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Medical Home Feedback Report

Practice Name
Practice Address

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CONTENTS

List of Abbreviations	2
Report Overview	3
Section 1: Results.....	4
Quality of Care Measures	7
Coordination and Continuity of Care Measures	8
Medicare Payments	10
Trends in Selected Measures	15
Section 2: Technical Reference Guide.....	18
Data Sources	18
Linking Medicare Beneficiaries to Your Practice	18
Comparison Benchmarks.....	18
Selected Measures.....	19
How to Read the Tables.....	21
Evaluation and Management CPT Codes Used to Assign Medicare Beneficiaries to Your Practice Location	25
Quality of Care Variables	26
Key Terms Used in This Report	27
Berenson-Eggers Type of Service (BETOS) Codes Used in This Report.....	28

LIST OF ABBREVIATIONS

ACSC	ambulatory care sensitive condition
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
DME	durable medical equipment
E&M	evaluation and management services
ER	emergency room
FFS	fee-for-service
FQHC	Federally Qualified Health Center
HHA	home health agency
LDL-C	low-density lipoprotein cholesterol
NCQA	National Committee for Quality Assurance
PAC	post acute care, such as long-term care hospital or skilled nursing facility
SNF	skilled nursing facility

REPORT OVERVIEW

With funding from the Centers for Medicare & Medicaid Services (CMS), RTI International, a nonprofit research organization, is conducting a research study to analyze patterns of care, health outcomes, and costs of care for Medicare fee-for-service (FFS) beneficiaries receiving healthcare services from clinical practices that are National Committee for Quality Assurance (NCQA)-recognized medical homes. In particular, we are interested in determining if there are particular attributes of medical homes that are more favorably related to better outcomes of care. The information from these analyses will be used by CMS to help design Medicare and Medicaid medical home demonstrations.

To thank you for your participation in this study, RTI has prepared a practice feedback report that provides data related to quality of care, coordination and continuity of care, and Medicare payments for Medicare FFS beneficiaries assigned to your practice. Additionally, this report compares your practice's data with those of other clinical practices with similar characteristics but that have not received NCQA medical home recognition. The report also provides data on the average values of measures for all NCQA-recognized medical homes in this study. Further, for some measures, the report shows how your data have changed over time from July 2007 to June 2010. This report may be useful to your practice for benchmarking and quality improvement purposes.

Section 1 of this report includes your practice's results. Three data categories are presented:

1. **Clinical quality of care measures**—Summary information about selected quality of care measures, such as LDL-Cholesterol (LDL-C) and HbA1c screening, as well as influenza vaccination. For the quality of care measures, please note the following: LDL-C screening is among beneficiaries with diabetes and/or heart disease; HbA1c testing is among beneficiaries with diabetes; and influenza vaccination is among all beneficiaries.
2. **Coordination and continuity of care measures**—Summary information for selected utilization measures, such as rates of hospitalization, readmissions, and ER use for your Medicare FFS beneficiaries, rates of follow-up visit within 2 weeks 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.

Section 1 includes tables and graphs that show the results. At the top of the tables and graphs are hyperlinks that will guide you to specific pages in the back of the report that contain more detail about the methodology and other technical specifications used in the analyses.

Section 2 includes a technical reference guide, which details the methodology that was used to produce the report. The technical reference guide also includes examples of the tables and graphs that are used in the report, accompanied by “how to read me” boxes explaining the content of the tables and graphs (see page 21). *Note that these graphs do not contain data from your practice; they are for illustrative purposes only.*

Other content in the technical reference guide are as follows:

- ◆ Evaluation and Management Current Procedural Terminology (CPT) codes used to assign Medicare beneficiaries to your practice (see page 25)
- ◆ Measure specifications for the quality of care measures (see page 26)
- ◆ Detailed definitions of key terms used in this report (see page 27)
- ◆ Berenson-Eggers Type of Service (BETOS) Codes (see page 28)

SECTION 1 RESULTS

Table 1 shows all of the measures that are compared between your practice and the benchmark practices that are not NCQA-recognized medical homes. In this table, up or down arrows are shown to indicate whether your practice performed statistically significantly higher or lower than the benchmark. No arrow means that there was not a statistically significant difference between the performance of your practice and the benchmark practices.

For more information on how the comparison benchmark group was created, see page 18.

For some of the measures, no judgment was made about whether being higher than the benchmark was an indication of good or poor performance (for example, the number of visits to and payments for primary care and/or specialists). For these measures, the arrows are shown in black and indicate whether your practice was statistically higher or lower than the benchmark.

↓ (black arrow down) = lower than benchmark

↑ (black arrow up) = higher than benchmark

For many of the measures, however, it is important to point out that being above the benchmark, or performing higher than expected, is not necessarily a positive attribute. For example, if your practice performed higher than the benchmark for percent of beneficiaries with ER visits, this may be an indication of poorer performance. Accordingly, if your practice performed lower than the benchmark for potentially avoidable ER payments, this may be an indication of good performance. To help you distinguish good and poor performance achievements, some of the arrows are color coded:

↓ (red arrow down) = lower than benchmark and poor performance

↓ (green arrow down) = lower than benchmark and good performance

↑ (red arrow up) = higher than benchmark and poor performance

↑ (green arrow up) = higher than benchmark and good performance

For more information on the selected measures shown in Table 1, see page 19 and page 20.

Table 1 also shows the average value for all measures across all 312 NCQA-recognized medical homes in this study, although statistical testing was not performed to compare your practice to the average of all practices in the study.

Table 1. Overview of Measures—Your Practice and Benchmarks: 7/1/2009 to 6/30/2010.*

During the period July 1, 2009 through June 30, 2010, your practice treated 479 Medicare FFS beneficiaries. Of these beneficiaries, 223 beneficiaries were assigned to your practice location based on the beneficiary assignment methodology. See page 18 for more information on beneficiary assignment.

Measure	Your Practice (N benes=479)	Benchmark (N benes=124,210)	Your Practice versus Benchmark	Average across all study NCQA Medical Homes (N benes =146,410 N practices=312)
Quality of Care (% of beneficiaries)				
LDL-C Screening (n=88)	80 %	84 %		85 %
HbA1c Testing (n=75)	83 %	87 %		90 %
Influenza Vaccination	28 %	22 %		50 %
Coordination and Continuity of Care				
Hospitalization (rate per 100 beneficiaries)	22.9	0.7		16.9
Follow-up within 2 weeks of hospital discharge (rate per 100 hospital discharges, n=50)	75.0	43.1	↑	57.3
30-day hospital readmission (rate per 100 hospital discharges, n=50)	8.3	22.6		13.2
ER Visits (rate per 100 beneficiaries)	83.9	72.7		32.3
Primary Care Visits (rate per beneficiary)	9.2	5.8	↑	4.3
Medical Specialist Visits (rate per beneficiary)	3.1	1.2		3.0
Surgical Specialist Visits (rate per beneficiary)	0.4	0.2		0.5
Annual Payments (Average \$ per beneficiary)				
Durable Medical Equipment (DME) Payments	\$526	\$242	↑	\$238
Hospice Payments	\$0	\$81		\$148
Home Health Payments	\$183	\$45		\$283
Physician Payments	\$2,262	\$1,153		\$2,033
Outpatient Department Payments	\$768	\$739		\$904
Skilled Nursing Facility (SNF) Payments	\$34	\$1		\$299
Acute Care Hospital Payments	\$1,441	\$24		\$1,613
Total Medicare Payments	\$5,485	\$1,597		\$5,715
Physician Payments by Type of Service (Average \$ per beneficiary)				
Office Visit Physician Payments	\$605	\$347		\$373
Hospital/ER Visit Physician Payments	\$146	\$30		\$119
Specialty Visits & Consultation Physician Payments	\$138	\$108		\$151
Imaging & Laboratory Physician Payments	\$626	\$346		\$453
Other Physician Payments	\$583	\$345		\$710
Potentially Avoidable Payments based on Ambulatory Care Sensitive Conditions (ACSCs)(Average \$ per beneficiary)				
Potentially Avoidable Inpatient Hospital Payments	\$921	\$8		\$790
Potentially Avoidable ER Payments	\$362	\$221		\$111

* See page 21 for additional information on how to interpret this table.

Table 2 shows the 3-year trends in selected measures for your practice between July 2007 and June 2010. To provide information on whether your practice is improving or worsening over time, this table also shows the percent change between Time Period 1 and Time Period 3, which is measured as: $(\text{Measure}_{\text{Time3}} - \text{Measure}_{\text{Time1}}) / \text{Measure}_{\text{Time1}} * 100$.

Average percent change for all NCQA-recognized medical homes in the study are also shown, although statistical testing was not performed to compare your practice to the average of all NCQA-recognized practices in the study.

For more information on the measures, see page 19 and page 20. Also, see page 22 for additional information on how to interpret this table.

Table 2. Overview of Trends in Measures for Your Practice: July 2007 to June 2010.

