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Evaluation of the Usefulness of Practice Feedback Reports

Report

Prepared for

Suzanne M. Goodwin, PhD
Centers for Medicare & Medicaid Services
Mail Stop WB-06-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Prepared by

RTI International
3040 Cornwallis Road
P.O. Box 12194
Research Triangle Park, NC 27709

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RTI INTERNATIONAL

Evaluation of the Usefulness of Practice Feedback Reports

by RTI International

Federal Project Officer: Suzanne Goodwin

RTI International

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RTI International is a trade name of Research Triangle Institute.

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EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS) contracted with Research Triangle Institute (RTI) to conduct a study of medical homes that have been recognized by the National Committee for Quality Assurance's Physician Practice Connections®–Patient-Centered Medical Home™ (PPC-PCMH) Recognition Program. The study analyzed the relationship between medical home attributes and patterns of health care quality, utilization, and cost for Medicare fee-for-service (FFS) beneficiaries receiving their health care services from PCMHs, compared with physician practices that were not NCQA-recognized. As an incentive for participation in the study, RTI developed a "Practice Feedback Report" containing practice-level data on patterns of care, health outcomes, and costs of care for their Medicare FFS patients. The feedback reports were given to the 312 practices that agreed to participate in the study.

A provider feedback web-based evaluation survey was administered to feedback report recipients to assess their perceptions about the overall utility of the feedback report and their satisfaction with specific elements of the report. It also assessed their perceptions about the ease of use and data interpretation and their likelihood of using information in the report in various ways (e.g., to guide quality improvement efforts, decision making about the practice). The purpose of this report is to describe the results of the evaluation survey. CMS plans to use the results from this evaluation survey to inform their planning activities for future medical home initiatives.

Overall, survey respondents indicated that they were satisfied with the report. Respondents reported that the most useful sections were the quality of care measures, the continuity of care measures, and the tables and graphs comparing their practice to the benchmark practices. Users also found helpful the technical reference guide at the end of the report.

Based on input we received through this survey, we recommend the following changes to future iterations of the feedback report:

- Omit the influenza vaccination rate measure, as this measure is not captured well in Medicare claims
- Include more quality of care measures, such as:
  - Rate of retinal eye examinations for beneficiaries with diabetes
  - Welcome to Medicare visit rate and annual wellness visit rate
  - Composite quality measure for beneficiaries with diabetes. This measure would inform practices of the proportion of their beneficiaries with diabetes who had all three of the following diabetes quality measures: 1) the proportion of patients with diabetes who had HbA1c testing, 2) LDL-C screening, and 3) retinal eye examination in the previous year.

- Provide actionable information such as patient-level utilization data, such as lists of hospitalized patients or those who have been treated in the emergency department, along with dates of service for such utilization.

SECTION 1
INTRODUCTION AND PURPOSE

The "patient-centered medical home" (PCMH) is the newest idea being promoted as a potentially transformative health system innovation. Current interest in the medical home as the anchor for a patient's interaction with the health care system derives from growing recognition that even patients with insurance coverage may not have an established source of primary care services and that care fragmentation can negatively affect the quality and cost of care that patients experience. The aim of the medical home model is to bring order to uncoordinated, inefficient health care system.

The Centers for Medicare & Medicaid Services (CMS) contracted with Research Triangle Institute (RTI) to conduct a study of PCMHs that have been recognized by the National Committee for Quality Assurance's Physician Practice Connections®–Patient-Centered Medical Home™ (PPC-PCMH) Recognition Program. The study analyzed the relationship between medical home attributes and patterns of health care quality, utilization, and cost for Medicare fee-for-service (FFS) beneficiaries receiving their health care services from PCMHs, compared with physician practices that were not recognized as PCMHs. The information from this evaluation is being used by CMS as they move forward with designing additional PCMH demonstrations, including the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration and the Federally Qualified Health Center Advanced Primary Care Practice (FQHC APCP) Demonstration.

Voluntary participation in this study was solicited from NCQA-recognized PCMHs. As an incentive for participation, RTI offered to send consenting practices a report that detailed their performance on key health care measures compared with a comparison group of non-PCMHs. A total of 225 of 312 participating PCMHs requested to receive the feedback report on their Medicare FFS beneficiaries. A PDF report was mailed to them in September 2011.

The feedback report provided results related to three health care indicators:

- Quality of care: LDL-C screening, HbA1c testing, and influenza vaccination rates;
- Utilization: types of physician visits, hospitalizations and emergency department 9ED) visits, follow-up visits within 2 weeks after hospitalization, and readmissions within 30 days following discharge; and
- Medicare payments: payments by type of provider, physician payments by type of service, and potentially avoidable payments based on ambulatory care sensitive conditions (ACSCs).

