QUESTIONS & ANSWERS ABOUT THE QUALITY AND RESOURCE USE REPORTS FOR MEDICAL GROUP PRACTICES

Updated December 31, 2013

ABOUT THE PHYSICIAN FEEDBACK PROGRAM

1. What is the Medicare Physician Feedback Program?

The Medicare Physician Feedback Program is part of a larger effort by the Centers for Medicare & Medicaid Services (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 group practices information through confidential feedback reports—called Quality and Resource Use Reports (QRURs)—about the resources used by and quality of care given to their Medicare fee-for-service (FFS) patients. Physicians can use these QRURs to see how they compare with other physicians or practices caring for Medicare patients. CMS created the program under the Medicare Improvements for Patients and Providers Act of 2008 (where it was called the Physician Resource Use Measurement and Reporting Program), and later extended and enhanced it under the 2010 Affordable Care Act (ACA).

The Physician Feedback Program also supports Section 3007 of the 2010 ACA, which directs the Secretary of the U.S. Department of Health and Human Services to develop and implement a budget-neutral, value-based payment modifier (VBM). The payment modifier will be used to adjust Medicare Physician Fee Schedule payments based on the quality and cost of care physicians deliver to Medicare beneficiaries. The QRURs preview each group of physicians' VBM.

2. Which physicians and medical group practices have already received feedback reports?

CMS has been using a phased approach to create and disseminate Physician Feedback reports to gain experience and to obtain stakeholder feedback:

- In 2008–2009, CMS tested resource use measures and prototype feedback reports with approximately 300 randomly-selected physicians in 12 metropolitan areas.
- In 2009–2010, CMS developed and tested feedback reports (that included both quality and resource use measures) with approximately 1,600 medical professionals and 36 medical group practices with which they were affiliated.
- In 2010–2011, CMS distributed group-level QRURs, based on 2010 data, to 35 medical group practices participating in the Group Practice Reporting Option (GPRO I) of the Physician Quality Reporting System (PQRS), and individual-level QRURs to more than 20,000 primary care and specialist physicians practicing in Iowa, Kansas, Missouri, and Nebraska.
- In December 2012, QRURs based on care provided in 2011 were produced for 54 medical group practices participating in the CMS PQRS's GPRO I with at least 200

eligible professionals. Also, CMS produced QRURs for nearly 95,000 individual primary care and specialist physicians practicing in groups of 25 or more eligible providers in California, Illinois, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, and Wisconsin. In May 2013, CMS also provide Supplemental QRURs to the 54 medical group practices that provided episode costs for cardiac and pneumonia conditions.

- In September 2013, CMS made available QRURs, based on care provided in 2012, to medical group practices that had at least 25 eligible professionals who billed under the group's taxpayer identification number (TIN) in 2012 and who had at least 20 Medicare FFS beneficiaries attributed to the group. This nationwide dissemination effort will include groups participating in the Medicare Shared Savings Program, the Pioneer ACO Model, and the Comprehensive Primary Care Initiative. CMS will not produce QRURs for individual physicians in 2013.

Throughout this process, CMS has collaborated with stakeholders inside and outside of the government, reached out to physician and medical specialty groups, and held public listening sessions to hear providers suggest approaches.

QRURS DISSEMINATED TO MEDICAL GROUP PRACTICES IN FALL 2013

3. Which medical group practices will get a QRUR in 2013?

In 2013, CMS is providing QRURs based on care provided in performance year (PY) 2012 to medical group practices nationwide that meet 2 criteria: they have at least 25 eligible professionals who billed under the group's TIN in 2012 and they have at least one quality or cost measure with at least 20 Medicare FFS cases. This includes groups participating in the PQRS GPRO and groups that did not participate. Medical group practices with 25 or more eligible professionals that are participating in the Medicare Shared Savings Program, the Pioneer ACO Model, and the Comprehensive Primary Care Initiative will also get QRURs.

By contrast, in PY 2011, only groups (or affiliated physicians) participating in GPRO I were eligible. Under GPRO I criteria in 2011, each group had to have at least 200 eligible professionals (defined by their National Provider Identifiers, or NPIs) billing under the same TIN in order to qualify.

CMS will not produce QRURs for individual physicians in 2013.

4. How are medical group practices defined in the QRURs?

CMS defines a group of physicians as a single Taxpayer Identification Number (TIN) with 2 or more individual eligible professionals (identified by their individual National Provider Identifier (NPI)) who have reassigned their Medicare billing rights to the TIN.

5. How are beneficiaries attributed to medical group practices in the QRURs?

For all cost and quality measures included in the Quality or Cost Composites that are calculated from Medicare administrative claims data, beneficiaries are attributed to groups of physicians using the same two-step approach to attribution used to attribute beneficiaries to ACOs in the Medicare Shared Savings Program. Under this rule, a beneficiary receiving primary care services from one or more primary care physicians is attributed to the group whose primary care physicians provided the plurality of allowable Medicare charges for the beneficiary's primary care services. Otherwise, the beneficiary is attributed to the group whose other physicians, clinical nurse specialists, nurse practitioners, and physician assistants provided the plurality of allowable Medicare charges for the beneficiary's primary care services, as long as at least one physician in the group, regardless of specialty, provided primary care services to the beneficiary.

Performance on the PQRS GPRO quality indicators included in the Quality Composite is based on a sample of beneficiaries who had at least 2 office or other outpatient visits with the medical group practice, and for whom the medical group practice provided the plurality of all office and other outpatient services during approximately the first 10 months of 2012. (Medicare Advantage enrollees and beneficiaries for whom Medicare was not the primary payer for all of 2012 were excluded). Primary care services include those detailed in the Healthcare Common Procedure Coding System (HCPCS) Primary Care Services Codes Criteria. These codes are detailed in Table 1, below:

Table 1. Healthcare Common Procedure Coding System (HCPCS) Primary Care Service Codes Criteria

HCPCS Codes	Brief Description
99201–99205	New patient, office or other outpatient visit
99211–99215	Established patient, office or other outpatient visit
99304–99306	New patient, nursing facility care
99307–99310	Established patient, nursing facility care
99315–99316	Established patient, discharge day management service
99318	Established patient, other nursing facility service
99324–99328	New patient, domiciliary or rest home visit
99334–99337	Established patient, domiciliary or rest home visit
99339–99340	Established patient, physician supervision of patient (patient not present) in home, domiciliary or rest home
99341–99345	New patient, home visit
99347–99350	Established patient, home visit
G0402	Initial Medicare visit
G0438	Annual wellness visit, initial
G0439	Annual wellness visit, subsequent

Note: Labels are approximate. See the American Medical Association's Current Procedural Terminology and the Centers for Medicare & Medicaid Services website (http://www.cms.gov) for detailed definitions.

