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Quality and Resource Use Reports (QRURs):

Frequently Asked Questions

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Q1: What is the Medicare Physician Resource Use Measurement and Reporting Program and Physician Feedback Program?

The Physician Resource Use Measurement and Reporting Program was established under the Medicare Improvements for Patients and Providers Act of 2008 (Section 131[c]). The program was extended and enhanced under the 2010 Patient Protection and Affordable Care Act (Section 1848 [n]) and is now called the Physician Feedback Program. The primary goal of the Physician Feedback Program is to provide confidential information to physicians and other medical professionals about the resources used to treat their Medicare fee-for-service (FFS) patients and the quality of care provided to these patients, in comparison to peer groups of medical professionals in similar specialty areas of practice.

The Physician Feedback Program is part of a larger Medicare effort (1) to encourage higher quality and more efficient medical practice, and (2) to create a transparent process for developing meaningful, actionable, and fair performance indicators that can later be used in CMS' physician value-based purchasing initiatives.

Starting in 2015, the 2010 Patient Protection and Affordable Care Act requires CMS to develop a "value-based modifier" that adjusts Medicare Physician Fee Schedule payments based on a medical professional's performance on both quality and resource use. As well, this Act requires that medical professionals' performance be publicly reported on Medicare's Physician Compare website at an unspecified future date.

CMS is using a phased approach to respond to these Congressional mandates. Phase I of the Physician Feedback Program (from April 2008 to April 2009) involved formative testing of resource use measures and prototype feedback reports with approximately 300 randomly-selected physicians in 12 metropolitan areas. During Phase II (currently underway), CMS is developing and testing feedback reports that include both quality and resource use measures with approximately 1,600 medical professionals and the 36 medical practice groups with which they are affiliated. In late 2011 and early 2012 (Phase III), feedback reports will be distributed more extensively to medical professionals and medical group practices throughout the country.

Throughout this iterative process, CMS is collaborating with stakeholders inside and outside of government, reaching out to physician groups and specialty societies, holding public listening sessions, and making use of the Medicare Physician Fee Schedule rulemaking process to develop performance measures that are fair, and feedback reports that are meaningful and actionable.

Q2: Why was I selected to receive a 2010 QRUR?

In Phase II of the Physician Feedback Program currently underway, CMS is preparing and distributing feedback reports that include both quality and resource use information to a limited number of medical professionals and group practices. This Phase II report is referred to as the 2010 Quality and Resource Use Report (QRUR).

Individual medical professionals designated to receive a 2010 QRUR met the criteria listed below:

- The medical professional practiced in one of the 12 designated metropolitan areas across the U.S. targeted for Phase II report distribution.
- The medical professional was affiliated with a selected medical practice group in 2007 (the year of claims data from which performance measures presented in the 2010 QRURs are derived).
- The medical professional had a valid Unique Physician Identification Number (UPIN) in the 2007 Medicare physician/supplier claims database, so that Medicare patients could be attributed to that medical professional based on Medicare claims submitted in 2007. Of note, the UPIN has now been changed to the National Provider Identification Number (NPI).
- The medical professional had at least one 2007 GEM measure (from CMS' Generating Medicare Physician Quality Performance Measurement Results project) that could be calculated, based on the following requirements:
  - the medical professional had at least 11 patients for whom the service captured by the measure was indicated; and
  - a peer group could be identified that had at least 30 medical professionals in the same medical specialty practicing in the same metropolitan area in 2007 who met the minimum patient size criterion of 11 patients.
- The medical professional met the following requirements for calculating 2007 per capita cost measures:
  - the medical professional had at least 30 Medicare patients that could be attributed to the medical professional, based on Medicare claims submitted in 2007; and
  - a peer group could be identified with at least 30 medical professionals in the same medical specialty practicing in the same metropolitan area in 2007 who met the minimum patient size criterion of 30 patients.

Medical practice groups (defined as a group of medical professionals billing under a single Tax Identification Number, or TIN) were selected to receive a 2010 QRUR if:

- the medical practice group had at least one medical professional who practiced in one of the 12 designated metropolitan areas in 2007,
- the medical practice group had at least one medical professional who participated in the Physician Quality Reporting Initiative (PQRI) program in 2007, 2008, 2009, or 2010, and
- the medical practice group had at least 5,000 Medicare patients that could be attributed to it, based on Medicare claims filed in 2007.

Q3: What was the basis for designating the particular geographic areas used in the QRUR report?

