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Important Information About
2010 Quality and Resource Use Reports
for GPRO I Medical Group Practices

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2010 GPRO QUALITY AND RESOURCE USE REPORTS **Disseminated September 2011**

BACKGROUND AND PURPOSE OF REPORT

Q1: What is the Medicare Physician Feedback Program?

The Physician Resource Use Measurement and Reporting Program was established under the Medicare Improvements for Patients and Providers Act of 2008. The program was extended and enhanced under the 2010 Affordable Care Act and is now called the Physician Feedback Program.

The Physician Feedback Program is part of a larger Medicare effort to improve the quality and efficiency of medical care and to help CMS develop meaningful, actionable, and fair ways to measure the performance of physicians. The primary goal of this program is to provide confidential information to physicians and physician group practices about the resources they use and quality of care they provide to their Medicare fee-for-service patients, compared to other physicians or practices caring for Medicare patients in similar specialties and in similar areas of the country.

Performance measures will later be included in CMS' physician "value-based payment modifier." CMS will use the modifier to adjust Medicare fee-schedule payments to physicians based on the quality of care they provide and the costs they incur. The 2010 Affordable Care Act requires Medicare to start phasing in this payment modifier in 2015. By 2017, Medicare will be required to apply this modifier to all physicians.

CMS is using a phased approach to respond to these congressional mandates. In Phase I (2008 to 2009), CMS tested resource use measures and prototype feedback reports with approximately 300 randomly selected physicians in 12 metropolitan areas. CMS followed the rulemaking process for the Medicare Physician Fee Schedule in developing the measures and reports. During Phase II (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. During Phase III (2010- 2011), CMS will distribute Quality and Resource Use Reports (QRURs) using 2010 data more extensively to physicians and medical group practices throughout the country. The Phase III confidential reports will help CMS identify potential measures for the value-based payment modifier. CMS expects to use the Physician Feedback reports in future years to develop components of the modifier before they are implemented and to share information with physicians.

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

Q2: How were medical group practices selected to receive a 2010 GPRO QRUR?

CMS sent the group-level 2010 QRURs to the 35 practices that participated in the group practice reporting option (GPRO I) of the Physician Quality Reporting System in 2010. To participate, medical group practices had to:

- Include at least 200 physicians or other eligible professionals (identified by individual National Provider Identifiers) who had reassigned their billing rights to the practice's tax identification number (TIN)
- Submit a self-nominating letter to CMS for the 2010 GPRO I program
- Comply with all other CMS requirements, such as agree to participate in mandatory trainings and be able to comply with a secure method for data submission.

CMS chose these 35 group practices to receive 2010 GPRO QRURs because they could be compared using 26 common quality measures collected through the GPRO I reporting tool. The combination of reporting these Physician Quality Reporting System measures with resource use measures furthers CMS' efforts to align the Physician Feedback Program and the physician value-based payment modifier with other Medicare value-based payment initiatives.

Q3: What should medical group practices do with the information in their reports?

At this time, the 2010 GPRO QRUR is for information only. It will not affect practices' Medicare payments or participation in Medicare, and the information will not be reported publicly.

CMS recognizes that physicians are central to ensuring the provision of quality health care and to controlling medical costs, and there are several ways this report can help practices with those efforts. The report will help practices compare their quality and costs to those of all 35 medical group practices that participated in GPRO I in 2010. CMS has not set thresholds for quality or ceilings for costs. QRURs can identify priority areas where quality could be improved or costs controlled. Reviewing the report will help practices become familiar with the type of information that CMS may use in the future to adjust physicians' Medicare payments using the value-based payment modifier

After information has been reviewed and discussed, please send an email with any comments or suggestions on how we could improve the reports to CMS_Medicare_Physician_Feedback_Program@mathematica-mpr.com.

VALUE-BASED PAYMENT MODIFIER

Q4: Will the quality and cost measures displayed in the 2010 GPRO QRURs be used for the future physician value-based payment modifier?

The 2010 Affordable Care Act (Section 3007) requires that CMS develop a value-based payment modifier for the Medicare Physician Fee Schedule. The payment modifier will adjust Medicare fee-for-service payments to physicians, based on the quality and cost of the care they provide to Medicare beneficiaries. However, CMS has some latitude in deciding (1) which quality and cost measures to include in the payment modifier, and (2) how to combine the values assigned to individual quality and cost measures to adjust fees.

