



# Physician Feedback Program: 2011 Individual Physician Quality Resource and Use Reports (QRURs)

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December 2012

Number

# PY 2011 Individual QRUR Teleconference Agenda

Introduction

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Review of the PY 2011 QRURs for Individual Physicians

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Dr. Sheila Roman

Questions/Answers

Michael Wroblewski  
Dr. Sheila Roman



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# What is the Physician Feedback Program?

- The Physician Feedback Program provides physicians with comparative information about the quality and cost of care delivered to their Medicare fee-for-service (FFS) patients, through feedback reports, also known as QRURs.
- In the **2013 Physician Fee Schedule Final Rule** (released November, 2012), CMS announced the initial phase of implementation of the VM to:
  - Physicians practicing in groups of 100 or more eligible professionals...
  - ...who can elect how their payment modifier will be calculated
  - ...to affect their payment in 2015 based on 2013 performance
- CMS will use future QRURs to provide physician groups with the information about how the VM affects their payment



# Number of Groups of 25 or more eligible professionals in 9 States

Distribution of Groups Across Nine States		
State	# of Groups	State % of Total
California	650	28%
Illinois	437	19%
Iowa	103	4%
Kansas	93	4%
Michigan	342	15%
Minnesota	210	9%
Missouri	267	11%
Nebraska	54	2%
Wisconsin	176	8%
Total	2,332	100%

**Each group is assigned to the state in which physicians had the most attributed beneficiaries.**

## Number of QRURs Produced

For Program Year 2011, QRURs were produced for 94,585 physicians who practiced in groups of at least 25 eligible professionals across nine states: CA, IL, IA, KS, MI, MN, MS, NE, WI.

## Number of Physicians (NPIs) Per Group

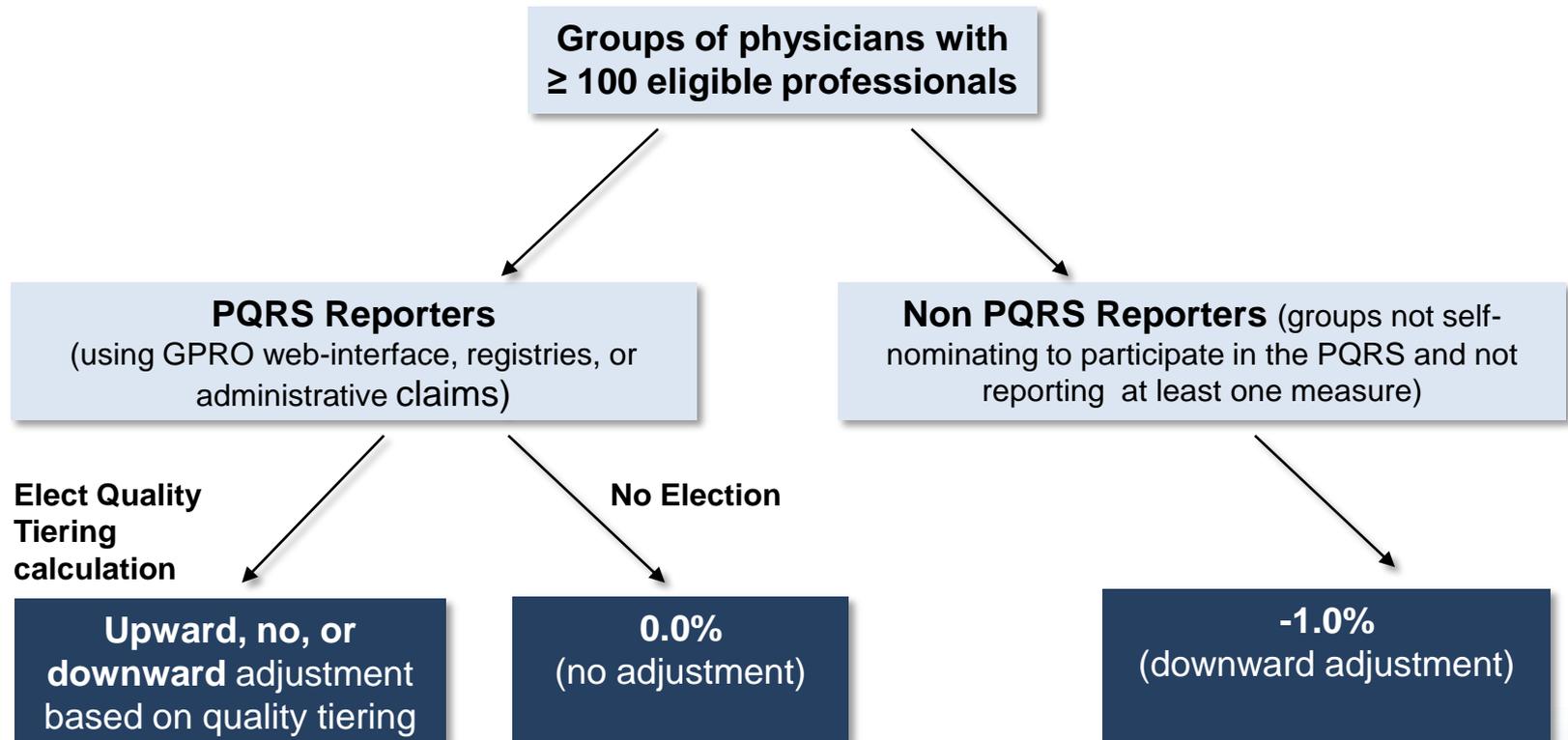
NPIs Per Group				Percentile			
	Mean	Standard Deviation	Min	25th	50th	75th	Max
	48	165	1	1	19	39	4,441