Measures	Your Practice Time Period 1: July 2007 – June 2008 (N benes=169)	Your Practice Time Period 2: July 2008- June 2009 (N benes=186)	Your Practice Time Period 3: July 2009- June 2010 (N benes=200)	Your Practice % Change (July 2007- June 2010)	Average % Change across all study NCQA Medical Homes (N benes=146,410 N practices=312)
Quality Of Care Measures (% of beneficiaries)					
LDL-C Screening	86 %	80 %	80 %	-7.0 %	3.5 %
HbA1c Testing	98 %	85 %	83 %	-15.3 %	1.5 %
Influenza Vaccination	10 %	34 %	28 %	180.0 %	20.2 %
Potentially Avoidable Hospitalizations / ER Visits based on Ambulatory Care Sensitive Conditions (ACSCs)					
Potentially Avoidable Hospitalizations (rate per 100 beneficiaries)	4.7	5.9	8.0	70.2 %	-2.2 %
Potentially Avoidable ER Visits (rate per 100 beneficiaries)	16.0	17.2	19.5	21.9 %	-5.2 %
Average Annual Payments (\$ per beneficiary)					
Average Total Medicare FFS Payments	\$4,650	\$5,328	\$6,103	31.3 %	12.0 %

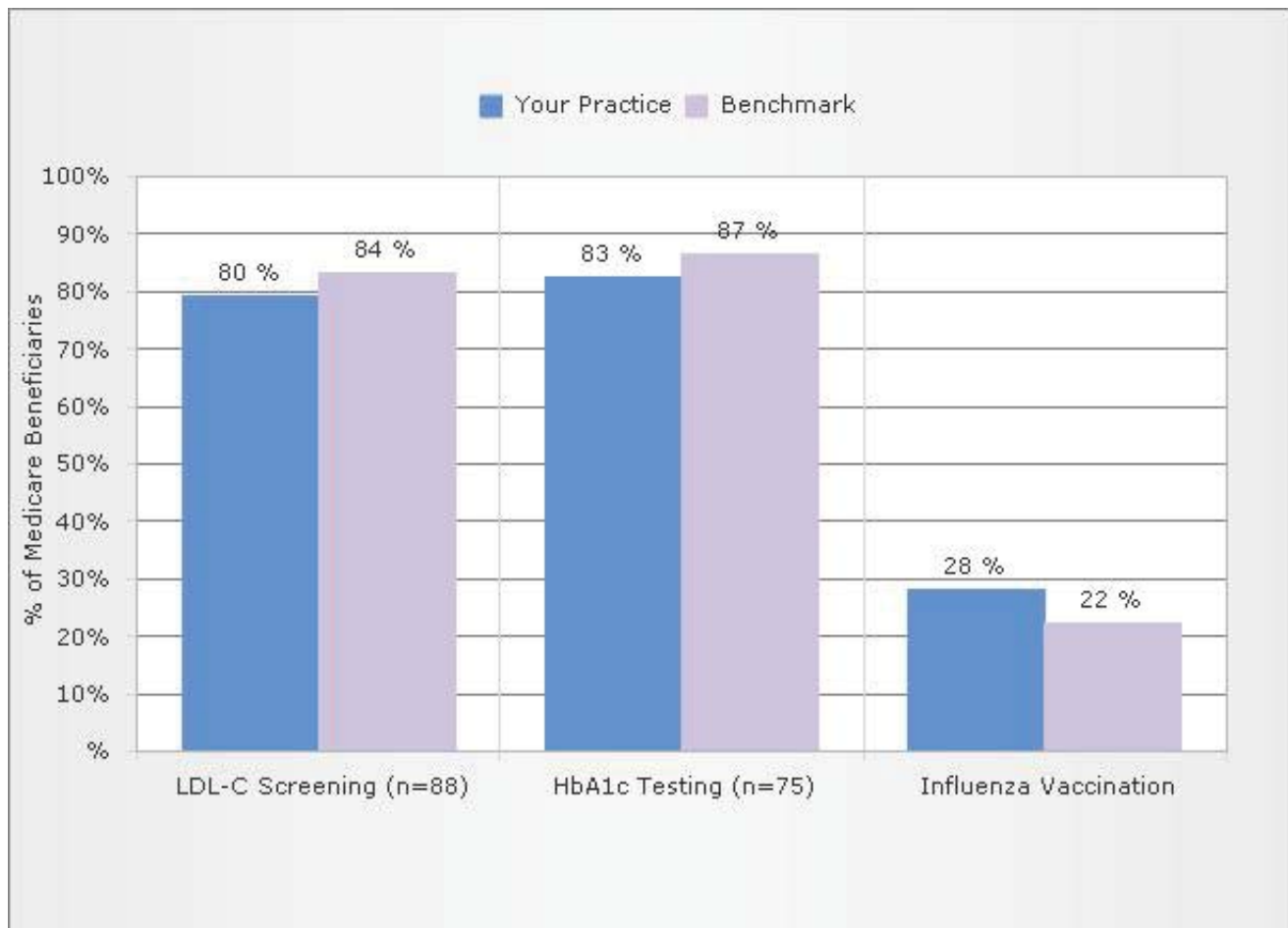
QUALITY OF CARE MEASURES

Figure 1 presents the percentage of Medicare beneficiaries who received LDL-C screening, HbA1c testing, and influenza vaccination. Recall that:

- LDL-C screening is among beneficiaries with diabetes and/or heart disease
- HbA1c testing is among beneficiaries with diabetes
- Influenza vaccination is among all beneficiaries

The number of beneficiaries considered for each measure (the denominator) is shown as $n=xx$ in the measure name. For more information on the quality of care measures, see page 19 and page 26. See page 23 for additional information on how to interpret this figure.

Figure 1. Selected Clinical Quality of Care Measures: 7/1/2009 to 6/30/2010.



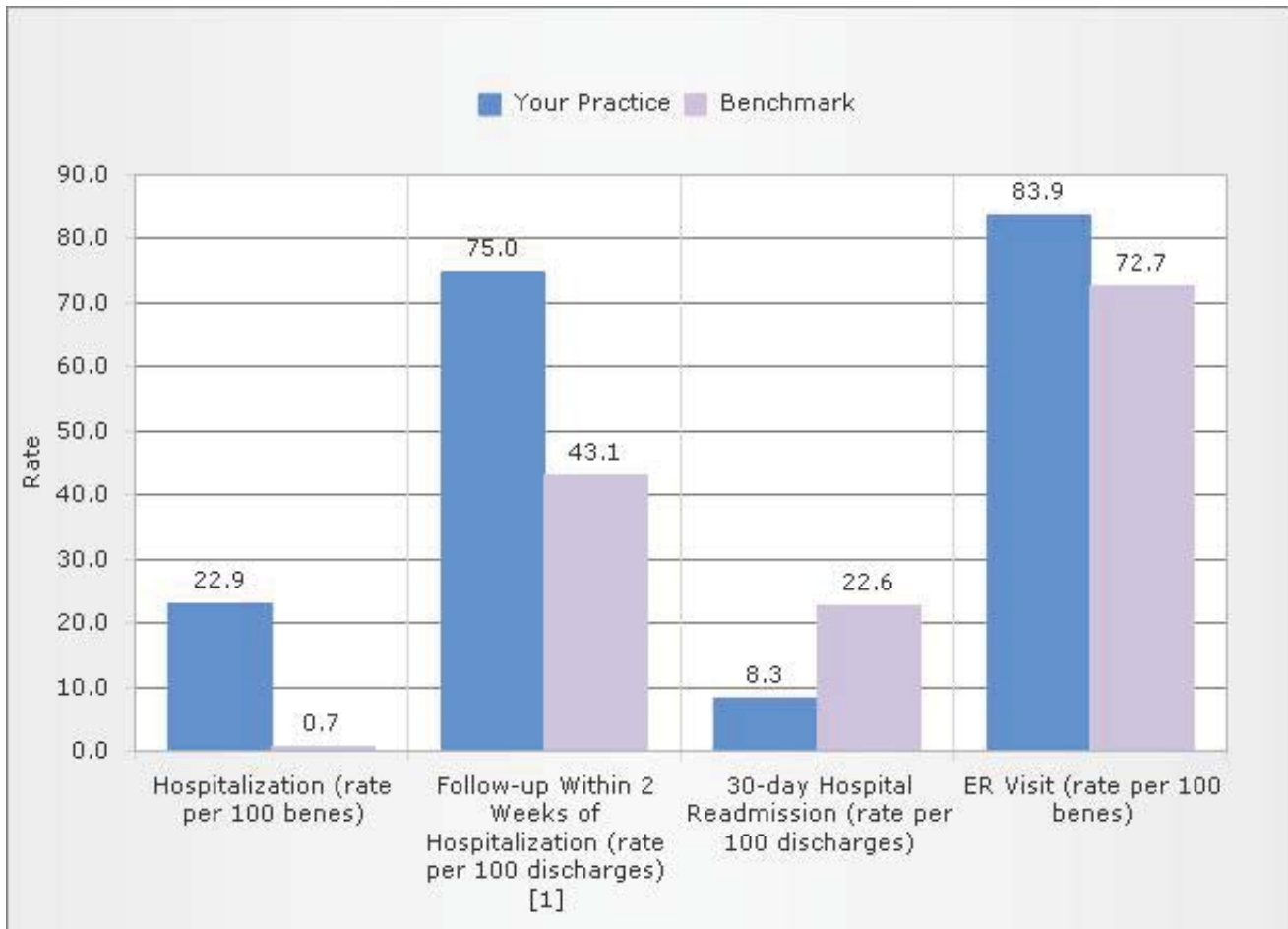
COORDINATION AND CONTINUITY OF CARE MEASURES

Figure 2a presents selected coordination and continuity of care measures including:

- Hospitalization rate per 100 beneficiaries
- Follow-up rate within 2 weeks of hospitalization (rate per 100 discharges)
 - Note that this does not include follow-up done by telephone, which is more likely to occur in medical home practices
- 30-day hospital readmission rate (per 100 hospital discharges)
- ER visit rate (per 100 beneficiaries)

For more information on these measures, see page 20 and page 27. Also, see page 23 for additional information on how to interpret this figure.

Figure 2a. Hospitalization Measures of Coordination and Continuity of Care: 7/1/2009 to 6/30/2010.