CMS has not yet determined which measures to include in the payment modifier or how the modifier will be calculated. CMS is seeking public comment on a set of proposed quality and cost measures for the modifier, including through the CY 2012 Physician Fee Schedule proposed rule, placed on display at the Federal Register on July 1, 2011. During the next several years, CMS will continue to gather input from stakeholders through a variety of mechanisms (such as feedback sessions with physicians, open door forums, and technical expert panels) to develop and refine the payment modifier.

The value-based payment modifier will likely include some measures other than those presented in the 2010 GPRO QRURs. For example, to promote compatibility across programs and to minimize the burden on physicians, CMS will strongly consider measures already in use by other programs (such as the Electronic Health Record Incentive Program). CMS may also use measures that can be derived from available administrative data. CMS also seeks to move as quickly as possible to the use of quality outcome, care coordination, patient experience, and episodes of care measures when valid, reliable, and fair measures are available for assessment of physician performance.

REPORT METHODOLOGY

Q5: What Medicare beneficiaries are represented in patient cost and quality measures of each group practice?

For the 2010 GPRO QRURS, CMS attributed Medicare beneficiaries to the GPRO I practice that:

- Billed for at least two office or other outpatient evaluation and management (E&M) services (e.g., face-to-face office visits) for a given beneficiary, and
- Charged for a larger share of E&M services for the beneficiary than any other physician practice, based on 2010 Carrier (Part B) Medicare claims for Medicare allowed charges

Under the Physician Quality Reporting System rules, CMS excluded from attribution in calculating the GPRO I quality measures any beneficiaries: who were not enrolled in both Medicare fee-for-service Parts A and B for all 12 months of 2010 (including those newly eligible for Medicare benefits after January 1, 2010 and those who died in 2010), who were age 65 or older and still working (that is, Medicare was their secondary payer for medical services), who

resided outside the United States, who were included in any Medicare fee-for-service demonstration, or who received hospice services in 2010.

To calculate the per capita cost and ambulatory care sensitive condition (ACSC) measures in the 2010 GPRO QRURs, CMS used the same criteria it used for attributing beneficiaries to GPRO I practices; however, CMS used all of a practice's attributed beneficiaries to calculate the cost and ACSC measures but used only a subset of beneficiaries to calculate the 26 GPRO I quality measures. Under the Physician Quality Reporting System rules, each practice was required to report clinical data to CMS for at least the first 411 beneficiaries who met CMS criteria for specific measures. If the practice had fewer than 411 beneficiaries, it was required to submit data for all of them.

Q6: How did CMS account for beneficiaries who were enrolled in Medicare for only part of 2010?

Following rules for the GPRO I reporting option for the 2010 Physician Quality Reporting System, the 2010 GPRO QRURs only included Medicare beneficiaries who were enrolled in both Part A (Hospital Insurance) and Part B (Medical Insurance) of the fee-for-service Medicare program for all of 2010. Beneficiaries who did not meet these criteria were not attributed to any medical practice.

Beneficiaries were excluded if for any month of the performance period they were enrolled in Medicare fee-for-service Part A only or Part B only; they were enrolled in a Medicare managed care plan; they were age 65 or older and still working (that is, Medicare was their secondary payer for medical services); they lived outside the United States; they were included in any Medicare fee-for-service demonstration program; they became newly eligible for Medicare benefits on or after January 1, 2010; they died in 2010; or they used hospice benefits.

Q7: What services and costs are included in the per capita cost measures in the 2010 GPRO QRURs?

The total per capita cost measures in the reports are the average (mean) of 2010 Medicare fee-for-service Parts A (Hospital Insurance) and B (Medical Insurance) payments to all providers who treated beneficiaries attributed to a given medical group practice (whether or not the providers were associated with the group). CMS obtained this cost information from 2010 administrative claims that included inpatient hospital, outpatient hospital, skilled nursing facility, home health, durable medical equipment, and Medicare carrier (non-institutional provider) costs. Part D (Outpatient Prescription Drug) claims and hospice claims were excluded from the measures. To the extent that Medicare claims include such information, costs included payments to providers from Medicare, from beneficiaries (co-payments and deductibles), and from third-party private payers.

