MEDICARE FEE-FOR SERVICE
2011 QUALITY AND RESOURCE USE REPORT
AND PHYSICIAN QUALITY REPORTING SYSTEM FEEDBACK REPORT

[FULL MEDICAL PRACTICE GROUP NAME]

Last Four Digits of Your Group's Tax Identification Number (TIN): [#]

ABOUT THIS REPORT FROM MEDICARE	
WHY	• This Quality and Resource Use Report includes many of the quality and cost measures that Medicare plans to use for the physician value-based payment modifier. However, it does not reflect some key aspects of the value-based payment modifier that will be incorporated into future reports. Those differences are described in the Glossary of Terms section of this report (see Key Differences entry). • For calendar year 2015, Medicare will apply a value-based payment modifier to groups of physicians (identified by a single Taxpayer Identification Number, or TIN) with 100 or more eligible professionals, based on their performance during calendar year 2013.
WHAT	• The value-based payment modifier will be based, in part, on (1) quality measures for which your medical group chooses to submit data as part of the Physician Quality Reporting System; (2) your patients' rate of hospital admissions for ambulatory care sensitive conditions; and (3) all-cause hospital readmissions. Exhibits 5, 6, and 7 show your group's performance on these indicators in 2011. • The cost measures used in the value-based payment modifier will include (1) total per capita costs, based on the amount that Medicare paid you and other Medicare providers to deliver care to the beneficiaries attributed to your medical group practice, and (2) per capita costs for beneficiaries with specific chronic conditions. Your group's 2011 performance on these measures is shown in Exhibits 9 and 15.
WHO	• Medicare is providing this confidential feedback report to each of the [#] medical group practices that participated in the Physician Quality Reporting System's Group Practice Reporting Option (GPRO I) during calendar year 2011 (see http://www.medicare.gov/find-a-doctor/(S(qsuddyukjjazx5243zyxyv55))/staticpages/data/pqrs/physician-quality-reporting-system.aspx). • This report also presents information about the dollar amount of the incentive payment your medical group practice earned for successfully reporting quality measures in 2011 as a participant in GPRO I.
WHAT YOU CAN DO	• Review your performance in advance, before the value-based payment modifier is implemented in 2015, to identify areas that may positively or negatively affect your reimbursement. • If you have questions about this report or want to share ways to improve its content and format, please e-mail cms_medicare_physician_feedback_program@mathematica-mpr.com or call 1-855-272-3635.

PERFORMANCE HIGHLIGHTS
[FULL MEDICAL GROUP PRACTICE NAME]

SUMMARY OF GPRO I EARNED INCENTIVE Based on satisfactory reporting for each disease module/preventive care measure required for GPRO I, your group's earned incentive amount was [#]% of your total estimated allowed Medicare Part B charges:				
Total Earned Incentive Amount	Total Estimated Allowed Medicare Part B Physician Fee Schedule Charges	Distribution of Total Incentive Earned Among Medicare Administrative Contractors (MACs) or Carriers		
		MAC or Carrier Identification Number	Earned Incentive Amount and Proportion for This MAC or Carrier	
$	$			

QUALITY OF YOUR PATIENTS' CARE Compared with other medical groups participating in 2011 GPRO I, your group's performance on the GPRO I quality measures (based on specified sample of 411 patients) fell in the following performance categories:					
Total Number of Measures	Number of Measures with Scores in Each Quartile Ranking				Number of Measures with Scores ≥ 95th percentile
	0 – 25th percentile	26th – 50th percentile	51st – 75th percentile	76th – 100th percentile	
[#]					

HOSPITAL ADMISSIONS FOR AMBULATORY CARE SENSITIVE CONDITIONS Hospital admissions for conditions where hospitalization often can be avoided through timely ambulatory care:		
	Your Medical Group Practice	Mean for GPRO I Medical Group Practices
Total hospital admission rate for selected conditions (rate per 1,000 attributed Medicare beneficiaries)		

TOTAL PER CAPITA COSTS OF YOUR PATIENTS' CARE Based on payment for 2011 Medicare Part A and B claims submitted by all providers who treated Medicare beneficiaries attributed to GPRO I medical group practices:		
	Your Medical Group Practice	Mean for GPRO I Medical Group Practices
Total annual costs per attributed beneficiary (payment standardized and risk adjusted)	$	$

PER CAPITA COSTS OF PATIENTS WITH CHRONIC CONDITIONS Average annual 2011 per capita costs (payment standardized and risk adjusted) for Medicare beneficiaries attributed to GPRO I medical group practices, by chronic conditions common in the Medicare population:			
Chronic Condition	Your Medical Group Practice		Mean Per Capita Costs for GPRO I Medical Group Practices
	Number of Patients with This Condition	Per Capita Costs	
Diabetes		$	$
Coronary Artery Disease			
Chronic Obstructive Pulmonary Disease			
Heart Failure			

INTRODUCTION

This report provides information on the quality and costs of care provided to Medicare beneficiaries in your medical group practice, and on beneficiaries' utilization of hospital services and follow-up care, compared to the average for [#] medical group practices that participated in the 2011 GPRO I Physician Quality Reporting System.

Terms and concepts are defined in the Glossary of Terms section of the report.

Medicare Beneficiaries Attributed to Your Medical Group Practice

For the purposes of this report, responsibility for all costs and quality of care provided to each individual Medicare beneficiary has been attributed to the single medical group practice (identified by Tax Identification Number, or TIN) that billed more office or other outpatient evaluation and management (E&M) services for that beneficiary (based on Medicare allowed charges) than any other TIN in 2011, provided the group billed for at least two office visits or other outpatient E&M services.

Based on outpatient E&M services provided by your group in 2011, [#] Medicare beneficiaries have been attributed to your medical group practice (Exhibit 1).

Exhibit 1. Summary of Outpatient E&M Services Provided to Beneficiaries Attributed to Your Medical Group Practice

Total Number of Attributed Beneficiaries	Office or Other Outpatient E&M Services Per Attributed Beneficiary		
	Average Number of Visits to All Providers	Average Number of Visits Provided by Your Group	Average Percentage of Visits Provided by Your Group
			%

Exhibit 2 shows the specialties accounting for the most office or other outpatient E&M services for attributed beneficiaries in your medical group practice.

Exhibit 2. Specialties* in Your Medical Group Practice Providing Office or Other Outpatient E&M Services to Attributed Beneficiaries

	Primary Care Physicians	Medical Specialists	Surgeons	Emergency Medicine Physicians	Other Physicians	Other Medical Professionals
Average Number of Office or Other Outpatient E&M Visits Per Attributed Beneficiary						
Percentage of Beneficiaries Whose Largest Share of Office or Other Outpatient E&M Visits Was With This Specialty	%					

* See Appendix A for the list of specialties assigned to each specialty category.

Exhibit 3 shows how many different medical professionals (including nurse practitioners and physician assistants) treated the beneficiaries attributed to your medical group practice, on average, and what proportion of those professionals were outside of your group, compared to the average among all medical group practices participating in the 2011 GPRO I Physician Quality Reporting System.

Exhibit 3. Medicare Beneficiaries Attributed to Your Medical Group Practice and the Medical Professionals Treating Them, 2011

	Your Medical Group Practice	Mean Among All [#] GPRO I Medical Group Practices
Number of Medicare patients attributed to your medical group practice		
Average number of professionals in all care settings who treated each patient		
Percentage of professionals treating patients attributed to your medical group practice who did not bill under your group's TIN	%	%

PERFORMANCE ON GPRO I QUALITY OF CARE INDICATORS

Based on a review of all data submitted for your medical group practice as part of 2011 GPRO I, your group [qualified to earn and incentive payment of $, equivalent to #% of your group's total estimated allowed Medicare Part B Physician Fee Schedule charges (see Performance Highlights)/did not qualify for an incentive payment.]

Eligibility for an incentive payment is determined by your group's satisfactory reporting on each of the required disease modules or preventive care measures based on a specified sample of 411 patients.

Exhibit 4, summarizing medical groups' successful reporting of GPRO I quality measures by disease module, is not included in the 2011 QRURs.

Exhibit 5 summarizes your group's performance on each of the [#] quality indicators reported for your samples of attributed patients as part of the 2011 GPRO I Physician Quality Reporting System (PQRS).

Exhibit 5. Your Medical Group Practice's Performance on GPRO I Quality Indicators, 2011

		Performance of Your Medical Group Practice		Performance of All [#] GPRO I Medical Group Practices					Performance of All PQRS Physicians
				Percentile					
	Disease Modules and Preventive Care Measures	Number of Patients	Rate	25th	50th	75th	95th	100th	Mean
	Diabetes Disease Module								
	For beneficiaries with a diagnosis of diabetes, the percentage …								
DM-1	who had HbA1c testing								
DM-2	whose most recent HbA1c was > 9.0% *								
DM-3	whose most recent blood pressure was < 140/90								
DM-5	whose most recent LDL-C was < 100 mg/dL								
DM-6	who received urine protein screening or medical attention for nephropathy								
DM-7	who had a dilated eye exam								
DM-8	who had a foot exam								
DM-9	who had a lipid profile within 12 months								
	Heart Failure Disease Module								
	For beneficiaries with a diagnosis of heart failure, the percentage…								
HF-1	who had LVF assessment results recorded								
HF-2	who were hospitalized with heart failure and had LVF testing								
HF-3	whose weight measurement was recorded								
HF-5	who were provided with patient education								
HF-6	who have LVEF < 40% and were prescribed beta-blocker therapy								
HF-7	who have LVEF < 40% and were prescribed ACE inhibitor or ARB therapy								
HF-8	who have atrial fibrillation and were prescribed warfarin therapy								
	Coronary Artery Disease Module								
	For beneficiaries with a diagnosis of coronary artery disease, the percentage…								
CAD-1	who were prescribed oral antiplatelet therapy								
CAD-2	who were prescribed a lipid-lowering therapy								
CAD-3	who had prior MI and were prescribed beta-blocker therapy								
CAD-7	who have diabetes and/or LVEF < 40% and were prescribed ACE inhibitor or ARB therapy								
	Hypertension Disease Module								
	For beneficiaries with a diagnosis of hypertension, the percentage…								
HTN-1	whose blood pressure was recorded								
HTN-2	whose most recent blood pressure is < 140/90								
HTN-3	with systolic pressure ≥ 140 OR diastolic pressure ≥ 90 who have a documented plan of care								
	Preventive Care Measures								
	For beneficiaries, the percentage . . .								
Prev-5	of women who had mammogram within 24 months								
Prev-6	who had colorectal cancer screening								
Prev-7	who had influenza immunization during flu season								
Prev-8	who ever had pneumococcal vaccine								

* For DM-2, a lower performance rate indicates better performance/diabetes control.

