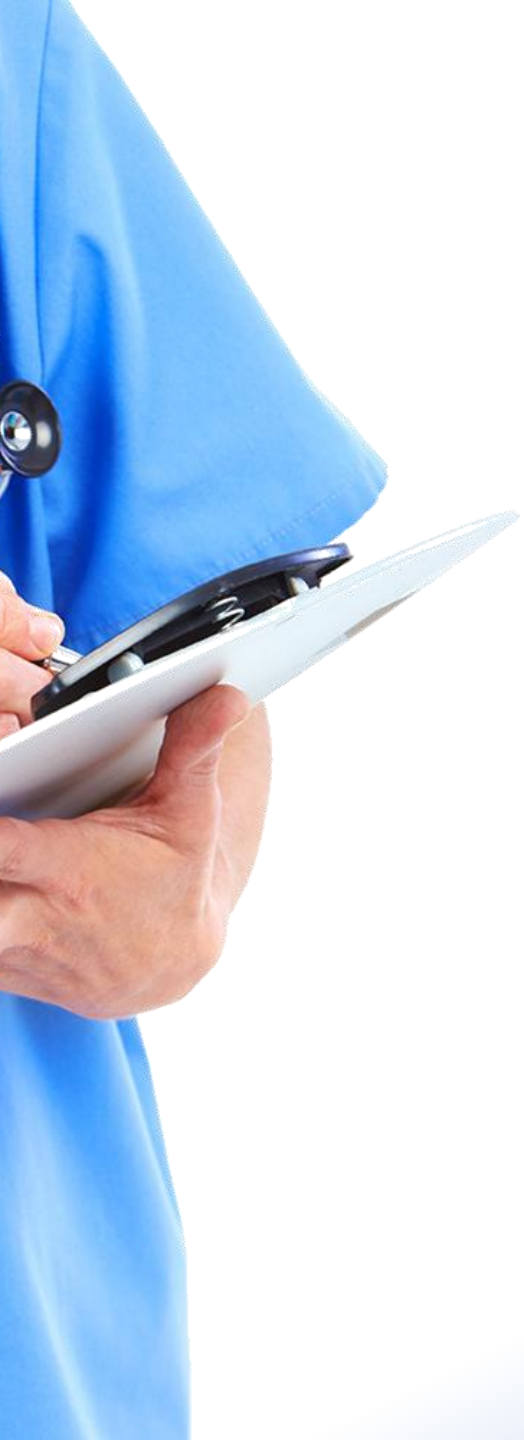

Physician Feedback Program: 2010 Individual Physician Quality and Resource Use Reports

Feedback Session 2
Sponsored by the CMS National Provider Calls Program
Thursday, April 5, 2012

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Purpose of this Feedback Session

- To provide an overview of findings from the 2010 Confidential Physician Quality and Resource Use Reports (QRURs) that CMS prepared for physicians in Iowa, Kansas, Missouri, and Nebraska.

- To solicit input from report recipients, to improve the content and the display of information in the QRURs so they provide meaningful and actionable information to physicians.

- To answer questions about the information and methodologies used in the QRURs.

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Agenda

- Overview of findings from Program Year (PY) 2010 Confidential Individual QRURs
- Run through of reports section-by-section
  - Overview of section
  - Participant questions and answers about the section
  - Participant suggestions for improvement in the section
- CMS closing comments

What are the QRURs?

- QRURs provide comparative information so that physicians can view examples of the clinical care their Medicare fee-for-service patients receive in relation to the average clinical care and costs of other physicians' Medicare fee-for-service patients.

- The 2010 QRURs did not use minimum case-size thresholds. For some physicians, therefore, the QRUR may only display information about a few fee-for-service-beneficiaries if that's all a physician treated in 2010.

- CMS has announced plans to place group practice (not individual physician) performance data on CMS Physician Compare website, https://www.cms.gov/physician-compare-initiative/

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Who Received PY2010 Confidential Feedback Reports?