6. What information is in the PY 2012 QRURs disseminated in 2013?

The PY 2012 QRURs contain information on both quality of care and resource use, and they provide a preview of the VBM that will go into effect in 2015 based on performance in 2013. Information about the VBM included in the PY 2012 QRURs aims to help medical group practices understand how their payments might be affected if they elect the quality-tiering option in 2013. However, CMS will not apply a VBM based on PY 2012 data. The PY 2012 QRURs will also include information on any incentive that PQRS GPRO participants earned.

VBM Methodology

The PY 2012 QRURs display each report recipient's Quality and Cost Composite Scores, their scores within each of the domains that make up the composites, and performance on individual measures that contribute to each domain. You can find additional information at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/CY2015ValueModifierPolicies.pdf.

Performance on the quality and cost composite scores is determined using standardized scoring, which shows how many standard deviations from the national mean (benchmark) a medical group practice's performance on a given measure falls. Quality benchmarks (peer group means) are based on prior performance year (2011) data. Cost benchmarks are based on current performance year (2012) data.

Quality Data

The quality data reported in the PY 2012 QRURs and used to calculate the Quality Composite Score varies, depending in part on a medical group's participation in the Medicare Shared Savings Program or PQRS in 2012:

- For medical group practices that reported data via the PQRS GPRO web-based interface in 2012, the Quality Composite Score is based, in part, on performance on 29 PQRS GPRO measures.
- For medical groups that participated in the Medicare Shared Savings Program or Pioneer ACO Model program in 2012, the Quality Composite Score is based, in part, on the 22 quality measures submitted by the ACO with which the group was affiliated.
- For groups other than those in the 2 bullets above, the Quality Composite Scores reported in the PY 2012 QRURs will be calculated, in part, from 14 administrative claims-based quality indicators reflecting aspects of the following treatment areas: bone, joint, and muscle disorders; chronic obstructive pulmonary disease; diabetes mellitus; ischemic vascular disease; mental health; medication management; and preventive care. These indicators are among those previously reported in the PY 2011 QRURs for Individual Physicians Practicing in Groups.
- For all medical group practices, CMS also will calculate 3 outcome measures that will be included in the Quality Composite Score based on FFS claims submitted for Medicare beneficiaries attributed to the group in 2012. These will include 2 composite measures of hospital admissions for ambulatory care-sensitive conditions (one for each acute and chronic conditions measure) and one measure of all-cause hospital readmissions.

Cost Data

As in previous years, cost data reported in the PY 2012 QRURs will reflect payments for all Medicare Part A and Part B claims submitted by all providers who treated beneficiaries attributed to a medical group practice, including providers not affiliated with the group. Outpatient prescription drug (Part D) costs will not be included. The Cost Composite Score will reflect total per capita costs for all attributed beneficiaries and for subgroups with specific chronic conditions: diabetes, coronary artery disease, chronic obstructive pulmonary disease, and heart failure.

7. How do the populations of Medicare beneficiaries represented in the resource use/cost data and the quality data differ from each other?

The populations used to calculate the resource use/cost data and the quality data differ, as follows:

- The resource use/cost data derived from Medicare claims represent all FFS Medicare beneficiaries attributed to the group practice, using the attribution rules described in Question 5. Medicare uses the same attribution rule to define the population for all of the administrative claims-based quality measures used in the QRURs.

- Performance on any displayed GPRO quality indicators, however, can be based on a sample of beneficiaries who had at least 2 office or other outpatient visits with the medical group practice and for whom the medical group practice provided the plurality of all office and other outpatient services during approximately the first 10 months of 2012; Medicare Advantage enrollees and beneficiaries for whom Medicare was not the primary payer for all of 2012 are excluded.
- For medical group practices participating in the Medicare Shared Savings Program and the Pioneer ACO Model, quality measures are also based on a sample of beneficiaries eligible for inclusion.

You can find additional information in Section II of the Detailed Methodology for the 2012 Medical Group Practice Quality and Resource Use Reports on the QRUR website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/PY2012-Detailed-Methods.pdf.

8. Does CMS assume that lower rates of hospital admission are better?

Yes. Lower rates of hospitalization presumably indicate better care, from both quality and cost perspectives. Safely maintaining patients who live with one or more chronic conditions to avoid acute episodes of illness is an important function of health care. However, at the individual level, hospitalization of a given patient at a given time might be the best or only choice, representing high quality of care.

9. What services and costs are included in the QRURs' per capita cost measures?

The total per capita cost measures in the QRURs include *all* 2012 Medicare Fee-for-Service Part A (Hospital Insurance) and Part B (Medical Insurance) payments to all providers who treated beneficiaries attributed to a given medical group practice, whether or not those providers themselves were associated with the group. These costs include costs associated with inpatient or outpatient hospital, skilled nursing facility, home health, hospice, and durable medical equipment services, along with the costs of all evaluation and management services, procedures, and other Medicare-covered services. Payments for Part D outpatient prescription drugs are not included. To the extent that Medicare claims include such information, costs comprise payments to providers from Medicare, beneficiaries (copayments and deductibles), and third-party private payers.

The QRURs also include subgroup-specific per capita cost measures for Medicare beneficiaries who had at least one of the following 4 chronic health conditions: diabetes, coronary artery disease, chronic obstructive pulmonary disease, or heart failure. The 4 conditions are not mutually exclusive—we count beneficiaries with more than one of these conditions within each relevant condition subgroup. Also, subgroup costs include all costs of care, not just those associated with treating the condition.

10. Why are hospital-based costs included in QRURs about medical group practices' performance?

The medical group practice providing the plurality of primary care services to beneficiaries over the course of the year is well positioned to influence the overall care of the patients attributed to its group. For example, all Part A (Hospital Insurance) and Part B (Medical

Insurance) services are ordered by the medical group practice, and particularly, the physicians within the practice providing the plurality of primary care services. For this reason, we compare all Medicare Part A and Part B costs for the year (2012) for each patient attributed to a specified medical group practice with the aggregated per capita costs of all group practices receiving a QRUR in 2013.