HOSPITAL UTILIZATION

Public and private payers view reducing avoidable hospital admissions as a way to improve quality of patient care and reduce unnecessary costs. The data shown in the tables below are provided for informational purposes, but are not currently risk adjusted. CMS plans to develop risk adjustment methodology for these measures in the future.

Hospital Admissions for Ambulatory Care Sensitive Conditions

Ambulatory care sensitive conditions (ACSCs) are medical conditions for which timely and coordinated outpatient care can potentially prevent the need for hospitalization. Exhibit 6 shows how 2011 hospital admission rates for ACSCs for all Medicare patients attributed to your medical group practice compared to the mean admission rates among medical group practices participating in the 2011 GPRO I Physician Quality Reporting System. In each instance, the condition was coded as the primary reason for hospitalization.

Exhibit 6. Hospital Admission Rates for Ambulatory Care Sensitive Conditions, 2011

Condition	Medicare Patients Attributed to Your Medical Group Practice		Medicare Patients of All [#] GPRO I Medical Group Practices	
	Number of Admissions	Admission Rate per 1,000 Beneficiaries	Mean Number of Admissions	Mean Admission Rate per 1,000 Beneficiaries
Total				
Chronic Conditions*				
Diabetes Composite of 4 diagnoses				
Chronic Obstructive Pulmonary Disease or Asthma				
Heart Failure				
Acute Conditions**				
Acute Conditions Composite Composite of 3 diagnoses: dehydration, bacterial pneumonia, and urinary tract infection				

* For chronic conditions, the denominator used to calculate admission rates is the total number of Medicare patients attributed to the medical group practice who were diagnosed with that condition.

** For acute conditions, the denominator used to calculate admission rates is the total number of Medicare patients attributed to the medical group practice.

Follow-Up After Hospital Discharge and All-Cause Hospital Readmissions

While poor quality of care during an initial hospital stay can lead to hospital readmissions, readmissions also can occur when patients do not receive appropriate follow-up care or ongoing outpatient management of other chronic conditions. Exhibit 7 shows how many of your group's Medicare patients had a physician visit within 30 days of discharge from the hospital and how many were readmitted to the hospital for any cause within 30 days of discharge.

Exhibit 7. 30-Day Post-Discharge Provider Visits and All-Cause Hospital Readmissions for Medicare Patients Attributed to Your Medical Group Practice, 2011

Medicare Patients Attributed to Your Medical Group Practice			Medicare Patients of All [#] GPRO I Medical Group Practices		
Total Hospital Discharges	Number of Patients Discharged Who Saw a Physician Within 30 Days per 1,000 Discharges	All-Cause 30-Day Readmission Rate per 1,000 Discharges	Mean Number of Hospital Discharges	Mean Number of Patients Discharged Who Saw a Physician Within 30 Days per 1,000 Discharges	Mean All-Cause 30-Day Readmission Rate per 1,000 Discharges
	Higher rates are better	Lower rates are better		Higher rates are better	Lower rates are better
				%	

Hospitals Admitting Your Patients

Based on all Medicare Part A claims submitted in 2011, at least five percent of your attributed patients' inpatient stays were at each of the hospitals shown in Exhibit 8. Information on hospital performance is available on the Hospital Compare website (http://www.hospitalcompare.hhs.gov).

Exhibit 8. Hospitals Admitting Patients Attributed to Your Medical Group Practice, 2011

Hospital		Medicare Patients Attributed to Your Medical Group Practice	
Name	Location	Number of Inpatient Stays	Percentage of All Inpatient Stays
Total			%
Hospital Name	City, State		%

PER CAPITA COSTS OF CARE

This section provides summary information about the per capita costs of care provided to Medicare fee-for-service (FFS) patients attributed to your medical group practice. All comparative cost data have been risk adjusted to account for differences in patient characteristics that may affect costs. In addition, all comparative cost data use payment standardization to account for differences in Medicare payments across geographic regions due to such factors as wages or rents. This information is derived from payments for all Medicare Parts A and B claims (excluding hospice) submitted by all providers who treated Medicare FFS patients attributed to your medical group practice, including providers who are not affiliated with your group. Outpatient prescription drug (Part D) costs are not included.

Based on payment of claims submitted for your Medicare patients in 2011, risk-adjusted and payment-standardized per capita costs for the Medicare patients attributed to your medical group practice were [$]. Exhibit 9 shows how the per capita costs of your Medicare patients, before and after risk adjustment,[1] compared to the mean per capita costs among all medical group practices participating in the 2011 GPRO I Physician Quality Reporting System.

Exhibit 9. Medicare FFS Patients' Per Capita Costs,* 2011

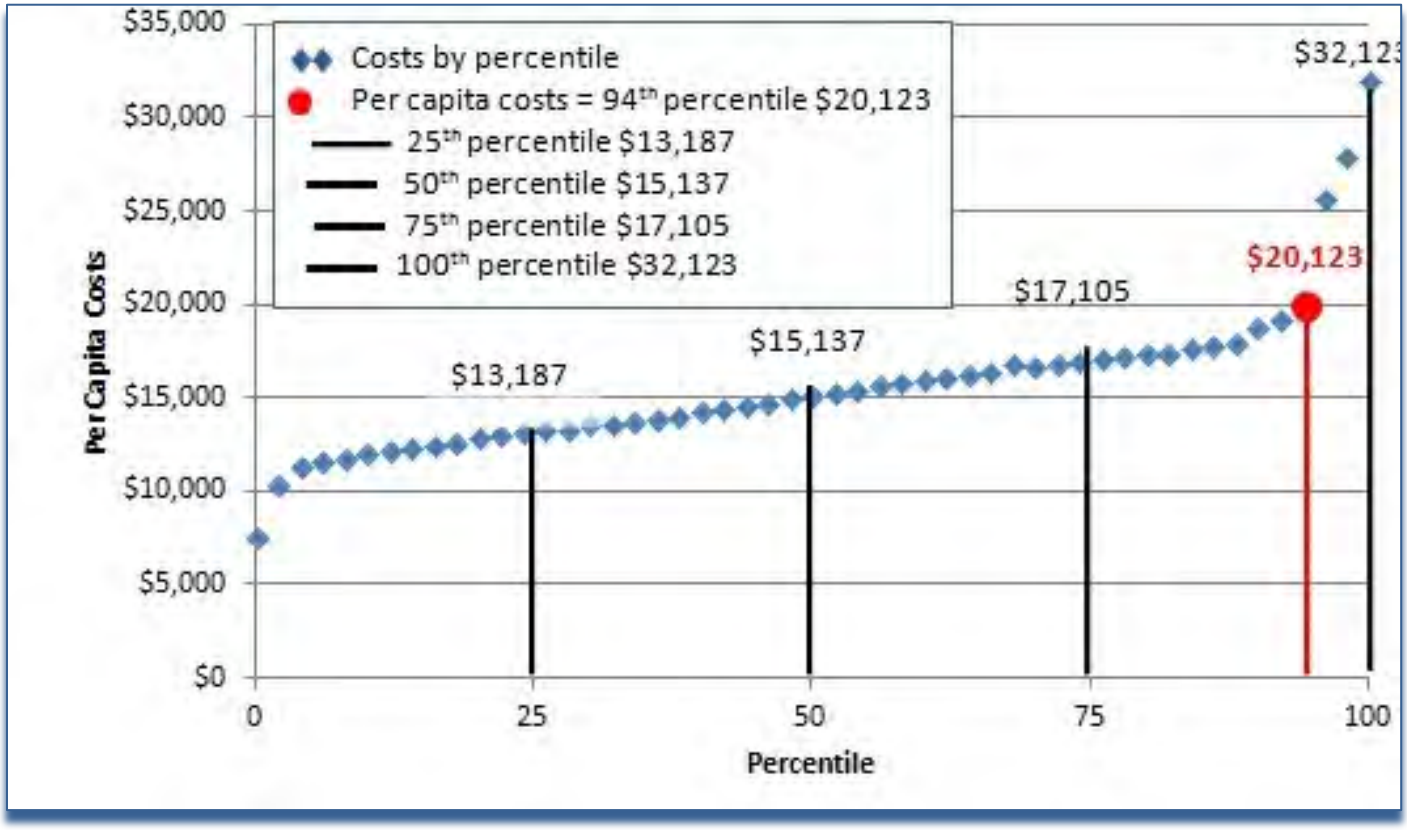
Per Capita Costs for Your Medical Group Practice (Payment Standardized)		Mean Per Capita Costs Among All [#] GPRO I Medical Group Practices
Before Risk Adjustment	After Risk Adjustment	Payment Standardized and Risk Adjusted
$	$	$

* Per capita costs are based on payments for Medicare Part A and Part B claims (excluding hospice) submitted in 2011 by all providers (including professionals, hospitals, and post-acute care facilities) for Medicare beneficiaries attributed to a medical group practice. Outpatient prescription drug (Part D) costs are not included.

[1] For medical group practices that have a higher than average proportion of patients with costly medical conditions or other risk factors, unadjusted costs will be higher than adjusted costs. For medical group practices with a healthier patient population, unadjusted costs will be lower than adjusted costs. See the Glossary of Terms for a description of risk adjustment used for this report.

Per capita costs for the medical group practices participating in the 2011 GPRO I Physician Quality Reporting System ranged from a low of [$] to a high of [$]. Average patient costs for your group were at the [#st/nd/rd/th] percentile of average costs among all GPRO I medical group practices (Exhibit 10).