CMS prepared 23,730 individual physician reports—one report for each physician in Iowa, Kansas, Missouri, and Nebraska that provided services to at least one Medicare fee-for-service beneficiary in 2010.

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What Should Physicians do with these Reports?

- The reports enable you to compare the quality and cost of your Medicare fee-for-service patients' care with that of Medicare patients treated by physicians in your specialty and by all physicians in Iowa, Kansas, Missouri, and Nebraska.

- The reports highlight your degree of involvement with all patients your treated, based on claims you submitted to Medicare.

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Two Types of Quality of Care Information: Claims Data Submitted through PQRS

- Of the 23,730 physicians, 5,891 (25%) participated in PQRS through the claims-based reporting methodology (not the EHR or registry methodologies) and this information is included in Exhibit 2 of the report.

- Approximately 23% were primary care physicians.

- Specialties with the highest participation rates were ophthalmology, anesthesiology, pathology, geriatric medicine.

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Two Types of Quality of Care Information: Claims Data Submitted through PQRS (cont'd)

Selected PQRS Claims Measure	Mean Performance Rate (IA, KS, MO, and NE)
2. DM: Low Density Lipoprotein (LDL-C) Control	57%
6. CAD: Oral Antiplatelet Therapy Prescribed for Patients with CAD	60%
9. Major Depressive Disorder: Antidepressant Medication during Acute Phase	77%
39. Screening or Therapy for Osteoporosis for Women > 65	79%
40. Osteoporosis: Management following Fracture of Hip, Spine, or Distal Radius for Mend and Women > 50	50%
51. Chronic Obstructive Pulmonary Disease: Spirometry Evaluation	91%
112. Preventive Care and Screening: Screening Mammography	84%
202. IVD: Complete Lipid Profile	54%
203. IVD: Low Density Lipoprotein Control	40%

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Two Types of Quality of Care Information: Administrative Claims-based Measures

- Exhibit 1 in all reports provides performance rates on up to 28 quality measures (with 13 sub-measures) for a total of 41 measures, depending upon whether the physician treated at least one beneficiary that was eligible for the measure. On average, a physician had information on 30 of 41 measures.

- These measures show whether the beneficiary received the indicated treatment during 2010. The reports provide this information for any beneficiary to whom the physician provided at least one service, even if the physician did not provide the indicated treatment.

- CMS believes it is important to inform physicians about the quality of care that their beneficiaries received for primary care and preventive services. Currently, physicians may be unaware whether the beneficiaries they treated received recommended care. The reports provide this important information for the fee-for-service beneficiaries they provided services to in 2010.

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Administrative Claims-Based Quality Data

Quality Measure Category	Mean Performance Rate on Measures in the Clinical Category for Physicians in IA, KS, MO, and NE
Chronic Obstructive Pulmonary Disease	50.0%
Bone, Joint, and Muscle Disorders	49.6%
Cancer	83.5%
Diabetes	77.3%
Gynecology	53.0%
Heart Conditions	49.4%
HIV	39.0%
Mental Health	47.3%
Prevention	64.0%
Medication Management	59.6%

Specifications for these measures are available at:
http://www.cms.gov/PhysicianFeedbackProgram/Downloads/claims_based_measures_with_descriptions_num_denom_excl.pdf

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Administrative Claims-Based Quality Data (cont'd)

On average, reports contained the following number of measures by broad specialty classification for those physicians that had at least 10 cases:

Type of Physician	Mean Number of Administrative Claims-Based Quality Measures
Primary care	19
Surgeons	18
Medical specialists	27
Emergency medicine	26
Other	30

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How Were Beneficiaries Attributed to Physicians?

The reports classified each physician's Medicare fee-for-service beneficiaries into three groups (shown on Exhibit 3 of the QRUR).