# What is the importance of my 2011 QRUR?

- Provides comparative quality and cost data for quality improvement purposes.
- Introduces you to how Medicare is phasing in the VM.
- Previews some of the quality and cost measures to be used in the VM so you can get a rough estimate of where you could stand.
- Uses the same risk-adjustment and payment standardization techniques for cost measures as the VM.
- Encourages you to suggest specific ways to make the QRUR more meaningful and actionable to improve the quality of care furnished.



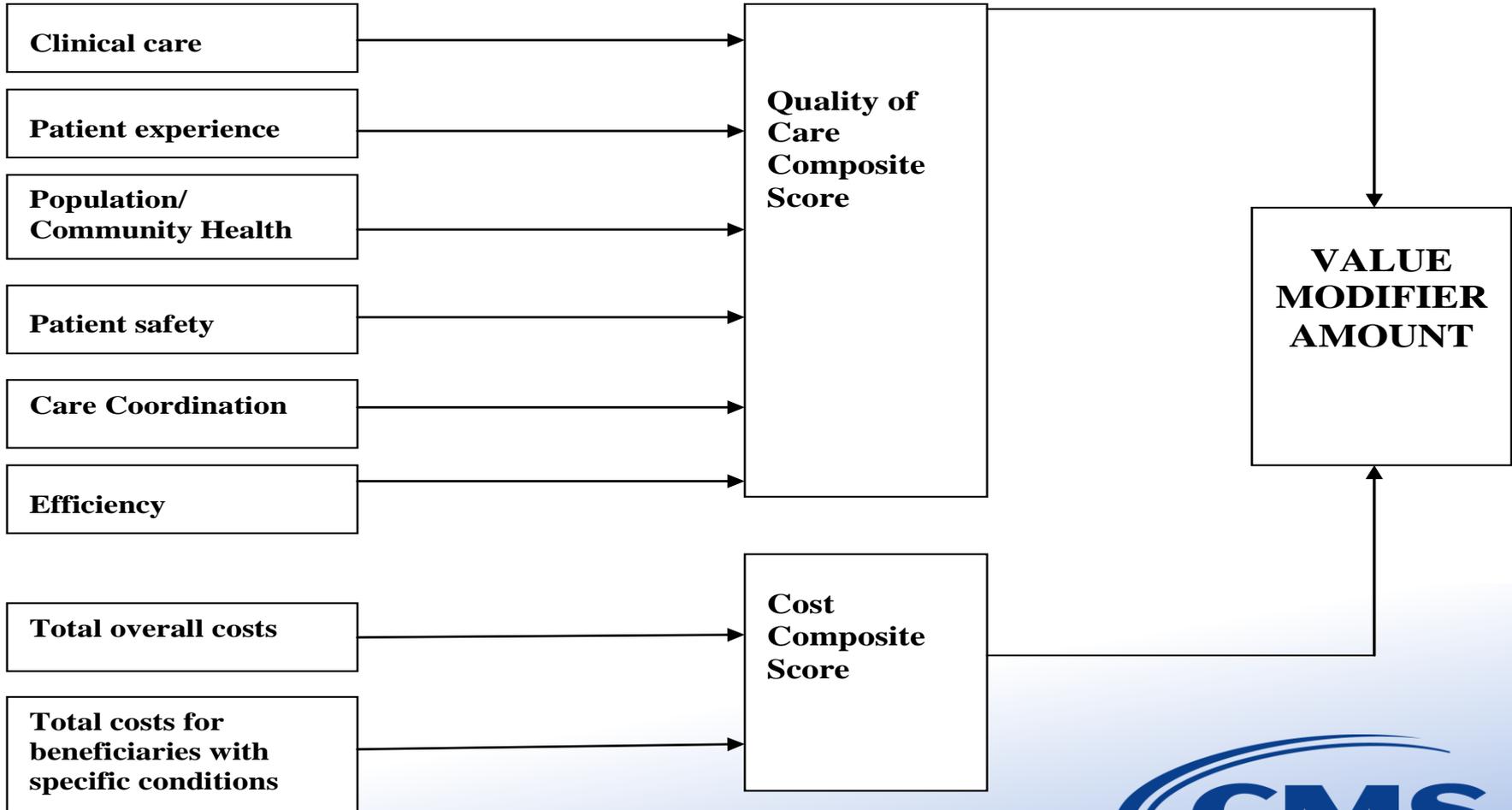
# Overview of How CMS Will Calculate the Value Modifier