The 12 metropolitan areas identified for use for Phases I and II of the Physician Feedback Program were those included in the Center for Studying Health System Change's Community Tracking Study (CTS). The CTS sites were designated because they provide a random sample of communities that represent different geographic areas, populations, physician and health care market structures, patterns of Medicare spending, and experience with public- or private-sector performance measurement. Designation of these sites provided CMS an opportunity to test feedback reports in diverse community contexts and to make use of CTS data gathered since 1996 to plan the phased pilot tests and interpret findings.

In the next phase of the Physician Feedback Program, CMS will select a much larger and broader geographic sample of medical professionals to receive confidential feedback reports. Although the sampling strategy for Phase III has yet to be finalized, CMS will take into account both rural, suburban, and urban areas in determining which physicians will receive feedback reports.

Q4: How did CMS determine my medical specialty?

CMS used the HCFA medical specialty code submitted by the medical professional on his or her 2007 Carrier Medicare claims to determine the specialty of peers to whom performance and resource use would be compared in the 2010 QRUR. In instances where a medical professional listed different specialties on different claims, CMS used the medical specialty cited in the majority of claims.

Q5: What should I do with the information in my report?

The 2010 QRUR is intended for informational purposes only at this time. It will not affect your participation in the Medicare program or your Medicare payment, and the information will not be reported publicly.

CMS recognizes that medical professionals are central to ensuring quality health care and controlling medical costs. There are several ways this report can help.

First, the information provided in the report can be educational. It can help you see how the quality of the care provided to your Medicare patients and the resources and services used in providing that care compare to that of your peers. While there are no "correct" patterns of quality or resource use, the report is designed to show the range of practice patterns among your peers.

A second potential use of the QRURs is to help you develop strategies for improving quality and reducing costs in your practice. Although the detail provided is limited, the reports can be a starting point to help you identify priority areas of focus, where quality of care may be improved or where service costs may be especially high compared with your peers.

Third, reviewing the report will help you become familiar with the type of information that CMS may use in the future to adjust your Medicare reimbursement under the value-based

payment modifier program and the type of information that may be posted on Medicare's Physician Compare website in the future.

Take time to read the report carefully, to digest the information presented, and to reflect on what it tells you about your Medicare practice. After spending some time reviewing your report, please send us your comments and suggestions about how CMS could make future reports more useful. You can send comments on your report to QRURfeedback@mathematica-mpr.com.

Q6: Why didn't CMS include Physician Quality Reporting Initiative (PQRI) measures in the 2010 QRURs?

CMS began gathering the measurement data for the pilot phases of the QRURs in mid-2008, when the PQRI program (begun in July 2007) was still in its infancy. Because there were few participants in PQRI at that time, CMS chose to delay inclusion of PQRI measures until future physician feedback reports (also see Questions 7 and 8).

Q7: What clinical quality measures were used in the 2010 QRURs? How were they calculated?

The quality measures included in the 2010 QRURs for medical practice groups and individual physicians are based on the methodology developed for the CMS Generating Medicare Physician Quality Performance Measurement Results (GEM) project. The GEM project, sponsored by CMS, used 2006 and 2007 Medicare administrative claims data to generate performance rates for 12 clinical quality measures, based on HEDIS® measures appropriate to the Medicare population. The 12 ambulatory care measures are as follows:

1. LDL Screening for Beneficiaries up to 75 Years of Age with Diabetes
2. Eye Exam (retinal) for Beneficiaries up to 75 Years of Age with Diabetes
3. HbA1c Testing for Beneficiaries up to 75 Years of Age with Diabetes
4. Medical Attention for Nephropathy for Diabetics up to 75 Years of Age
5. LDL-C Screening for Beneficiaries up to 75 Years of Age with Cardiovascular Conditions
6. β-Blocker Treatment after Heart Attack
7. Persistence of β-Blocker Treatment after Heart Attack
8. Colorectal Cancer Screening for Beneficiaries up to 80 Years of Age
9. Breast Cancer Screening for Women up to 69 Years of Age
10. Annual Monitoring for Beneficiaries on Persistent Medications (ACE Inhibitors or Angiotensin Receptor Blockers, Digoxin, Diuretics, and Anti-Convulsants)
11. Antidepressant Medication Management (Acute Phase)
12. Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis

Each performance measure is calculated by determining the number of beneficiaries attributed to the medical practice group or medical professional for whom the particular health

care service, screening test, medication, or other intervention was indicated (the denominator) and the number of attributed beneficiaries who received the recommended health care service (the numerator). A measure rate is then calculated by dividing the numerator by the denominator and expressing the result as a percentage. The highest possible rate for a GEM quality measure is 100 percent and the lowest possible rate is 0 percent. Criteria for the GEM project stipulate that no statistics for a given measure be calculated if there are fewer than 11 eligible patients in the denominator for a given measure.

