fall 2015 and provides information about performance on cost and quality measures for the 2014 calendar year.

IS YOUR GROUP A LOW- OR HIGH-QUALITY PROVIDER?

QRURs now assist groups in answering this question. Taken directly from Medicare's Sample Annual QRUR, Figure 1 illustrates how TIN quality and cost composite scores will be displayed and graphically plotted based on relative performance in cost and quality measures and then compared to a representative sample of peers.

WHAT DATA ARE INCLUDED IN A QRUR?

The QRUR separately identifies services that (1) a physician directed (the physician billed for $\geq 35\%$ of all of the patient's outpatient evaluation and management [E/M] visits); (2) a physician influenced (the physician billed $< 35\%$ of the patient's outpatient E/M visits, but accounted for $\geq 20\%$ of the professional cost of care); and (3) the physician contributed to (the physician billed for $< 35\%$ of the patient's outpatient E/M visits and accounted for $< 20\%$ of the patient's total professional cost of care).

For each category, the actual Medicare costs of care are assigned per attributed beneficiary and are risk-adjusted by medical history and patient demographics. Costs are also adjusted for geographic payment differences and specialty designation. Percentages are provided for higher or lower cost per care, per physician, compared with peers, and whether the quality of care was better than, equal to, or worse than average for the particular quality measures.

Table 1 shows the per capita or per episode costs that providers are measured on. Note that heart failure and coronary artery disease are specifically measured and scored. Table 2 provides an outline of the QRUR.

CMS has articulated a number of goals for the QRURs:

- Provide comparative quality and cost data for quality improvement purposes—CMS hopes that you will alter your practice patterns when you see these data in order to increase the quality of care you are providing while simultaneously decreasing your costs.
- Introduce you to how Medicare is phasing in the VBM.

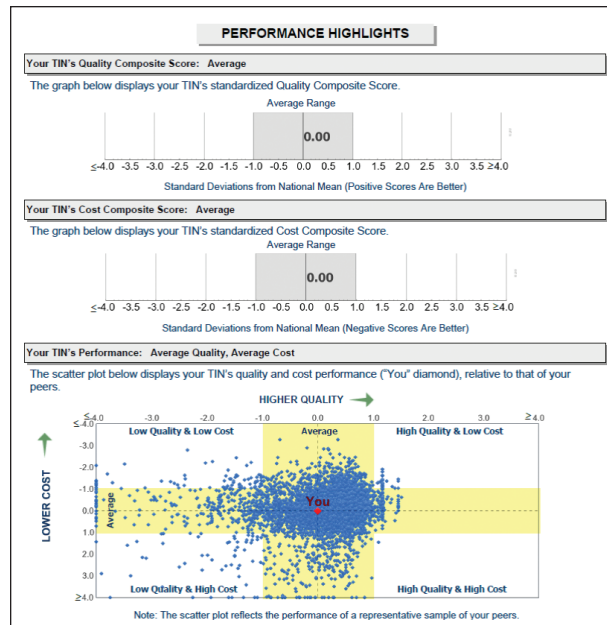


Figure 1. A sample annual QRUR.

- Preview some of the quality and cost measures to be used in the VBM—CMS believes that this preview will allow you to gauge how you will stand once the VBM applies to you.
- Use the same risk-adjustment and payment standardization techniques for cost measures as the VBM.
- Encourage you to suggest specific ways to make the QRUR more meaningful and actionable to improve the quality of care provided.

ACCESSING YOUR QRUR

QRURs are provided for each Medicare-enrolled TIN made available via the CMS Enterprise Portal at <https://portal.cms.gov>. Authorized representatives can access QRURs using a valid Individuals Authorized Access to the CMS Computer Services (IACS) user ID and password. A solo practitioner or an authorized representative of a solo practitioner must obtain an IACS account with one of the following individual-specific Physician Value-PQRS (PV-PQRS) roles:

- PV-PQRS individual practitioner
- PV-PQRS individual practitioner representative

Instructions on how to access your QRUR can be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2014-MYQRURS-Quick-Reference-Guide.pdf>.