**Reporting is a necessary first step towards improving quality.**

# Quality-Tiering Methodology

Combine each quality measure reported through the PQRS into a quality composite and the five per capita cost measures into a cost composite using the following domains:



# How are Value Based Payment Modifiers Calculated Using the Quality-Tiering Approach?

Each group receives two composite scores (quality of care; cost of care), based on the group's **standardized performance** (e.g. how far away from the national mean).

This approach identifies statistically significant **outliers** and assigns them to their respective cost and quality tiers.

Quality/cost	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Medium quality	+1.0x*	+0.0%	-0.5%
Low quality	+0.0%	-0.5%	-1.0%

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

**In 2013, all groups of 25 or more eligible professionals will receive a 2012 QRUR with their tier assignment based on 2012 data.**

# How do I get my QRUR in December 2012?

- Physicians in groups of 25 or more EPs will be able to obtain their individual reports electronically via a secure Internet portal, [www.QRURinfo.com](http://www.QRURinfo.com).
  - A representative acting on behalf of the group can obtain all the individual reports for physicians in the group
- or**
- An individual physician within the group, can access his/her report directly using several authentication elements.

2011 QUALITY AND RESOURCE USE REPORT MEDICARE FEE-FOR-SERVICE	
<b>Dr. PHYSICIAN NAME</b> National Provider Identifier (NPI): # _____ Specialty: _____	
ABOUT THIS REPORT FROM MEDICARE	
WHY	<ul style="list-style-type: none"> <li>This report includes many of the quality and cost measures that Medicare plans to use for the physician <b>value-based payment modifier</b>. It will not affect your Medicare payments.</li> <li>The report is intended as a preview and does not reflect some key aspects of the value-based payment modifier that will be incorporated into future Quality and Resource Use Reports. Those differences are described in the Terms/Definitions section of this report (see Key Differences entry).</li> <li>Starting for calendar year 2015, Medicare will apply a value-based payment modifier to groups of physicians (identified by a single Taxpayer Identification Number, or TIN) with 100 or more eligible professionals, based on their performance during calendar year 2013.</li> </ul>
WHAT	<ul style="list-style-type: none"> <li>The value-based payment modifier will be based, in part, on those quality measures for which your medical group chooses to submit data as part of the Physician Quality Reporting System. Exhibit 1 shows performance on the quality measures for which you submitted data in 2011.</li> <li>Medical groups that do not submit data as part of the Physician Quality Reporting System will be able to request that Medicare compute their performance based on a set of claims-based quality measures. Exhibit 2 shows performance on these and other measures, based on Medicare fee-for-service patients for whom you filed at least one claim in 2011. <b>These measures would be used for the value-based payment modifier only if your medical group chooses this option.</b></li> <li>The cost measures that will be used in the value-based payment modifier, and your 2011 performance on these measures, are shown in Exhibits 4 and 12.</li> </ul>
WHO	<ul style="list-style-type: none"> <li>Medicare is providing 2011 Quality and Resource Use Reports to Medicare fee-for-service physicians who practiced during 2011 as part of a group of 25 or more eligible professionals in <b>nine states</b>: California, Illinois, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, or Wisconsin.</li> <li>According to Medicare's billing records, you submitted Medicare fee-for-service claims for services provided in 2011 as part of a medical group with 25 or more eligible professionals.</li> </ul>
WHAT YOU CAN DO	<ul style="list-style-type: none"> <li>Review your performance in advance, before the value-based payment modifier is implemented in 2015, to identify areas that may positively or negatively affect your reimbursement.</li> <li>Participate in the Physician Quality Reporting System, if you are not already doing so.</li> <li>If you have questions about this report or want to share ways to improve its content and format, please e-mail <a href="mailto:cms_medicare_physician_feedback_program@mathematica-mpr.com">cms_medicare_physician_feedback_program@mathematica-mpr.com</a>.</li> </ul>

Your QRUR contains information about all of your Medicare patients- the quality and cost of their overall care, **delivered by you and other physicians.**

# Performance Highlights

## The Performance Highlights page shows:

**PERFORMANCE HIGHLIGHTS**  
Dr. Physician Name

**YOUR MEDICARE PATIENTS AND THE PHYSICIANS TREATING THEM**

*Based on Medicare claims filed in 2011:*

- You submitted Medicare claims for # Medicare fee-for-service patients.
- On average, # different physicians treated each of the Medicare patients for whom you submitted any claim.