The process of development included pilot testing with nine practices and revising based on feedback obtained from the pilot testers. The final Feedback Report template that incorporates the input received during pilot testing and that was sent to the 225 practices is shown in **Appendix A.**

When the reports were sent to the practices via email, we included a link to a brief electronic evaluation survey for practices to complete to provide us with feedback about the reports. This report describes the results of the evaluation survey. The remainder of this report describes the development of the survey and survey items (**Section 2**), the survey results (**Section 3**), and a brief discussion of the survey results and their impact on feedback reports for future CMS PCMH demonstrations (**Section 4**).

SECTION 2
EVALUATION SURVEY

The provider feedback web-based evaluation survey was designed to assess users' perceptions about the overall utility of the feedback report and their satisfaction with specific elements of the report. It also assessed their perceptions about the ease of use and data interpretation; their likelihood of using information in the report in various ways (e.g., to guide quality improvement efforts, decision making about the practice); and to inform planning activities for future CMS medical home initiatives. The full survey can be found electronically at https://apc.rti.org.

The full survey contained 25 questions. The first 16 questions were designed to assess satisfaction with and the usefulness of various aspects of the feedback report, and respondents could select from 4 Likert-scale response options (such as "Extremely Useful" to "Not At All Useful.") There were five open-ended questions that encouraged respondents to provide additional detail on what they liked most and least about the feedback report, what aspects they found most and least useful, and what they would suggest including or removing from future iterations of the report. Finally, there were five questions that asked about practices' experiences with receiving supplemental payments from other payers, which were included to inform CMS planning activities.

The feedback reports were emailed to all practices on September 2, 2011. The email included a "cover letter" informing the practices about the contents of the feedback report and to encourage them to respond to the web-based survey. **Figure 1** below shows the contents of that email. Our key contacts at the practices received a unique username and password that, when entered, would take them to the survey home page, shown in **Figure 2**. Respondents had the option of saving their responses as they were completing the survey and returning to complete it at a later time. Reminder emails were sent to practices a week after the first email.

Figure 1.
Cover letter emailed to practices when feedback reports were distributed and participation in the survey was solicited

Dear [USERNAME]:

In January 2011, you were invited to participate in our study comparing patterns of care between clinical practices that have received National Committee for Quality Assurance (NCQA) recognition as a medical home and clinical practices with similar characteristics that have not received NCQA medical home recognition. To thank you for your participation, we have prepared this report summarizing information for your practice and providing comparative information. We use Medicare fee-for-service (FFS) billing data as our information source. If you are part of a practice with multiple practice sites, we have produced this report for your specific practice location.

Three data categories are presented:

1. **Clinical quality of care measures**—Summary information about selected quality of care measures, such as LDL-C, HbA1c, and influenza vaccination.
2. **Coordination and continuity of care measures**—Summary information for selected utilization measures, such as emergency room (ER) visits and hospitalizations for ambulatory care sensitive conditions, percentage of your Medicare FFS patients that had a follow-up visit within 2 weeks of a hospital discharge, percentage readmitted within 30 days of a hospital discharge, and rates of medical and surgical specialty use.
3. **Medicare payments**—Summary information on the share of care that you provide your Medicare FFS patients, total Medicare payments per beneficiary, and average Medicare provider payments by type of service.

After reviewing the report, we invite you to take a short survey to let us know your thoughts on the usefulness of the report. The Practice Feedback Reports will be produced for another upcoming research study, so we look forward to hearing your opinions on the report so that we can make improvements that may benefit other clinical practices such as yours.

This survey should take approximately 10 minutes to complete. You may use our Web-based survey to provide your responses. To access the Web-based survey go to https://apc.rti.org. The first screen will ask for your user name and password.

Your user name is: [USERNAME]
Your password is: [PASSWORD]

We appreciate your response by September 7, 2011.

(continued)

Figure 1. (continued)
Email sent to practices when feedback reports were distributed and participation in the survey was solicited