11. If a medical group practice is affiliated with a hospital, but some patients attributed to the group were admitted to an unaffiliated hospital, are those unaffiliated hospital costs included in the calculation of the group's costs?

Yes. All Medicare claims paid for Medicare beneficiaries attributed to a group are included in that group's per capita costs for 2012.

12. Could "split billing" affect how costs are distributed among various types of services?

Yes. "Split billing" or "provider-based billing" could affect reported categories of service in the QRUR, as well as per capita costs. There are several reasons why 2 separate bills (that is, split billing) are generated for a single service. One common instance is when 2 bills are generated separately for the professional and technical components of a service provided by a physician in a hospital facility. The professional component of the service might include physician consultation or physician interpretation of an X-ray, CT scan, MRI, or laboratory test done in the hospital. Professional component reimbursements are given to the physician or physician practice. The technical component of the service might include laboratory, X-rays, or any other non-professional aspect of the service. Technical component reimbursement is directed to the hospital. The site-of-service coding on Medicare claims determine how costs with split bills are categorized. Medicare's reimbursement accounts for higher overhead costs at hospitals than at free-standing sites, so the site-of-service coding also will determine how those costs are standardized.

13. Do claims-based quality and cost measures in the QRURs capture services provided in non-FFS settings, such as at Rural Health Clinics or Federally Qualified Health Centers?

No. The methodology for calculating claims-based quality and cost measures captures only services reimbursed according to the Medicare Physician Fee Schedule. This means, for example, that services provided in Rural Health Clinics, Federally Qualified Health Centers, and Critical Access Hospitals (for physicians electing Method II billing) are not included in the calculation.

14. How does CMS account for differences in patients' medical histories (risk-adjustment) when calculating measures of cost, utilization, or resource use?

Risk-adjustment smoothes out large differences in utilization or resource use caused by physiologic differences in patients (shown by complex disease histories) that could be expected to make costs higher- or lower-than-average, regardless of the efficiency of the care.

For all cost measures reported in the PY 2012 QRURs, CMS uses the Hierarchical Condition Categories (CMS-HCC) risk-adjustment model, which predicts patients' resource use for the coming year, based on diagnoses from Medicare claims for the patient from the previous

year. The CMS-HCC model assigns *International Statistical Classification of Diseases and Related Health Problems Ninth Revision* (ICD-9) codes to 70 clinical conditions. For each beneficiary enrolled in Medicare FFS the previous year, the CMS-HCC model generates a risk score based on the presence of these 70 conditions and on the beneficiary's age, sex, original reason for Medicare entitlement (age or disability), and Medicaid entitlement.

The 2 composite measures of hospital admissions for ambulatory care-sensitive conditions that Medicare calculates for the PY 2012 QRURs also are risk-adjusted to account for differences in the age and gender of beneficiaries attributed to different groups. For measures in the acute conditions composite (bacterial pneumonia, urinary tract infection, and dehydration), the denominator includes all Medicare patients attributed to the group. However, the denominator for measures in the chronic conditions composite (diabetes, chronic obstructive pulmonary disease/asthma, and heart failure) is restricted to patients diagnosed with the specific condition.

Similarly, the all-cause hospital readmissions measure is risk-adjusted to account for differences in beneficiary case mix based on patient age and clinical characteristics.

15. How does CMS account for differences in Medicare payment rates for medical services in calculating cost measures (payment standardization)?

Before calculating any cost measures for the QRURs, CMS standardizes the unit costs (prices) for the 2012 Medicare claims. This process equalizes the costs to Medicare associated with a specific service, so that a given service is priced at the same level across all providers in the same type of health care setting regardless of geographic location or differences in Medicare payment rates (such as from payments to hospitals for graduate medical education, indirect medical education, and for serving a disproportionate number of poor and uninsured patients).

Medicare payments for the same services can vary depending on local input prices (such as wage rates and real estate costs) and on payment rates for different classes of providers in a given category. Without payment standardization, a provider with higher Medicare payments could appear to have higher costs than other providers in the peer group when, in fact, differences in geographic location or facility-specific payments (rather than resource use) might be responsible.

16. Does CMS trim "outliers" from the data when calculating performance for quality and cost measures?

Prior to risk-adjustment, beneficiaries whose payment-standardized costs fall below the first percentile of all attributed beneficiaries' per capita costs are eliminated from the cost calculations. Also, CMS rounds costs above the 99th percentile down to the 99th percentile. No trimming is done for any of the quality measures.

17. How does CMS define peer groups for benchmarking purposes?

In calculating standardized scores for the Quality and Cost Composite Scores in the PY 2012 QRURs, each group's performance on quality and cost measures is compared with a weighted mean (benchmark) performance of its peers. Quality benchmarks are based on prior year (2011) performance and cost benchmarks are based on current year (2012) performance.

For most of the PY 2012 QRUR quality and cost measures, CMS defines the peer group based on the number of eligible professionals billing under the group's TIN in 2012. For groups with 25 to 99 eligible professionals, the peer group is composed of all practices nationwide that have 25 or more eligible professionals billing under the group's TIN. For groups with 100 or more eligible professionals, the peer group includes all practices with 100 or more eligible professionals billing under their group's TIN.

For the GPRO and ACO-GPRO groups, the peer group for the PQRS quality measures is defined differently from the other quality measures. Peer group means (benchmarks) are defined as all PQRS participants nationwide, participating either as an individual physician or as a medical group practice, that reported a comparable measure in the prior calendar year (2011). By including individual eligible professionals who did not participate in PQRS as a group, these means are more representative of the experiences of PQRS participants generally. If there is no comparable prior-year measure, CMS does not calculate the benchmark for that measure and does not display it in the PY 2012 QRURs.

18. Why are there blank cells in some exhibits of my report?

Cells are intentionally left blank if it is not possible to calculate a particular statistic or performance measure because there are zero eligible cases. For example, Exhibit 1 shows the basis for attributing Medicare beneficiaries to your practice. If zero beneficiaries were attributed on the basis of receiving primary care from non-primary care specialists, then the number shown in the corresponding column of row 1 would be zero (0). Since there are no cases in this category, however, then the corresponding statistic in row 2 (average percentage of primary care services provided by your group) would not be calculated, and that cell would be left blank. See the example below:

Table 2. QRUR Exhibit 1 with Blank Cell

.	Total	Plurality of Primary Care Services Provided by Primary Care Physicians in Your Group	Plurality of Primary Care Services Provided by Non-Primary Care Specialists in Your Group
Number of Medicare patients attributed to your medical group practice	56	56	0
Average percentage of primary care services provided by your group, per attributed beneficiary	65%	65%	<blank>

19. If the PY 2012 QRUR shows a medical group practice had "insufficient data" to assess its performance on quality or cost, how would that affect its VBM?