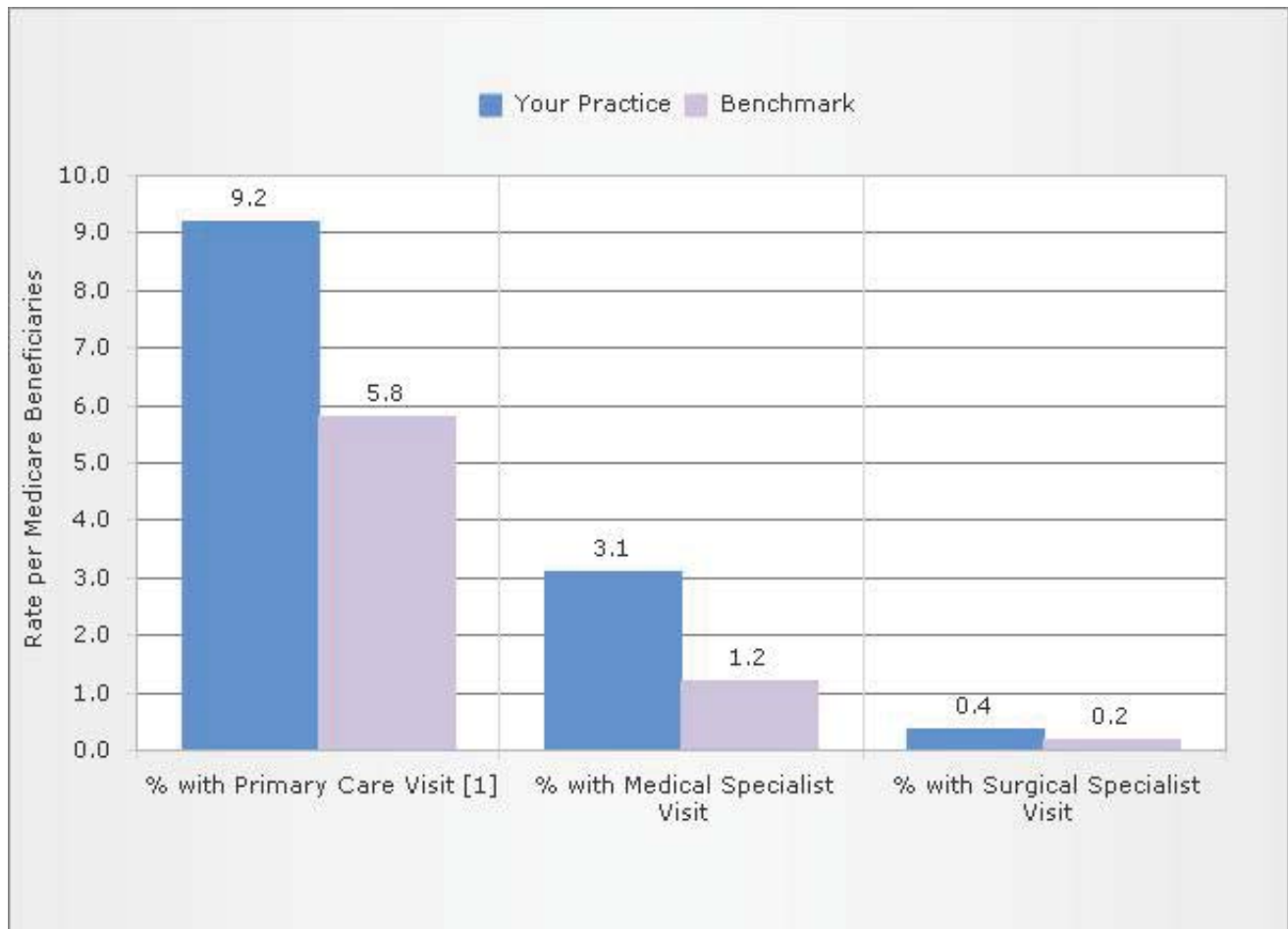


[1] Compared to the benchmark, your practice had a significantly higher rate of follow-up visits within 2 weeks of hospital discharge (rate per 100 discharges).

Figure 2b presents coordination and continuity of care measures for the rates of visits to primary care, medical and surgical specialty utilization (rates per beneficiary).

See page 23 for additional information on how to interpret this figure.

Figure 2b. Office Visit Measures of Coordination and Continuity of Care: 7/1/2009 to 6/30/2010.



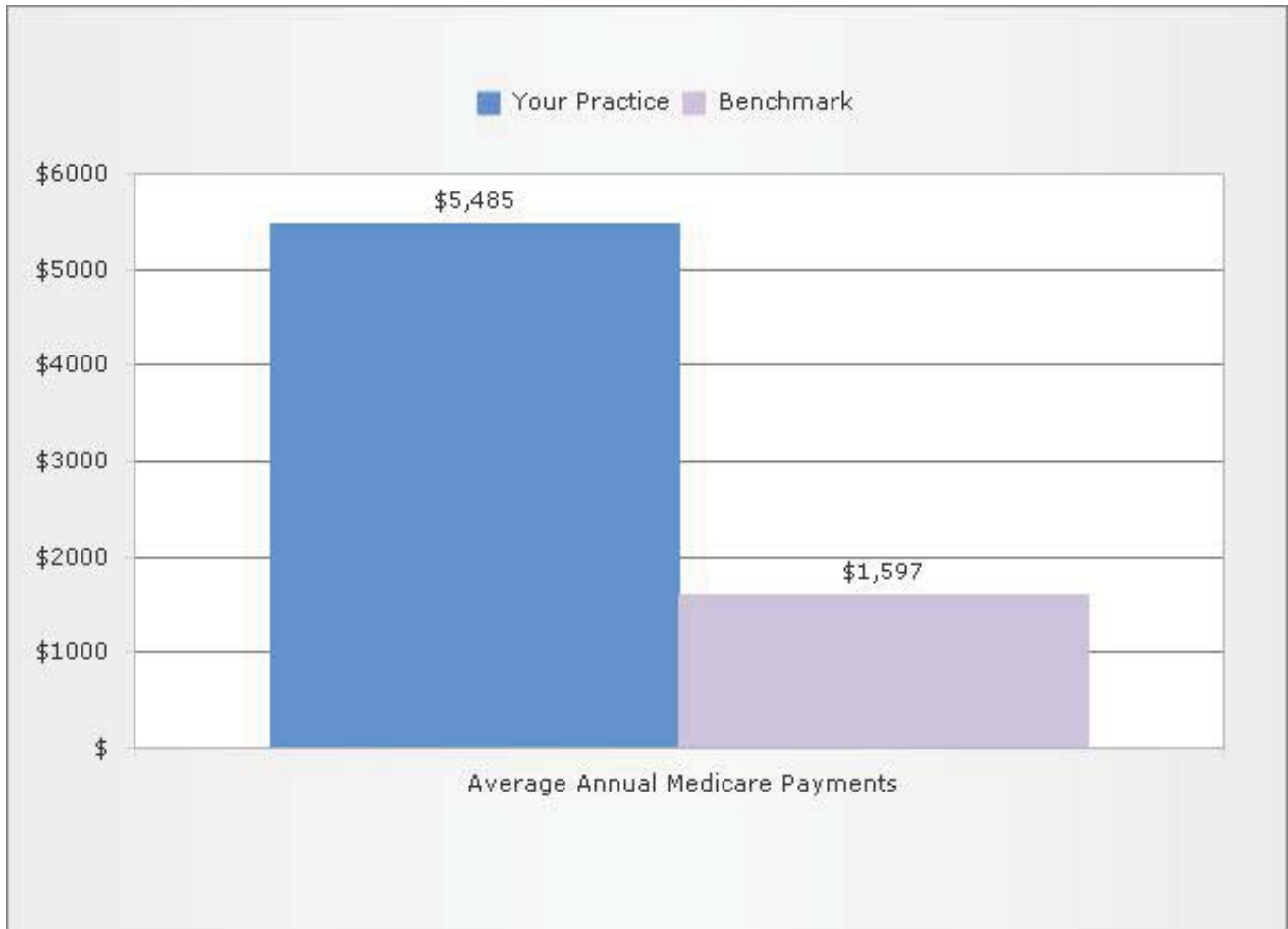
[1] Compared to the benchmark, your practice had a significantly higher rate of primary care visits (rate per beneficiary).

MEDICARE PAYMENTS

In this section, we use graphs to compare your practice's average annual Medicare payments with those of the benchmark group. All payments are presented as an average dollar amount per beneficiary.

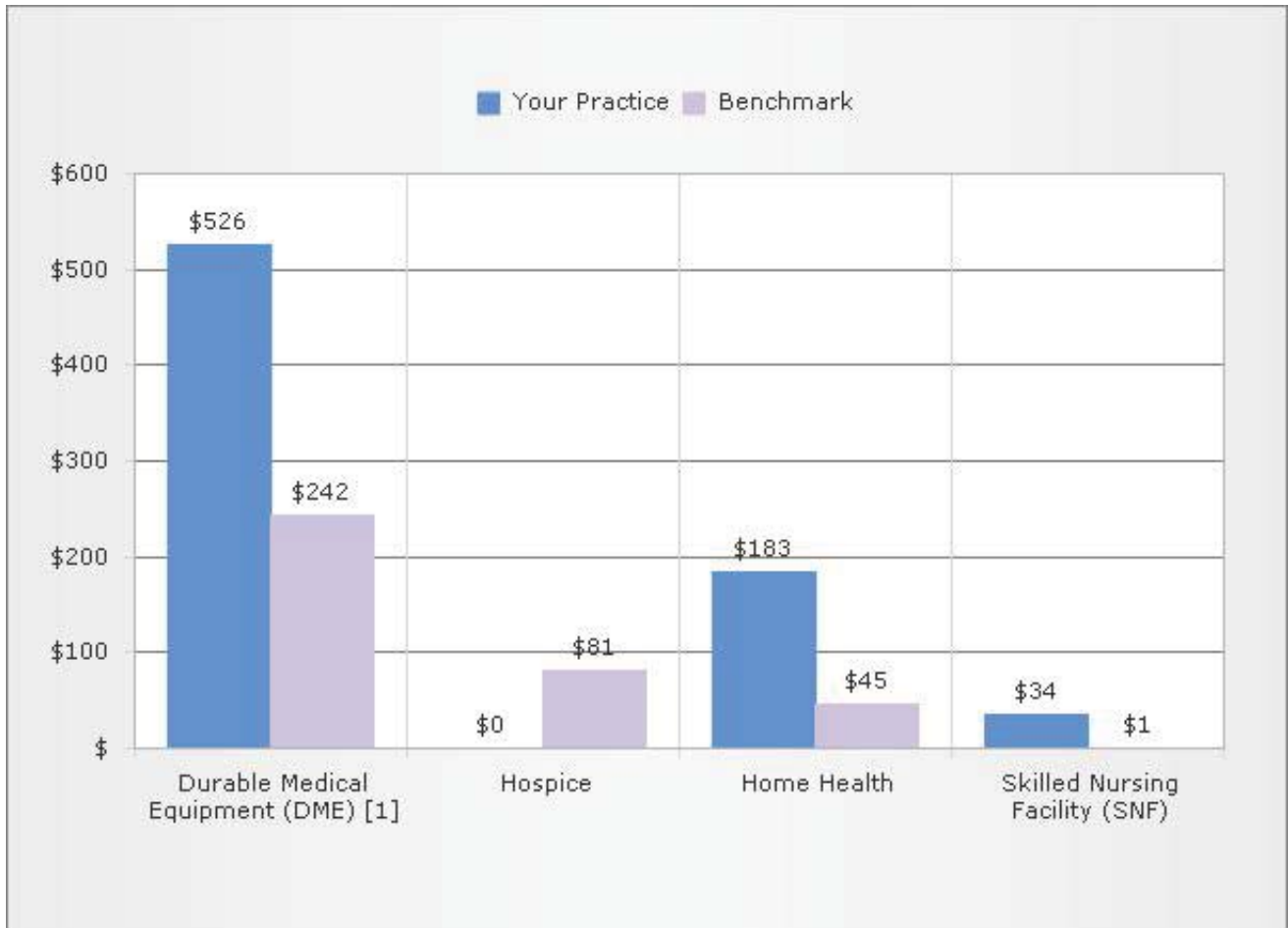
Figure 3 represents the average total annual Medicare payments per beneficiary.