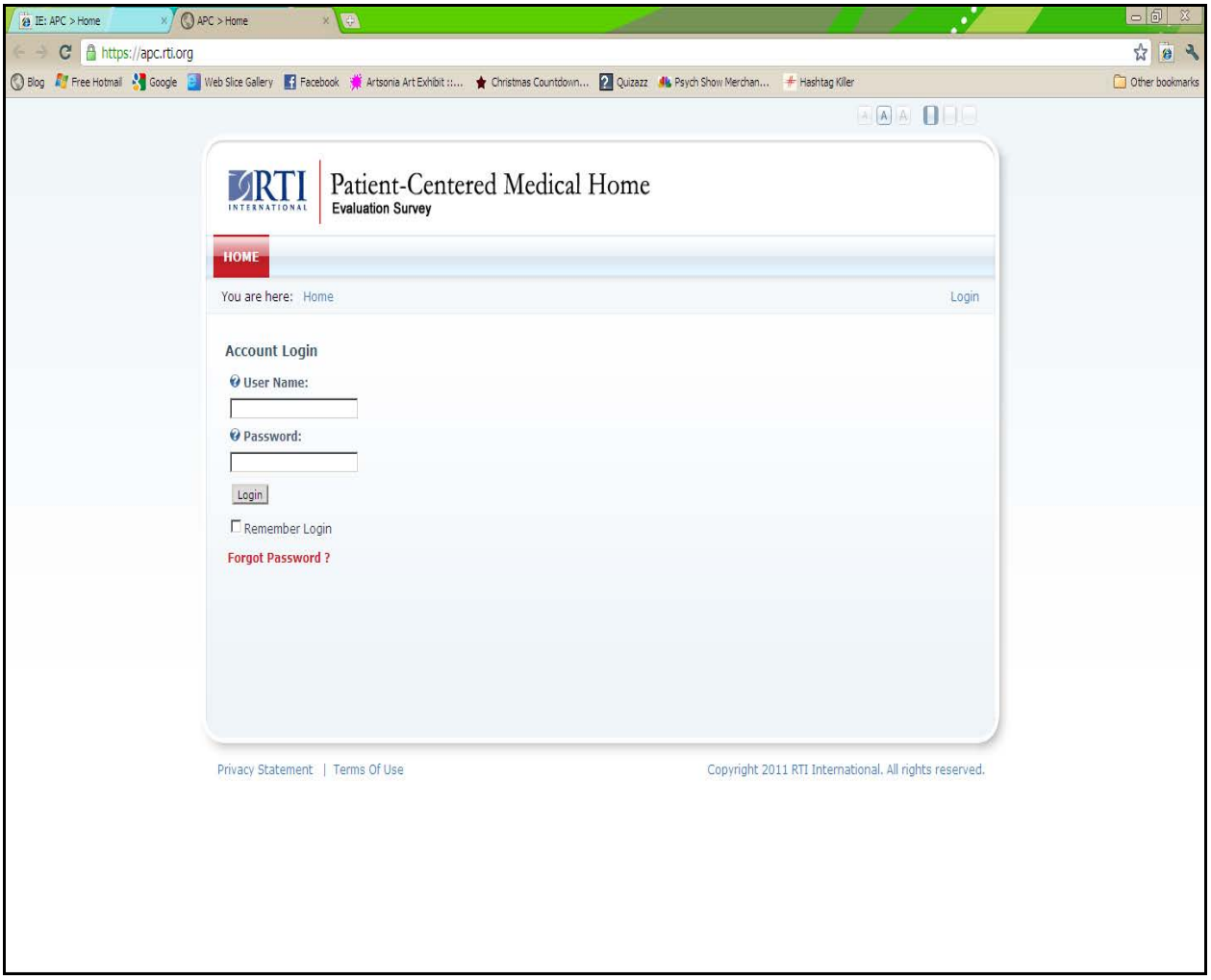
All information you provide will reside at RTI on a secure network with password-protected access. Completing the survey is completely voluntary, and refusal to participate will not affect your practice or your recognition as a medical home in any way. You may skip any questions that you do not wish to answer. Results will be analyzed in aggregate and we want to assure you that no practices will be individually identified when reporting to CMS. There are no known risks or benefits for completing the survey. This research has been reviewed and approved by RTI's Institutional Review Board.

Should you have any questions about the report, please contact me directly at (919) 990-8330 or via e-mail at pspain@rti.org. If you need assistance with the survey, please contact Noëlle Richa Siegfried at (202) 319-1266 or MedHome@rti.org.

Sincerely,

Dr. Pam Spain
Research Health Services Analyst

Figure 2.
Home Page of PCMH Evaluation Survey



SECTION 3
SURVEY RESULTS

This section presents tables and graphs showing the evaluation survey results. Data were analyzed using SAS version 9.2. The PROC FREQ procedure was used to determine the N and % for each response choice. In this section, we discuss the results from: (1) questions regarding the usefulness of and satisfaction with the feedback reports; (2) open-ended survey questions; and (3) questions designed to inform planning activities for future CMS reports.

At the time of the analysis, 62 respondents (28 percent response rate) had completed the survey and two surveys were "in progress" (these two incomplete surveys were not included in the analysis).

3.1 Usefulness of and Satisfaction with Practice Feedback Reports

Table 1 shows the responses of 62 respondents who answered questions about the usefulness of and satisfaction with the practice feedback reports. Overall, the results indicate that respondents were satisfied with the reports. Ninety-five percent of respondents reported that the report was "extremely or somewhat useful" and 4.8 percent of respondents reported that the report was "not useful at all" (Question 20 of Table 1).