GEM measures were calculated only for the following medical specialists: those deemed to be primary care specialists, cardiologists, neurologists, psychiatrists, nephrologists, endocrinologists, rheumatologists, and neuropsychiatrists. Only medical professionals or medical practice groups with at least one of the above-listed GEM measures were eligible to receive a 2010 QRUR.

For detailed information on GEM measures, please visit the CMS website at: http://www1.cms.gov/GEM/05_TechnicalDocuments.asp#TopOfPage.

Q8: What other clinical data may be included in future feedback reports?

Future feedback reports and the new value-based payment modifier required by the 2010 Patient Protection and Affordable Care Act will increasingly rely upon additional claims-based measures of clinical quality and resource use. In addition, clinical data that can be submitted electronically via electronic health records (EHRs) offer much promise.

CMS views electronic reporting as a potentially cost-effective method to incorporate clinical data into its physician-based performance measures. However, clinical data for a broad array of medical professionals are not yet widely available electronically. CMS is actively exploring ways to improve the collection of clinical data and to encourage adoption of EHR systems. For example:

- The Health Information Technology for Economic and Clinical Health (HITECH) Act (enacted as part of the American Recovery and Reinvestment Act of 2009) established a program under Medicare and Medicaid to provide incentive payments for the "meaningful use" of certified EHR technology. The Congressional Budget Office estimates that within the next decade, HITECH provisions will result in the adoption of comprehensive EHRs by approximately 90 percent of doctors and 70 percent of hospitals.
- The Medicare Care Management Performance Demonstration (MCMP), mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, is a pay-for-performance demonstration designed to promote the adoption and use of health information technology to improve care quality. Physicians are eligible for incentive payments for implementing a certified EHR system and reporting quality data via the EHR.
- CMS also sponsors the e-Prescribing (eRx) program, authorized under the Medicare Improvements for Patients and Providers Act of 2008, which is an incentive program for medical professionals who use a qualified eRx system.

Q9: Why did CMS use 2007 Medicare claims data in the 2010 QRURs?

When CMS began its phased implementation of the Physician Resource Use Measurement and Reporting Program and Physician Feedback Program in 2008, the most recent year for which complete Medicare claims data for calculating resource use cost and utilization measures were available was 2007. Because the 2010 QRURs were produced for limited distribution and the amount of data processing required to produce the physician feedback reports was quite significant, it was deemed most efficient and practicable to continue to use 2007 claims data in Phase II.

CMS will use more current claims data in future feedback reports. Those reports will likely include new quality and resource use measures and will be distributed to a much larger number of medical professionals and medical practice groups.

Q10: How did CMS determine which Medicare beneficiaries were "my" patients in the feedback reports that went to individual physicians?

For the purposes of the 2010 QRUR, Medicare beneficiaries were "attributed" to an individual medical professional using what is known as the "plurality-minimum" attribution rule. In a step-wise process, CMS first identified all evaluation and management (E&M) services billed for a beneficiary during calendar year 2007. Next, CMS identified all medical professionals who billed for E&M services for that beneficiary during 2007. Each beneficiary was then attributed to the individual medical professional who billed for the greatest number of the beneficiary's E&M services, provided that medical professional was responsible for at least 20 percent of the beneficiary's annual E&M costs.

Q11: How did CMS define "medical practice group" in the 2010 QRURs?

For purposes of the 2010 QRURs, a medical practice group was defined as a provider entity identified by a single tax identification number (TIN), which met three criteria:

- The medical practice group had at least 5,000 Medicare beneficiaries living in one of the 12 designated geographic areas included in the 2010 QRURs who could be attributed to the TIN in 2007.
- The medical practice group included at least one primary care physician and at least one medical specialist or surgeon who billed for E&M Medicare services under the TIN in the 2007 Medicare Carrier (Physician/Supplier) claims file.
- The medical practice group had at least one medical professional billing Medicare Carrier claims under the TIN in 2007 who could be identified as practicing in one of the 12 designated geographic areas included in the 2010 QRURs.

Q12: How did CMS determine which Medicare beneficiaries belonged to a medical practice group?

