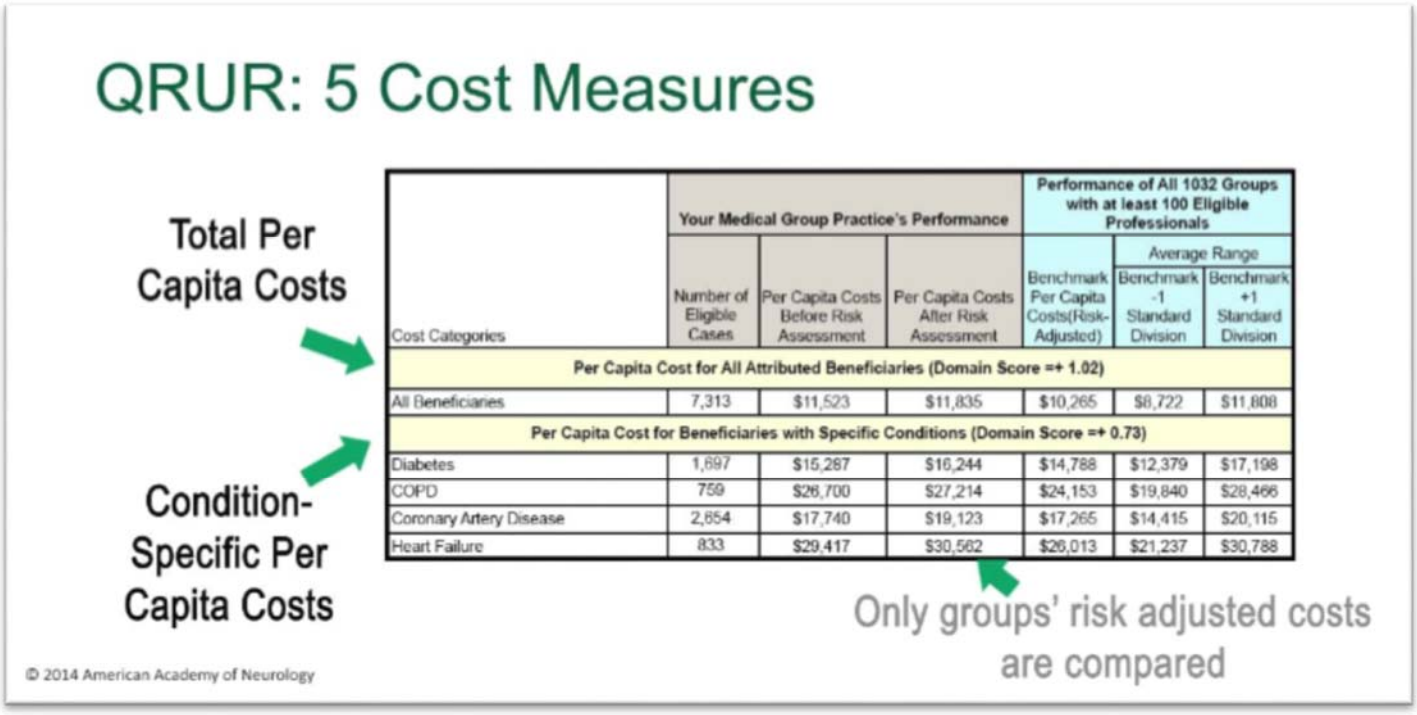
# Resource Use

## Background

Long before MACRA, CMS developed a Quality Resource Utilization Report (QRUR). Every practice has access to this data on an annual basis. The QRUR, while not perfect, seeks to develop a "score" based upon physician group resource use, adjusted for risk assessment. The QRUR is based upon claims data. This report analyzes cost based on tax identification number (TIN) so it is often aggregated on a group-wide basis.