All respondents thought that the Introduction explained clearly the purpose and content of the report (Question 1), and almost all thought that the report was well-organized (Question 2). Respondents were less clear on how beneficiaries were assigned to practices. Twenty-three percent thought that the explanation was "not very clear" or was "not at all clear" (Question 3). Five percent of respondents were also not totally clear on how comparison benchmarks were chosen (Question 4).

Respondents were asked if they would prefer the comparison group be non-PCMHs matched on key characteristics or other NCQA-recognized PCMHs. Over half (62.9 percent) indicated that they would prefer to be compared to other NCQA-recognized PCMHs (Question 5).

One table within the survey asked respondents about their opinion of the clarity of certain measures presented in the reports. Almost all of the respondents thought the quality of care measures as well as the coordination and continuity of care measures were clear (Question 6). All but 6.4 percent of respondents thought the annual payment measures and the physician payments by type of service measures were clear (Questions 8–9). The potentially avoidable payments based on ambulatory care sensitive conditions were the least clear set of measures, with 11.3 percent saying they were "not very clear" or "not clear at all" (Question 10).

Respondents were also asked which of the categories of measures were of greatest interest to them (Question 11). The two measures of greatest interest were the quality of care measures (59.7 percent) and the potentially avoidable payments based on ACSCs (17.7 percent). The two measures of least interest were the annual payment measures (3.2 percent) and physician payments by type of service measures (1.6 percent).

Several questions in the survey also asked the respondents about the usefulness of the graphs showing comparisons between their practice and comparison practices (Question 12), the technical reference guide (Question 13), and the example tables and graphs showing how to read the report (Question 14). Over 90 percent of respondents found these parts of the report to be extremely or somewhat useful.

Respondents were asked what types of individuals in their practice would be most interested in the reports (and could select more than one response)(Question 15). Overall, almost 90 percent responded that physicians would be most interested in the reports. Practice managers (66.1 percent) and administrators (56.4 percent) were the next most frequent responses to this question. Only 8.1 percent of practices indicated that patients would be most interested in the feedback reports.

The survey asked respondents how they planned to use the report (and again, respondents could select more than one response)(Question 16). Most indicated that they planned to use the report for quality improvement (80.6 percent), benchmarking (72.6 percent) and sharing with stakeholders (43.5 percent). Relatively few respondents indicated they planned to use the reports for marketing or to solicit funding.

Respondents noted that if given the choice, they would prefer to receive these results by PDF (38.7 percent), by Microsoft Excel (25.8 percent), or by a web portal (12.9 percent)(Question 17). Also, many respondents were interested in continuing to receive these reports (Question 18). Half responded that they would like to receive them on a quarterly basis and 25.8 percent reported that they would like to receive them every six months. Only 11 percent preferred to receive them on a monthly basis (Question 20).

Overall, respondents were pleased with the reports, with 59.7 percent responding that they thought the reports were overall "extremely useful" and another 35.5 percent thought they were "somewhat useful" (Question 19).

See **Table 1** for all questions regarding the usefulness of and satisfaction with the feedback reports, along with the N and % for each response choice.

Table 1.
Survey questions to assess usefulness of and satisfaction with practice feedback reports (N = 62). Cells show the N and (%) for each response choice.

	Question	Response
1.	How well did the introduction explain the purpose and content of the report?	
	Extremely well	45 (72.6)
	Somewhat well	17 (27.4)
	Not very well	0 (0.0)
	Not well at all	0 (0.0)
2.	How clear was the organization of the report (i.e., data in the beginning, technical information at the end)?	
	Extremely clear	44 (71.0)
	Somewhat clear	17 (27.4)
	Not very clear	1 (1.6)
	Not at all clear	0 (0.0)
3.	How clear was the explanation on how beneficiaries were assigned to your practice?	
	Extremely clear	17 (27.4)
	Somewhat clear	31 (50.0)
	Not very clear	12 (19.4)
	Not at all clear	2 (3.2)
4.	How clear was the explanation on how the comparison benchmark practices were chosen?	
	Extremely clear	36 (58.1)
	Somewhat clear	23 (37.1)
	Not very clear	3 (4.8)
	Not at all clear	0 (0.0)
5.	If you had to choose one, would you prefer the comparison group be non-medical home practices matched on key characteristics or other NCQA-recognized medical home practices?	
	Non-medical home practices matched on key characteristics	22 (35.5)
	Other NCQA-recognized medical home practices	39 (62.9)
	Not Reported	1 (1.6)
6.	How clear were the *Quality of Care* measures presented in the report?	
	Extremely clear	39 (62.9)
	Somewhat clear	21 (33.9)
	Not very clear	1 (1.6)
	Not at all clear	0 (0.0)
	Not Reported	1 (1.6)

(continued)

Table 1. (continued)
Survey questions to assess usefulness of and satisfaction with practice feedback reports (N = 62). Cells show the N and (%) for each response choice