Figure 3. Average Annual Medicare Payment per Beneficiary: 7/1/2009 to 6/30/2010.



Figures 4a and 4b present average annual Medicare payments per beneficiary for different types of providers.

Figure 4a. Average Annual Medicare Payments per Beneficiary by Type of Provider: 7/1/2009 to 6/30/2010.



[1] Compared to the benchmark, your practice had significantly higher DME payments.

Note that the “Physician” category includes registered nurses, nurse practitioners, physician assistants and any other person billing under the physician.

Figure 4b. Average Annual Medicare Payments per Beneficiary by Type of Provider: 7/1/2009 to 6/30/2010.

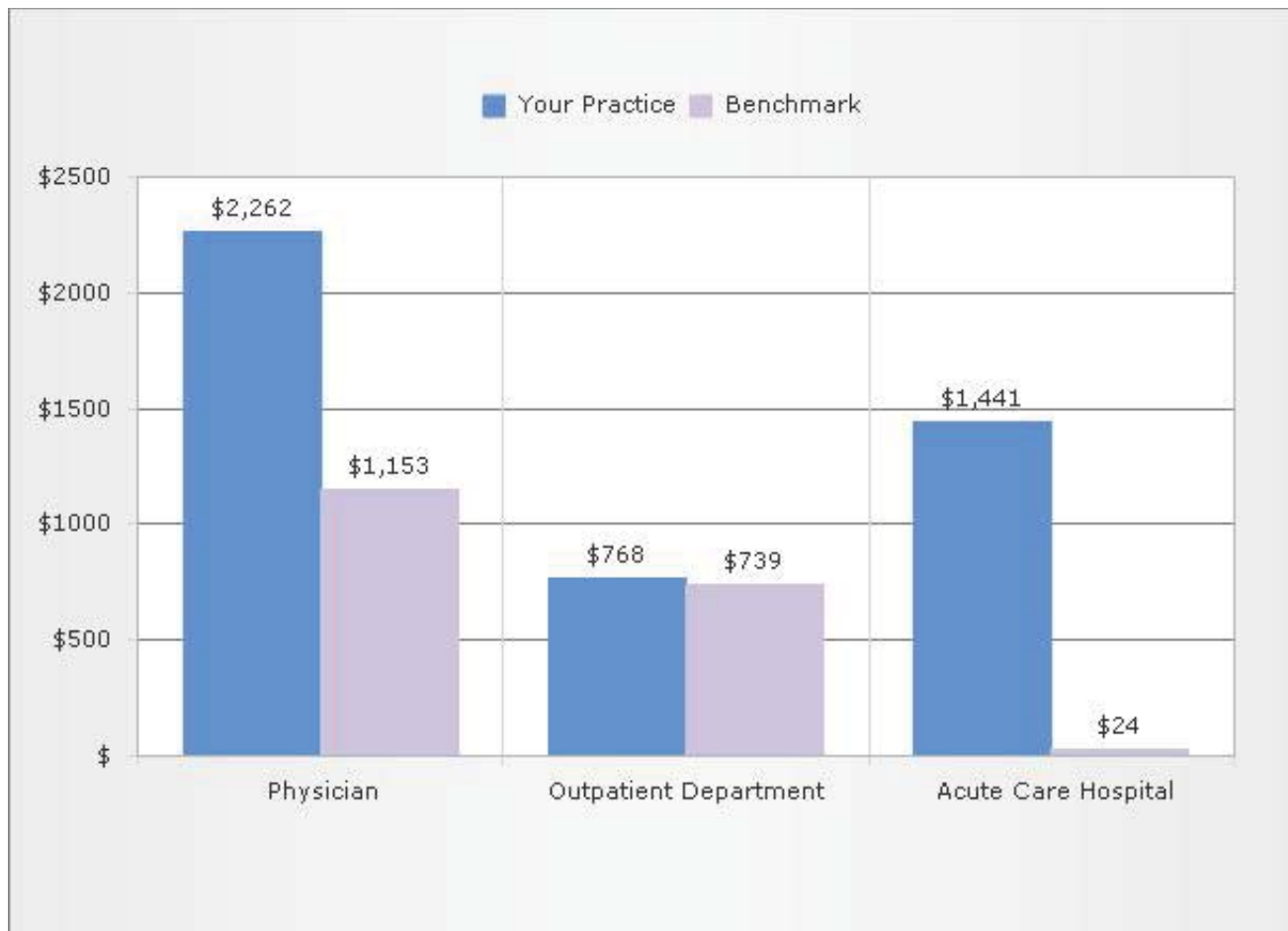


Figure 5 presents average annual Medicare payments for physician services by major types of service. Major types of service are defined by the Berenson Eggers Type of Service (BETOS) categories. For more information on the BETOS categories and what services are grouped with each category, see page 28.

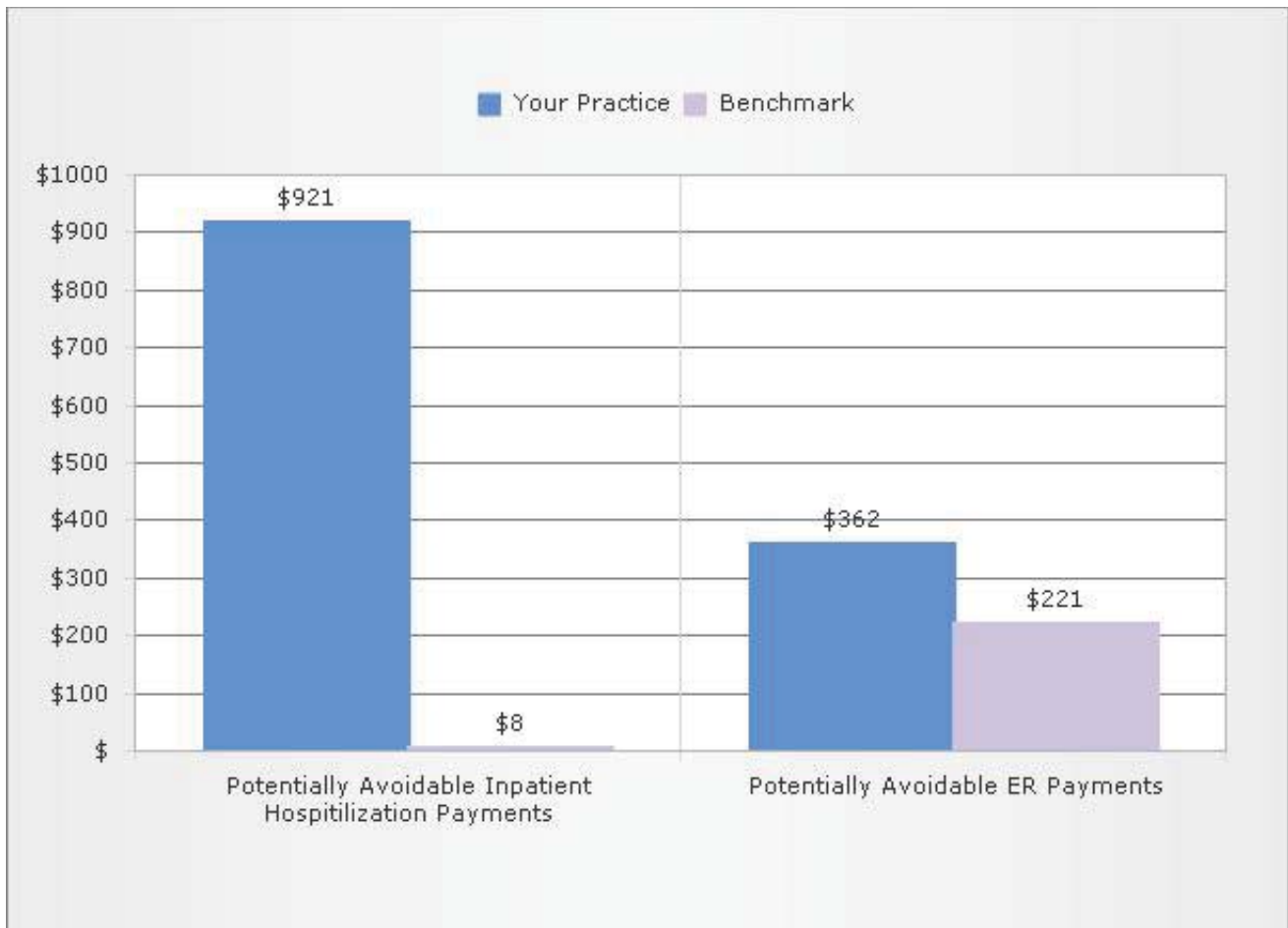
Figure 5. Average Annual Medicare Physician Payments by Major Type of Service: 7/1/2009 to 6/30/2010.



Figure 6 presents two Medicare payment measures for potentially avoidable inpatient hospitalizations and ER visits. Potentially avoidable payments are based on ambulatory-care sensitive conditions (ACSCs).

For more information on ACSCs and types of potentially avoidable hospitalizations and ER visits, see page 27.

Figure 6. Average Annual Potentially Avoidable Medicare Payments Based on Ambulatory Care Sensitive Conditions (ACSCs): 7/1/2009 to 6/30/2010.



TRENDS IN SELECTED MEASURES (YOUR PRACTICE ONLY)

This section presents three figures of selected clinical quality measures, utilization rates, and Medicare payment information for your practice for the following three time periods:

- July 1, 2007–June 30, 2008
- July 1, 2008–June 30, 2009
- July 1, 2009–June 30, 2010

Figure 7 presents the trends in the percentage of Medicare beneficiaries who received LDL-C screening, HbA1c testing, and influenza vaccination consistent with quality of care guidelines. Please recall that:

- LDL-C screening is among beneficiaries with diabetes and heart disease
- HbA1c testing is among beneficiaries with diabetes
- Influenza vaccination is among all beneficiaries

See page 24 for additional information on how to interpret these trend figures.