The QRUR has 3 components:

1. **Total Cost Per Capita for Medicare Parts A & B costs** (excluding Part D costs). This is a risk- and specialty-adjusted measure that assigns costs to physicians (groups) who provided the most primary care services to the patient. Costs include *all Part A & B annual costs*, even those not performed by the attributed physician. Some patients are excluded from this calculation, including patients who were not enrolled in both Part A & B, were part of a Medicare Advantage Plan or who resided outside of the US for some time during the year. Notably, primary care services can be attributed to PCPs and to specialists—whomever provides the plurality of primary services. These services are defined as new and follow-up outpatient E/M codes, home care and nursing home visits and annual wellness visits. Charges for patients who die during the year are annualized (for example, if a patient incurs costs of $1,000 and dies on June 30th, his or her annualized costs attributed to the physician would be $2,000).
2. **Total Cost Per Capita for Disease Specific Conditions**. This measurement includes costs associated with overall care of four specific conditions, including diabetes mellitus (DM), chronic obstructive pulmonary disease (COPD), heart failure (HF), and coronary artery disease (CAD). As above, these are annualized, risk- and specialty-adjusted measures and include the entirety of Medicare Parts A & B costs for patients with these conditions (with the same parameters as above). Patients are again attributed to a single physician (or medical group). Only patients that had a primary care service (as defined above) within the year are eligible and these costs are again attributed to the physician or group that provided the plurality of services (charges). As above, it is possible for a patient to be attributed to specialists, rather than PCPs.
3. **Medicare Spending per Beneficiary for Hospitalizations**. This measurement evaluates "episodes" of inpatient care and includes both Parts A & B costs from 3 days prior to 30 days post discharge (adjusted by DRG, patient risk and specialty composition of the group). Currently, this requires 125 total hospitalizations per group. These charges are also attributed to the physician (group) that is responsible for the plurality of services.




| Cost Categories | Your Medical Group Practice's Performance | | | Performance of All 1032 Groups with at least 100 Eligible Professionals | | |
|---|---|---|---|---|---|---|
| | | | | | Average Range | |
| | Number of Eligible Cases | Per Capita Costs Before Risk Assessment | Per Capita Costs After Risk Assessment | Benchmark Per Capita Costs(Risk-Adjusted) | Benchmark -1 Standard Division | Benchmark +1 Standard Division |
| **Per Capita Cost for All Attributed Beneficiaries (Domain Score =+ 1.02)** | | | | | | |
| All Beneficiaries | 7,313 | $11,523 | $11,835 | $10,265 | $8,722 | $11,808 |
| **Per Capita Cost for Beneficiaries with Specific Conditions (Domain Score =+ 0.73)** | | | | | | |
| Diabetes | 1,697 | $15,287 | $16,244 | $14,788 | $12,379 | $17,198 |
| COPD | 759 | $26,700 | $27,214 | $24,153 | $19,840 | $28,466 |
| Coronary Artery Disease | 2,654 | $17,740 | $19,123 | $17,265 | $14,415 | $20,115 |
| Heart Failure | 833 | $29,417 | $30,562 | $26,013 | $21,237 | $30,788 |

When it comes to resource utilization, under MACRA, government payers not only will hold physicians responsible for the cost of care but are also interested in making resource utilization more transparent. Specifically, CMS has noted that "Although an estimated 80 percent of overall health care costs are attributable to the decisions made by clinicians, these same clinicians are often not aware of how their care decisions influence the overall costs of care. The cost category of MIPS provides an opportunity for informing clinicians on the costs for which they are directly responsible, as well as the total costs of their patients' care."

By combining the cost component with physician PQRS and non-PQRS quality outcomes, CMS developed the Value-based Payment Modifier (VBPM). Based upon cost and quality, participating medical groups were eligible for either a small payment bonus or penalty.

Currently, the QRUR is published twice a year. The mid-year report is for informational purposes only and does not directly affect physician payment. [CMS announced that they will not release a mid-year report in 2017.] The annual report, which does determine VBPM, becomes available in the fall following the performance year (i.e. Fall 2017 for 2016 payments).

## Changes under MACRA

Moving forward, MACRA doubles down on quality and resource utilization for physicians with a goal to "compare resources used to treat similar care episodes and clinical condition groups across practices."

While the current QRUR and Value Modifier Program is not the exact means of scoring for the merit-based incentive payment system (MIPS), it does serve as a foundation. There is no data reporting required by the group since the data will be based on claims.

