Download PO Reports – Medicare Practice Feedback Reports
Quick Reference

The Medicare Practice Feedback Reports (MPFRs) were produced by Research Triangle Institute (RTI), the CMS evaluation contractor, to provide key measure rate comparisons for Medicare patients at a Practice level. This report provides:

- An overview of how a Practice's Medicare outcomes compare to other Practices in the MiPCT who have a similar overall patient risk burden.
- Trending information for a Practice's utilization, cost, and quality over time.

Time Period

The initial time period covered is from Jan 2012 – Jun 2013, and RTI plans to produce updated reports on a quarterly basis.

Location

You can find the MPFRs in the `<PO Name>_Medicare_Practice_Reports_YYYY_MM.zip` file, which is located on the Download Reports tab of the MiPCT Dashboards. The .zip file contains a report in PDF format for each Practice and Report Summary in Excel, which lists the results for each Practice in the PO. You can use Report Summary to compare Practice rates or to conduct additional analysis.

Contents

The reports contain data for the following:

- Utilization measures: hospitalization rates (all cause and ACSCs), ED visit rates, % of ED visits that do not lead to a hospitalization
- Medicare expenditures: average Medicare expenditures per beneficiary (total and by type of service)
- Quality of care: diabetes measures (LDL-C, HbA1c, retinal eye exams, nephropathy screening) and a heart disease measure (total lipid panel)

  Note: The RTI Diabetic Eye Exam rates will be lower than the MiPCT-reported rates (by an average of about 15 percent). This is because MDC also uses CMS Taxonomy codes to detect the occurrence of an eye exam in addition to the standard HEDIS-defined procedure codes.
- Trend charts

Comparison

Using HCC (a CMS risk score), Practices are grouped into either a high acuity practice group (HCC score greater than .771) or a low acuity practice group. The reports display the measure rates for a Practice and the comparison measure rates for either the High or Low HCC practice group (depending on which group the practice is grouped into).

Notes

Some notes about the reports:

- Pediatric practices were excluded from these reports.
- If a Practice/PO does not have a DUA on file, the report for this entity will not be included.
- Comparison is to other MiPCT practices, not the CMS control group.

This section of the Report Summary contains the report header information, including the time period covered.

Each Practice is listed separately.

Medicare Practice Feedback Report Summary
Based on Medicare FFS Beneficiaries Assigned: January, 2012 - Jun , 2013
Date Created: 3/11/2014
MiPCT PO-PU Rable Used: January, 2014

PO Name	Practice Name	Practice ID	Number of Beneficiaries
ABCD Health	Practice 1	P00MI123	1253
ABCD Health	Practice 2	P00MI124	965
ABCD Health	Practice 3	P00MI125	1102
ABCD Health	Practice 4	P00MI126	510
ABCD Health	Practice 5	P00MI127	
ABCD Health	Practice 6	P00MI128	410
ABCD Health	Practice 7	P00MI129	1640
ABCD Health	Practice 8	P00MI130	1250
ABCD Health	Practice 9	P00MI131	
ABCD Health	Practice 10	P00MI132	1081
ABCD Health	Practice 11	P00MI133	502
ABCD Health	Practice 12	P00MI134	
ABCD Health	Practice 13	P00MI135	660
ABCD Health	Practice 14	P00MI136	

This section of the Report Summary contains Utilization data. You can find info about the Utilization methodology on Page 5 of the Practice Feedback Report Technical Reference Guide (created by RTI).

UTILIZATION			
Hospitalization Rate For Any Cause (rate per 1,000 beneficiaries per quarter)	Hospitalization Rate For ACSCs (rate per 1,000 beneficiaries per quarter)	ER Visits / Observation Stays Rate for Any Cause (rate per 1,000 beneficiaries per quarter)	Percent of ER Visits / Observation Stays Not Leading to a Hospital Admission
59	0	127.3	73.8%
68.4	13	168.2	72.9%
75.2	5.8	157.2	67.5%
59.9	4.1	173.5	75.0%
64.9	5.4	156.8	62.1%
86	7.2	181.1	61.6%
79.9	3.4	160.7	63.9%
75.5	12.2	150	60.5%
57.4	10.6	117	61.8%
57.7	1.6	159.1	73.5%

This section of the Report Summary contains Cost data.

COST (Average $ per beneficiary per month)												
Total Medicare	Acute Care Hospital (all-cause)	Acute Care Hospital (for ACSCs)	All other Inpatient Facilities	ER/Observation Stay	Outpatient Department	Federally Qualified Health Centers (FQHC) and Rural Health Center	Primary Care Provider Services	Specialty Care provider Services	Laboratory	Imaging	Home Health	Other
$671	$226	$0	$64	$21	$111	$0	$38	$99	$4	$12	$27	$70
$732	$238	$33	$88	$24	$116	$0	$48	$96	$5	$14	$37	$66
$744	$236	$14	$94	$25	$154	$0	$39	$100	$5	$12	$18	$60
$620	$233	$22	$64	$24	$101	$0	$31	$71	$4	$10	$30	$53
$760	$281	$15	$21	$23	$135	$0	$41	$128	$5	$11	$52	$63
$868	$311	$18	$104	$24	$139	$0	$49	$110	$4	$14	$25	$88
$798	$244	$12	$99	$32	$132	$0	$39	$108	$5	$15	$34	$91
$670	$211	$30	$32	$25	$137	$0	$42	$102	$5	$13	$30	$73
$728	$201	$33	$101	$18	$141	$0	$35	$88	$12	$11	$40	$81
$667	$204	$2	$19	$27	$166	$0	$37	$105	$4	$11	$33	$62

This section of the Report Summary contains Diabetes Quality of Care Measures. You can find info about the methodology on Page 6 and Pages 9-12 of the Practice Feedback Report Technical Reference Guide (created by RTI).

Note: The RTI Diabetic Eye Exam rates will be lower than the MiPCT-reported rates (by an average of about 15 percent). This is because MDC also uses CMS Taxonomy codes to detect the occurrence of an eye exam in addition to the standard HEDIS-defined procedure codes.

QUALITY OF CARE MEASURES - Diabetes						
Number of assigned beneficiaries with claims-based diagnosis of diabetes	% had HbA1c testing	% had retinal eye examinations	% had medical attention for nephropathy	% had LDL-C screening	% had all 4 diabetes process measures	% had none of the diabetes process measures
153	98.0%	78.4%	92.2%	91.5%	68.6%	0.7%
138	89.1%	56.5%	84.1%	90.6%	46.4%	2.2%
137	95.6%	49.6%	76.6%	81.8%	33.6%	2.2%
84	91.7%	41.7%	66.7%	72.6%	27.4%	4.8%
74	94.6%	70.3%	86.5%	91.9%	56.8%	1.4%
239	94.6%	67.4%	86.6%	91.6%	56.5%	2.5%
142	92.3%	69.7%	78.9%	81.0%	50.0%	1.4%
167	97.0%	64.7%	88.6%	92.8%	55.7%	0.6%
61	95.1%	67.2%	91.8%	95.1%	59.0%	1.6%
81	95.1%	75.3%	71.6%	82.7%	45.7%	1.2%

This section of the Report Summary contains IVD Quality of Care Measures. You can find info about the methodology on Page 13 of the Practice Feedback Report Technical Reference Guide (created by RTI).

QUALITY OF CARE MEASURES - IVD	
Number of assigned beneficiaries with claims-based diagnosis of ischemic vascular disease (IVD)	% had total lipid panel test
214	81.3%
231	84.0%
223	77.6%
105	59.0%
74	83.8%
354	85.3%
215	74.4%
231	85.7%
83	88.0%
119	84.0%