CMS calculated per capita costs by adding up the total price-standardized and risk-adjusted Medicare Parts A and B costs during 2010 for all Medicare beneficiaries attributed to a practice. This sum was then divided by the number of beneficiaries attributed to the practice.

The 2010 GPRO QRURs also include subgroup-specific per capita cost measures for Medicare beneficiaries who had at least one of the following chronic health conditions:

- Diabetes
- Coronary artery disease (CAD)
- Chronic obstructive pulmonary disease (COPD)
- Heart failure (HF)

Like the total per capita cost measures, the per capita costs for each subgroup are the average of 2010 Medicare fee-for-service Parts A and B payments (excluding hospice and Part D outpatient prescription drug payments) per attributed beneficiary. CMS calculated the per capita costs for each subgroup by (1) adding up the price-standardized and risk-adjusted Medicare Parts A and B costs during 2010 for all Medicare beneficiaries attributed to a practice who had the given condition, and (2) dividing this sum by the number of attributed beneficiaries with the condition. These subgroup costs include all costs of care, not just those associated with treating the condition.

The four chronic health conditions are not mutually exclusive. Beneficiaries with multiple conditions are counted within each relevant condition subgroup. However, for each subgroup, CMS used a separate model to risk adjust per capita costs for that subgroup in order to control for other chronic and acute comorbidities that beneficiaries had at the same time.

Q8: How did CMS determine whether a Medicare beneficiary had any of the four chronic conditions for the subgroup-specific per capita cost measures included in the 2010 GPRO QRURs?

Data from the CMS Chronic Condition Data Warehouse (CCW) were used to identify beneficiaries who had any of the four conditions of interest to CMS: chronic obstructive pulmonary disease, coronary artery disease, diabetes, and heart failure. Per capita cost measures were constructed for each subgroup of beneficiaries who had at least one of these conditions.

CMS created the CCW database in response to the Medicare Modernization Act of 2003, which outlined a plan to improve quality and reduce the cost of care for chronically ill Medicare beneficiaries. Typically, the CCW identifies fee-for-service beneficiaries with one of the 21 chronic conditions based on ICD-9, CPT4, and HCPCS codes on claims submitted for patients who had at least one inpatient or facility claim or two outpatient claims in a given measurement period for the given condition. For more information on the definitions of chronic conditions in the CCW, see http://www.ccwdata.org/cs/groups/public/documents/document/ccw_userguide.pdf (accessed July 4, 2011).

Q9: How did CMS take into account differences in patients' medical histories (risk adjustment)?

CMS used the Hierarchical Condition Categories (HCC) risk-adjustment model, which predicts patients' resource use for the coming year based on diagnoses from Medicare claims for the patient filed in the previous year. Risk adjustment of 2010 costs also took into account whether a beneficiary had end-stage renal disease in 2009. CMS uses the HCC model to risk adjust Medicare capitation payments to private health care (Medicare Advantage) plans.

The HCC model assigns International Statistical Classification of Diseases and Related Health Problems (ICD)-9 diagnosis codes to 70 clinical conditions. For each beneficiary

enrolled in the Medicare fee-for-service program in the previous year, the HCC model generates a risk score for the beneficiary in the current year based on the presence of these conditions on previous year's claims and on the beneficiary's sex, age, original reason for Medicare entitlement (age or disability), and Medicaid entitlement. Risk scores for beneficiaries enrolled in Medicare fee-for-service for only part of 2009 did not include the ICD-9 diagnostic codes from 2009 claims (because their claims were incomplete for 2009) but did take into account all other risk factors included in the HCC model. Risk adjustment standardizes costs (smoothes out large differences) that are caused by physiologic differences in patients (evidenced by disease and cost histories) that could be expected to make future costs of care higher or lower than average, no matter where the patient is treated or how efficient the care is.

Q10: How did CMS account for differences in costs for medical services that are due to variations in the cost of living across the United States (price standardization)?