Figure 7. Trends of Selected Clinical Quality of Care Measures: 7/1/2007 to 6/30/2010.

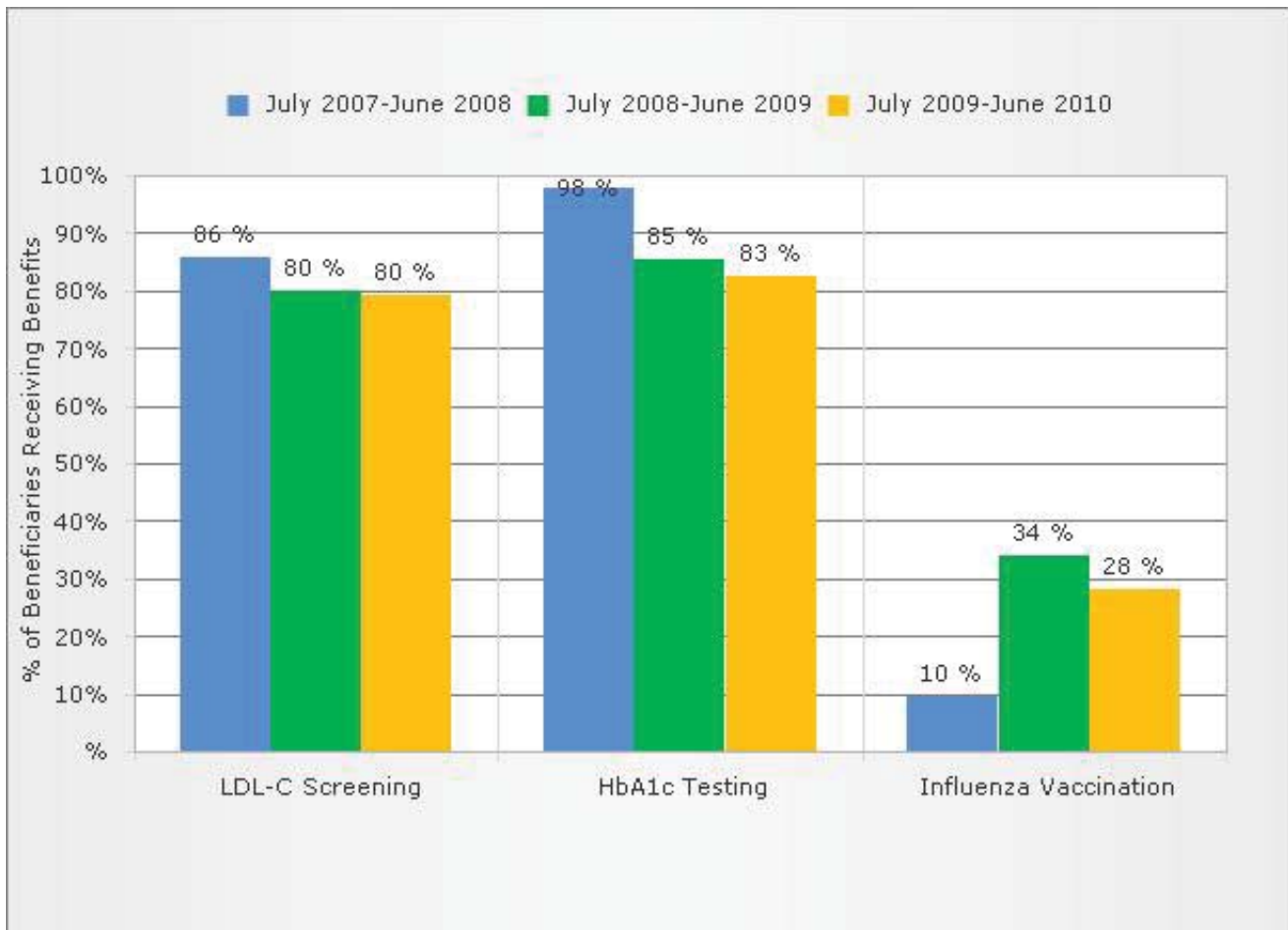


Figure 8 presents the trends in the percent of beneficiaries with potentially avoidable hospitalizations and ER visits for ambulatory care sensitive conditions (ACSCs) in your practice.

For more information on types of potentially avoidable hospitalizations and ER visits, please see page 27.

See page 24 for additional information on how to interpret this trend figure.

Figure 8. Trends of Potentially Avoidable Hospitalizations and ER Visits (for ACSCs) (Rate per 100 beneficiaries): 7/1/2007 to 6/30/2010.

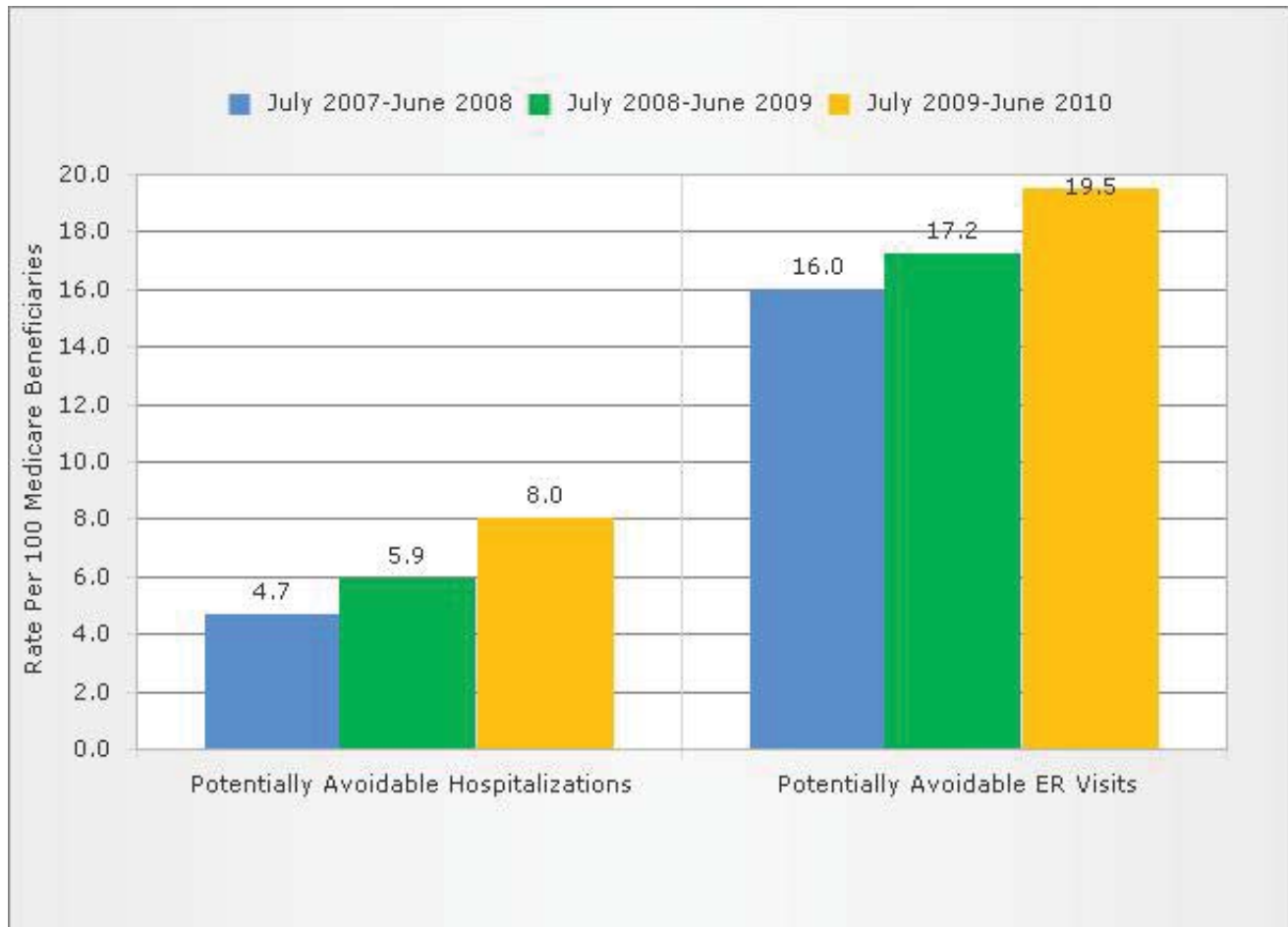
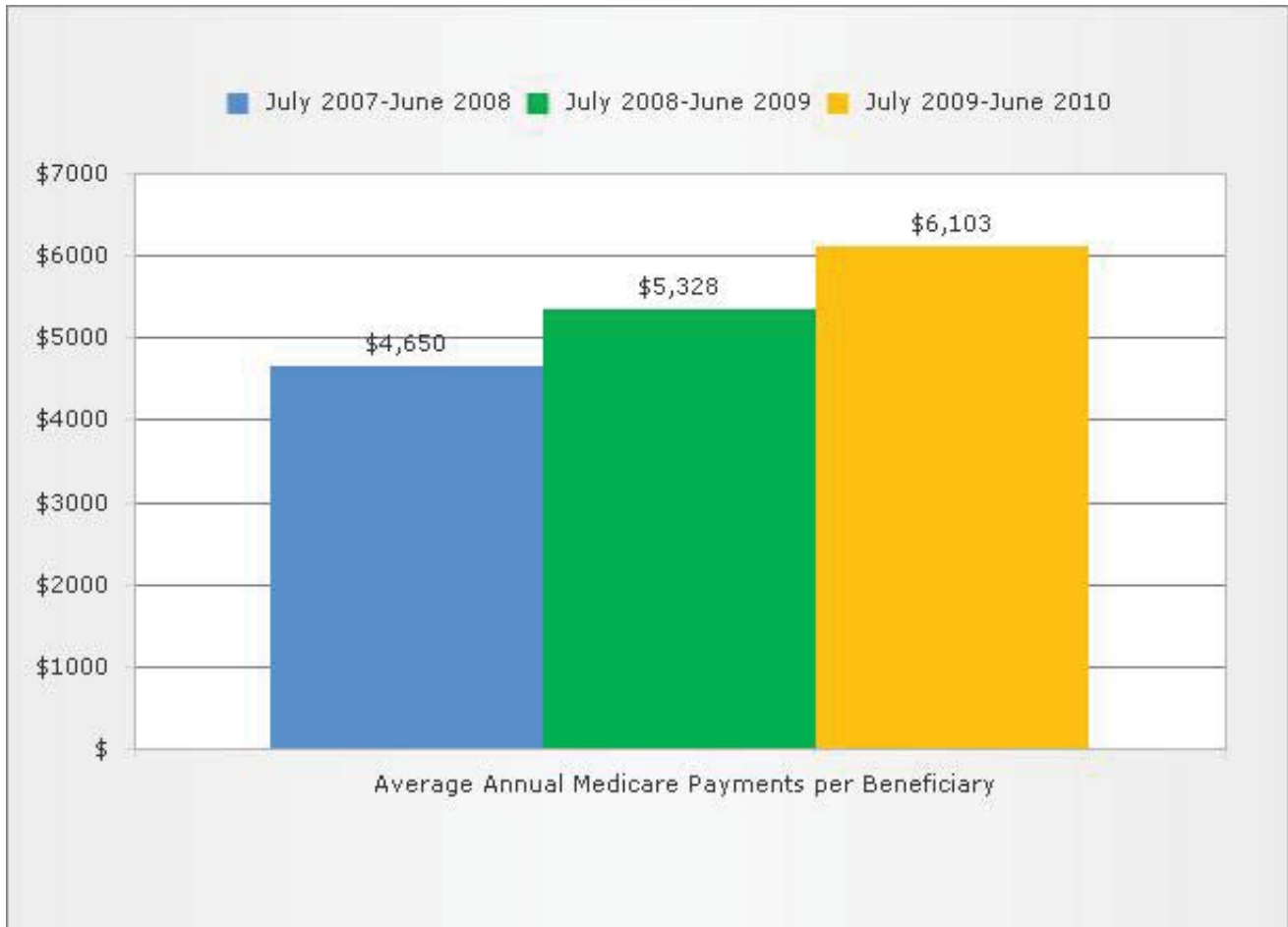