Medicare beneficiaries were attributed to a single medical practice group (identified by its tax identification number or TIN) based on the "plurality-minimum" attribution rule. In a

stepwise process, CMS first identified all evaluation and management (E&M) services billed for the beneficiary during calendar year 2007. Next, CMS identified the TIN under which medical professionals billed for the greatest number of the beneficiary's E&M services during 2007. Each beneficiary was then attributed to the medical practice group that billed for the greatest number of the beneficiary's E&M services, provided at least 30 percent of the beneficiary's annual E&M costs were billed under that group's TIN.

Q13: How did CMS determine which medical professionals were "affiliated" with a specific medical practice group?

Any physician, nurse practitioner, or physician's assistant billing as a performing physician (provider) on a 2007 Medicare Carrier (Part B physician/supplier) claim that was filed under a given TIN was identified as being affiliated with the medical practice group associated with that TIN. All medical professionals billing under more than one TIN in 2007 were assigned to the TIN under which they billed the most Part B Medicare Carrier (physician/supplier) claims in 2007.

Q14: How did CMS adjust per capita cost measures to reflect differences in patient mix (risk adjustment)?

For the 2010 QRURs, CMS used the Hierarchical Condition Categories (HCC) risk adjustment model, which predicts patients' potential resource utilization for the upcoming year based on diagnoses and claims in the previous year.

The HCC model assigns ICD-9 diagnosis codes to 70 clinical conditions. For each Medicare beneficiary enrolled in Medicare fee-for-service for all of the previous year, the HCC model generates a risk score based on the presence of these conditions and on the beneficiary's sex, age, reason for Medicare entitlement (either age or disability), Medicaid entitlement, and presence of end-stage renal disease. Risk scores for beneficiaries enrolled in Medicare fee-for-service for only part of the previous year do not include ICD-9 diagnostic codes for the 70 clinical conditions, but do take into account all of the other factors included in the HCC model.

Q15: How did CMS account for patients who were enrolled in Medicare only for part of 2007 (part-year beneficiaries)?

Both "full-year" Medicare beneficiaries (who were enrolled in both Part A and Part B of original FFS Medicare for the entire 12 months of the 2007 calendar year) and "part-year" beneficiaries (enrolled for at least one month but fewer than 12) were included in all resource use/cost of care measures in the 2010 QRURs. For part-year beneficiaries, CMS weighted annualized resource use or cost measures to reflect the portion of the year that the beneficiary could incur Medicare costs during the year. Retaining part-year beneficiaries in measure calculations ensures that, to the extent practicable, the performance measure reflects the entirety of the medical professional's Medicare practice population during the year.

Q16: How did CMS account for differences in prices or costs of services that result from differences in the cost of living across the United States?

"Medicare costs" refer to the total reimbursement paid to providers for services provided to Medicare beneficiaries. These include discrete services (such as physician 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). Payments for the same services will vary, depending on location and Medicare payment rates.

Prior to calculating any cost measures for the 2010 QRURs, CMS standardized unit costs (prices) for the 2007 Medicare claims. Price standardization equalizes the costs associated with a specific service, regardless of when and where it was provided, and regardless of differences in Medicare payment rates. Cost standardization allows "apples-to-apples" comparisons among medical practice groups or medical professionals that practice in locations or settings where reimbursement rates are higher or lower.

Q17: How did CMS determine that a Medicare beneficiary had one or more of the five chronic conditions included in the QRUR?

Data from CMS's Chronic Condition Warehouse (CCW) were used to identify beneficiaries with any of the five conditions of interest designated by CMS: chronic obstructive pulmonary disease, coronary artery disease, diabetes, prostate cancer, and congestive heart failure. Per capita cost measures were constructed for each of these chronic condition subgroups.

The CCW database was created in response to the Medicare Modernization Act of 2003 (MMA), which outlined a plan to improve quality and reduce the cost of care for chronically ill Medicare beneficiaries. An essential component of this plan was the establishment of a data warehouse that contains beneficiary-level Medicare data collected across the various types of health care settings. The CCW includes institutional and non-institutional claims, assessment data, and enrollment/eligibility information for 100 percent of the Medicare FFS population from 2005 forward.

The CCW identifies patients with one or more of 21 defined chronic conditions, based on ICD-9, CPT4, and HCPCS codes on claims submitted for FFS beneficiaries who had at least one inpatient or facility claim or two outpatient claims in the given calendar year for the given condition. For more information on the definition of chronic conditions included in the CCW, see http://www.ccwdata.org/downloads/CCW_UserManual.pdf (accessed July 7, 2010).

Q18: Why did CMS decide that the mean or median (average) performance of the peer group was the right benchmark to use? Will CMS use this same type of benchmark for the value-based modifier program?