Question	Response
7. How clear were the *Coordination and Continuity of Care* Measures presented in the report?	
Extremely clear	39 (62.9)
Somewhat clear	22 (35.5)
Not very clear	1 (1.6)
Not at all clear	0 (0.0)
8. How clear were the *Annual Payment* measures presented in the report?	
Extremely clear	36 (58.1)
Somewhat clear	22 (35.5)
Not very clear	4 (6.4)
Not at all clear	0 (0.0)
9. How clear were the *Physician Payments by Type of Service* measures presented in the report?	
Extremely clear	36 (58.1)
Somewhat clear	21 (33.9)
Not very clear	4 (6.5)
Not at all clear	0 (0.0)
Not Reported	1 (1.6)
10. How clear were the *Potentially Avoidable Payments based on Ambulatory Care Sensitive Conditions* measures presented in the report?	
Extremely clear	32 (51.6)
Somewhat clear	23 (37.1)
Not very clear	6 (9.7)
Not at all clear	1 (1.6)
11. Which sets of measures were of greatest interest to you?	
Quality of care	37 (59.7)
Coordination and continuity of care	10 (16.1)
Annual payments	2 (3.2)
Physician payments by type of service	1 (1.6)
Potentially avoidable payments based on ACSCs	11 (17.7)
Not Reported	1 (1.6)

(continued)

Table 1. (continued)
Survey questions to assess usefulness of and satisfaction with practice feedback reports (N = 62). Cells show the N and (%) for each response choice

Question	Response
12. How useful were the graphs showing comparisons between your practice and the comparison benchmark?	
Extremely useful	38 (61.3)
Somewhat useful	20 (31.3)
Not very useful	4 (6.5)
Not at all useful	0 (0.0)
13. How useful was the technical reference guide at the end of the report?	
Extremely useful	32 (51.6)
Somewhat useful	26 (41.9)
Not very useful	2 (3.2)
Not at all useful	1 (1.6)
Not Reported	1 (1.6)
14. How useful were the example tables and graphs at explaining how to read the report?	
Extremely useful	41 (66.1)
Somewhat useful	20 (32.3)
Not very useful	1 (1.6)
Not at all useful	0 (0.0)
15. What types of individuals in your practice are most interested in the report?	
**Note: Percentages will not add to 100 because more than one choice could be selected.*	
Practice manager	41 (66.1)
Physicians	55 (88.7)
Administrators	35 (56.4)
Case managers	10 (16.1)
Stakeholders	20 (32.2)
Patients	5 (8.1)
Other—please specify	▪ IPA executives helping achieve PCMH ▪ care managers(RN's) ▪ non physician providers

(continued)

Table 1. (continued)
Survey questions to assess usefulness of and satisfaction with practice feedback reports (N = 62). Cells show the N and (%) for each response choice

Question	Response
16. How do you plan to use this report?	
**Note: Percentages will not add to 100 because more than one choice could be selected.*	
Benchmarking	45 (72.6)
Quality improvement	50 (80.6)
Marketing	4 (6.5)
Sharing with stakeholders	27 (43.5)
Soliciting funding	6 (9.7)
Other—please describe	▪ changing reimbursement methodology ▪ showing to staff
17. Do you receive information like this already from other payers?	
Yes—please specify from whom.	28 (45.2)—Medicaid and Various Private Payers
No	27 (43.5)
Don't know/Not Reported	7 (11.3)
18. If given the choice, which method would you prefer receiving these data (choose one)?	
Web portal	8 (12.9)
PDF	24 (38.7)
Microsoft Word	6 (9.7)
Microsoft Excel	16 (25.8)
Microsoft PowerPoint	6 (9.7)
Hard-copy mailed to me	1 (1.6)
Other—please specify	0 (0.0)
Not Reported	1 (1.6)
19. How frequently would it be useful to receive this information?	
Monthly	7 (11.3)
Quarterly	31 (50.0)
Biannually	16 (25.8)
Annually	8 (12.9)
20. How useful did you find the report overall?	
Extremely useful	37 (59.7)
Somewhat useful	22 (35.5)
Not very useful	3 (4.8)
Not useful at all	0 (0.0)

3.2 Open-Ended Survey Questions

There were several open-ended questions in the survey that allowed respondents to provide additional detail regarding what they liked and did not like about the report and to suggest changes to the report. These questions included:

1. What did you like best and least about the report?
2. What did you find most and least useful about the report?
3. Are there parts of the report that were difficult to understand or were confusing?
4. Was there anything you think should have been included in or deleted from the report?
5. Do you have any other questions or comments about the report that you would like to share with us or with CMS?