Note that employed physicians likely will not have access to the group or health system's QRUR. These physicians can ask their administrative staff if they can view

TABLE 1. PER CAPITA OR PER EPISODE COSTS FOR YOUR TIN'S ATTRIBUTED MEDICARE BENEFICIARIES

Cost Domain	Cost Measure	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	0	—	\$0	\$0	\$0	—	Yes
	Medicare spending per beneficiary	0	—	\$0	\$0	\$0	—	No
Per capita costs for beneficiaries with specific conditions	Diabetes	0	—	\$0	\$0	\$0	—	No
	Chronic obstructive pulmonary disease	0	—	\$0	\$0	\$0	—	No
	Coronary artery disease	0	—	\$0	\$0	\$0	—	No
	Heart failure	0	—	\$0	\$0	\$0	—	No

Note: For the per capita costs for all attributed beneficiaries measure and the four per capita costs for beneficiaries with specific conditions measures, 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 TIN for a given measure. For the Medicare spending per beneficiary measure, per episode costs are based on Parts A and B expenditures surrounding specified inpatient hospital stays (3 days prior through 30 days postdischarge). Part D prescription drug costs are not included.

the QRUR to see how their individual quality and cost outcomes compare to the group's overall performance. Employed physicians may also consider using this information to leverage contract negotiations (eg, using strong QRUR results to bargain for better income or benefits).

Suggestions for Viewing Your QRUR

Understanding the QRUR, with its many tables and complicated calculations, can seem daunting. To get started, it is recommended that you first look at page 3 of the QRUR, which acts as the big picture for the report. Page 3 outlines how you compare to other groups on cost and quality measures in the scatter diagram (Figure 1). In the simplest of terms, 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 page 3 shows your average beneficiary risk percentile and adjustment factor.

WHAT PHYSICIANS NEED TO DO IN 2016 TO AVOID VBM PAYMENT PENALTIES IN 2017

To determine whether an automatic VBM payment reduction will be applied to you, CMS will first review whether you participated in PQRS. To avoid an automatic

VBM payment penalty, you must participate in the PQRS. If you do not participate in PQRS, you will receive both a PQRS payment penalty and a VBM payment penalty. The PQRS penalty is 2%, and the VBM penalty amount is based on practice size: (1) groups with between two to nine eligible providers and physician solo practitioners will receive an automatic negative 2% payment PQRS penalty *and* a 2% VBM payment penalty (4% total); (2) groups with ≥ 10 eligible providers will receive an automatic negative 2% PQRS payment penalty *and* a 4% VBM payment penalty (6% total).

BEYOND REIMBURSEMENT RISK: WHY PHYSICIANS SHOULD CARE ABOUT THEIR QRUR

The intent of the QRUR is to provide quality and cost performance data. Whether providers are in support of or opposed to health reform, the growing release of physician-specific data is here to stay and will only continue to expand. Currently, patients can use the Physician Compare website (<https://www.medicare.gov/physiciancompare>) to find a physician, and soon they will have access to some of the quality and costs metrics being reported in PQRS and

TABLE 2. OUTLINE OF THE QRUR

Annual QRUR Section	Exhibit	Use the Information in the Report to:
Cover page	—	Understand how the 2016 Value-Based Payment Modifier applies to your TIN. This includes your TIN's PQRS participation status
Performance highlights	—	Identify how your TIN's performance in 2014 influenced your TIN's VBM payment adjustment in 2016, if applicable
About the data in this report	—	Read a summary of the report methodology and access links to supplementary exhibits and glossary items (if viewing the report dashboard); download or print report as a PDF file
Eligible professionals in your TIN	1	Understand how many eligible professionals were in your TIN during the performance period based on PECOS and claims data
Attribution of Medicare beneficiaries and episodes to your TIN for claims-based measures	2–4	Understand how Medicare fee-for-service beneficiaries and episodes of hospital care were attributed to your TIN for claims-based quality and cost measures
Performance on quality (composite and domain level)	5	Review your TIN's performance at the composite level, as reflected in the performance highlights section, and at the domain level
Performance on quality (measure level)	6	Review your TIN's performance on PQRS measures, CMS-calculated outcome measures, and CAHPS measures (if applicable) within each quality domain
Hospitals admitting your patients	7	Identify the hospitals that provided at least 5% of your TIN's attributed beneficiaries' inpatient stays during the performance period for the three claims-based quality outcome measures and the five per capita cost measures
	8	Identify the hospitals that provided at least 5% of the inpatient episodes of care surrounding a hospital admission attributed to your TIN during the performance period for the Medicare spending per beneficiary measure
Performance on costs (composite and domain level)	9	Review your TIN's cost performance at the composite level, as reflected in the performance highlights section, and at the domain level
Performance on costs (measure level)	10	Review your TIN's performance on six cost measures across two domains
Per capita and per episode costs of care for specified services	11–12	Understand the dollar difference between your TIN's attributed beneficiaries' payment-standardized, risk-adjusted, and specialty-adjusted per capita of per episode costs, by category of service, and the corresponding costs for your TIN's peer group for the six cost measures
Abbreviations: CAHPS, Consumer Assessment and Healthcare Providers and Systems; CMS, Centers for Medicare & Medicaid Services; PECOS, Provider Enrollment, Chain, and Ownership System; PQRS, Physician Quality Reporting System; TIN, tax identification number; VBM, value-based modifier.		