Comparative benchmarks may be defined in terms of high performers in a given peer group (for example, the 90th percentile), low performers (10th percentile), or peer group norms (for example, the 50th percentile median or mean). There are strength and weaknesses to each approach.

- *High-performance benchmarks:* During Phase I testing of physician feedback reports, many medical professionals preferred comparisons to the highest performers. The use of high-performance benchmarks acknowledges the "best" performers, while incentivizing all others to improve. However, values at the extreme upper end of peer group distributions are generally less statistically reliable than values near the middle of the distribution. A high performance benchmark may appear unattainable to low-performing professionals, undermining their motivation to improve.
- *Low-performance benchmarks:* The use of low-performance benchmarks may serve to target performers most in need of improvement. Here, too, however, values at lowest end of peer group distributions are generally less statistically reliable than those near the middle of the distribution. Few medical professionals are likely to perform below a low-performance benchmark, creating little incentive for others to improve.
- *Average-performance benchmarks:* Peer group averages (medians or means) are commonly used and readily understood by lay and professional audiences. As noted, values near the middle of peer group distributions are also generally more statistically reliable than values near the "tails" of the distribution. Performance highlighted as "worse than average" can provide a strong signal to lower performers that they are outside the norm. However, the upper half of the distribution will, by definition, have already attained the benchmark and might need additional incentives to encourage further improvement.

For the 2010 QRURs, CMS designated the middle ground of mean or median provider 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 program. CMS will work in close collaboration with many different experts and stakeholders to determine how the payment modifier will be calculated and how benchmarks will be determined.

Q19: Will the quality/cost measures in the 2010 QRURs be used for the value-based payment modifier program?

The 2010 Patient Protection and Affordable Care Act (Section 3007) requires that CMS develop a value-based payment modifier to the Medicare Physician Fee Schedule that will differentially pay individual medical professionals based on the quality of care furnished to Medicare beneficiaries compared to the cost of that care. However, CMS has latitude in deciding which individual quality and cost indicators will make up the components of the value-based payment modifier, and in determining how values assigned to those individual measures will be combined to affect payment.

CMS has not yet decided which quality and cost measures will be used for the value-based payment modifier or how that modifier will be calculated. Over the next two years, CMS will gather input from stakeholders through a variety of mechanisms (for example, public listening sessions, open door forums, and technical expert panels) to define the value-based payment modifier. If the quality and resource use indicators included in the 2010 QRURs are deemed by

experts, stakeholders, and CMS to be important measures of value, these or similar types of measures may be included in the value-based payment modifier program.

It is likely that the value-based payment modifier program will include quality and resource use measures other than those included in the 2010 QRURs. The 2010 Patient Protection and Affordable Care Act provides five years of funding to CMS and the Agency for Healthcare Research and Quality (AHRQ) to support the development of patient outcome measures and efficiency measures. In order to promote compatibility across programs and minimize the reporting burden on medical professionals, CMS will examine most closely measures already in use by programs such as the Physician Quality Reporting Initiative (PQRI) or Health Information Technology for Economic and Clinical Health (HITECH), or that can be derived from available administrative data.

Q20: How can I provide feedback to CMS on the 2010 QRURs and the Physician Feedback Program?

There are several ways to provide feedback to CMS on the 2010 QRURs in particular, and on the Physician Feedback Program in general.

1. You can provide comments to CMS via the QualityNet Help Desk:
   - Phone: 1-866-288-8912 (Monday-Friday 7:00 a.m.-7:00 p.m. CST)
   - Email: Qnetsupport@sdps.org
2. You can volunteer to take part in a small group discussion or a brief (ten-minute) telephone discussion to share your thoughts by e-mailing QRURfeedback@mathematica-mpr.com and letting them know you would like to be included in a 2010 QRUR discussion. A CMS contractor will get in touch with you to set up a convenient time and discussion format.
3. You can provide comments on the program via e-mail QRURfeedback@mathematica-mpr.com, specifically set up to collect your comments and ideas.

CMS is interested in hearing *all* of your suggestions for improving future QRURs. In particular, the Agency would like to hear your views on such topics as the following:

- Whether the methods used to define medical practice groups and affiliated medical professionals are accurate and valid—that is, whether you recognize the NPI assigned to you and see yourself as being affiliated with the medical group (TIN) with which you have been associated
- Whether the reports appear to be an accurate reflection of your practice
- Whether you find the information interesting and/or useful
- How well the report distribution mechanism works