Exhibit 10. Medicare Patients' Per Capita Costs* Among All 54 GPRO I Medical Group Practices, by Percentile, 2011

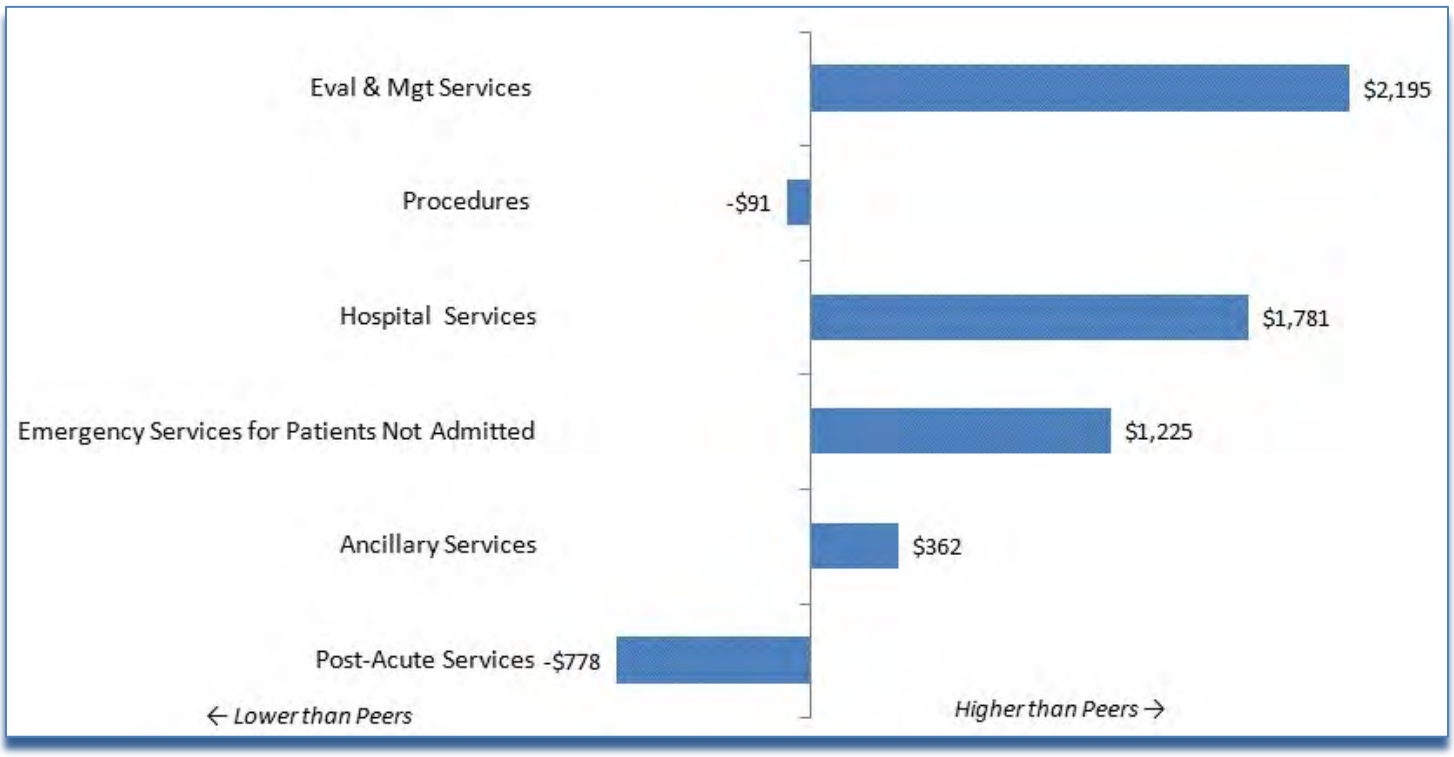


* Per capita costs are risk adjusted and payment standardized and are based on payments for Medicare Part A and Part B claims (excluding hospice) submitted in 2011 by all providers (including professionals, hospitals, and post-acute care facilities) for Medicare beneficiaries attributed to a medical group practice. Outpatient prescription drug (Part D) costs are not included.

PER CAPITA COSTS FOR SPECIFIC SERVICES

Exhibit 11 shows the difference between the per capita costs of specific types of services for Medicare patients attributed to your medical group practice and the mean among all medical group practices participating in the 2011 GPRO I Physician Quality Reporting System.

Exhibit 11. Difference Between Per Capita Costs* of Services** for Your Group's Patients and Mean Per Capita Costs Among All 54 GPRO I Medical Group Practices, 2011



* Per capita costs are based on payments for Medicare Part A and Part B claims (excluding hospice) submitted in 2011 by all providers (including professionals, hospitals, and post-acute care facilities) for Medicare beneficiaries attributed to your group. Outpatient prescription drug (Part D) costs are not included. All per capita costs are payment standardized and risk adjusted.

** In calculating service-specific per capita costs, the numerator is the total costs for a category of service used by attributed patients; the denominator is the total number of Medicare patients attributed to a medical group, not just those who used the service.

Exhibit 12 shows additional detail on per capita costs of services for Medicare patients attributed to your medical group practice, compared to average costs among all medical group practices participating in the 2011 GPRO I Physician Quality Reporting System.

Exhibit 12. Medicare Patients' Per Capita Costs for Specific Services, 2011*

	Your Medical Group Practice			Mean for All [#] GPRO I Medical Group Practices		
	Your Group's Attributed Medicare Patients Using Any Service in This Category		Per Capita Costs for Your Medicare Patients	Attributed Medicare Patients Using Any Service in This Category	Per Capita Costs for Attributed Medicare Patients	Amount by Which Your Group's Costs Were Higher or (Lower) than GPRO I Mean
Service Category	Number	Percentage				
All Services		100%	$	100%	$	$/($)
Evaluation and Management Services in All Non-Emergency Settings						
All Professional Evaluation & Management Services						
Primary Care Physicians						
Medical Specialists						
Surgeons						
Other Professionals						
Procedures in All Non-Emergency Settings						
All Procedures						
Primary Care Physicians						
Medical Specialists						
Surgeons						
Other Professionals						
Hospital Services (Excluding Emergency Outpatient)						
All Hospital Services						
Inpatient Hospital Facility Services						
Outpatient Hospital Facility Services						
Emergency Services That Did Not Result in a Hospital Admission						
All Emergency Services						
Emergency Visits						
Procedures						
Laboratory and Other Tests						
Imaging Services						
Services in Non-Emergency Ambulatory Settings						
All Ancillary Services						
Laboratory and Other Tests						
Imaging Services						
Durable Medical Equipment						
Post-Acute Care						
All Post-Acute Services						
Skilled Nursing Facility						
Psychiatric, Rehabilitation, or Other Long-Term Facility						
Home Health						
Other Services						
All Other Services						

* In calculating service-specific per capita costs, the numerator is the total costs for a category of service used by attributed patients; the denominator is the total number of Medicare patients attributed to a medical group practice and whose costs were risk adjusted, not just those who used the service. See Appendix A for the list of physician specialties assigned to each specialty category.

COSTS AND HOSPITAL UTILIZATION FOR SUBGROUPS OF PATIENTS WITH CHRONIC CONDITIONS

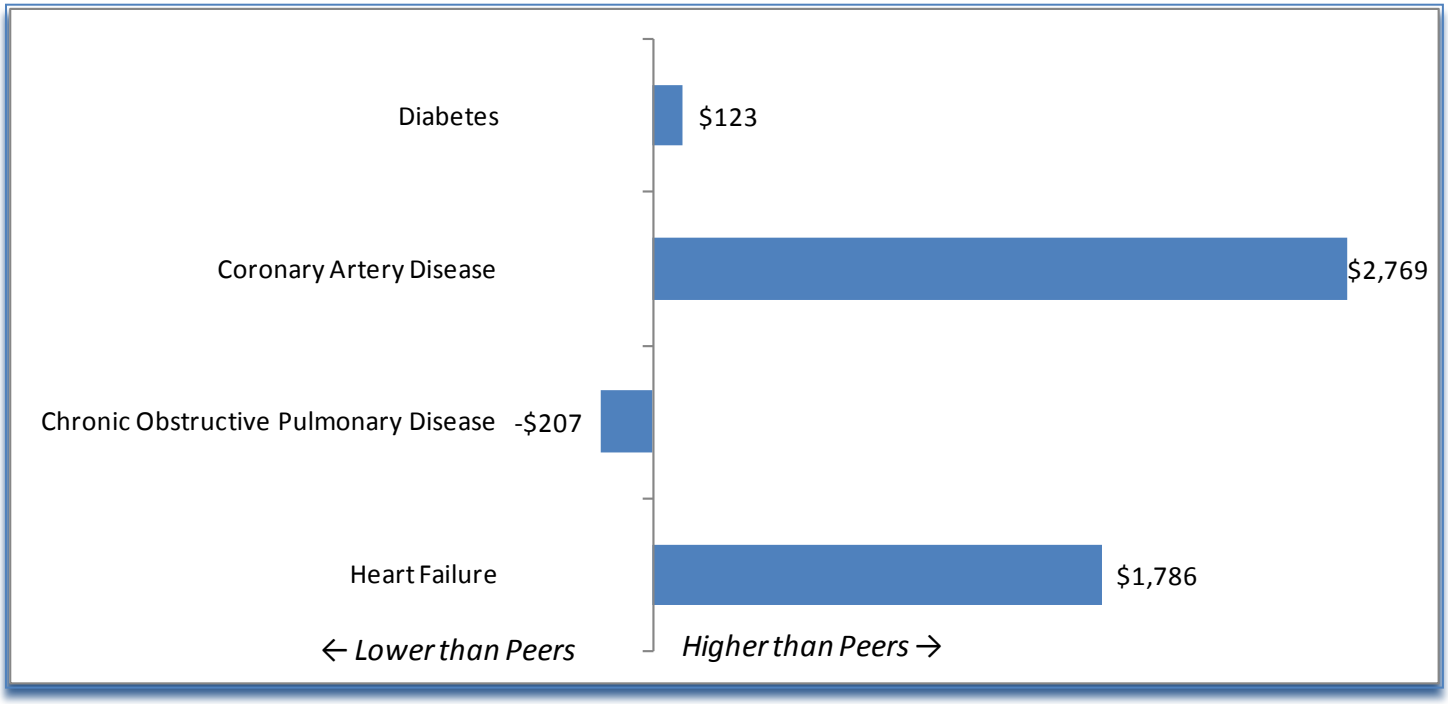
This section provides information on the total risk-adjusted and payment-standardized per capita costs incurred by subgroups of your Medicare patients identified as having specific chronic health conditions in 2011. It also provides information on hospital utilization by subgroup.