**QUALITY OF YOUR MEDICARE PATIENTS' CARE**

*Compared with all incentive-eligible PQR participants nationwide, your 2011 performance rate was:*

- Better than or equal to average for # out of # quality indicators that you reported.
- Worse than average for # out of # quality indicators that you reported.

*Compared with all patients of physicians in the nine states, beneficiaries for whom you submitted a claim in 2011 received (from you or another physician) recommended services indicated by selected claims-based quality measures:*

- More often than or the same as average for # out of # quality indicators for which you had at least one eligible patient.
- Less often than average for # out of # quality indicators for which you had at least one eligible patient.

**MEDICARE'S COSTS FOR YOUR PATIENTS' CARE**

- All cost data in this report have been risk adjusted to account for differences in patient characteristics (age, gender, Medicaid eligibility, history of medical conditions, and ESRD status).
- Based on your patients' characteristics, CMS risk adjusted average total annual capita costs for all your Medicare patients downward/upward by # percent.
- After risk adjustment, Medicare's average total annual per capita costs for all Medicare patients for whom you submitted any claim in 2011 were # percent higher than/# percent lower than/equal to the average risk-adjusted total annual per capita costs of physicians in your specialty in the nine states.
- The degree and direction of the risk adjustment applied to the total per capita cost measures for patients with four specific chronic conditions in Exhibit 12 of this report will differ from the risk-adjustment percentage shown above if those specific patient populations have different characteristics than your total Medicare patient population.



The number of Medicare patients you treated



Your performance on the PQR measures you reported compared to other PQR participants nationwide.



Your risk adjusted costs for your patients

### Quality

How did the quality of care your Medicare patients received compare to that of other physicians' Medicare FFS

patients?

**Exhibit 1:**  
PQRS  
measures

**Exhibit 2:**  
Administrative  
Claims-based  
Measures

### Cost

How do your Medicare patients' total per capita Medicare costs compare to those of all Medicare FFS patients attributed to physicians practicing in my specialty?

**Exhibits 3,4:**  
How your  
Medicare FFS  
patients break  
out into care  
categories

**Exhibits 8,9:**  
Per Capita costs  
for the  
Medicare FFS  
patients whose  
care you  
"Influenced"

**Exhibits 12:**  
Per Capita costs  
for your  
Medicare FFS  
patients with  
chronic  
conditions

**Exhibits 5,6,7:**  
Per Capita costs  
for the  
Medicare FFS  
patients whose  
care you  
"Directed"

**Exhibits 10,11:**  
Per Capita costs  
for the  
Medicare FFS  
patients to  
whose care you  
"Contributed"

# Exhibit 1. Physician Quality Reporting System (PQRS)

Exhibit 1. Physician Performance on PQRS Quality Measures in 2011					
PQRS Measure Number	Clinical Condition and PQRS Measure  Specifications for PQRS clinical measures are posted at <a href="http://www.cms.gov/PQRS/Downloads/2011_PhysQualRptgMeasuresList_033111.pdf">http://www.cms.gov/PQRS/Downloads/2011_PhysQualRptgMeasuresList_033111.pdf</a>	PQRS Performance			
		You		All PQRS Participants Nationwide	
		Number of Cases You Reported	Performance Rate for Cases You Reported	Number of Participating Physicians Reporting Cases	Mean Performance Rate
Diabetes Mellitus (DM) Measures Group					
1	DM: Hemoglobin A1c Poor Control in Diabetes Mellitus		%		%
2	DM: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus				
3	DM: High Blood Pressure Control in Diabetes Mellitus				
117	DM: Dilated Eye Exam in Diabetic Patient				
119	DM: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients				
126	DM: Diabetic Foot and Ankle Care, Peripheral Neuropathy-Neurological Evaluation				
127	DM: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear				
163	DM: Foot Exam				

**Your performance compared to that of all physicians participating in PQRS**

**Only the measures you selected via claims, registries or EHRs to report on will be shown.**

# Exhibit 2. Administrative Claims-Based Quality Measures

Quality

Exhibit 2. Medicare Claims-Based Quality Measures  
For All Patients for Whom a Physician Filed at Least One Medicare Claim in 2011

Clinical Condition and Measure	All Medicare Patients for Whom You Submitted a Claim		All Medicare Patients for Whom Physicians in the Nine States Submitted a Claim	
	Number of Medicare Patients for Whom This Service Was Indicated	Percentage of Medicare Patients Who Received the Service	Number of Physicians with Patients for Whom This Service Was Indicated	Percentage of Medicare Patients Who Received the Service
<b>Chronic Obstructive Pulmonary Disease (COPD)</b>				
Pharmacotherapy Management of COPD Exacerbation		%		%
1. Dispensed Systemic Corticosteroid Within 14 Days of Event				
2. Dispensed Bronchodilator Within 30 Days of Event				
Use of Spirometry Testing to Diagnose COPD				
<b>Bone, Joint, and Muscle Disorders</b>				
* Osteoporosis Screening for Chronic Steroid Use*				
Osteoporosis Management in Women ≥ 67 Who Had a Fracture				
* Disease-Modifying Antirheumatic Drug Therapy for Rheumatoid Arthritis*				
<b>Cancer</b>				
* Breast Cancer Surveillance for Women with a History of Breast Cancer*				
* PSA Monitoring for Men with Prostate Cancer*				