Figure 9 presents the trends in the average (per beneficiary) annual Medicare FFS payments. Total average Medicare payments per beneficiary are reported in nominal dollars.

See page 24 for additional information on how to interpret this trend figure.

Figure 9. Trends in the Average Annual Medicare Payments per FFS Medicare Beneficiary: 7/1/2007 to 6/30/2010.



SECTION 2 TECHNICAL REFERENCE GUIDE

Data Sources

To create this report, we used Medicare Part B billing data from the following types of providers: inpatient hospital, hospital outpatient department, physician, skilled nursing facility (SNF), home health agency (HHA), hospice, and durable medical equipment (DME). We used July 1, 2009 through June 30, 2010 billing data to prepare statistics comparing your practice with non-medical home practices, and July 1, 2007 through July 30, 2010 billing data to prepare trend statistics for your practice. Note we did not include Medicare Part D billing data in any of the analyses in this report.

Linking Medicare Beneficiaries to Your Practice (“Loyal Beneficiaries”)

Medicare FFS beneficiaries were assigned to your practice location if your practice provided more evaluation and management (E&M) visits to that beneficiary than any other primary care provider, regardless of location, during the period of July 1, 2009 through June 30, 2010. If a patient had only one E&M visit and it was provided by your practice, the patient was assigned to your practice. If the patient had equal numbers of E&M visits to two practices, then the patient was not assigned to either practice. The Current Procedural Terminology (CPT) E&M visit codes we used to make the linkages are provided on page 25.

To assign beneficiaries to your practice, we used only E&M visit codes billed with the following Medicare specialty codes on the claim:

- general practice
- family practice
- internal medicine
- geriatric medicine
- clinic or group practice
- nurse practitioners, certified clinical nurse specialists, and physician assistants

For Federally Qualified Health Centers (FQHCs), we used all inclusive bills as the measure of an E&M visit. Additionally, the FQHC claims were included in the beneficiary assignment process.

Once we assigned Medicare FFS beneficiaries to your practice location, we retrieved Medicare bills submitted for those patients for the 3-year study period, regardless of whether the service was provided by your practice or by another provider.

Comparison Benchmarks

We created benchmark values based on the experiences of a set of practices that do not have NCQA medical home recognition. These practices were selected using a matching process that identified a set of non-medical home practices that were similar in composition to the full set of NCQA-recognized medical home practices to which we are sending feedback reports.

The specific characteristics that were used to match your practice to the comparison group included:

- Average age of beneficiaries as of 7/1/2009
- Percent female beneficiaries
- Percent disabled beneficiaries
- Percent of beneficiaries on Medicaid
- Percent of beneficiaries whose current reason for eligibility is End Stage Renal Disease
- Number of people with 2 of 3 consecutive months with CPT code 99324-99337 (Home Care and Domiciliary Care Visits)

- Practice average prospective Hierarchical Condition Category (HCC) risk score using claims from 7/1/07 - 6/30/08
- Practice average Charlson comorbidity score
- Number “loyal” beneficiaries (A person is loyal to a medical home if the majority of their Primary Care E&M visits were provided by physicians from the medical home during the year between 7/1/2009 - 6/30/2010)
- Single practice vs. multi-location practice
- Number of providers at practice
- Number of primary care doctors per 2007 population (zip code)¹
- Number of specialist doctors per 2007 population (zip code)¹
- Percent of population that had at least one primary care visit per 2007 population (zip code)¹
- Percent of population that had at least one emergency dept. visit per 2007 population (zip code)¹
- Number of Federally Qualified Health Centers in the area (zip code)¹

Using the experiences of these comparison practices, we calculated your practice’s **benchmark** level of performance on quality of care measures, coordination and continuity of care measures, and Medicare payments for the period from July 1, 2009 to June 30, 2010. Your practice’s benchmark level of performance is what we would expect for a practice that has characteristics similar to yours but has not received NCQA recognition as a medical home. Your comparison benchmarks were adjusted for the factors listed above.

In the tables and graphs showing your results, we present both your actual performance and the benchmark performance value for each of the measures.

Selected Measures

This report includes performance metrics on three important aspects of health care: Quality of Care, Coordination and Continuity of Care, and Medicare Payments.

Quality of Care. We define quality of care as adherence to evidence-based, guideline-concordant care and have selected measures from the February 2008 National Quality Forum (NQF)-endorsed National Voluntary Consensus Standards for Physician-Focused Ambulatory Care. The selected measures are used by other CMS pay-for-performance initiatives, such as the Physician Quality Reporting System, or in evaluations of other pay-for-performance demonstrations (Physician Group Practice demonstration), or pilot programs (Medicare Health Support). Thus, these measures have been extensively tested and are widely accepted as clinically important measures.

This report provides the percentage of beneficiaries assigned to your practice location that received one of the following three recommended evidence-based, process-of-care measures during the measurement year:

1. LDL-C screening for beneficiaries with diabetes or heart disease
2. HbA1c testing for beneficiaries with diabetes
3. Influenza vaccination for all beneficiaries

We include services billed by your practice and any other Medicare FFS provider, including laboratories. If the service was provided by an entity that does not bill the Medicare program, such as a grocery store providing influenza vaccination, the provision of the service was not captured in the reported rate. Thus, one important caveat is that the influenza vaccination rates at your practice in this report are likely underestimated.

¹ Dartmouth Institute for Health Policy and Clinical Practice, Primary Care Service Area (PCSA) 2007 ZIP Code Tabulation Area (ZCTA) data. http://pcsa.dartmouth.edu/pcsa_data.php

See page 26 for descriptions of how these quality-of-care variables were created.

Coordination and Continuity of Care. Coordination and continuity of care are considered important goals of the medical home model. Coordination and continuity of care measures provided in this report include:

- Hospitalizations and visits to an ER
- Follow-up visits within 2 weeks after hospitalization discharge
- Readmissions within 30 days following discharge
- Number of physician visits by specialty: primary care, medical specialists, and surgical specialists

See page 27 for descriptions of primary care physician, medical and surgical specialists.

Medicare Payments. This report summarizes information for your practice on four measures of Medicare payments (presented as the average annual “per beneficiary”):

- Total annual Medicare payments
- Medicare payments by type of provider
- Medicare physician payments by major types of physician services
- Potentially avoidable inpatient hospitalization payments and ER payments for ACSCs

See page 27 for descriptions ambulatory care sensitive conditions for which ER visits and hospitalizations are considered potentially avoidable.

It is important to note that we did *not* risk-adjust the payments or perform any price standardization. Also, the cost measures include individuals with no claims. Because the payments are presented as average per beneficiary, those with \$0 costs will affect the averages.

How to Read the Tables

Reporting period

“How to Read Me” Table 1. Overview of Measures—Your Practice and Benchmarks: 7/1/2009 to 6/30/2010

	Your Practice (N benes = XX)	Benchmark (N benes = 124,210)	Your Practice versus Benchmark	Average across all study NCQA Medical Homes (N benes=146,410 N practices=312)
Measure				
Quality of Care (% of beneficiaries)				
LDL-C Screening (n=xx)				
HbA1c Testing (n = xx)				
Influenza Vaccination				
Coordination and Continuity of Care				
Hospitalization (rate per 100 beneficiaries)				
Follow-up within 2 weeks of hospitalization (rate per 100 hospitalizations)				
30-day hospital readmission (rate per 100 hospital discharges)				
ER Visits (rate per 100 beneficiaries)				
Primary Care Visits (rate per beneficiary)				
Medical Specialist Visits (rate per beneficiary)				
Surgical Specialist Visits (rate per beneficiary)				
Annual Payments (Average \$ per beneficiary)				
Durable Medical Equipment (DME) Payments				
Hospice Payments				
Home Health Payments				
Physician Payments				
Outpatient Department Payments				
Skilled Nursing Facility (SNF) Payments				
Acute Care Hospital Payments				
Total Medicare Payments				
Physician Payments by Type of Service (Average \$ per beneficiary)				
Office Visit Physician Payments				
Hospital/ER Visit Physician Payments				
Specialty Visits & Consultation Physician Payments				
Imaging & Laboratory Physician Payments				
Other Physician Payments				
Potentially Avoidable Payments based on Ambulatory Care Sensitive Conditions (ACSCs)(Average \$ per beneficiary)				
Potentially Avoidable Inpatient Hospital Payments				
Potentially Avoidable ER Payments				

Measure category and measures within each category, for which results are displayed

Number of “loyal” beneficiaries on which calculations are based (i.e., N included in denominator)

Indicates whether results for your practice are statistically significantly higher than (↑) or lower than (↓) benchmarks. Green arrows indicate that your practice is performing better than the benchmark, and red arrows indicate that your practice is performing significantly worse. Black arrows indicate higher or lower, with no judgment about whether this is better or worse. No arrow in the cell indicates that there is no significant difference between your practice and the benchmark.