The responses to these questions are summarized in **Table 2**. Because of the similarity in the responses to "What did you like best about the report?" and "What did you find most useful about the report?" the responses to those questions are shown together in the table. For similar reasons, the responses to "What did you like least about the report?" and "What did you find least useful about the report?" are shown together.

In general, respondents liked many aspects about the report (Question 1 of Table 2). In particular, they liked the three categories of information provided in the reports (quality, continuity of care, and payments) and the benchmark comparisons to other practices. They also liked the color graphs and color-coding of the arrows in the overview table. Also appealing was the organization of the report—the overview table that was provided, the technical information in the back of the report, and the repeated explanations of how to read and interpret the information contained in the report.

The most commonly reported aspect of the report that respondents liked least or found least useful were the "potentially avoidable payment" measures (Question 2). A few users reported that the concept or term "potentially avoidable" was confusing. Other aspects that respondents liked least were the lack of risk adjustment and the lack of statistical sensitivity (which resulted in not many statistically significant differences between the PCMHs and their benchmark). In terms of the organization of the report, a few respondents indicated that they thought the report was too long and that they "got lost" in the Introduction (i.e., too much technical information in the front part of the report, before the report results are shown).

Respondents were asked if they thought any parts of the report were difficult to understand or were confusing (Question 3). Respondents most commonly thought that the benchmark comparison information was confusing—how the benchmark practices were selected and how the benchmark performance measures were calculated. Others reported that the technical pieces were confusing (or that the introduction was too technical), and that they did not understand the physician payments based on type of service.

When asked if there was anything that should have been included or deleted from the report (Question 4), respondents had many suggestions. Respondents suggested including the results stratified by different categories (such as urban or rural, US region, or academic medical center status) as well as by provider within the practice. Other suggested inclusions to the report were: additional quality measures, information on whether the benchmark comparison practices had ever applied for NCQA PCMH recognition, additional comparisons based on Hierarchical Condition Categories (HCC) scores, and reports based on median rather than mean scores. Suggestions for improving the report's organization were: more explanation of how the readmission rates were calculated and how benchmark practices were derived, and different graphs (i.e., line graphs) better depicting performance trends over time. One practice reported that they would like to have patient-identifiable data on hospital admissions, readmissions, and ED visits, so that the information would be more actionable for them in their daily practice.

A few respondents answered the question, "Do you have any other questions or comments about the report that you would like to share with us or with CMS?" (Question 5). Respondents to this question indicated that they would like to see more quality and risk-adjusted performance measures and receive information on whether the benchmark practices had ever applied for NCQA recognition. Also, several respondents indicated that they would like to continue to receive the performance feedback report (more than just once, for this project), to see if their performance changed as a result of changes they implement based on the information in their feedback report.

Table 2.
Summary of responses received from open-ended survey questions

Summary of responses
1. What did you like best about the report? and What did you find most useful about the report? ▪ Benchmark comparisons to other practices. ▪ Comparison to non-medical home practices, to show statistically our differences or gaps. ▪ Comparisons with benchmark and other NCQA-recognized medical homes ▪ Graphing and color coding of the graphs ▪ The ease in seeing the results clearly. It will be very easy to share with all staff members. ▪ Payer data ▪ Avoidable charges information ▪ Quality information ▪ Comparison from year to year ▪ The quality initiatives were covered ▪ Data summary pages along with the graphs ▪ Table 1 Overview of our patient care ▪ It clearly outlined how we were doing and our trends ▪ Just getting this information in a readable form is the best part ▪ Lots of useful info with feedback on the results of our investment in PCMH ▪ Organization of the report appealed to me the most ▪ I liked getting data- especially the comparisons- abstract numbers don't tell much without the comparison. ▪ Clinical benchmark for hospice payments- most useful ▪ Most useful is we now have a tool to use, as we are working on a higher level of PCHM. It will allow us to see if and what improvements we make in patient care. ▪ Admission, readmission and ER visits most useful ▪ Repeated explanations were useful ▪ Most useful to see that our practice has an unexpectedly high rate of readmissions, in spite of a very high rate of post-hospitalization follow-up.

(continued)

Table 2. (continued)
Summary of responses received from open-ended survey questions