Total Per Capita Costs by Subgroup

Exhibit 13 shows the difference between the per capita costs of Medicare patients attributed to your medical group practice by chronic condition subgroup and mean costs for each subgroup among all medical group practices participating in the 2011 GPRO I Physician Quality Reporting System.

The subgroups are not mutually exclusive, which means that 100 percent of the 2011 per capita costs for a beneficiary with more than one of the four chronic conditions below are included in each relevant condition subgroup. However, subgroup per capita costs are risk adjusted to account for other chronic and acute co-morbidities that affect the per capita costs of beneficiaries in the subgroup.

Exhibit 13. Difference Between Your Group's Per Capita Costs* of Care for Patient Subgroups and Mean Among All 54 GPRO I Medical Group Practices, 2011



* Per capita costs are based on payment for Medicare Part A and Part B claims (excluding hospice) submitted by all providers in 2011 for Medicare beneficiaries attributed to a medical group practice within each diagnostic subgroup, whether or not costs were related to treatment of that condition. Outpatient prescription drug (Part D) costs are not included. All costs are payment standardized and risk adjusted.

Hospital Utilization by Subgroup

Exhibit 14 shows the number of your group's Medicare patients in each chronic condition subgroup in 2011 and the utilization rates for inpatient and emergency hospital services among patients within each subgroup.

Data on hospitalizations and emergency department (ED) use are not restricted to the condition of interest. All inpatient hospital admissions and ED visits are included, whether or not such use was directly related to the condition of interest. Beneficiaries with more than one of the four conditions displayed (and their associated hospital utilization statistics) are included in each relevant condition subgroup.

Exhibit 14. Use of Inpatient and Emergency Hospital Services,* by Chronic Condition Subgroup, 2011

	Medicare Patients Attributed to Your Medical Group Practice				Medicare Patients Attributed to All [#] GPRO I Medical Group Practices			
		Hospital Admissions				Hospital Admissions		
Chronic Condition Subgroup	Number of Patients with This Condition	Hospital Admissions per 1,000 Patients with This Condition	Percentage of Hospital Admissions via the ED	Hospital ED Visits** per 1,000 Patients with This Condition	Mean Number of Patients with This Condition	Mean Number of Hospital Admissions per 1,000 Patients with This Condition	Mean Percentage of Hospital Admissions via the ED	Mean Number of Hospital ED Visits** per 1,000 Patients with This Condition
Diabetes			%				%	
Coronary Artery Disease								
Chronic Obstructive Pulmonary Disease								
Heart Failure								

* Hospital utilization statistics are based on any reported use of inpatient or emergency services, whether or not it was related to the condition of interest.

** Includes only ED visits that did not result in a hospital admission.

Total Per Capita Costs for Patients with Diabetes

Based on all Medicare Part A and Part B claims submitted in 2011 for [#] patients in the diabetes subgroup attributed to your medical group practice,[2] per capita costs for Medicare patients with this condition were [$].

Exhibit 15.Diabetes shows how the per capita costs of your Medicare patients with diabetes, before and after risk adjustment,[3] compared to the mean per capita costs of diabetes patients for all medical group practices participating in the 2011 GPRO I Physician Quality Reporting System.

Costs displayed include all costs for each beneficiary diagnosed with diabetes, not just costs related to treatment of diabetes itself.

Exhibit 15.Diabetes. Per Capita Costs* of Medicare Patients with Diabetes, 2011

Per Capita Costs for Your Medical Group Practice (Payment Standardized)		Mean Per Capita Costs Among All [#] GPRO I Medical Group Practices That Treat Patients with This Condition
Before Risk Adjustment	After Risk Adjustment	Payment Standardized and Risk Adjusted
$	$	$

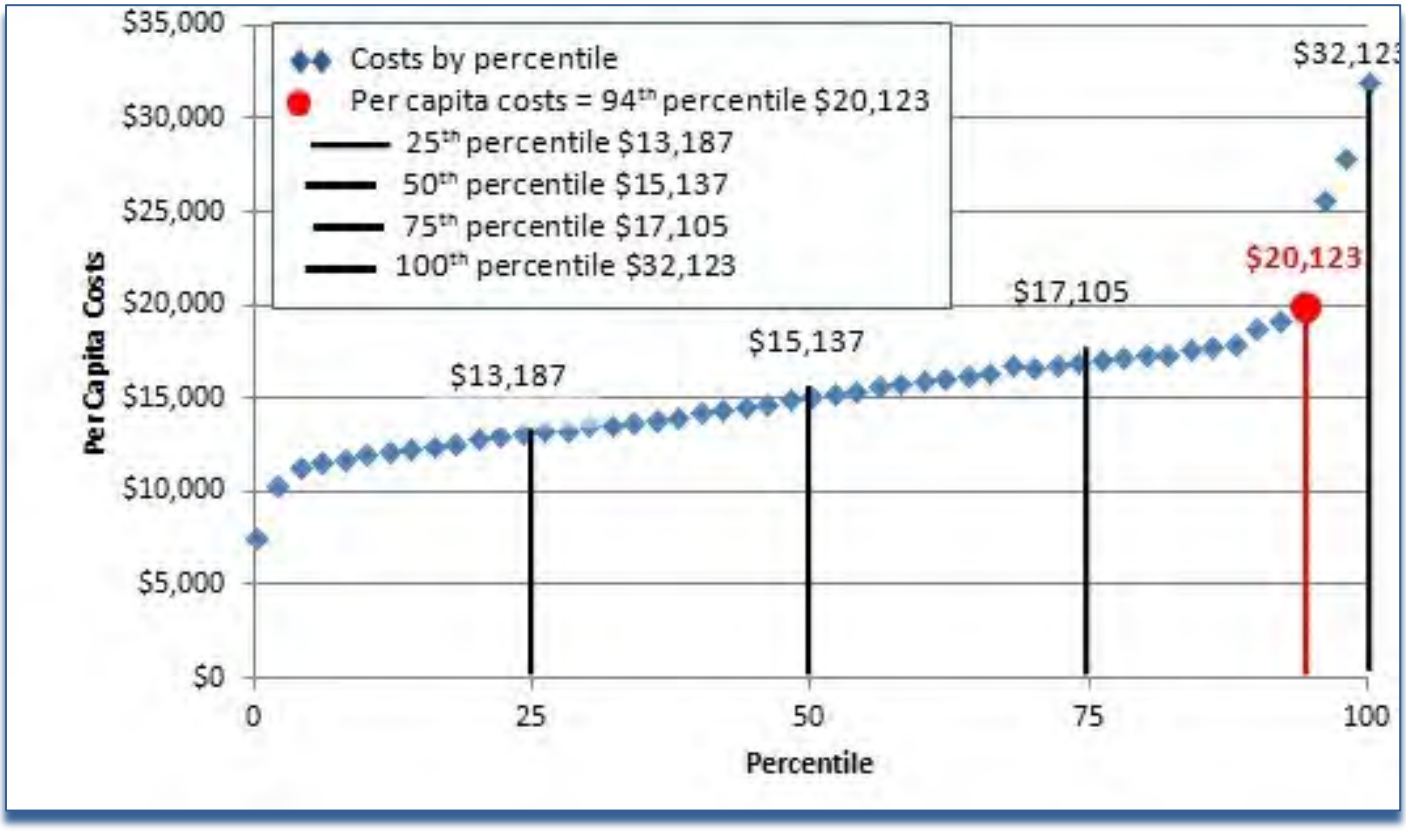
* Per capita costs are based on payments for Medicare Part A and Part B claims (excluding hospice) submitted in 2011 by all providers (including professionals, hospitals, and post-acute care facilities) for Medicare beneficiaries with diabetes attributed to a medical group practice. Outpatient prescription drug (Part D) costs are not included.

[2] Because some patients with missing data were dropped from the analysis during risk adjustment, the number of patients reported here may be smaller than indicated elsewhere in the report.

[3] For medical group practices that have a higher than average proportion of diabetes patients with costly co-morbidities or other risk factors, unadjusted costs will be higher than adjusted costs. For medical group practices with a lower than average proportion of diabetes patients with such co-morbidities or other risk factors, unadjusted costs will be lower than adjusted costs. See the Glossary of Terms for a description of risk adjustment methods used for this report.

Among all medical group practices participating in the 2011 GPRO I Physician Quality Reporting System that treat patients with diabetes, per capita costs for patients with diabetes ranged from a low of [$] to a high of [$]. Your group's per capita costs for patients with this condition were at the [#st/nd/rd/th] percentile among GPRO I medical group practices (Exhibit 16.Diabetes).

Exhibit 16.Diabetes. Per Capita Costs* for Medicare Patients with Diabetes
Among All 54 GPRO I Medical Group Practices That Treat Patients with This Condition,
by Percentile, 2011



* Per capita costs are based on payments for Medicare Part A and Part B claims (excluding hospice) submitted by all providers in 2011 for Medicare beneficiaries within this diagnostic subgroup attributed to each medical group practice, whether or not costs were related to treatment for that condition. All costs are payment standardized and risk adjusted. Outpatient prescription drug (Part D) costs are not included.

Total Per Capita Costs for Patients with Coronary Artery Disease

Based on all Medicare Part A and Part B claims submitted in 2011 for [#] patients in the coronary artery disease subgroup attributed to your medical group practice,[4] per capita costs for Medicare patients with this condition were [$].

Exhibit 15.CAD shows how the per capita costs of your Medicare patients with coronary artery disease, before and after risk adjustment,[5] compared to the mean per capita costs of coronary artery disease patients for all medical group practices participating in the 2011 GPRO I Physician Quality Reporting System.

Costs displayed include all costs for each beneficiary diagnosed with coronary artery disease, not just costs related to treatment of coronary artery disease itself.