- **Directed**: The physician billed for 35 percent or more of the patient's office or other outpatient Evaluation and Management (E&M) visits.
- **Influenced**: The physician billed for fewer than 35 percent of the patient's outpatient E&M visits, but for 20 percent or more of the patient's total professional costs.
- **Contributed**: The physician billed for fewer than 35 percent of the patient's outpatient E&M visits, and for less than 20 percent of the patient's total professional costs.

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Beneficiary Attribution by Physician Type: Average Number of Beneficiaries

Type of Physician	Mean Number of Attributed Beneficiaries	Mean Number of Directed Beneficiaries	Mean Number of Influenced Beneficiaries	Mean Number of Contributed Beneficiaries
Primary care	279	81	17	181
Medical specialist	471	45	46	380
Surgeons	309	32	60	217
Emergency medicine	367	5	13	349
Other	860	3	24	834

Notes:

- The plurality of CMS specialty codes on all professional claims billed to Medicare for which the physician was listed as the performing provider determined the physician's medical specialty.
- Other physicians include radiologist, anesthesiologists, and pathologists.

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Analysis of Directed Beneficiaries: Billing and Professional Costs

Type of Physician	Number of Physicians Directing Care	Mean Number of Directed Beneficiaries	Average Number of Visits Per Year Per Physician Directing Care	Average Percent of Professional Costs Billed per Physician Directing Care
Primary care	6,194	105	3.6	89.8%
Medical specialist	4,096	59	3.0	85.0%
Surgeons	4,729	36	2.3	84.1%
Emergency medicine	192	35	2.6	83.6%
Other	508	18	2.6	79.4%

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Analysis of Influenced Beneficiaries: Billing and Professional Costs

Type of Physician	Number of Physicians Influencing Care	Mean Number of Beneficiaries Whose Care was Influenced	Average Number of Visits Per Year Per Physician Influencing Care	Average Percent of Professional Costs Billed Per Physician Influencing Care
Primary care	7,389	19	1.0	81.7%
Medical specialist	4,874	51	1.1	85.2%
Surgeons	5,012	64	1.1	89.2%
Emergency medicine	1,327	14	0.1	79.6%
Other	2,478	34	0.2	79.9%

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Analysis of Contributed Beneficiaries: Billing and Professional Costs

Type of Physician	Number of Physicians Contributing to Care	Mean Number of Beneficiaries Whose Care was Contributed to	Average Number of Visits Per Year Per Physician Contributing to Care	Average Percent of Professional Costs Billed Per Physician Contributing to Care
Primary care	8,033	181	0.9	20.9%
Medical specialist	5,382	381	0.7	17.5%
Surgeons	5,317	217	0.9	20.6%
Emergency medicine	1,411	350	0.1	15.2%
Other	3,521	840	0.2	14.9%

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Mean Total Per Capita Costs in the QRURs

Type of Physician	Overall	Directed	Influenced	Contributed
Primary care	$16,580	$9,733	$6,780	$19,019
Medical specialist	$19,765	$11,256	$9,219	$21,276
Surgeons	$17,535	$11,482	$15,182	$18,313
Emergency medicine	$20,729	$10,389	$3,675	$21,217
Other	$23,704	$11,442	$8,987	$23,980

- Per capita cost data has been standardized ~~to~~ in order to make comparisons of service use within or across geographic areas.

- Per capita cost also has been risk adjusted either higher or lower, to account for differences in expected health costs of individuals. The risk model uses beneficiary demographic characteristics and prior year diagnoses to predict relative Part A and Part B Medicare Fee-For-Service program (payments).

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Mean of Average Total Per Capita Costs for Beneficiaries with Specific Conditions

Type of Physicians	Diabetes	COPD	Coronary Artery Disease	Heart Failure
Primary care	$22,417	$28,283	$22,795	$30,303
Medical specialists	$26,473	$32,955	$26,660	$35,331
Surgeons	$23,635	$28,848	$23,483	$31,127
Emergency medicine	$27,683	$34,420	$27,722	$36,614
Other	$30,703	$37,434	$30,949	$39,845

- Per capita cost data has been standardized and risk adjusted.