	Summary of responses
2.	What did you like least about the report? and What did you find least useful about the report? ▪ The avoidable events- not enough information that is actionable ▪ Statistical sensitivity—not many things popped out as different so harder to identify areas to ▪ Disappointed that our growth rate was not taken into consideration ▪ Being a solo physician with one PA-C, the Clinic is small enough to have wide variations in these numbers each report ▪ The misuse of the term 'benchmark'. Your benchmark is actually a comparison 'norm'. Benchmark should refer to the 90th percentile which you use as a stretch goal. ▪ Length of the report ▪ The data was not risk-adjusted and I think this makes the data significantly less valuable. It is very common for providers to feel they have the "sickest" patients ▪ The introduction is still drawn out and I think the reader gets lost in it. ▪ Clinical benchmark for DME payments-least useful ▪ Least useful: avoidable admissions and emergency room visits. Really? Show me the data and I'll share it with the hospital CEO. He'll flip then go hire some more PCPs for his network, afraid I will stop ▪ Least useful- avoidable events because it was not explained well
3.	Are there parts of the report that were difficult to understand or were confusing? ▪ ER rates of pay, as we do not see our patients in the ER ▪ How benchmarks were selected. ▪ I feel the report leaves a lot to personal interpretation. ▪ Influenza immunizations ▪ It took a bit of time to get comfortable with the scoring and graphing. ▪ Last page (BETOS) I had no clue what these codes were used for ▪ The intro was just boring and a little too technical, so it's easy as a reader to not want to go through the whole thing. ▪ The technical parts were somewhat confusing to me, but won't be to our director of measurements and data collection. ▪ The payment area was difficult to understand.

(continued)

Table 2. (continued)
Summary of responses received from open-ended survey questions

	Summary of responses
4.	Was there anything you think should have been included in or deleted from the report? ▪ There should be different categories, i.e., rural vs. urban. ▪ More explanation regarding the readmissions i.e., dx information—were they readmitted from a SNF or from Home, were they getting home health? ▪ It would be great to see this type of benchmarking with all insurances and totaling all types of patient visits. ▪ By provider would be great ▪ It would have been valuable to see the raw data and then see other comparisons such as HCC & RxHCC summaries to compare the practices ▪ Detail around benchmarking ▪ Graph better depicting improvement over time ▪ I think comparing us to non-NCQA recognized homes generates more questions and although is interesting, really doesn't tell us anything. ▪ Included: risk-adjustment of data. Deleted: some of the bar graphs repeating data from page 5. ▪ It would have been nice to see how this data compared with practices that were not medical homes. Perhaps more quality measures ▪ Reporting MEDIAN values, rather than averages, and adding confidence interval bars would help convince me of important differences. My sample size of 43 inpatients is likely skewed by a case or two ▪ Rural Health Clinic Medicare data ▪ The Data comparison from the NCQA base on region ▪ Whether or not the non-medical home practices used for benchmarking had ever applied for recognition as medical home or not (i.e., were they not medical homes due to not meeting the standards ▪ Would love to have patient names on the admission readmission and ER visits- this would provide actionable information for our practice.
5.	Do you have any other questions or comments about the report that you would like to share with us or with CMS? ▪ The quality data are definitely not accurate compared to the data we have in-house. So there is either a discrepancy on how we bill for certainly quality services or some other data conflict. ▪ I would like to see it with more measures ▪ I like having the explanations follow the sections instead of being lumped at the end. This is a preference issue (I had to keep scrolling back and forth) and not something you can fix ▪ Whether or not the non-medical home practices used for benchmarking had ever applied for recognition as medical home or not (i.e., were they not medical homes due to not meeting the standards) ▪ It would be interesting to know the risk-adjusted rates for continuity of care measures ▪ Growth rate of the practice ▪ I would like to continue to see the comparison to both nonmedical home and medical home practices.

3.3 Questions to Inform Planning Activities for Future CMS Medical Home Initiatives

Table 3 shows the responses to the survey questions that asked about additional payments received beyond those for covered services, from whom they received the payments, and what they most often did with those payments. Only 29 of the 62 respondents (46.8 percent) responded that they received a supplemental payment from other payers beyond what was received for covered services (Question 1 of Table 3). The remaining questions (Questions 2–5) in this section were applicable only to those 29 respondents.

Respondents were asked what kind of additional payments they received (and they could choose more than one response)(Question 2). Overall, 24 (or 82.7 percent) reported that they received a per-member-per-month (PMPM) fee, 41.4 percent reported that they received an outcome-based incentive bonus, and 10.3 percent reported receiving shared savings payments. A few practices reported that they received a small end-of-year lump sum payment or management bonus.

Respondents were asked for what proportion of their patient panel did they receive the supplemental payments (Question 3). Twenty-two of the 29 respondents answered this question. The average reported proportion was 34.7 percent and the median was 17.5 percent. The range was 2 percent to 100 percent. The two most often reported payers from which practices received these supplemental payments were from private insurers (72.4 percent) and Medicaid (41.4 percent)(Question 4).

Respondents were asked what investments or changes they made in their practice using the supplemental payments (Question 5). Overall, 31 percent of respondents reported that they hired or increased hours for care managers, 24.1 percent hired or increased hours for data analysts, and 20.7 percent purchased or upgraded to new technologies. Others used the payments to expand office space, extend office hours, or provide after-hours care assistance for patients.

Table 3.
Survey questions to inform planning activities for future CMS medical home initiatives. Cells show the N and (%) for each response choice.