Exhibit 15.CAD. Per Capita Costs* of Medicare Patients with Coronary Artery Disease, 2011

Per Capita Costs for Your Medical Group Practice (Payment Standardized)		Mean Per Capita Costs Among All [#] GPRO I Medical Group Practices That Treat Patients with This Condition
Before Risk Adjustment	After Risk Adjustment	Payment Standardized and Risk Adjusted
$	$	$

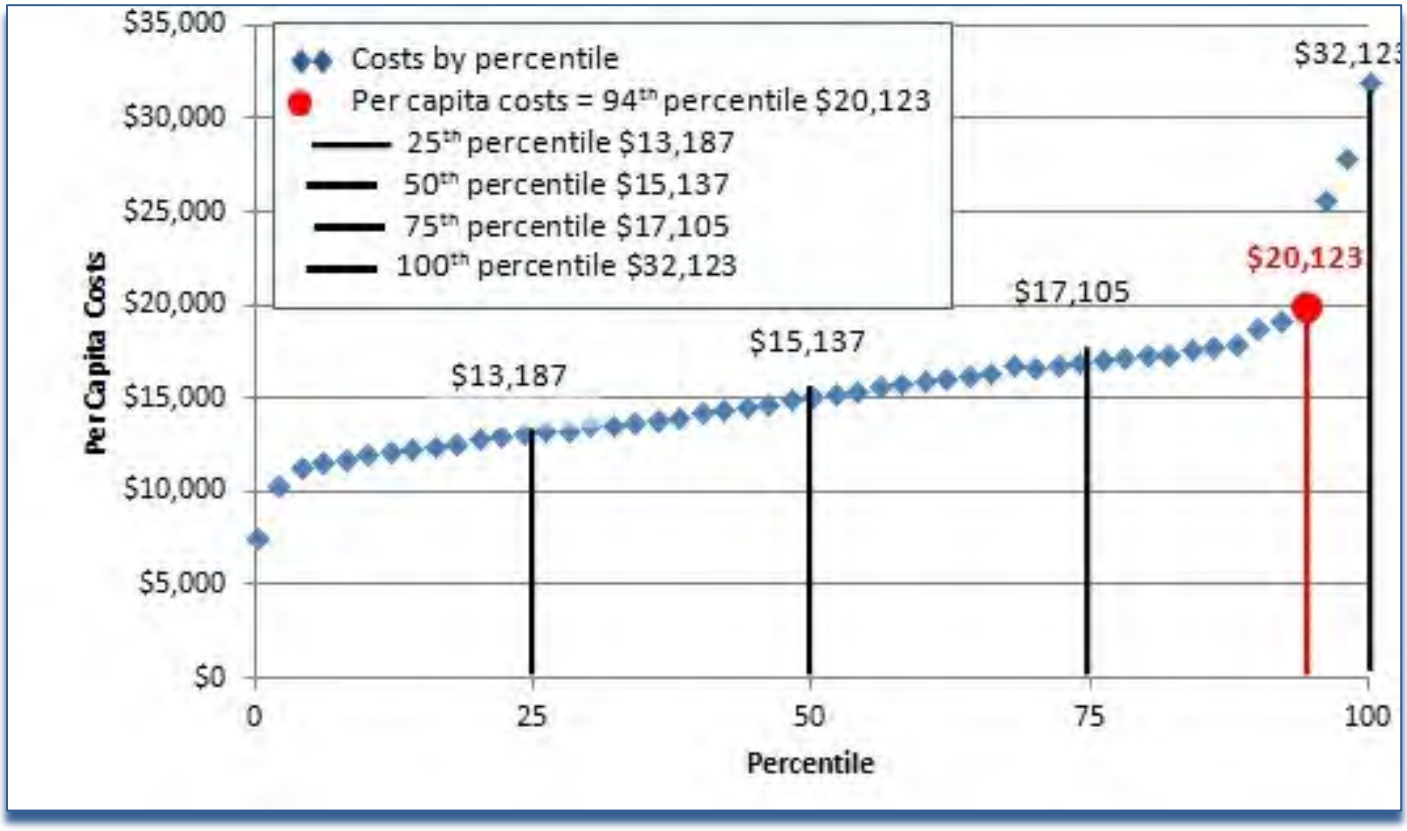
* Per capita costs are based on payments for Medicare Part A and Part B claims (excluding hospice) submitted in 2011 by all providers (including professionals, hospitals, and post-acute care facilities) for Medicare beneficiaries with coronary artery disease attributed to a medical group practice. Outpatient prescription drug (Part D) costs are not included.

[4] Because some patients with missing data were dropped from the analysis during risk adjustment, the number of patients reported here may be smaller than indicated elsewhere in the report.

[5] For medical group practices that have a higher than average proportion of coronary artery disease patients with costly co-morbidities or other risk factors, unadjusted costs will be higher than adjusted costs. For medical group practices with a lower than average proportion of coronary artery disease patients with such co-morbidities or other risk factors, unadjusted costs will be lower than adjusted costs. See the Glossary of Terms for a description of risk adjustment methods used for this report.

Among all medical group practices participating in the 2011 GPRO I Physician Quality Reporting System that treat patients with coronary artery disease, per capita costs for patients with coronary artery disease ranged from a low of [$] to a high of [$]. Your group's per capita costs for patients with this condition were at the [#st/nd/rd/th] percentile among GPRO I medical group practices (Exhibit 16.CAD).

Exhibit 16.CAD. Per Capita Costs* for Medicare Patients with Coronary Artery Disease Among All 54 GPRO I Medical Group Practices That Treat Patients with This Condition, by Percentile, 2011



* Per capita costs are based on payments for Medicare Part A and Part B claims (excluding hospice) submitted by all providers in 2011 for Medicare beneficiaries within this diagnostic subgroup attributed to each medical group practice, whether or not costs were related to treatment for that condition. All costs are payment standardized and risk adjusted. Outpatient prescription drug (Part D) costs are not included.

Total Per Capita Costs for Patients with Chronic Obstructive Pulmonary Disease

Based on all Medicare Part A and Part B claims submitted in 2011 for [#] patients in the chronic obstructive pulmonary disease (COPD) subgroup attributed to your medical group practice, [6] per capita costs for Medicare patients with this condition were [$].

Exhibit 15.COPD shows how the per capita costs of your Medicare patients with COPD, before and after risk adjustment,[7] compared to the mean per capita costs of COPD patients for all medical group practices participating in the 2011 GPRO I Physician Quality Reporting System.

Costs displayed include all costs for each beneficiary diagnosed with COPD, not just costs related to treatment of COPD itself.

Exhibit 15.COPD. Per Capita Costs* of Medicare Patients with COPD, 2011

Per Capita Costs for Your Medical Group Practice (Payment Standardized)		Mean Per Capita Costs Among All [#] GPRO I Medical Group Practices That Treat Patients with This Condition
Before Risk Adjustment	After Risk Adjustment	Payment Standardized and Risk Adjusted
$	$	$

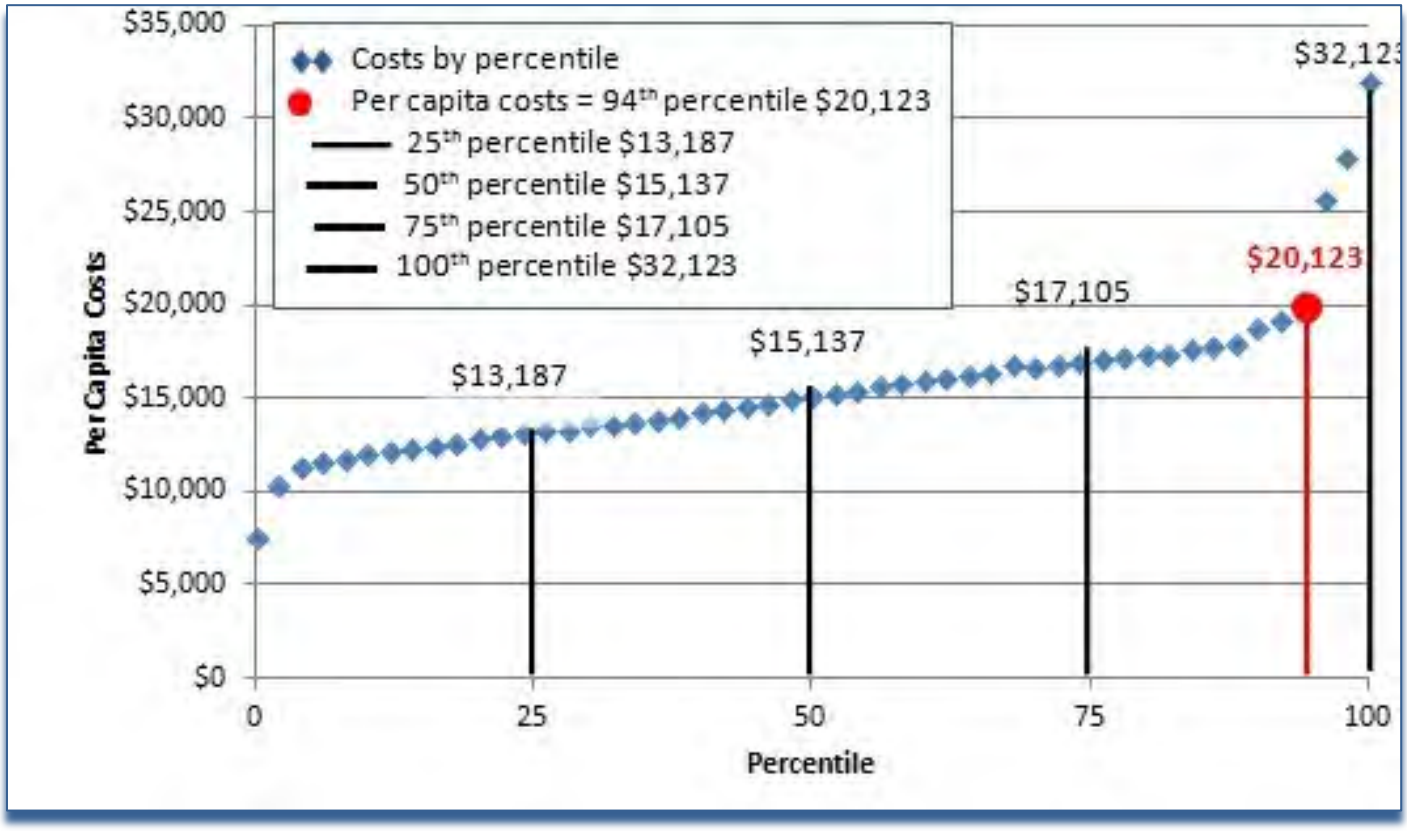
* Per capita costs are based on payments for Medicare Part A and Part B claims (excluding hospice) submitted in 2011 by all providers (including professionals, hospitals, and post-acute care facilities) for Medicare beneficiaries with COPD attributed to a medical group practice. Outpatient prescription drug (Part D) costs are not included.

[6] Because some patients with missing data were dropped from the analysis during risk adjustment, the number of patients reported here may be smaller than indicated elsewhere in the report.