Quality or Cost Composite Scores may not be shown in displays of VBM performance in the QRUR if there are insufficient data to calculate a score. There might be insufficient data if a medical group practice has fewer than 20 eligible cases for every measure included in the composite score or if the score is more than one standard deviation from the mean but not statistically different from the mean at the 5 percent level of significance. In both cases, the

phrase "Insufficient Data to Determine" is displayed in place of the composite score. However, for purposes of calculating the VBM, the score is categorized as average.

20. Why would the QRUR indicate that a performance rate was calculated for at least one measure within a quality or cost domain (in Exhibit 4 or 7) but not show a domain score for that domain (in Exhibit 3 or 6)?

Domain scores for the Quality and Cost Composites are calculated and displayed in Exhibits 3 and 6 if the group practice has **at least 20** eligible cases for at least one measure in that cost or quality domain. In contrast, Exhibit 4 (quality measures) and Exhibit 7 (cost measures) show all measures in the domain for which the group practice had **at least one** eligible case.

The Quality or Cost Composite domain score is a simple average of the domain scores. If a domain score cannot be calculated for a medical group practice because the practice had fewer than 20 eligible cases for all individual measures included in the domain, the other domain scores for which the group practice did have at least 20 eligible cases for at least one measure in the domain will be included in the composite calculation. This is most likely to occur with small practices (with fewer eligible professionals billing under a single TIN), which tend to have fewer attributed beneficiaries eligible to be included for some measures. For example, several quality measures and all of the condition-specific per capita cost measures apply only to beneficiaries with the particular health condition. In addition, beneficiaries attributed to a group practice that do not have a valid HCC score, which is used in the per capita cost risk-adjustment model, are not included in any of the per capita cost measures.

If no domain scores can be calculated due to too few cases for all measures included in each domain, CMS will not calculate the group practice's Quality or Cost Composite score.

21. Please provide an example of how composite scores are calculated.

The quality and costs composite scores in the QRUR summarize a group's performance on multiple individual quality and cost measures, respectively. Only measures with at least 20 cases are eligible for inclusion in composite score calculations. The first step in computing a composite score is to standardize the scores for these eligible individual measures by subtracting the benchmark score from the report recipient's score and dividing the result by the standard deviation. Domain scores are then formed for each measure domain by averaging the standardized scores of the measures within that domain. Next, these domain-level scores are combined into an average domain score. (Only domains with at least one measure with at least 20 cases are included in the average domain score.) Finally, the average domain score itself is standardized by subtracting the report recipient's average domain score from the mean average domain score--computed across all physician groups in the report recipient's peer group--and divided by the standard deviation of the average domain score. The result is a score that reflects the report recipient's performance in terms of number of standard deviations above or below the peer group mean.

The table below illustrates the calculation of a composite cost score. The cost composite consists of two equally weighted domains: Per Capita Costs for All Attributed Beneficiaries and Per Capita Costs for Attributed Beneficiaries with Specific Conditions. The former domain includes only one measure - the Total Per Capita Costs for All Beneficiaries measure. The latter domain includes four condition-specific measures for diabetes, chronic obstructive pulmonary

disease (COPD), coronary artery disease, and heart failure. To compute the cost composite score, first begin by computing standardized scores for each of the five measures. These are calculated by subtracting the benchmark performance rate (column C in the table below) from the group's score (column B) and dividing by the standard deviation (column D). The result is the standardized score for the individual performance measure (column E). For example, in the table below, the group's Per Capita Costs for All Attributed Beneficiaries (row 1) is $17,795, the benchmark is $10,370, and the standard deviation is $1,864. The standardized score is therefore ($17,795–$10,370)/$1,864 = 3.98. This rate is also the domain score, because there is only one measure in the domain. The second domain score for Per Capita Costs for Attributed Beneficiaries with Specific Conditions is the average of the standardized scores for the diabetes, coronary artery disease, and heart failure measures (rows 3, 5, and 6). Note that the COPD measure (row 4) is not included because there are fewer than 20 eligible cases (column A). Therefore, the domain's score is (4.64+4.28+4.37)/3 = 4.43.

With the two domain scores in hand (rows 2 and 7, column E), the average domain score may now be computed as (3.98+4.43)/2 = 4.21. The final step is to standardize the average domain score by subtracting the mean across all peers of 0.16 from the report recipient's own score of 4.21 and dividing by the standard deviation of 2.16, yielding a composite score of 1.88. Thus, this group's composite cost score was 1.88 standard deviations higher than the mean composite score among the group's peers, reflecting the group's higher risk-adjusted costs across the individual performance measures.

The computation of the quality composite score is analogous, differing only in the specific measures and domains that constitute the composite. The mean and standard deviation (S.D.) standardization factors used to convert a group's average domain score into a final composite score are displayed to ten decimal places in rows 10–13 of the table below:

Table 3. Example Cost Composite Score Computation

.	.	Group's Number of Eligible Cases (A)	Group's Risk-Adjusted Per Capita Cost (B)	Benchmark (Mean) (C)	Standard Deviation (D)	Standardized Score (E)
(1)	Per Capita Costs for *All* Attributed Beneficiaries	207	$17,795	$10,370	$1,864	3.98
(2)	Domain Score: Per Capita Costs for *All* Attributed Beneficiaries (from Row 1)	.	.	.	.	3.98
(3)	Per Capita Costs for Attributed Beneficiaries with Diabetes	84	$28,153	$14,946	$2,848	4.64
(4)	Per Capita Costs for Attributed Beneficiaries with COPD	18	$39,969	$24,270	$4,934	3.18
(5)	Per Capita Costs for Attributed Beneficiaries with Coronary Artery Disease	84	$31,808	$17,333	$3,384	4.28
(6)	Per Capita Costs for Attributed Beneficiaries with Heart Failure	54	$50,376	$26,190	$5,537	4.37
(7)	Domain Score: Per Capita Costs for Attributed Beneficiaries with Specific Conditions	.	.	.	.	4.43
(8)	Average Domain Score	.	.	0.16	2.16	4.21
(9)	Standardized Cost Composite Score	.	.	.	.	1.88
(10)	Average Cost Domain Score Mean & S.D. Across Peers (Use for Groups with 25–99 EPs)	.	.	0.1643038569	2.1592221477	.
(11)	Average Cost Domain Score Mean & S.D. Across Peers (Use for Groups with 100+ EPs)	.	.	0.1047921738	1.7956868943	.
(12)	Average Quality Domain Score Mean & S.D. Across Peers (Use for Groups with 25–99 EPs)	.	.	-0.3455023540	1.3753496253	.
(13)	Average Quality Domain Score Mean & S.D. Across Peers (Use for Groups with 100+ EPs)	.	.	-0.2391460220	0.9683496236	.