“Medicare costs” refer to the total amount paid to providers for medical services rendered to Medicare beneficiaries. These include discrete services (such as office visits) as well as bundled services (such as hospital stays). For most types of medical services, Medicare adjusts payments to providers to reflect differences in local input prices (for example, wage rates and real-estate costs). Additionally, in some instances, Medicare singles out designated classes of providers to be paid on a different basis than other providers. For example, most acute care hospitals are paid on a prospective Diagnosis-Related Group (DRG) basis. Critical Access Hospitals, however, are paid retrospectively on a cost basis. Payments for the same services, therefore, can vary depending on geographic location and Medicare payment rates among facilities of the same type (e.g., hospitals). Comparing costs for the same services among providers of the same type without price standardization could make one provider with higher treatment costs appear to use more resources than the provider's peers, when in fact differences in geographic or facility-specific payments may be responsible for the higher costs.

Before calculating any cost measures for the 2010 GPRO QRURs, CMS standardized the unit costs (prices) for the 2010 Medicare claims. This process equalized the costs associated with a specific service such that a given service was priced at the same level across all providers within the same facility type or health care setting, regardless of geographic location or differences in Medicare payment rates. Cost standardization allows “apples-to-apples” comparisons among medical groups that practice in areas or settings where reimbursement rates are higher or lower than average.

Q11: Why did CMS decide to use the mean or median (average) performance of the peer group as the performance benchmark for comparing practice performance? Will CMS use this same type of benchmark for the physician value-based modifier program?

Benchmarks can be set based on the high performers in a peer group (for example, the 90th percentile), the low performers (for example, the 10th percentile), or the average performers (for example, the 50th percentile median or the mean). There are strengths and weaknesses to each approach.

- *High-performance benchmarks:* During Phase I testing of physician feedback reports, many physicians said they preferred to be compared to the highest or best performers. The use of high-performance benchmarks acknowledges the best

performers, while incentivizing all others to improve. However, values at the highest end of a distribution are often less statistically reliable than values near the middle of the distribution. A high-performance benchmark may also appear unattainable to low-performing providers, undermining their motivation to improve.

- *Low-performance benchmarks:* Low-performance benchmarks can be used to target providers most in need of improvement. But values at the lowest end of a distribution are generally less statistically reliable than values near the middle of the distribution. In addition, few providers are likely to perform below a low-performance benchmark, creating little incentive for most providers to improve.
- *Average-performance benchmarks:* The average value (median or mean) in a peer group is commonly used and readily understood by lay and professional audiences. Such values also tend to be more statistically reliable than values near the “tails” of a distribution. Performance highlighted as “worse than average” can provide a strong signal to low-end performers that they need to improve. However, the upper half of the distribution will, by definition, have already attained the benchmark and might need additional incentives to improve.

For the 2010 GPRO QRURs, CMS designated the middle ground of mean or median performance as the benchmark for peer group comparisons. CMS has not determined which benchmarks will be used for future Physician Feedback Reports or for the physician value-based payment modifier. The agency will work closely with experts and stakeholders to determine how to calculate the payment modifier and how to establish peer group benchmarks for comparing performance in terms of quality and resource use across providers.

PROGRAM FEEDBACK FOR CMS

Q12: How can I provide comments to CMS about the 2010 GPRO QRURs and the Physician Feedback Program?

There are two key ways to provide feedback to CMS:

- 1) Send your comments via e-mail to CMS_Medicare_Physician_Feedback_Program@mathematica-mpr.com.
- 2) Take part in two small-group telephone discussions about the 2010 GPRO QRUR by sending an e-mail to CMS_Medicare_Physician_Feedback_Program@mathematica-mpr.com. The dates of these telephone discussions are listed on the cover letter sent with your 2010 GPRO QRUR.

CMS is interested in hearing all of your suggestions for improving future QRURs. In particular, CMS would like to hear your views on:

- Whether you had difficulty interpreting your report
- Whether you had difficulty understanding any terms or exhibits in the report
- The appropriateness of methods used to produce the reports, such as the method of attributing beneficiaries to group practices, computing per capita costs for patients, or risk adjusting per capita cost measures
- Whether the report accurately reflects the Medicare fee-for-service patients treated by your practice in 2010
- How your practice might use the report
- How the reports could be made more useful in terms of helping you improve your practice's efficiency and quality of care
- How the reports could be used to support the value-based payment modifier, to be phased into the Medicare program starting in 2015