Results for all NCQA-recognized medical homes in this study. Numbers represent average value across all beneficiaries in all study participants.

In the **Quality of Care** section, numbers in the cells represent the percent of beneficiaries in the category. In the **Coordination and Continuity of care** section, numbers in the cells represent rates per beneficiary (or per 100 beneficiary). In **Annual Payments, Physician Payments,** and **Potentially Avoidable Payments** sections, numbers in the cells represent the average amount paid (in dollars) per beneficiary by Medicare.

“How to Read Me” Table 2. Overview of Trends in Measures for Your Practice: July 2007 to June 2010

Percent change in measures for your practice and the average percent change across all NCQA-recognized medical homes in study to show trends between Time Period 1 and Time Period 3

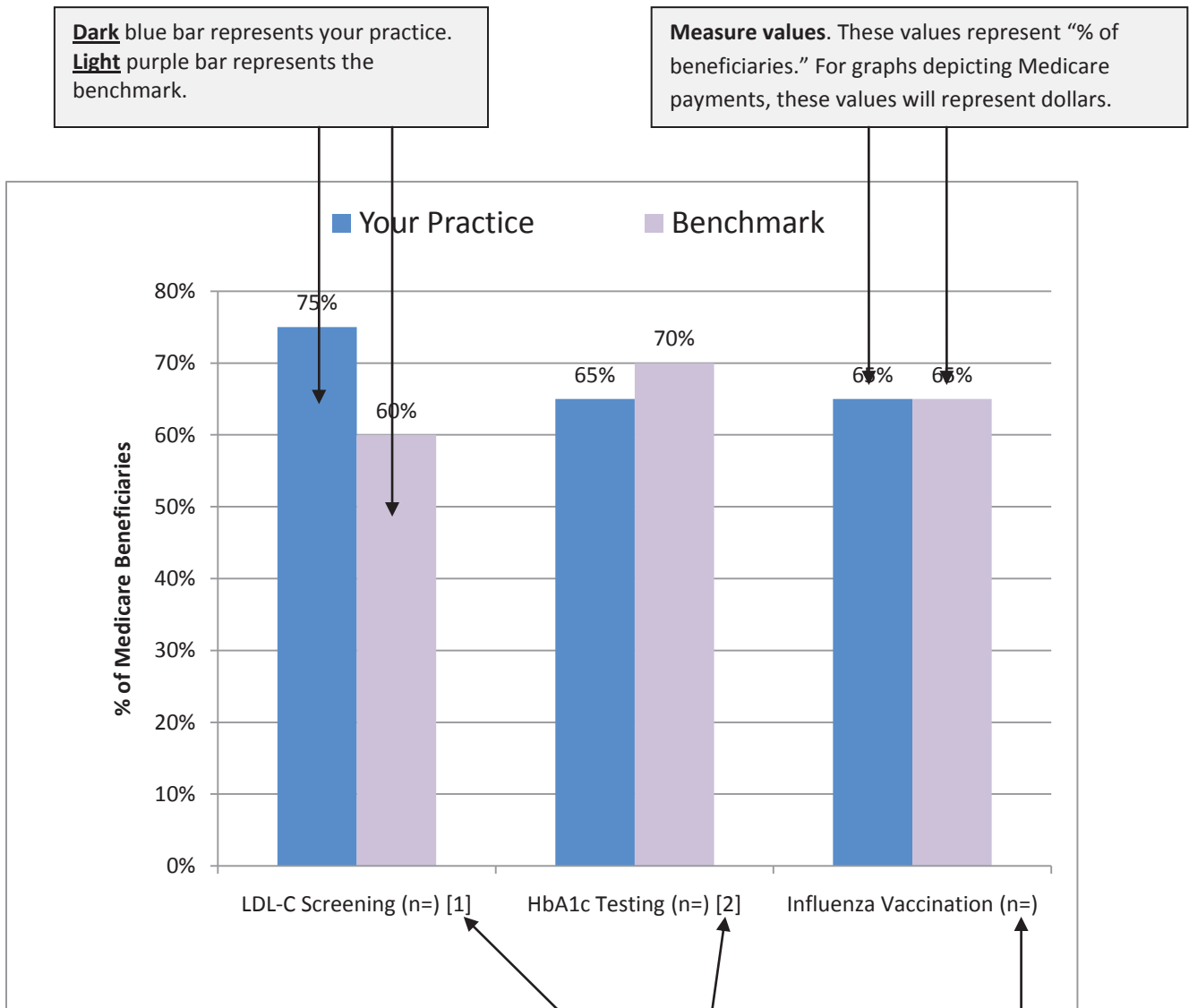
$$\left(\frac{\text{Measure}_{\text{Time}3} - \text{Measure}_{\text{Time}1}}{\text{Measure}_{\text{Time}1}} \right) * 100$$

Measures	Your Practice Time Period 1: July 2007 – June 2008	Your Practice Time Period 2: July 2008- June 2009	Your Practice Time Period 3: July 2009- June 2010	Your Practice % Change (July 2007- June 2010)	Average % Change across all study NCQA Medical Homes (N benes=146,410 N practices=312)
Quality Of Care Measures (% of beneficiaries)					
LDL-C Screening (n=)					
HbA1c Testing (n=)					
Influenza Vaccination					
Potentially Avoidable Hospitalizations / ER Visits based on Ambulatory Care Sensitive Conditions (ACSCs) (% of beneficiaries)					
Potentially Avoidable Hospitalizations (rate per 100 beneficiaries)					
Potentially Avoidable ER Visits (rate per 100 beneficiaries)					
Average Annual Payments (\$ per beneficiary)					
Average Total Medicare FFS Payments					

Measures for your practice during Time Period 1, Time Period 2, or Time Period 3 (percent of beneficiaries, rates, or dollars).

“How to Read Me” Figure 1. Selected Clinical Quality of Care Measures: 7/1/2009 to 6/30/2010

Note that these graphs do not contain data from your practice; they are for illustrative purposes only.



1. Narrative text to describe significant differences.
2. Narrative text to describe significant differences.

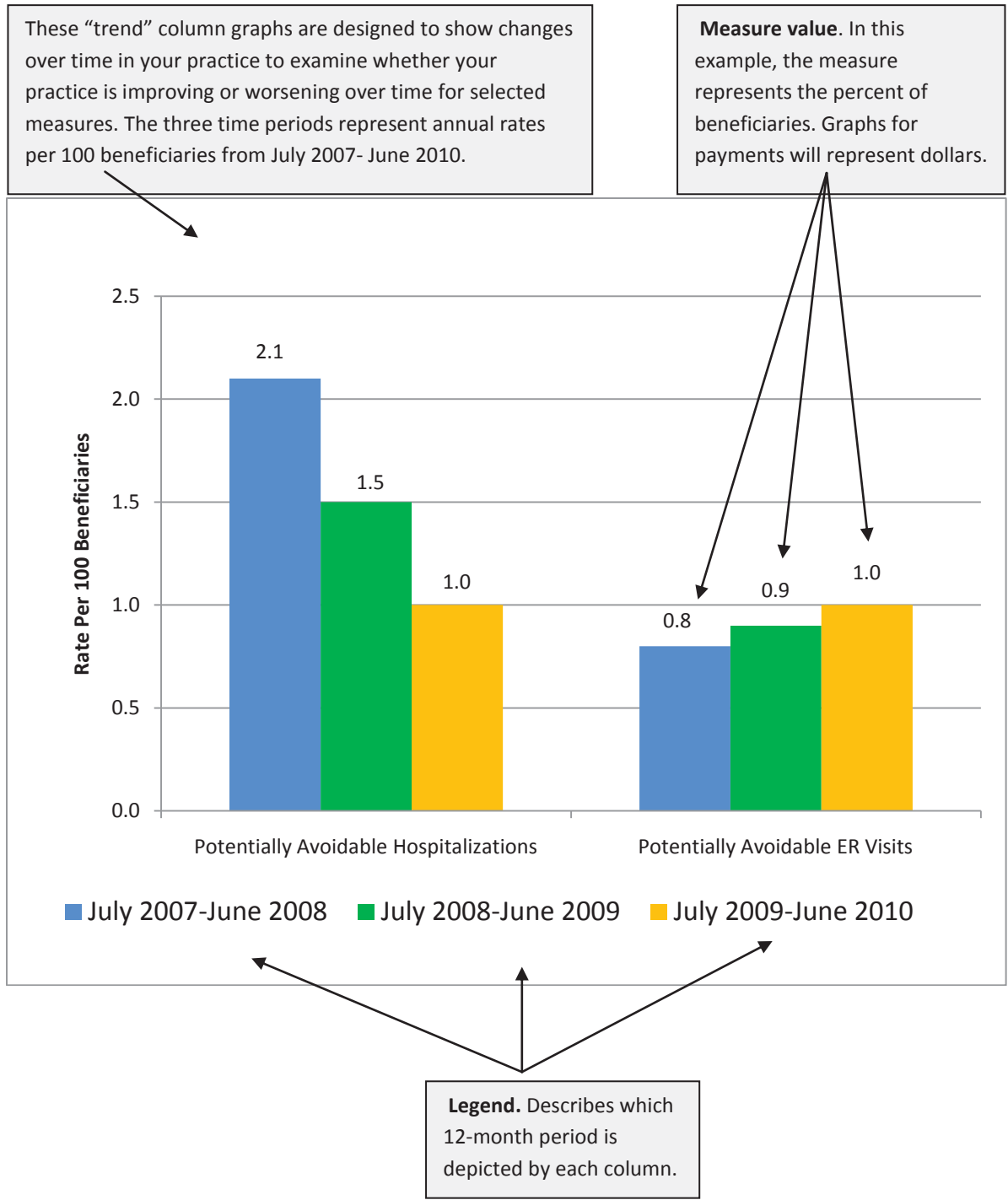
Narrative Text.
Describes statistically significant differences between your practice and the benchmark

Numbers in brackets. These indicate that the measure differed significantly between your practice and the benchmark (and link to the footnotes that are narrative text describing differences). No number in brackets indicates that there was no significant difference between your practice and the benchmark.

n=XX indicates the number of “loyal beneficiaries”, or used in the measure calculation (i.e, the denominator)

“How to Read Me” Figure 8. Trends of Potentially Avoidable Hospitalizations and ER Visits (for ACSCs): 7/1/2007 to 6/30/2010

Note that these graphs do not contain data from your practice; they are for illustrative purposes only.