22. Will CMS give patient-level data (with beneficiary identifiers) to medical group practices, so the practices can see which patients have been attributed to their group and what services the patients used?

Yes. Tables 1 and 3 in the drill-down report include information on the beneficiaries attributed to the medical group practice, including gender, date of birth, risk status, Medicare FFS claims filed and services provided, chronic conditions, and hospital admissions.

23. How can I give feedback about the QRURs?

Provider groups can submit comments about the content and format of the QRUR by email at pvhelpdesk@cms.hhs.gov or call the Physician Value Help Desk at 1-888-734-6433 (press option 3). Normal business hours are Monday–Friday, 8 a.m. to 8 p.m. EST.

THE VALUE-BASED PAYMENT MODIFIER

24. What is the value-based payment modifier (VBM)?

The value-based payment modifier (VBM) is a new, per-claim adjustment to payments under the Medicare Physician Fee Schedule that will reward physicians for delivering higher quality care at a lower cost. The VBM is completely separate from both the geographic adjustment factors currently in place for the Medicare Physician Fee Schedule and the separate payment adjustment under the Physician Quality Reporting System (PQRS).

Section 3007 of the Affordable Care Act requires the Secretary of the U.S. Department of Health and Human Services to establish a payment modifier that provides for differential payment to a physician or a group of physicians based upon the quality of care furnished compared with the cost of care.

25. When will the VBM start to be applied to physician fees?

By statute, the VBM will be applied to specific physicians or groups of physicians, as the Secretary determines appropriate, for services furnished beginning January 1, 2015. Implementation began in 2013 through the rulemaking process for the Medicare Physician Fee Schedule. In this first phase of implementation, CMS finalized policies to phase in the VBM by applying it, starting January 1, 2015, to physician payments under the Medicare Physician Fee Schedule for physicians in groups of 100 or more eligible professionals. CY 2013 is the performance period for the VBM that will be applied to payments beginning January 1, 2015.

The definition of an eligible professional is specified in section 1848(k) (3) (B) of the Social Security Act.

Eligible professionals consist of:

- Physicians
  - Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Dental Surgery, Doctor of Dental Medicine, Doctor of Chiropractic
- Practitioners
  - Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist, Certified Nurse Midwife, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Nutrition Professional, Audiologists
- Therapists
  - Physical Therapist, Occupational Therapist, Qualified Speech-Language Therapist

CMS defines a group of physicians as a single Taxpayer Identification Number (TIN) with 2 or more individual eligible professionals (identified by their individual National Provider Identifier (NPI)) who have reassigned their Medicare billing rights to the TIN.

The Affordable Care Act stipulates that the VBM be applied to all physicians and groups of physicians paid under the Medicare Physician Fee Schedule for services furnished beginning no later than January 1, 2017.

26. Will the VBM apply to all physicians treating Medicare beneficiaries?

No. The VBM will apply to payments to all physicians participating in the Medicare FFS program paid under the Medicare Physician Fee Schedule. It will not apply to physicians who are not paid under the Medicare Physician Fee Schedule, including those providing services in Rural Health Clinics, Federally Qualified Health Centers, and Critical Access Hospitals.

Physicians are defined as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors.

27. How will the VBM be applied to groups of physicians during the initial implementation phase?

In the first phase of implementation (starting on January 1, 2015), CMS will apply the VBM to physicians in groups of 100 or more eligible professionals (with exceptions for groups already participating in the Medicare Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care Initiative).

CMS will separate these groups of physicians with 100 or more eligible professionals into 2 categories (see Diagram 1 below).