Based upon the above attribution criteria and building the QRUR/VM resource subsets, physician groups will be accountable for the following costs within MIPS.

1. **Total Cost Per Capita for Medicare Parts A & B.** This remains essentially unchanged compared to QRUR/VM with slight changes to the attribution process, still requiring two steps. Similar to the QRUR with attribution typically following the physician with primary responsibility for the patient's overall care (Primary Care or Primary Physician) and is based upon the volume of billing charges of outpatient E/M codes. Minor changes include better alignment with Medicare Shared Savings and will include codes billed for Chronic Care Management (CCM) and Transition of Care Management (TCM) codes.

2. **Total Cost Per Capita for Episode-Specific Conditions**. This category will expand significantly with new episode groups (currently set at 40+ clinical conditions and episode-based measures) and would require a minimum number of patients with a given condition before attribution could occur. These would include acute episodes (triggered by and admission/DRG), chronic conditions (triggered by E/M code combined with ICD-10 diagnosis) and procedures (triggered by ICD procedure codes or HCPCS). For acute episode-specific conditions, attribution will include all physicians that bill at least 30% of the inpatient E/M visits. Therefore, a single event may be attributed to more than one physician (group).

   CMS developed 5 criteria for these episode-specific measures:

   A. **Define the Episode Group:** Three types of episodes include: Acute inpatient medical condition, chronic condition and procedural.
   B. **Assign costs to the episode**. Includes pre-op and anesthesia for a surgery. Includes Complications, readmissions, ER visits etc. Some costs would not be assigned to the episode. For example costs associated with the ongoing care associated with a chronic condition that occurs within an entirely different acute condition or procedure (i.e. dialysis for ESRD patient admitted for appendicitis).
   C. **Attribute the episode to 1 or more clinicians**: Assigned first to a principal, managing physician. Other costs attributed to physicians responsible for a part of the care.
   D. **Risk adjust** based upon type of beneficiary including geography, severity, risk, age, comorbidities, possibly based upon hierarchical condition categories (HCC).
   E. **When possible, align costs associated with an episode with indicators of quality** (hospitalization, readmission, complications). This includes outcomes, processes of care, functional status and patient experience.

3. **Medicare Spending per Beneficiary for hospitalizations**. This measure will continue to evaluate care around hospitalizations, adjusted by DRG and patient risk. However, there are two adjustments compared to QRUR/VM. The minimum number of cases will decrease from 125 to 20 cases and the specialty adjustment will be removed.

## MIPS Scoring

What does that mean for nephrologists in 2018 and beyond? Each measure will be converted into points (1-10, based upon performance percentile). Physicians and groups will vary in the number of measures that qualify, due to case volume. For this reason, the equation will be: Total points received / total available points x 100.

In general, nephrologists may be responsible for patients falling into each of the 3 categories above:

1. **Category 1**: Patients for whom the nephrology office has billed the plurality of outpatient E/M codes may be attributed to the nephrologist. This will also include the TCM/CCM codes, even if the patient has a PCP. These payments are risk-adjusted based on a CMS algorithm that includes age, sex, Medicaid status and medical history (ICD-9/10). Additionally, outlier patients with costs in the bottom 1% or top 99% are excluded.
2. **Category 2**: For 2018, the 40+ clinical episodes have not been finalized. However, some that could affect nephrologists and may be included are:
    a. Acute episodes: Renal failure, toxic ingestions, diabetes, CHF
    b. Chronic episodes: CKD, diabetes, lupus
    c. Procedure episodes: Dialysis access, +/-nephrectomy, +/-kidney stone removal.
3. **Category 3:** Depending on overall charges, it is possible that ESRD patients that are hospitalized for dialysis-related conditions could fall into this category. It is unclear what role hospitalist-related charges will have, as those providers rarely care for these patients in the post-discharge timeframe.

Notably, there are several medical conditions that aid in risk adjustment. Among others, they include diabetes, liver failure, drug/alcohol dependence, congestive heart failure (CHF), acute kidney injury (AKI), and ESRD. For these reasons, it is exceedingly important to document patient conditions thoroughly.