[7] For medical group practices that have a higher than average proportion of COPD patients with costly co-morbidities or other risk factors, unadjusted costs will be higher than adjusted costs. For medical group practices with a lower than average proportion of COPD patients with such co-morbidities or other risk factors, unadjusted costs will be lower than adjusted costs. See the Glossary of Terms for a description of risk adjustment methods used for this report.

Among all medical group practices participating in the 2011 GPRO I Physician Quality Reporting System that treat patients with COPD, per capita costs for patients with COPD ranged from a low of [$] to a high of [$]. Your group's per capita costs for patients with this condition were at the [#st/nd/rd/th] percentile among GPRO I medical group practices (Exhibit 16.COPD).

Exhibit 16.COPD. Per Capita Costs* for Medicare Patients with COPD
Among All 54 GPRO I Medical Group Practices That Treat Patients with This Condition,
by Percentile, 2011



* Per capita costs are based on payments for Medicare Part A and Part B claims (excluding hospice) submitted by all providers in 2011 for Medicare beneficiaries within this diagnostic subgroup attributed to each medical group practice, whether or not costs were related to treatment for that condition. All costs are payment standardized and risk adjusted. Outpatient prescription drug (Part D) costs are not included.

Total Per Capita Costs for Patients with Heart Failure

Based on all Medicare Part A and Part B claims submitted in 2011 for [#] patients in the heart failure subgroup attributed to your medical group practice, [8] per capita costs for Medicare patients with this condition were [$].

Exhibit 15.HF shows how the per capita costs of your Medicare patients with heart failure, before and after risk adjustment,[9] compared to the mean per capita costs of heart failure patients for all medical group practices participating in the 2011 GPRO I Physician Quality Reporting System.

Costs displayed include all costs for each beneficiary diagnosed with heart failure, not just costs related to treatment of heart failure itself.

Exhibit 15.HF. Per Capita Costs* of Medicare Patients with Heart Failure, 2011

Per Capita Costs for Your Medical Group Practice (Payment Standardized)		Mean Per Capita Costs Among All [#] GPRO I Medical Group Practices That Treat Patients with This Condition
Before Risk Adjustment	After Risk Adjustment	Payment Standardized and Risk Adjusted
$	$	$

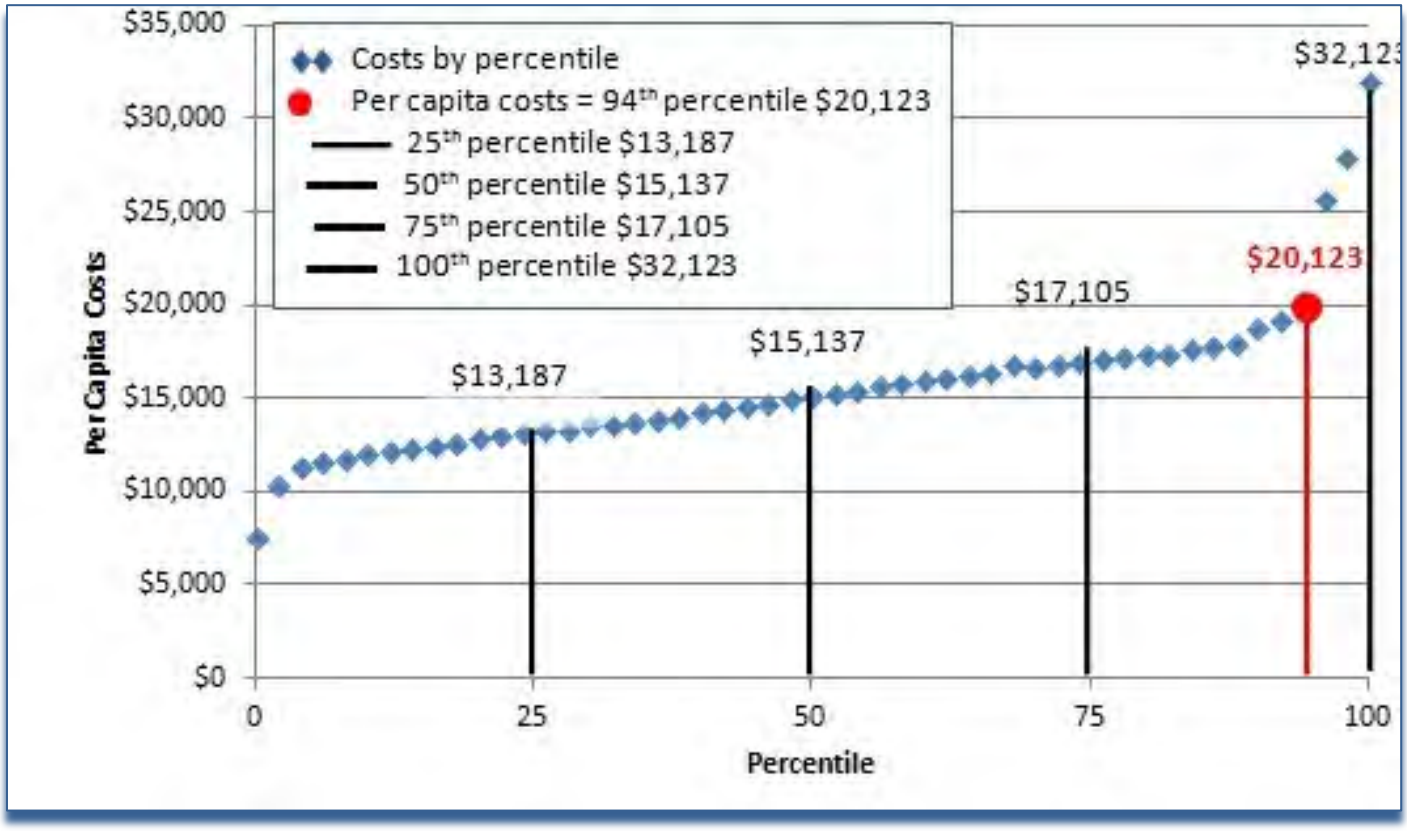
* Per capita costs are based on payments for Medicare Part A and Part B claims (except hospice) submitted in 2011 by all providers (including professionals, hospitals, and post-acute care facilities) for Medicare beneficiaries with heart failure attributed to a medical group practice. Outpatient prescription drug (Part D) costs are not included.

[8] Because some patients with missing data were dropped from the analysis during risk adjustment, the number of patients reported here may be smaller than indicated elsewhere in the report.

[9] For medical group practices that have a higher than average proportion of heart failure patients with costly co-morbidities or other risk factors, unadjusted costs will be higher than adjusted costs. For medical group practices with a lower than average proportion of heart failure patients with such co-morbidities or other risk factors, unadjusted costs will be lower than adjusted costs. See the Glossary of Terms for a description of risk adjustment methods used for this report.

Among all medical group practices participating in the 2011 GPRO I Physician Quality Reporting System that treat patients with heart failure, per capita costs for patients with heart failure ranged from a low of [$] to a high of [$]. Your group's per capita costs for patients with this condition were at the [#st/nd/rd/th] percentile among GPRO I medical group practices (Exhibit 16.HF).

Exhibit 16.HF. Per Capita Costs* for Medicare Patients with Heart Failure
Among All 54 GPRO I Medical Group Practices That Treat Patients with This Condition,
by Percentile, 2011



* Per capita costs are based on payments for Medicare Part A and Part B claims (excluding hospice) submitted by all providers in 2011 for Medicare beneficiaries within this diagnostic subgroup attributed to each medical group practice, whether or not costs were related to treatment for that condition. All costs are payment standardized and risk adjusted. Outpatient prescription drug (Part D) costs are not included.

GLOSSARY OF TERMS

(2011 GPRO I Physician Quality Reporting System Medical Group Practices)

ALL OTHER SERVICES. Exhibit 12 displays six categories of Medicare-covered services: evaluation and management in non-emergency settings, procedures in non-emergency settings, hospital (excluding emergency outpatient), emergency services that did not result in a hospital admission, services in non-emergency ambulatory settings, and post-acute care services. With the exception of prescription drug costs covered under Medicare Part D, Medicare-covered services not included in those six categories are captured as "All Other Services." Anesthesia, ambulance services, chemotherapy, other Part B drugs, orthotics, chiropractic, enteral and parenteral nutrition, some vision services, some hearing and speech services, and influenza immunization are grouped as "All Other Services."

AMBULATORY CARE SENSITIVE CONDITIONS (ACSCs). ACSCs are conditions for which good outpatient care can prevent complications or more serious disease. These conditions include diabetes, chronic obstructive pulmonary disease (COPD) or asthma, heart failure, bacterial pneumonia, urinary tract infection, and dehydration.

The Agency for Healthcare Research and Quality (AHRQ) developed measures of potentially avoidable hospitalizations for ACSCs as part of a larger set of Prevention Quality Indicators (PQIs). The measures rely on hospital discharge data but are not intended to measure hospital quality. Rather, high or increasing rates of hospitalization for these conditions in a defined population of patients may indicate inadequate access to high-quality ambulatory care.

This Quality and Resource Use Report (QRUR) presents ACSC admission rates per thousand Medicare beneficiaries attributed to GPRO I Physician Quality Reporting System medical group practices, for diabetes (a composite measure), chronic obstructive pulmonary disease or asthma, heart failure, and acute conditions (a composite measure). The admission rates are calculated from 2011 Medicare Part A claims data, based on the individual indicators shown in Table G-1.

Table G-1. AHRQ Prevention Quality Indicators Used to Calculate ACSC Rates

Chronic Conditions	
	Diabetes Composite
PQI #01	Diabetes Short-Term Complications Admission Rate
PQI #03	Diabetes Long-Term Complications Admission Rate
PQI #14	Uncontrolled Diabetes Admission Rate
PQI #16	Rate of Lower-Extremity Amputation Among Patients With Diabetes
PQI #05	COPD or Asthma in Older Adults Admission Rate
PQI #08	Congestive Heart Failure Admission Rate
Acute Conditions	
	Acute Conditions Composite
PQI #10	Dehydration Admission Rate
PQI #11	Bacterial Pneumonia Admission Rate
PQI #12	Urinary Tract Infection Admission Rate

Source: Mathematica Policy Research; Battelle, prepared for Agency for Healthcare Research and Quality, August 2011.