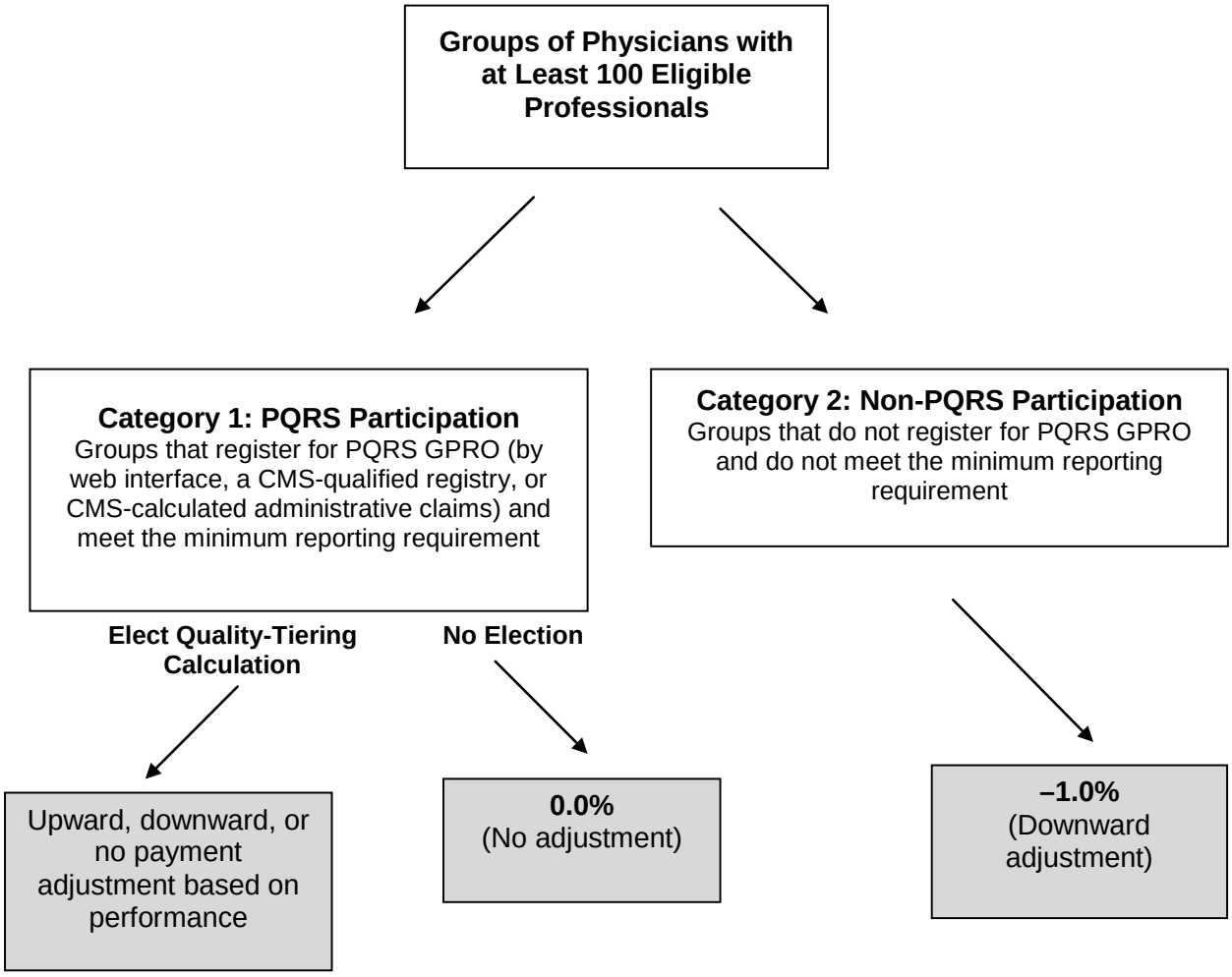
1. *Groups of physicians reporting under the PQRS GPRO and meeting the minimum reporting requirement:*

   Category 1 includes groups of physicians that have self-nominated as a group for the PQRS and reported at least one GPRO measure. Groups within Category 1 will receive no adjustment for CY 2015 or they may elect to have their VBM for CY 2015 (based on performance in 2013) calculated using the quality-tiering methodology, which could result in an upward, neutral, or downward adjustment amount. Before the deadline for electing the quality-tiering approach, CMS will provide Physician Feedback Reports in 2013 that will give groups in this category a preview of what their VBM would be based on 2012 performance data.

2. *Groups of physicians not participating in PQRS GPRO or meeting the minimum reporting criteria:*

   Category 2 includes those groups of physicians with 100 or more eligible professionals that do not participate in PQRS GPRO reporting mechanism or have not met the minimum PQRS GPRO reporting criteria identified earlier. Because CMS will not have quality measure performance rates on which to assess the quality of care these groups of physicians furnish, CMS will set their VBM for 2015 at –1.0 percent. This downward payment adjustment will be in addition to the –1.5 percent payment adjustment assessed for failing to meet satisfactory reporting criteria under the PQRS program.

Diagram 1. How the Value-Based Payment Modifier Will Be Assessed in 2015



28. How will CMS calculate the VBM for groups of physicians electing the quality-tiering approach for 2015?

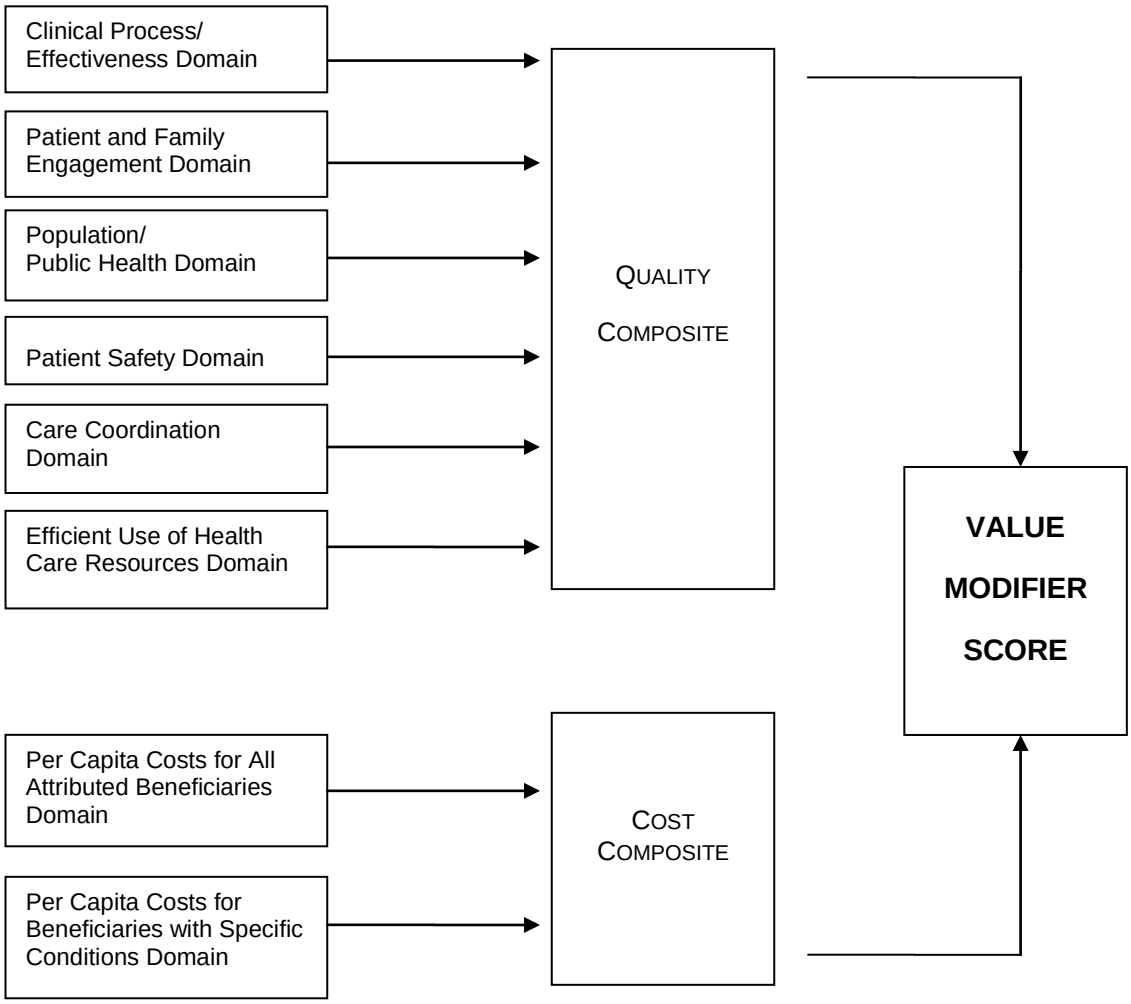
The Value Modifier Score will be composed of a quality composite and a cost composite, each containing domains that will be weighted equally (see Diagram 2 below). In addition, CMS will use a standardized scoring approach that focuses on how much the group's performance differs from a peer group mean on a measure-by-measure basis. For each quality and cost measure included in the quality or cost composite, a score expressed in standardized units will be calculated based on the number of standard deviations that group's performance rate is away from the peer group mean.