% of your Medicare FFS patients who received this service (from you or any other provider)

Comparison of rendered services within your patient population compared to that of all Medicare FFS patients attributed in these reports.

Same set of measures (calculated by CMS) are included on each physician's report.

The measures marked by an \* are not included in the administrative claims based option for PQRS and the VM.

Exhibit 3. Categories of Your Medicare Patients

	Number of Your Patients*	Number of Office or Other Outpatient E&M Visits You Billed Per Patient **	Your Share of Costs Billed by Medical Professionals for Your Patients**
Total for Whom You Filed Any Claim			%
Patients Whose Care You Directed			
Patients Whose Care You Influenced			
Patients to Whose Care You Contributed			

Your Medicare FFS patient population can be categorized based upon your degree of involvement with each patient.

\* The number of patients is the total included in calculating per capita costs, after risk adjustment. Because some patients with missing data were dropped from the analysis during the risk adjustment process, this number may be smaller than the total shown in the Highlights section and in Exhibit 2.  
 \*\* Numbers are approximate due to rounding. Because you may have treated many patients for whom you did not submit an office or other outpatient E&M code, the average number of office or other outpatient E&M visits across all patients whom you treated may be significantly less than one.

Exhibit 4. Total Per Capita Costs, 2011

	Total Per Capita Costs for Your Patients	Per Capita Costs for Medicare Patients of Physicians in Your Specialty Receiving a Report
Total for Whom Physician Filed Any Claim	\$	\$
Patients Whose Care Physician Directed		
Patients Whose Care Physician Influenced		
Patients to Whose Care Physician Contributed		

Total per capita cost (Part A & B) for your patients compared to that of all attributed Medicare FFS patients in your specialty

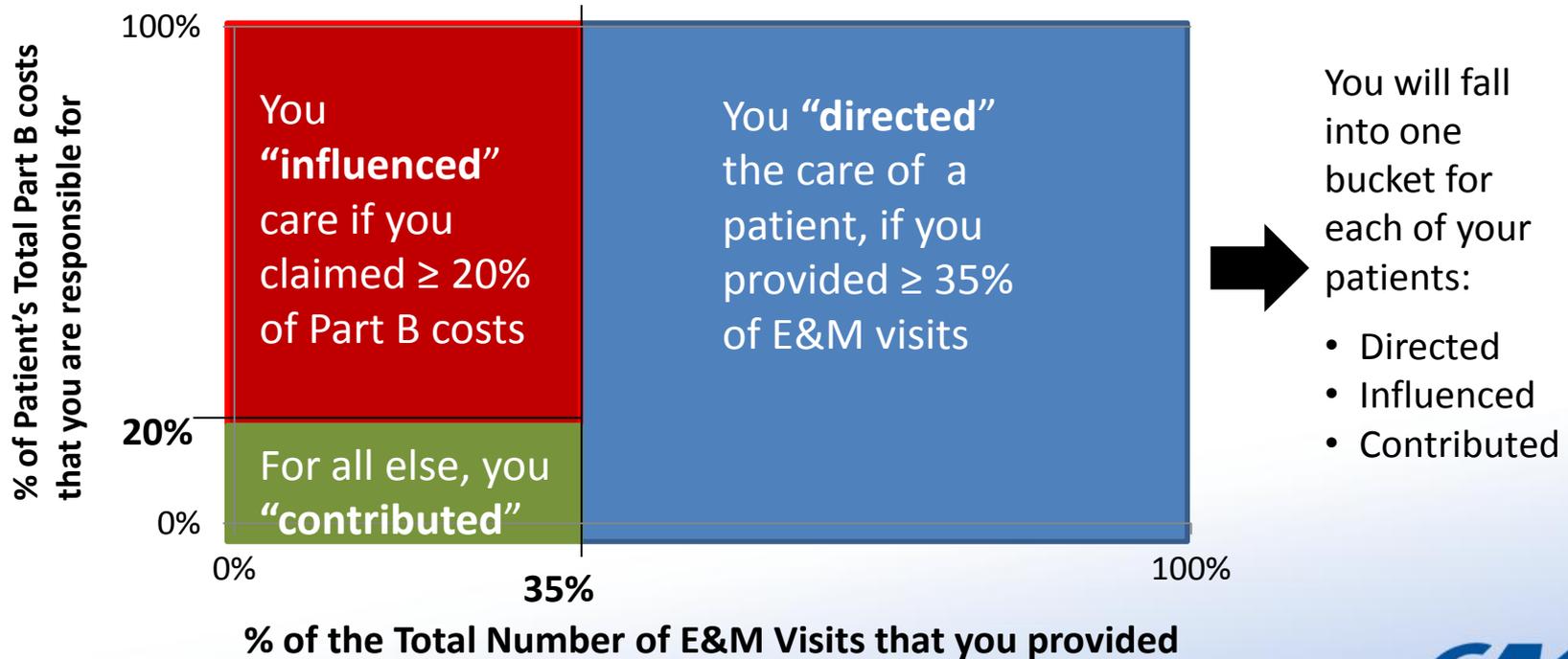
**Total Per Capita costs are Risk-Adjusted and Price-Standardized to ensure fair comparisons**