the QRURs. This move to increase consumerism in health care appears to be rapidly increasing. In 2014, Medicare released physician-level charges and payments for the first time. In many markets, local newspapers ran stories of the highest-paid physicians nationally.

The next phase of this program will be to publish the lowest-quality and highest-cost providers nationally and, as these data become public, it is important to realize that the effects are not limited to Medicare. These CMS initiatives will also likely pave the way for private payors that want to move to a pay-for-quality approach. Many private payors have already begun to create narrow networks based on similar data. This trend has even begun receiving venture

funding into organizations such as Castlight Health, which sells data to employers comparing health care providers across a variety of metrics to optimize pricing and quality.

WARNING: QRURS ARE NOT PERFECT

Beneficiaries are assigned to the provider or 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 nonphysician providers. The nature of this attribution is potentially subject to errors. In

HOW IT ALL TIES TOGETHER

Key points to remember:

- The Medicare Physician Feedback/Value-Based Payment Modifier Program is part of a larger effort by CMS to improve the quality and efficiency of medical care by developing meaningful, actionable, and fair ways to measure physician performance.
- The program's main goal is to give physicians and physician groups information through confidential feedback reports—QRURs—about the resources used by and the quality of care furnished to their Medicare fee-for-service patients.
- Physicians and physician groups can use these QRURs to see how they compare with others in caring for Medicare patients.
- This program began under the Medicare Improvements for Patients and Providers Act of 2008 (formerly called the Physician Resource Use Measurement and Reporting Program) and later was extended and enhanced under the 2010 Affordable Care Act. The Physician Feedback/Value-Based Payment Modifier Program also supports Section 3007 of the 2010 Affordable Care Act, which directs the secretary of the US Department of Health and Human Services to develop and implement a budget-neutral VBM.
- The payment modifier will be used to adjust Medicare physician fee schedule payments based on the quality and cost of care that physicians deliver to Medicare beneficiaries.
- For physicians and groups of physicians subject to the VBM, the QRURs will report their VBM.

fact, CMS identified issues that impacted the 2014 QRURs, which were first released in September 2015. There were issues with data submitted via electronic health record and Qualified Clinical Data Registry, as well as a technical issue with the claims used to calculate claims-based measures. CMS has successfully corrected these issues and produced revised 2014 annual QRURs, which were made available in November 2015. However, it is important to note that only for a small percentage of groups, this correction resulted in a change to their VBM calculation, and these groups received a separate notification.

Finally, MACRA 2015 establishes a merit-based incentive payment system that consolidates many of these existing Medicare initiatives, which is scheduled to begin in 2019.

SUMMARY

CMS, private payors, and self-funded employers are using cost and quality data to direct care and establish reimbursement rates. Providers must understand where they stand today and deploy strategies as the landscape continues to evolve around these measures. Although true of many of the recent CMS programs, QRURs are not yet perfected, and many physicians, particularly specialists, have noted that they should only be held accountable for patients whose care they directed and not for the costs incurred for patients to whose care they either influenced or contributed. The services tracked through QRUR today are largely focused on preventive care, and therefore interventional cardiologists and other specialists can argue they have little or no impact on the care being measured. CMS has acknowledged this concern, but the system continues nonetheless, and despite these challenges, the data are already having an impact. CMS wants providers to see the entire spectrum of care their patients receive and to monitor and perhaps influence that care.

Providers must begin to access their QRUR and should understand how they would have performed if the VBM were applied in 2015. Providers must make sure their organizations are attesting for PQRS and use the data from their QRUR and other sources (eg, National Cardiovascular Data Registry, Physician Compare website, etc) to guide program strategy. In addition to concerns of market share and procedure growth, providers must become confident that they are providing high-quality, low-cost care. Recognize that CMS has launched an array of measurement and incentive programs, which collectively are the key elements that CMS is using to try and transform health care, and ignoring their implications will have negative consequences to providers and their practices. ■

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