CHANGES IN THE QUALITY AND RESOURCE USE REPORTS FROM PROGRAM YEAR 2011 TO PROGRAM YEAR 2012

CMS made the following changes to this year's QRURs, in response to stakeholder feedback and as part of our continuing effort to enhance the usefulness of the QRURs:

1. **Expand the number of groups of physicians receiving reports.** CMS expanded the number of groups of physicians eligible to receive a QRUR to all groups nationwide meeting two criteria: (a) at least 25 eligible professionals billed under the group's TIN in 2012, and (b) the group had at least 20 eligible cases for at least one of the quality or cost measures included in the QRUR. The 2011 group QRURs were provided only to those groups that participated in the Physician Quality Reporting Systems (PQRS) Group Practice Reporting Option (GPRO), which required participating groups to submit information related to a set of primary and preventive care quality measures.

2. **Include a preview of how the group might score on the quality and cost composite measures that will be used for the value-based payment modifier.** The 2012 QRURs display each report recipient's quality and cost composite measure score based on 2012 data, as well as scores for the cost and quality domains that constitute the composites. The report also displays how the group's scores compare with their peers' performance. This information allows groups of physicians to see how they might fare under the value-based payment modifier that will be applied in 2015, based on a computation of these same composite measures using 2013 data. Additional information is available at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html**.

3. **Provide detailed data on each group's attributed beneficiaries and their hospitalizations, and the group's associated eligible professionals.** Complementing the 2012 QRURs are three Drill Down tables that provide information on each beneficiary attributed to the group and each eligible professional billing under the group's Taxpayer Identification Number (TIN).

   a. Beneficiaries (Drill Down Table 1): beneficiary identifying information (such as health insurance claim number and date of birth), number and percentage of primary care services billed by the group, the specific service categories in which the beneficiary incurred expenditures in 2012, and whether the beneficiary had certain chronic conditions (diabetes, for example).

   b. Hospitalizations (Drill Down Table 3): beneficiary identifying information, admission date, admitting hospital, principal diagnosis, discharge date, readmission information, information on whether admission was potentially preventable, discharge date, and discharge location.

   c. Eligible Professionals (Drill Down Table 2): each eligible professional, identified by National Provider Identifier (NPI), billing under the group's TIN in 2012, the professional's specialty, and an indication of whether the professional is a physician or a non-physician practitioner.

4. **Employ a new attribution rule.** The QRURs use the same two-step attribution rule used to attribute beneficiaries to Accountable Care Organizations (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 more primary care services (as measured by allowed charges) than any other group. Otherwise, the beneficiary is attributed to the group whose other physicians, clinical nurse specialists, nurse

practitioners, and physician assistants provided the most primary care services, as long as at least one physician in the group provided such services to the beneficiary.

5. **Include part-year and other beneficiaries in the attribution rule.** Unlike the 2011 QRURs, the following types of beneficiaries are eligible for attribution to a group of physicians: those who died, were newly enrolled in Medicare, were enrolled in a Medicare FFS demonstration, used hospice benefits, had Medicare coverage through the Railroad Retirement Board, or received any Medicare-covered services for which Medicare was not the primary payer. Even if these beneficiaries are attributed to a group of physicians, however, they may still be excluded from specific performance measures if the measure's specification requires their exclusion.

6. **Include CMS-calculated administrative claims-based quality indicators for groups of physicians not participating in the PQRS GPRO or in an ACO.** For groups that did not participate in the GPRO program or in an ACO in 2012, the 2012 QRURs report performance on 14 administrative claims-based quality measures covering aspects of the following areas of treatment: bone, joint, and muscle disorders; COPD; diabetes mellitus; ischemic vascular disease; mental health; medication management; and preventive care. (These indicators previously were reported in the 2011 QRURs for Individual Physicians but not in the 2011 Group QRURs.)

7. **Adjust the three outcome measures for age and gender.** The QRURs report performance rates on three outcome measures and, in the 2012 QRURs, these rates are risk adjusted. For the chronic and acute Ambulatory Care Sensitive Condition (ACSC) measures, the risk adjustment accounts for differences in the age and gender of beneficiaries attributed to different groups. The all-cause hospital readmissions measure is also risk adjusted to account for differences in beneficiaries' demographic and health status.

8. **Use prior-year data to benchmark quality measures.** The 2012 QRURs include benchmarks for each quality measure based on the mean performance of physician groups and individual physicians reporting the measure *in the year prior to the performance year* (2011) rather than in the performance year itself (if a comparable prior year measure is available); cost benchmarks continue to be based on current year (2012) performance.

9. **Provide data for additional categories of service.** The 2012 QRURs continue to report per capita costs for evaluation and management (E&M) services by type of provider. Moreover, they additionally distinguish E&M services provided by the report recipient's group versus all other groups. In addition, the All Other Services category now breaks out three separate subcategories: Ambulance Services, Chemotherapy and Other Part B–Covered Drugs, and All Other Services Not Otherwise Classified.