# Attribution of Beneficiaries by “Degree of Involvement”

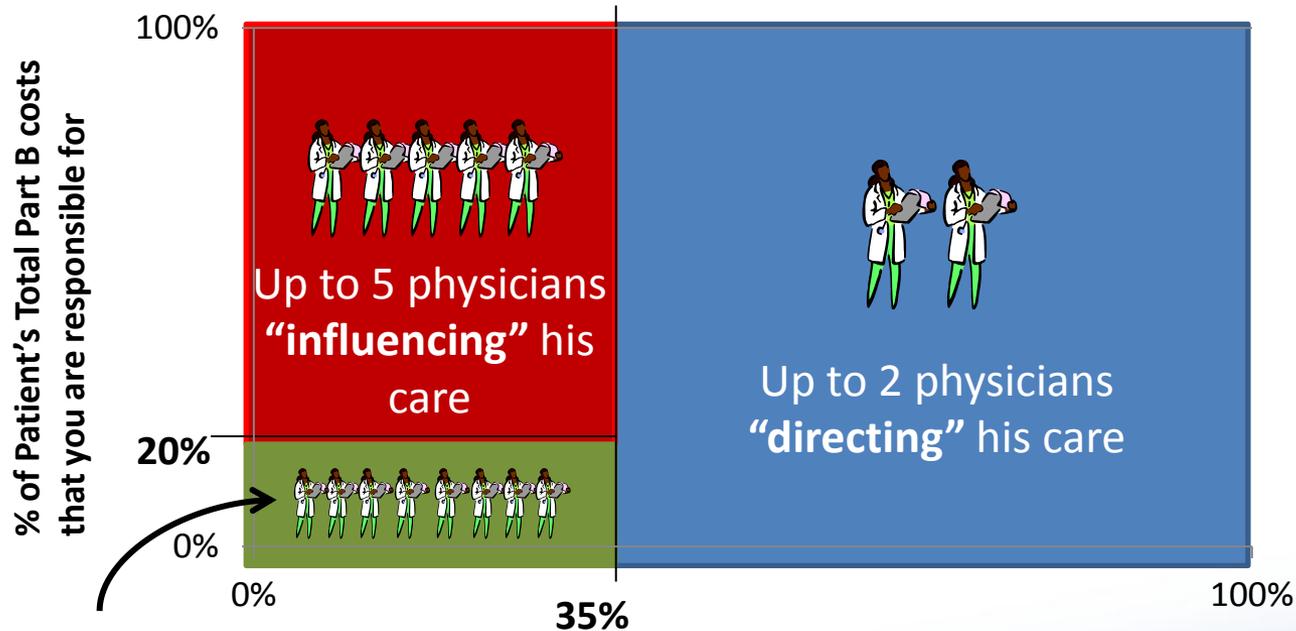
*“I have varying degrees of involvement with my patients – how is CMS attributing their care to me in this report?”*