In calculating ACSC rates, the numerator is the number of beneficiaries attributed to the medical group who were identified as having been hospitalized for each of the individual PQI conditions in 2011. Only those admissions where the measure of interest is listed as the primary diagnosis are counted. The denominator for the chronic conditions (diabetes, COPD/asthma, heart failure) is restricted to patients diagnosed with the specific condition. For the acute conditions (pneumonia, urinary tract infection, dehydration), the denominator includes all Medicare patients attributed to a medical group practice. The quotient (numerator divided by denominator) is then multiplied by 1,000, to yield rates per thousand attributed beneficiaries. The total rate is sum of the numerators for the four component ACSCs—the diabetes composite, COPD/asthma, heart failure, and the acute conditions composite—divided by the sum of denominators, also multiplied by 1,000. A medical group practice's ACSC admission rates are compared to the mean rates among all medical group practices

participating in the 2011 GPRO I Physician Quality Reporting System. ACSC hospital admission rates are not currently risk adjusted. However, CMS plans to develop risk adjustment methodology for these measures in the future. The ACSC/PQI measure specifications, including numerator diagnoses, are available on AHRQ's website, at http://www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx.

ATTRIBUTION OF BENEFICIARIES TO MEDICAL GROUP PRACTICES. Medicare beneficiaries were attributed to the single medical group practice (Tax Identification Number, or TIN) that billed for at least two office or other outpatient Evaluation and Management (E&M) services (listed in Table G-2 below) and a larger number of E&M services for the beneficiary (measured by Medicare allowed charges) than any other medical group practice,[10] based on 2011 Carrier (Part B) Medicare claims (that is, the plurality of E&M services).

Beneficiaries who were not enrolled in both Medicare Parts A and B for the entire 2011 calendar year were not attributed to any medical group practice. Thus, beneficiaries were excluded if, for any month in 2011, any of the following situations applied to them: they were enrolled in Part A only or Part B only; they were enrolled in Medicare managed care; they were working aged; they resided outside the United States; they were enrolled in Hospice; they were included in any Medicare fee-for-service demonstration; they became newly eligible for Medicare benefits on or after January 1, 2011; they died in 2011 (as indicated in Medicare's enrollment file); or the beneficiary did not have any Medicare allowed charges in the six claim types used to calculate resource use measures in this report.

The same population of beneficiaries attributed to a GPRO I medical group practice is used for calculating the denominators of the cost, utilization, and quality measures included in this report. However, while all of a medical group practice's attributed beneficiaries are used to calculate the cost and utilization measures, only a sample of the group's attributed beneficiaries is used to calculate the GPRO I quality measures. Each GPRO I group practice is required to report clinical data for at least the first 411 beneficiaries from a list that CMS compiles of all attributed beneficiaries that CMS has determined meet criteria for each specific measure; a group may elect to report on more than the first 411 beneficiaries on the CMS list, however. If the group practice has fewer than 411 attributed beneficiaries eligible for the measure, clinical indicators must be submitted for 100 percent of attributed measure-eligible beneficiaries.

[10] In case of an E&M services tie between medical group practices, total Part B allowed charges were used as the tie-breaker.

Table G-2: Medicare Part B Evaluation & Management Service Codes Included in Beneficiary Attribution Criteria

Included	Codes	Labels*
Office or Other Outpatient Services	99201	New Patient, brief
	99202	New Patient, limited
	99203	New Patient, moderate
	99204	New Patient, comprehensive
	99205	New Patient, extensive
	99211	Established Patient, brief
	99212	Established Patient, limited
	99213	Established Patient, moderate
	99214	Established Patient, comprehensive
	99215	Established Patient, extensive
Excluded		
Hospital Inpatient Services		
Nursing Facility Services		
Care Plan Oversight Services		
Home Care Services		
Domiciliary, Rest Home, or Custodial Care Services		
Consultations		
Emergency Department Services		
Patient Transport		
Critical Care Services		
Neonatal Intensive Services		
Newborn Care		
Special Evaluation and Management Services		
Other Evaluation and Management Services		
Preventive Medicine Services		
Case Management Services		
Prolonged Services		
Hospital Observation Services		

SOURCE: RTI International.

* Labels are approximate. See AMA, Current Procedural Terminology for detailed definitions.

CHRONIC HEALTH CONDITIONS. Chronic health conditions are diseases or illnesses that are commonly expected to last at least six months, require ongoing monitoring to avoid loss of normal life functioning, and are not expected to improve or resolve without treatment. For this report, subgroup-specific per capita cost measures were calculated for four specific chronic health conditions common to the Medicare population:

1. Diabetes
2. Coronary Artery Disease
3. Chronic Obstructive Pulmonary Disease
4. Heart Failure

Data from the CMS Chronic Condition Warehouse were used to identify patients with the four conditions of interest.

ELIGIBLE PROFESSIONALS. An eligible professional is any of the following: (1) a physician, (2) a practitioner, (3) a physical or occupational therapist or a qualified speech-language pathologist, or (4) a qualified audiologist.

GPRO I PHYSICIAN QUALITY REPORTING SYSTEM. In accordance with section 1848(m)(3)(C) of the Social Security Act, CMS created a new group practice reporting option (GPRO I) for the Physician Quality Reporting System (PQRS) in 2010. Group practices that satisfactorily report data on PQRS measures for a particular reporting period are eligible to earn a PQRS incentive payment equal to a specified percentage of the group practice's total estimated Medicare Part B physician fee schedule allowed charges for covered professional services furnished during the reporting period. For purposes of determining whether a group practice satisfactorily submits PQRS quality measures data for 2011, each group practice selected to participate in the 2011 Physician Quality Reporting System GPRO I is required to report 26 quality measures. A description of each of the 26 measures can be found in the "2011 Physician Quality Reporting System GPRO I Narrative Measure Specifications" and the updates made to the measures from 2010 can be found in the "2011 Physician Quality Reporting System GPRO I Narrative Specification Release Notes" document, both downloadable from the GPRO website (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/CMS-Selected-Group_Practice_Reporting_Option.html).

HOSPITAL READMISSIONS (ALL-CAUSE). The all-cause hospital readmissions measure is a medical group practice-specific all-cause 30-day rate of acute care hospital readmissions (defined as readmission for any cause within 30 days from the date of discharge of an index admission in 2011) per 1,000 hospitalizations where the attributed beneficiary was discharged alive from an acute care hospital with any diagnosis. Zero-day stays are included. The measure applies to attributed beneficiaries age 18 or older by January 1, 2011.

HOSPITAL UTILIZATION STATISTICS FOR CHRONIC CONDITION SUBGROUPS. To provide more detail on the subgroup-specific per capita costs for the selected four chronic conditions displayed in the reports, the following statistics are provided for each condition subgroup:

1. The number of beneficiaries attributed to the medical group practice who had the chronic condition in 2011
2. The number of inpatient hospital admissions per 1,000 attributed beneficiaries with the chronic condition in 2011 (whether or not the hospital admissions were specifically related to that chronic condition)
3. The percentage of all hospital inpatient admissions that were via the hospital emergency department (ED)
4. The number of hospital ED visits (that did not lead to an inpatient admission) per 1,000 attributed beneficiaries with the chronic condition in 2011 (whether or not the ED visits were specifically related to that chronic condition)

A medical group practice's count of beneficiaries and their utilization statistics are presented in the report relative to the average (mean) performance of all GPRO I Physician Quality Reporting System medical group practices.

KEY DIFFERENCES. Key differences between the Quality and Resource Use Reports and the value-based payment modifier are the following:

- Quality Measures. The quality composite component of the value-based payment modifier will use the data that a group reports via PQRS during 2013. Groups of physicians with 100 or more eligible professionals will be able to report data through multiple options available through PQRS. A description of the options and associated deadlines are available at www.cms.gov/physicianfeedbackprogram. Exhibit 5 of this report shows your group's performance

on the quality measures submitted through the GPRO web interface. Exhibits 6 and 7 of this report provide your group's performance rates on the outcome measures (Hospital Admission Rates for Ambulatory Care Sensitive Conditions and All-Cause Hospital Readmissions) that CMS will use for all groups, regardless of which PQRS method the group selects.

- Attribution for Quality of Care and Cost Measures. In this report, attribution of beneficiaries to medical groups for all quality of care and cost measures was based on a plurality-of-care rule, provided that the group provided at least two E&M visits for the beneficiary (see Attribution of Beneficiaries to Medical Group Practices). For the value-based payment modifier, CMS will instead use a two-step attribution rule that attributes beneficiaries to groups of physicians that provide the plurality of primary care services.

MEASURE POPULATIONS. Per capita cost measures, utilization statistics, and ambulatory care sensitive condition (ACSC) rates in this report are calculated based on all Medicare fee-for-service (FFS) beneficiaries attributed to the medical group practice (see "Attribution of Beneficiaries to Medical Group Practices" above). In contrast, the GPRO I quality measures are calculated based on a sample of Medicare FFS beneficiaries attributed to the medical group practice. Each GPRO I medical group practice is required to report clinical data for the first 411 beneficiaries (but may report on more than 411 beneficiaries) on their list of assigned beneficiaries that CMS has determined meet criteria for specific measures. If the group practice is assigned fewer than 411 beneficiaries, clinical indicators must be submitted for 100 percent of the beneficiaries who are assigned.

MEDICAL GROUP PRACTICE. Medical group practice refers to a single provider entity, identified by its Tax Identification Number (TIN), which met the criteria for participation in the 2011 GPRO I Physician Quality Reporting System. These include the following:

- The physician group practice had to have at least 200 individual physicians or other medical professionals (identified by individual National Provider Identifiers, or NPIs) who had reassigned their billing rights to the TIN.
- The group practice had to submit a self-nomination letter to CMS to participate in the 2011 GPRO I Physician Quality Reporting System.
- CMS had to determine that the self-nominating group practice met the program definition of a group practice and complied with other program requirements.

MEDICAL PROFESSIONALS. Medical professionals include Medicare physicians and other medical practitioners (including physician assistants and nurse practitioners) who are eligible for payment from Medicare for Medicare-covered services. The medical professionals identified as being affiliated with a medical group practice are those who billed under the medical group practice's Tax Identification Number (TIN) in 2011. A professional's medical specialty was determined based on the CMS medical specialty code listed most often on those 2011 Part B claims for which the professional was the performing provider.