Survey questions	Response
1. Do you receive from any payers a supplemental PCMH/care management/care coordination payment, beyond what you receive for covered services?	
No	33 (53.2)
Yes	
(if yes, please answer the following questions)	29 (46.8)
2. What kind of additional payment do you receive?	
**Note: Percentages will not add to 100 because more than one choice could be selected.*	
**Note: Percentage based on N=29 (respondents who reported receiving supplemental PCMH/care management/care coordination payment)*	
Per member per month fee	24 (82.7)
Shared savings	3 (10.3)
Outcome-based incentive bonus	12 (41.4)
Other—please specify	▪ payments for additional staff based on VT legislation ▪ small end of year management bonus ▪ small lump sum payment
Not Reported	3 (4.8)
3. For what proportion of your patient panel do you receive these payments?	
Average (n=22)	34.7%
Median (n=22)	17.5%
Minimum (n=22)	2%
Maximum (n=22)	100%

(continued)

Table 3. (continued)
Survey questions to inform planning activities for future CMS medical home initiatives. Cells show the N and (%) for each response choice.

Survey questions	Response
4. From which payers do you receive these payments?	
**Note: Percentages will not add to 100 because more than one choice could be selected.*	
Private insurers	21 (72.4)
Medicaid	12 (41.4)
Medicare Advantage	7 (24.1)
Medicare fee-for-service	7 (24.1)
Other government-sponsored program (e.g., TRICARE, VA)	4 (6.4)
Other—please specify	▪ Various private payers
Not Reported	2 (3.2)
5. What investments/changes did you make in your practice using these payments?	
Hired or increased hours for care manager(s)	9 (31.0)
Hired or increased hours for behavioralist(s)	5 (17.2)
Hired or increased hours for pharmacist(s)	1 (3.4)
Hired or increased hours for data analyst(s)	7 (24.1)
Purchased or upgraded new technology	6 (20.7)
Increased clinician or staff salaries	3 (10.3)
Expanded office space	1 (3.4)
Extended office hours	1 (3.4)
Provided after-hours care assistance for patients	1 (3.4)
Other—please specify	▪ Admin/front office staff ▪ Medical assistants trained to provide higher than typical levels of care ▪ Population management ▪ Care Coordinator ▪ Change quality models ▪ Maintaining the practice ▪ Not enough money to effect change or offset costs ▪ Purchase lunch for staff and advertised ▪ Nursing and quality officer
Not Reported	6 (9.7)

SECTION 4
DISCUSSION AND IMPLICATIONS

Overall, survey respondents indicated that they were satisfied with the report. The sections of the report that were most useful to respondents were the quality of care measures, the measures of continuity of care, and the tables and graphs comparing their practice to the benchmark practices. Users also found the technical reference guide at the end of the report helpful. However, there were a few comments and suggestions from users that we recommend CMS consider for future CMS initiatives.

One concern was that influenza vaccinations are not captured well in Medicare claims, as many beneficiaries receive their influenza vaccine at locations other than their primary care providers. Physicians were concerned that the rate depicted in the feedback report was much lower than the true rate. We recommend that future iterations of the feedback reports do not include the influenza vaccination rate.

Another suggestion was to include more quality of care measures. We purposely did not provide many quality of care measures because many are not measured well with claims data. (Many National Quality Forum- and NCQA-endorsed quality of care measures require the use of either pharmacy claims, laboratory results, or electronic medical records for valid measurement calculation.) However, one additional measure that we recommend adding to future iterations is the rate of retinal eye examinations for beneficiaries with diabetes. This measure is valid when captured through claims. We expect that this rate will be relatively high for most practices (as are HbA1c testing and LDL-C screening).

Additionally, we recommend creating a composite quality measure for beneficiaries with diabetes that combines three measures: the proportion of patients with diabetes who had HbA1c testing, LDL-C screening, and retinal eye examination in the previous year. This measure will inform practices of the proportion of their beneficiaries with diabetes who had all three of the key diabetes quality measures.

Another change we propose for future iterations of the feedback report is to include a trend graph (rather than a bar graph) when displaying trends over time. Also, because respondents appreciated and valued the trend measures, we recommend that future iterations include trend information for more measures than just the few that were included in this feedback report.

Although the practices indicated that they liked the "summary" information we provided them on their performance, one suggestion was that we provide the practices actionable, patient-level utilization data. We recommend that future iterations include a list of practices' assigned Medicare FFS patients and indicators (or "flags") for whether the patient had been hospitalized or re-hospitalized within 30 days, and whether the patient had been treated in the ED, along with dates of service for such utilization. We believe this will help providers better manage their Medicare patients' care and potentially reduce the likelihood of future expensive hospitalizations or ED visits.

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APPENDIX A:
PRACTICE FEEDBACK REPORT