Quality measure peer group means will be calculated using average performance on the measure by groups in the year before the performance measurement year; cost measure peer group means will be calculated using average performance on the measure in the performance measurement year. For the non-PQRS quality measures and all cost measures, the peer group will be composed of all group practices nationwide that have 100 or more eligible professionals.

For the PQRS GPRO quality measures, peer group means will be calculated based on average prior-year performance of all PQRS participants nationwide, who participated either as an individual eligible professional or as part of a medical group practice. By including individual eligible professionals who did not participate in PQRS as a group, these means are more representative of the experiences of PQRS participants generally.

Diagram 2. Relationship Between Quality and Cost Composites and the Value-Based Payment Modifier

(Note that not all of the quality composite domains currently contain measures, but rather are placeholders for future measures that might be included in the Value Modifier Score.)



29. What if a medical group practice's performance cannot be measured for some domains of the Quality or Cost Composites?

The Quality or Cost Composite score is a simple average of the domain scores. If a domain score cannot be calculated for a medical group practice because it has fewer than 20 eligible cases for all individual measures included in the domain, the other domain scores for which the group practice does have at least 20 eligible cases for at least one measure in the domain will be included in the composite calculation. This is most likely to occur for small practices (practices with fewer eligible professionals billing under a single TIN), which tend to have a smaller number of attributed beneficiaries eligible to be included in specific quality or cost measures. For example, several quality measures and all of the specific-condition per capita cost measures apply only to beneficiaries with the particular health condition. Beneficiaries attributed to a practice that do not have a valid CMS-HCC score (which is used in the per capita cost risk-adjustment model) are also not included in any of the per capita cost measures.

If no domain scores can be calculated due to too few cases for all measures included in each domain, the group practice's Quality or Cost Composite score is not calculated.

30. What quality measures will be included in the 2015 VBM?

The VBM will include quality measures reported by groups of physicians using one of 3 PQRS GPRO reporting mechanisms: (1) GPRO web interface, (2) CMS-qualified registry, or (3) PQRS administrative claims-based option (a set of 14 administrative claims-based measures). Additionally, 3 administrative claims-based outcome measures will be used to evaluate quality performance—2 composite measures of potentially preventable hospital admissions for ambulatory care-sensitive conditions (one for acute conditions and one for chronic conditions) and one measure of all-cause hospital readmissions.

31. What cost measures will be included in the 2015 VBM?

The cost component of the VBM will include (1) total (non condition-specific) per capita costs and (2) total per capita costs for Medicare beneficiaries with one or more of the following chronic conditions: diabetes, heart failure, chronic obstructive pulmonary disease, and coronary artery disease (chronic condition cost domain).

32. How will CMS ensure that cost comparisons are fair, given geographic and institutional variations in Medicare payment rates and demographic differences in patient populations served?

When calculating per capita costs attributed to physicians, CMS will use standardized payments to account for local, regional, and institutional price differences. For example, the payment standardization methodology removes adjustments in Medicare payments that reflect practice expense and regional labor cost differences, as well as supplemental payments to hospitals that treat a high share of poor and uninsured patients or those that receive indirect graduate medical education payments.

CMS will also use the HCC risk-adjustment methodology to account for patient demographic characteristics such as age and gender; clinically-based factors, such as Medicaid dual-eligible status; and prior health conditions that can affect a beneficiary's costs, regardless of the efficiency of care provided. You can find more information on the risk-adjustment of the cost measures in Appendix D of the Detailed Methodology for the 2012 Medical Group Practice Quality and Resource Use Reports at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/PY2012-Detailed-Methods.pdf.

33. How will beneficiaries be attributed to groups of physicians for the VBM?

There is no separate attribution rule for the VBM. See Question 5 for additional information on how attribution is done at the measure-level.

34. How will beneficiaries be attributed to individual physicians?

CMS has not yet proposed a methodology for attributing beneficiaries to individual physicians. In the first phase of implementation of the VBM in 2015, all performance on cost and quality measures included in the Cost and Quality Composites will be evaluated at the group practice level (for groups of physicians with 100 or more eligible professionals).

35. How much money is at risk under the VBM in 2015?

Per legislative mandate, the VBM must be budget neutral, such that the net effect will not increase or decrease payments to physicians in the aggregate. Thus, in any given year, application of the VBM will result in positive adjustments to payments for some physicians and negative adjustments for others. Precise numbers will vary from year to year, based on performance. However, Table 2 below shows the ratio of payment adjustments for the quality-tiering approach in 2015, as outlined in the 2013 final rule:

Table 4. Calculation of the Value-Based Payment Modifier Using the Quality-Tiering Approach

.	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0x%*	+2.0x%*
Average Cost	–0.5%	+0.0%	+1.0x%*
High Cost	–1.0%	–0.5%	+0.0%

Note: x refers to a payment adjustment factor yet to be determined that will ensure budget neutrality.

* Eligible for an additional +1.0x%, if reporting clinical data for quality measures and the average beneficiary risk score is in the top 25 percent of all beneficiary risk scores.