**If CMS were to divide the amount care you provided to patients into 3 buckets, where would you fall?**



# Attribution of Beneficiaries by “Degree of Involvement”

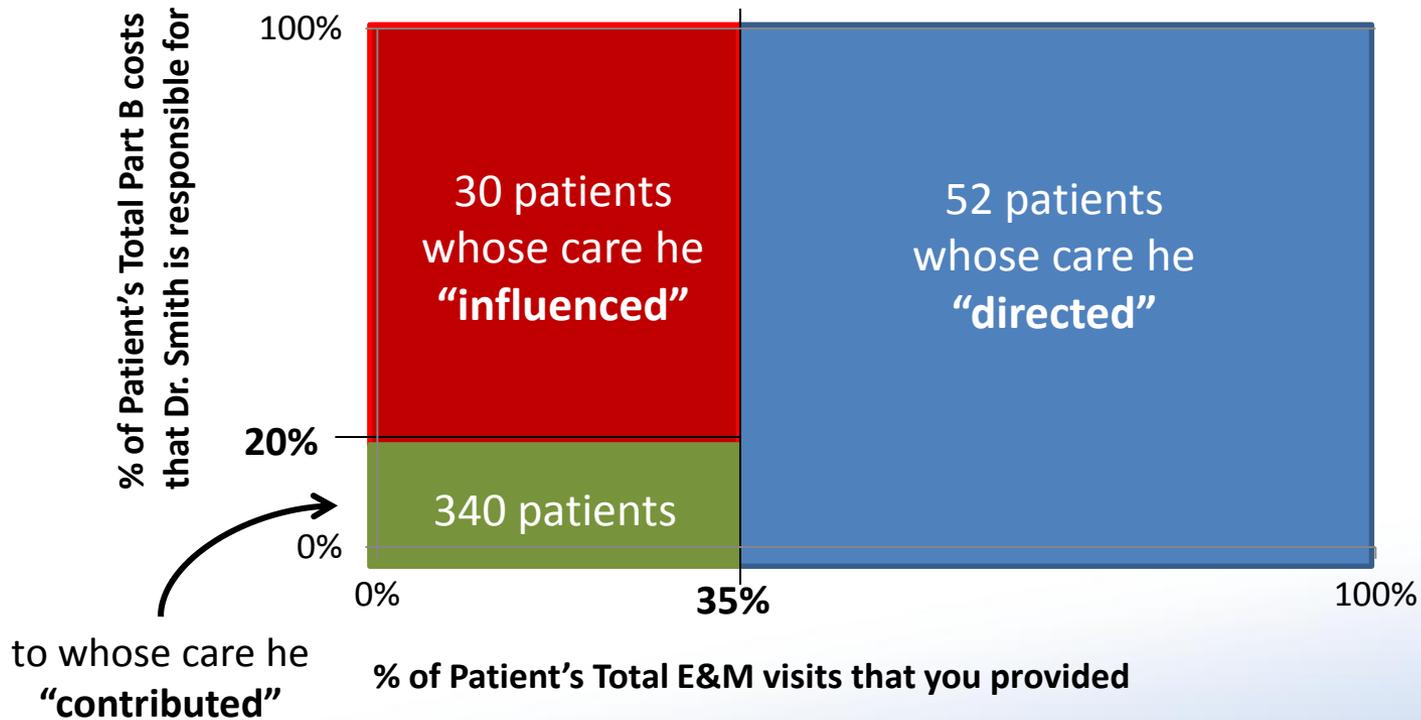
... However, a patient may have seen multiple physicians, also with varying degrees of involvement. Therefore that patient would be attributed to multiple physicians, each in the appropriate care category.



Multiple physicians can “contribute”

# Attribution of Beneficiaries by “Degree of Involvement”

Repeating this attribution process for each Medicare beneficiary results in a profile of your involvement with all Medicare beneficiaries



# Exhibit 5. Total Per Capita Cost – “Directed” Patients

Cost

Exhibit 5. 2011 Total Per Capita Costs for Specific Services for the # Patients Whose Care You Directed

Service Category	Medicare Patients Whose Care You Directed		Average for Medicare Patients Whose Care Was Directed by # Physicians in Your Specialty in the Nine States			Amount by Which Your Medicare Patients' Per Capita Costs Were Higher (or Lower) than Average	
	Your Medicare Patients Using Any Service in This Category		Total Risk-Adjusted Per Capita Costs	Medicare Patients Using Any Service in This Category			Total Risk-Adjusted Per Capita Costs
	Number	Percentage		Number	Percentage		
<b>All Services</b>		100%	\$		100%	\$	\$(/)\$
<b>Evaluation and Management Services in All Non-Emergency Settings</b>							
Provided by YOU for Your Patients		%	\$		%	\$	\$(/)\$
Provided by OTHER Physicians Treating Your Patients							
<b>Procedures in All Non-Emergency Settings</b>							
Provided by YOU for Your Patients							
Provided by OTHER Physicians Treating Your Patients							
<b>Hospital Services (Excluding Emergency Outpatient)</b>							
<b>All Hospital Services</b>							
Inpatient Hospital Facility Services							
Outpatient Hospital Facility Services							
<b>Emergency Services That Did Not Result in a Hospital Admission</b>							
<b>All Emergency Services</b>							
Emergency Visits							

How costs for your patients compared to those of all “directed” patients attributed to your specialty

Costs include all Part A&B payments for services furnished by you and other Medicare physicians

Total per capita costs across 7 different service categories

Are there other services that could be included in this report?