Ways to Use the Information Contained in the QRURs

- Quality Improvement
- Care Coordination
- Awareness of resource use and total per capita costs
- Preview of candidate data for use in calculating the Value Modifier

To view the 2010 Individual QRUR Template:

http://www.CMS.gov/PhysicianFeedbackProgram/Downloads/2010_Individual_QRUR_Template.pdf

Outstanding Comments & Questions

If we were unable to hear your comment or address your question on today's call, please email it to QRUR@cms.hhs.gov for our consideration.

For specific questions about your report, please email: CMS_Medicare_Physician_Feedback_Program@mathematica-mpr.com

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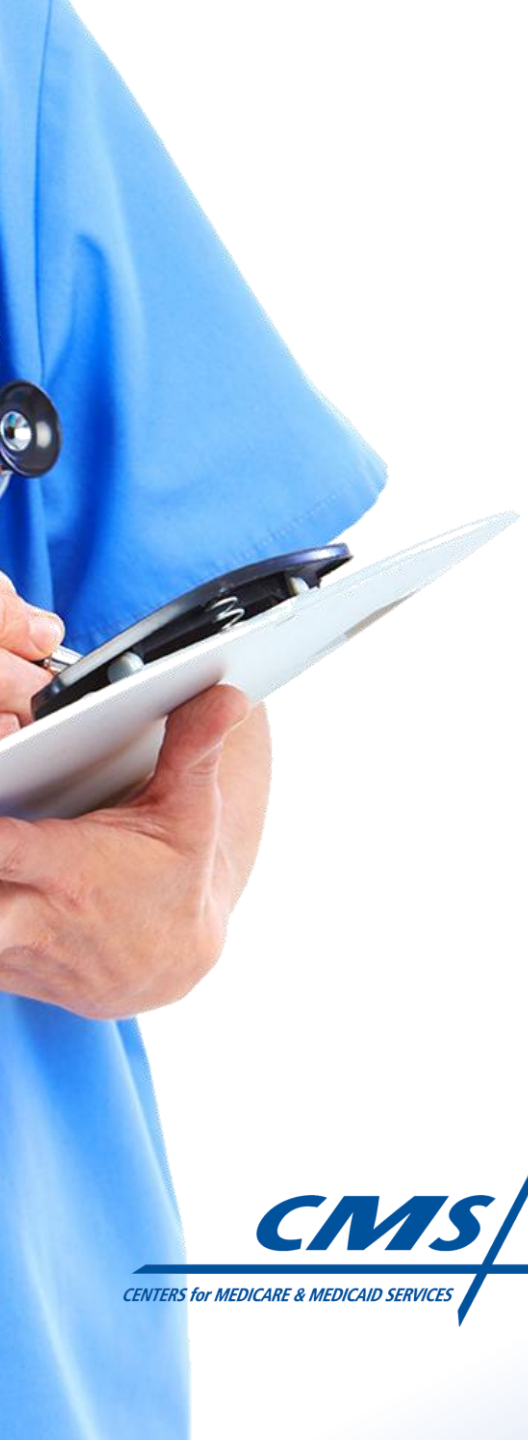

Evaluate Your Experience with Today's Call

To ensure that the National Provider Call (NPC) Program continues to be responsive to your needs, we are providing an opportunity for you to evaluate your experience with today's call. Evaluations are anonymous and strictly voluntary.

To complete the evaluation, visit http://npc.blhtech.com/ and select the title for today's call from the menu.

All registrants will also receive a reminder email within two business days of the call. Please disregard this email if you have already completed the evaluation.

We appreciate your feedback!

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Medicare Learning Network®
Official CMS Information for Medicare Fee-For-Service Providers

Further Information on the Individual QRURs, as well as the Physician Feedback Program, is available at:

http://www.CMS.gov/PhysicianFeedbackProgram

Thank you for your participation in today's call.

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