In addition, CMS will apply a 1 percent downward adjustment for all groups of physicians with 100 or more eligible professionals who choose not to participate in PQRS as a group. CMS will also apply an additional 1 percent upward adjustment (multiplied by the to-be-determined payment adjustment factor) for groups reporting through GPRO web interface or through registries that serve a higher-risk beneficiary population (that is, a population that is less healthy than other beneficiaries). CMS will use the same 2012 HCC risk scores (that are used to risk-adjust the per capita cost measures included in the VBM Cost Composite) to measure the average risk of each group's attributed beneficiaries. CMS will determine the 2012 HCC score distribution (from lowest to highest beneficiary risk score) and percentile thresholds for all Medicare FFS beneficiaries nationally. Next, it will compare average risk scores for beneficiaries attributed to QRUR groups with these national percentile thresholds. Groups who participate in the GPRO web interface or registry PQRS GPRO with average beneficiary risk scores at or above the 75th percentile of all beneficiary risk scores nationwide will be eligible for an additional upward 1 percent applied to the payment adjustment factor, if they are categorized as low cost/average quality, low cost/high quality, or average cost/high quality.

36. Will the 2015 and 2016 VBM also be applied to ACOs?

No. CMS will not apply the VBM in CYs 2015 and 2016 to any group of physicians in which a physician in the group is participating in the Medicare Shared Savings Program, the Pioneer ACO model, or the Comprehensive Primary Care Initiative.

37. Will the VBM be applied to hospital-based physicians (physicians who furnish at least 90 percent of their services in either inpatient or emergency departments of a hospital)?

Yes. For 2015, the value-based payment modifier will apply to groups of hospital-based physicians. CMS will determine their VBM using the same methodology and measures it uses for all other medical group practices subject to the VBM in 2015. However, as it develops future proposals for the VBM, CMS will continue to consider differential performance measures as they relate to hospital-based physicians.

38. How would the VBM be affected for a medical group practice that elected the quality-tiering option but had insufficient data to assess its performance on quality or cost?

Quality and Cost Composite scores are calculated for any medical group practice that has at least 20 eligible cases for at least one measure in at least one cost or quality domain. To be categorized in the high- or low- cost or quality categories for purposes of calculating the VBM under the quality-tiering approach in 2015, a medical group practice's performance must be precisely measured and meaningfully different from the benchmark mean. This means the quality or cost score must be at least one standard deviation above or below the benchmark mean and significantly different from the benchmark mean at the 5 percent level of significance. In addition, scores are calculated only for individual measures with at least 20 cases. Quality or cost scores that do not meet these criteria are categorized as average.

Quality or Cost Composite Scores might not be shown in displays of VBM performance in the QRUR if there is insufficient data to calculate a score. This can happen if a medical group practice has fewer than 20 eligible cases for every measure included in the composite score, or if the score is not statistically different from the mean at the 5 percent level. In both cases, the phrase "Insufficient Data to Determine" will be displayed in place of the composite score. However, for purposes of calculating the VBM, the score would be categorized as average.

INDIVIDUAL ELIGIBLE PROFESSIONAL PQRS PERFORMANCE REPORTS

39. What is an Individual Eligible Professional PQRS Performance Report?

An Individual Eligible Professional PQRS Performance Report contains two tables. Table A.1 presents group-level performance on PQRS measures, reporting both a performance rate and the total number of cases eligible for a given measure. Table A.2 provides information on PQRS performance at the individual eligible professional level, of all eligible professionals affiliated with the group, and presents the performance rate and number of eligible cases for each reporting mechanism under which the eligible professional reported a measure. Only groups with at least 25 eligible professionals and with at least one eligible professional who was incentive-eligible will receive Table A.1. Table A.2 will be received by all groups who have at least 25 eligible professionals and at least one eligible professional who reported a PQRS measure as an individual in 2012.

40. Why did my TIN receive an Individual Eligible Professional PQRS Performance Report but not a full QRUR report?

Individual Eligible Professional PQRS Performance Reports are provided to all groups with at least 25 eligible professionals for which at least one eligible professional reported PQRS measures as an individual in 2012 and was found to be incentive eligible. A partial Individual Eligible Professional PQRS Performance Report (that is, Table A.2 only) will be provided to all groups that have at least 25 eligible professionals and at least one eligible professional who reported a PQRS measure as an individual in 2012, regardless of whether any eligible professional was incentive-eligible. Therefore, groups that did not receive a full QRUR may receive an Individual Eligible Professional PQRS Performance Report.

41. How would performance rates be displayed in Table A.2 for eligible professionals who reported PQRS measures through multiple reporting mechanisms?

For eligible professionals who reported a particular PQRS measure more than once or through more than one of the five possible individual reporting mechanisms (claims, claims measures group, registry, registry measures group, or EHR), an algorithm is applied to produce one performance rate for each of claims, registry, and EHR reporting. In this algorithm, registry measures group measures reported over a six-month reporting period (the only mechanism for which six-month reporting is available) are only retained if the eligible professional did not report any twelve-month registry record, either as individual measure or as a measures group. In cases in which an eligible professional reported the same measure more than once using the same reporting mechanism, only the record with the highest performance rate is retained. Ties between records for the highest performance rate are settled by selecting the record with the highest performance denominator.

Using these selected records, cases in which an eligible professional reported an individual claims measure and a claims measures group measure or, alternatively, an individual registry measure and a registry measures group measure, are addressed by calculating one aggregated performance rate for each of claims and registry reporting. Aggregated performance rates are calculated as the ratio between the aggregated performance numerator, summed over the individual and measures group measure, and the aggregated performance denominator, summed over the individual and measures group measure. Claims and registry measures that were reported with a zero performance denominator are not displayed.

42. How are the TIN-level performance rates in Table A.1 calculated?

TIN-level performance rates are calculated for each measure from the performance rates presented in Table A.2 by aggregating performance numerators and performance denominators across all eligible professionals who were both incentive-eligible under the TIN and reported at least one eligible case for the measure. [The performance rates do not include measures reported over a six-month reporting period by eligible professionals as part of a measures group by registry if the eligible professional also reported the measure by registry over a twelve-month reporting period, either as an individual measure or as part of a measures group.] The ratio of the aggregated performance numerator to the aggregated performance denominator provides the performance rate for the TIN. In cases in which an individual eligible professional submitted a measure through more than one reporting mechanism, only the record with the highest performance rate is counted in the TIN-level performance results. Ties between records for the

highest performance rate are settled by selecting the record with the highest performance denominator. Records submitted through the EHR reporting mechanism with a performance rate equal to zero are excluded from these calculations.