**EVALUATION AND MANAGEMENT CPT CODES USED TO ASSIGN
MEDICARE BENEFICIARIES TO YOUR PRACTICE LOCATION**

Evaluation and Management Category	CPT codes
Office/Other Outpatient Services	New patient: 99201-99205 Established patient: 99211-99215
Domiciliary, Rest Home, or Custodial Care Services	New patient: 99324-99328 Established patient: 99334-99337
Domiciliary, Rest Home, or Home Care Plan Oversight Services	99339-99340
Home Services	New patient: 99341-99345 Established patient: 99347-99350
Prolonged Physician Service Without Direct Patient Contact	99358-99359
Case Management Services	Medical team conferences: 99366-99368
Care Plan Oversight Services	99374-99380
Preventive Medicine Services	New patient: 999381-99387 Established patient: 99391-99397
Counseling Risk Factor Reduction and Behavior Change Intervention	New or established patient: 99401-99412 Other preventive medicine services: 99420-99429
Non-Face-to-Face-Physician Services	Telephone services: 99441-99443 On-line medical evaluation: 99444
Medicare-Covered Wellness Visits	Initial exam, annual visits: G0402, G0438, G0439
Federally Qualified Health Center (FQHC) Global Visit	Clinic visit: <u>Revenue Code</u> 0521 Home visit: <u>Revenue Code</u> 0522

QUALITY OF CARE VARIABLES

1. Rate of annual low-density lipoprotein cholesterol (LDL-C) testing—beneficiaries with diabetes or ischemic vascular disease

- **Denominator:** All beneficiaries with diabetes or ischemic vascular disease, including CAD, peripheral vascular disease, carotid stenosis, etc.
- **Numerator:** Beneficiaries who have a claim for a LDL-C test as defined by CPT codes in the physician and outpatient department file:
 - 80061 Lipid Panel
 - 83700 Lipoprotein, blood; electrophoretic separation and quantitation
 - 83701 Lipoprotein, blood; high resolution and quantitation of lipoproteins
 - 83704 Lipoprotein, blood; quantitation of lipoprotein particle numbers and lipoprotein particle subclasses
 - 83721 LDL cholesterol

2. Rate of annual HbA1c testing—beneficiaries with diabetes

- **Denominator:** All beneficiaries with diabetes.
- **Numerator:** Beneficiaries who had a claim for a HbA1c test as defined by CPT codes in the physician and OPD file:
 - 83036 Hemoglobin; glycosylated (A1c)
 - 83037 Hemoglobin; glycosylated (A1c) by device cleared by FDA for home use

3. Rate of influenza vaccinations during influenza season (September through February) for adults—all beneficiaries

- **Denominator:** All Medicare FFS beneficiaries. (We did not exclude those with egg allergies or known adverse reaction to influenza vaccine in the past as both of these contraindications are not easily determined from Medicare billing data.)
- **Numerator:** Beneficiaries who received an influenza vaccine between September 1 and February 28. CPT Codes to define receipt of influenza vaccine in either physician claims or outpatient department file:
 - 90656 Influenza virus vaccine, split virus, preservative free for intramuscular
 - 90658 Influenza virus vaccine, split virus for intramuscular
 - 90660 Influenza virus vaccine live for intranasal
 - 90661 Influenza virus vaccine derived from cell cultures
 - 90662 Influenza virus vaccine, split virus, preservative free enhanced immunogenicity
 - 90663 Influenza virus vaccine, pandemic formulation
 - G0008 Administer influenza vaccine

KEY TERMS USED IN THIS REPORT

Follow-up visits within 2 weeks after hospital discharge: These are measured as in-person, follow-up visits with a provider that are captured in claims. Other types of follow-up, such as telephone follow-up, that may be more likely to occur in medical homes cannot be captured in claims.

Readmissions within 30 days after hospital discharge: Readmissions are estimated for index admissions that occur during 12-month spans for each of the three years in our analyses. We count readmissions that occurred within 30 days after an index hospitalization discharge date.

Ambulatory Care Sensitive Conditions (ACSCs): ACSCs are defined by AHRQ as “conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.” These conditions include: Adult failure to thrive, Altered mental status/acute confusion/delirium, Anemia, Angina, Asthma, Bacterial Pneumonia, Cellulitis, Chronic obstructive pulmonary disease (COPD) and chronic bronchitis, Heart Failure (HF), Constipation/fecal impaction/ obstipation, Dehydration (acute renal failure, hypokalemia, hyponatremia), Diabetes Mellitus, Diarrhea and Gastroenteritis with nausea and vomiting, C. Difficile, Severe Ear, Nose and Throat Infections, Falls and trauma, Hypertension, Hypoglycemia, Hypotension, Immunization/Preventable Conditions, Invasive Cervical Cancer, Ischemic Stroke, Nutritional deficiencies, Organic brain syndrome, Perforated or Bleeding Ulcer, Poor Glycemic Control, Psychosis, Pyelonephritis, Ruptured Appendix, Severe agitation, Seizures, Septicemia, Severe Ear, Nose, and Throat Infections, Skin ulcers including pressure ulcers, Tuberculosis, Urinary tract infection (UTI), and Weight loss.

Potentially Avoidable Hospitalizations and Emergency Room (ER) Visits: Hospitalizations and ER visits for ambulatory care sensitive conditions that could have been potentially prevented with appropriate outpatient management and care

Primary Care Physician: General Practice, Family Practice, Internal Medicine, Geriatric Medicine, Preventive Medicine, Nurse Practitioner, Physician Assistant, and Certified Clinical Nurse Specialist

Medical Specialists: Allergy/immunology, Otolaryngology, Cardiology, Dermatology, Gastroenterology, Neurology, Obstetrics/Gynecology, Ophthalmology, Pathology, Physical medicine and rehabilitation, Psychiatry, Pulmonary disease, Pulmonary disease, Diagnostic radiology, Urology, Nephrology, Optometry, Infectious disease, Endocrinology, Podiatry, Rheumatology, Multispecialty clinic or group practice, Peripheral vascular disease, Critical care (intensivists), Hematology, Hematology/oncology, Neuropsychiatry, Medical oncology, Radiation oncology, Emergency medicine, and Gynecologist/oncologist

Surgical Specialists: General surgery, Anesthesiology, Neurosurgery, Oral surgery (dentists only), Orthopedic surgery, Plastic and reconstructive surgery, Colorectal surgery, Thoracic surgery, Hand surgery, Vascular surgery, Cardiac surgery, Maxillofacial surgery, and Surgical oncology.

BERENSON-EGGERS TYPE OF SERVICE (BETOS) CODES USED IN THIS REPORT

OFFICE VISITS

- M1A = Office visits - new
- M1B = Office visits – established

HOSPITAL/ER VISITS

- M2A = Hospital visit - initial
- M2B = Hospital visit - subsequent
- M2C = Hospital visit - critical care
- M3 = Emergency room visit

SPECIALTY VISITS & CONSULTATIONS

- M5A = Specialist - pathology
- M5B = Specialist - psychiatry
- M5C = Specialist - ophthalmology
- M5D = Specialist - other
- M6 = Consultations
- O1B = Chiropractic
- O1C = Enteral and parenteral
- O1D = Chemotherapy
- O1E = Other drugs
- O1F = Hearing and speech services
- O1G = Immunizations/Vaccinations
- Y1 = Other - Medicare fee schedule
- Y2 = Other - non-Medicare fee schedule
- Z1 = Local codes
- Z2 = Undefined code

OTHER

- T2A = Other tests - electrocardiograms
- T2B = Other tests - cardiovascular stress tests
- T2C = Other tests - EKG monitoring
- T2D = Other tests - other
- D1A = Medical/surgical supplies
- D1B = Hospital beds
- D1C = Oxygen and supplies
- D1D = Wheelchairs
- D1E = Other DME
- D1F = Prosthetic/Orthotic devices
- D1G = Drugs Administered through DME
- O1A = Ambulance
- MB4 = Nursing Home Visits
- P0 = Anesthesia
- P4A – P4E = Eye Procedures
- P5A – P5E = Minor Procedures
- P8A – P8I = Endoscopy
- P9A – P9B = Dialysis

IMAGING and LABORATORY TESTS

- I1A = Standard imaging - chest
- I1B = Standard imaging - musculoskeletal
- I1C = Standard imaging - breast
- I1D = Standard imaging - contrast gastrointestinal
- I1E = Standard imaging - nuclear medicine
- I1F = Standard imaging - other
- I2A = Advanced imaging - CAT/CT/CTA: brain/head/neck
- I2B = Advanced imaging - CAT/CT/CTA: other
- I2C = Advanced imaging - MRI/MRA: brain/head/neck
- I2D = Advanced imaging - MRI/MRA: other
- I3A = Echography/ultrasonography - eye
- I3B = Echography/ultrasonography - abdomen/pelvis
- I3C = Echography/ultrasonography - heart
- I3D = Echography/ultrasonography - carotid arteries
- I3E = Echography/ultrasonography - prostate, transrectal
- I3F = Echography/ultrasonography - other
- I4A = Imaging/procedure - heart including cardiac catheter
- I4B = Imaging/procedure – other
- T1A = Lab tests - routine venipuncture (non Medicare fee schedule)
- T1B = Lab tests - automated general profiles
- T1C = Lab tests - urinalysis
- T1D = Lab tests - blood counts
- T1E = Lab tests - glucose
- T1F = Lab tests - bacterial cultures
- T1G = Lab tests - other (Medicare fee schedule)
- T1H = Lab tests - other (non-Medicare fee schedule)