# Exhibits 6,7. Total Per Capita Cost – “Directed” Patients

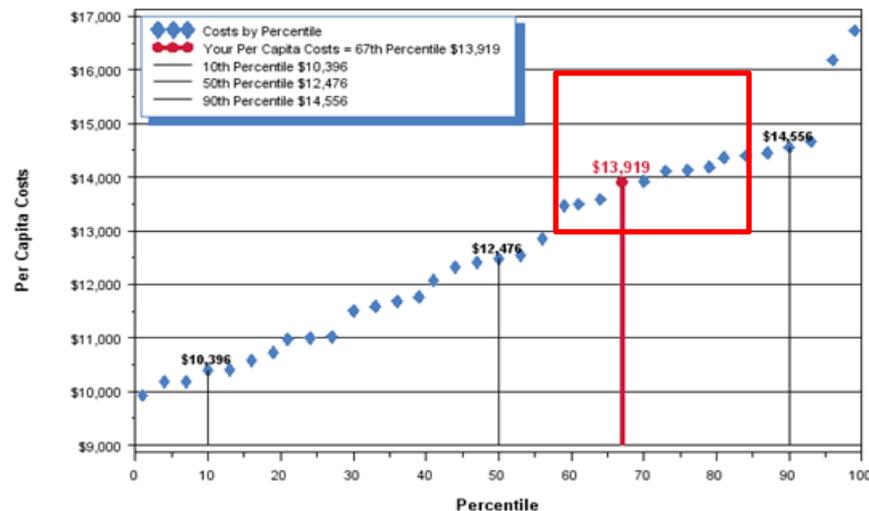
Cost

Exhibit 6. Number of Other Physicians Treating the Medicare Patients Whose Care Was Directed

	For Your Medicare Patients	Average for Medicare Patients of ☒ Physicians in Your Specialty in the Nine States	Average for Medicare Patients of All ☒ Physicians in the Nine States
Number of Other Physicians Who Submitted Claims			

Exhibit 7 shows the distribution of total risk-adjusted and payment-standardized per capita costs, by percentile, among physicians in your specialty in the nine states, for patients whose care was directed.

Exhibit 7. Distribution of the 2011 Total Per Capita Costs of Patients Whose Care Was Directed by Physicians in Your Specialty in the Nine States



This is where your patients Medicare costs fall, relative to your specialty.

This is the number of other Medicare physicians, your patients are seeing on average, in addition to you.

The same analysis is repeated for “Influenced” and “Contributed”

# Exhibits 12. Total Per Capita Cost – Patients with Chronic Conditions

Exhibit 12. 2011 Total Per Capita Costs for Medicare Patients with Specific Chronic Conditions, for All Patients for Whom You Filed at Least One Medicare Claim in 2011

	Medicare Patients for Whom You Filed a Claim		Medicare Patients Treated by Physicians* in Your Specialty Receiving a Report	
	Number of Your Patients	Total Risk-Adjusted Per Capita Costs	Average Number of Patients Per Physician	Average Total Risk-Adjusted Per Capita Costs
Diabetes		\$		\$
Coronary Artery Disease				
Chronic Obstructive Pulmonary Disease				
Heart Failure				

\* Includes only physicians who treated one or more patients with the condition.

**Total Per Capita Costs for patients with any of 4 chronic conditions**

**Costs are risk-adjusted and include services furnished by you and all other Medicare providers seen by the beneficiary**

**Per capita costs for patients with these chronic conditions include all costs for patients and not just those related to the specific condition.**

# Future Directions

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## **CY 2014 Physician Feedback Reports**

- Provided to all groups of physicians with  $\geq 25$  eligible professionals.
- Disseminated in Fall 2014 based on 2013 data.
- Will show the amount of the value modifier and the basis for its determination.

## **Add patient level data to the Physician Feedback Reports**

**Inclusion of episode based cost measures for several episode types in the Physician Feedback Reports.**

# Does CMS have Your Current Info?

## Update PECOS!

**Important information in the QRURs and the Value Modifier come from PECOS\***

- PECOS is Medicare's primary source of information for physician, healthcare professional and group practice information such as
  - **Your medical specialty**
  - **The state in which you practice**
  - **The location of your practice**
  - **Group practice affiliations**
  - **How to contact you**
    - **Please go there now to ensure your information is current:**  
[https:// pecos.cms.hhs.gov/pecos/login.do](https://pecos.cms.hhs.gov/pecos/login.do)

**\* Provider Enrollment, Chain and Ownership System**



## Outstanding Comments & Questions

For specific questions about the content of your report, please email:

[CMS Medicare Physician Feedback Program@mathematica-mpr.com](mailto:CMS_Medicare_Physician_Feedback_Program@mathematica-mpr.com)

For questions on how to access your report please visit:

[www.QRURINFO.com](http://www.QRURINFO.com)

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





Further Information on the Individual  
QRURs is available at:

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<http://www.cms.gov/PhysicianFeedbackProgram>

Thank you for your participation in today's call.

# Evaluate Your Experience with Today's National Provider Call

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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 NPC. 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!



Official CMS Information for  
Medicare Fee-For-Service Providers