MEDICARE CLAIMS DATA USED IN THE QUALITY AND RESOURCE USE REPORT (QRUR). This QRUR uses 2011 Medicare claims data to provide feedback to medical group practices about selected resource use measures related to the care provided to Medicare beneficiaries attributed to their group. The resource use measures consist of 2011 per capita cost measures for all attributed beneficiaries and for particular subgroups of attributed beneficiaries who have one of four chronic conditions. The QRURs also report rates of hospital admission for ambulatory care sensitive conditions, all-cause hospital readmissions, and hospital utilization among subgroups of patients who have chronic conditions. Calculations for the 2011 per capita cost and the hospital-related measures include all beneficiaries who were enrolled in both Parts A and B of original fee-for-service (FFS) Medicare for all of the calendar year.

PAYMENT STANDARDIZATION. Payment standardization equalizes the costs associated with a specific service, such that a given service is priced at the same level across all providers of the same type, regardless of geographic location, differences in Medicare payment rates among facilities, or the year in which the service was provided. These may include discrete services (such as physician office visits or consultations) or bundled services (such as hospital stays).

For most types of medical services, Medicare adjusts payments to providers to reflect differences in local input prices (for example, wage rates and real estate costs). The costs reported in the QRUR are therefore payment standardized to allow for comparisons to peers who may practice in locations or facilities where reimbursement rates are higher or lower. Payment standardization is performed prior to calculating per capita payment-adjusted and risk-adjusted cost measures.

PEER GROUPS. To provide a comparative context for the information in this report, a medical group practice's performance on cost, utilization, and quality measures is compared to that of its peers. For the measures displayed in this report, the peer group is defined as medical group practices participating in the 2011 GPRO I Physician Quality Reporting System. A list with the name and state of group practices who satisfactorily reported Physician Quality Reporting System measures for the 2011 program year is available at http://www.medicare.gov/find-a-doctor/(S(qsuddyukjjazx5243zyxyv55))/staticpages/data/pqrs/physician-quality-reporting-system.aspx. Each exhibit in the report includes the number of medical practice groups that comprise the peer group for that data. All peer group totals include data for the specific medical group practice profiled in the QRUR.

PER CAPITA COSTS. Per capita costs are the average (mean) of all 2011 Medicare fee-for-service (FFS) Parts A and B payments (excluding hospice) to all providers for beneficiaries attributed to a medical group practice. A medical group's per capita cost measures are presented in the report compared to the mean (average) performance of all medical group practices participating in the 2011 GPRO I Physician Quality Reporting System.

Per capita cost measures in this report were calculated using 2011 Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) claims (except hospice claims) for all FFS Medicare beneficiaries attributed to the medical group practice. Medicare costs were obtained from 2011 administrative claims data using inpatient hospital, outpatient hospital, skilled nursing facility, home health, durable medical equipment, and Medicare Carrier (non-institutional provider) claims. Outpatient prescription drug (Part D) claims were not included in the 2011 cost measure calculations. Costs are primarily comprised of payments to providers from Medicare. To the extent that Medicare claims contain information on beneficiary copayments and deductibles and third-party private payers, those amounts are also included in costs.

Payment-standardized but non-risk-adjusted per capita costs were calculated by first summing the payment-standardized Medicare Parts A and B costs during the 2011 calendar year for all Medicare beneficiaries who were attributed to the medical group (the numerator) and then dividing by the number of beneficiaries attributed to the medical group (the denominator). Part-year beneficiaries (for example, those who became eligible for Medicare during the year, were enrolled in a Medicare Advantage program for part of the year, or who died in the year) and the costs associated with their care were excluded.

Payment-standardized and risk-adjusted per capita costs were measured by dividing the medical group practice's actual payment-standardized but non-risk-adjusted per capita costs by the group's expected payment-standardized costs for all attributed beneficiaries. Expected costs were computed by multiplying the coefficients of the risk-adjustment model (see "Risk Adjustment" below) by the characteristics of the medical group practice's attributed beneficiaries. This ratio was then multiplied by the mean per capita cost of all beneficiaries attributed to any medical group practice in the sample.

To provide more detail on the per capita cost measures displayed in the reports, additional type-of-service breakdowns are provided for the following categories:

- All professional evaluation and management (E&M) services provided by primary care physicians, medical specialists, surgeons, and other professionals in non-emergency settings; Appendix A shows how medical professionals were grouped into one of these four categories.
- All procedures performed in non-emergency settings by primary care physicians, medical specialists, surgeons, and other professionals
- Hospital facility services, including inpatient and outpatient services but excluding emergency department services that did not result in an inpatient hospital admission
- Emergency department services for beneficiaries not admitted to a hospital, including visits, procedures, laboratory and other tests, and imaging services
- Services provided in non-emergency ambulatory settings, including laboratory and other tests, imaging services, and durable medical equipment
- Post-acute services including skilled nursing care; psychiatric, rehabilitation, or other long-term facility care; and home health care
- All other Medicare-covered services not captured in other categories (such as anesthesia, ambulance services, chemotherapy, other Part B drugs, orthotics, chiropractic, enteral and parenteral nutrition, vision services, hearing and speech services, and influenza immunization).

Subgroup-specific per capita costs are the average of 2011 Medicare FFS Parts A and B payments per attributed beneficiary with one of four specific chronic health conditions:

1. Diabetes
2. Coronary Artery Disease
3. Chronic Obstructive Pulmonary Disease
4. Heart Failure

The per capita costs for each subgroup were computed in the same manner as the per capita costs for all attributed beneficiaries (described above), with the exception that expected costs for beneficiaries in each subgroup were computed based on a risk adjustment model that included only beneficiaries with the condition. These subgroup per capita costs include all costs and are not limited to costs associated with treating the condition itself.

The four chronic health conditions are not mutually exclusive. Beneficiaries with two or more conditions are counted (as are their per capita costs) within each of the condition subgroups. However, for each chronic condition subgroup, the separate condition-specific risk adjustment model estimated for that subgroup captures other chronic and acute co-morbidities associated with beneficiaries in the particular subgroup.

PHYSICIAN VISIT WITHIN 30 DAYS OF DISCHARGE (30-DAY POST-DISCHARGE PROVIDER VISIT). This measure shows the number of hospital discharges for beneficiaries attributed to the medical group practice who were discharged alive from an acute care hospital in 2011 and who saw a physician (either associated with or not associated with the group practice) within 30 days of discharge or who saw a physician prior to a hospital readmission if the readmission occurred within 30 days of the initial discharge, per 1,000 attributed beneficiaries' acute care hospitalizations in 2011. The measure applies to beneficiaries age 18 or older by January 1, 2011. The measure excludes hospitalizations for which the beneficiary was discharged to a

Medicare-certified or approved skilled nursing facility, hospice care, or a critical access, long-term care, inpatient rehabilitation, or psychiatric hospital.

RISK ADJUSTMENT. Risk adjustment accounts for differences in patient characteristics that can affect their medical costs or utilization, regardless of the care provided. For peer comparisons, a medical group practice's per capita costs are risk adjusted based on the unique mix of patients attributed to the group. For medical group practices that have a higher than average proportion of patients with serious medical conditions or other higher-cost risk factors, risk-adjusted per capita costs will be lower than unadjusted costs (because costs associated with higher-risk patients are adjusted downward). For medical group practices that treat comparatively lower-risk patients, risk-adjusted per capita costs will be higher than unadjusted costs (because costs for lower-risk patients are adjusted upwards).

For these reports, risk adjustment was based on the hierarchical condition categories (HCC) model developed for CMS that assigns ICD-9 diagnosis codes (each with similar disease characteristics and costs) to 70 clinical conditions. For each Medicare beneficiary attributed to a medical group practice in 2011, the HCC model generates a 2011 score based on the presence of these conditions in 2010—and on sex, age, original reason for Medicare entitlement (either age or disability), and Medicaid entitlement—as a predictor of beneficiary costs in 2011. Risk adjustment of 2011 costs also takes into account the presence of end-stage renal disease (ESRD) in 2010.

A statistical risk-adjustment model estimates the independent effects of these factors on absolute beneficiary costs and adjusts 2011 annual beneficiary costs for each beneficiary prior to calculating per capita risk-adjusted cost measures for a medical group practice. To ensure that extreme outlier costs do not have a disproportionate effect on the cost distributions, costs below the 1st percentile are eliminated from the cost calculations, and costs above the 99th percentile are rounded down to the 99th percentile.

VALUE-BASED PAYMENT MODIFIER. The value-based payment modifier is an adjustment to payments under the Medicare physician fee schedule that will reward higher quality care delivered at lower cost, as required under Section 3007 of the Affordable Care Act. The value-based payment modifier will begin in 2015 and will be based on performance during 2013. CMS will apply the value-based payment modifier only to physicians practicing in a medical practice group with 100 or more eligible professionals billing under a single Taxpayer Identification Number (TIN). CMS proposes to separate these groups into two categories, based on their satisfactory participation in the Physician Quality Reporting System (PQRS). Physicians may participate by submitting patient quality measure data under available PQRS reporting options or by requesting that CMS compute the group's performance on a defined set of administrative claims-based quality indicators. Those groups that have not met satisfactory reporting criteria or do not choose to participate would have a value-based payment modifier set at -1.0 percent for 2015. Groups that have satisfactorily participated would have their value-based modifier payment set at 0.0 percent, meaning that they would incur no negative payment adjustment under the physician fee schedule. CMS will offer all groups of physicians that satisfactorily report under the PQRS the ability to have their value-based payment modifier based on their performance using a quality-tiering approach that evaluates performance on the PQRS quality measures submitted and on five cost measures. The five cost measures include a total per capita cost measure for all attributed patients and four measures of total per capita costs incurred by patients identified as having one or more of four specific chronic health conditions (diabetes, coronary artery disease, chronic obstructive pulmonary disease, and heart failure).

Appendix A
CMS Specialty Codes
For Determining Provider Stratification Category in Exhibits 2 and 12

CMS Specialty Code	CMS Specialty Description	Provider Stratification Category
01	General Practice	Primary Care Physicians
02	General Surgery	Surgeons
03	Allergy/Immunology	Medical Specialists
04	Otolaryngology	Surgeons
05	Anesthesiology	Other Physicians
06	Cardiology	Medical Specialists
07	Dermatology	Medical Specialists
08	Family Practice	Primary Care Physicians
09	Interventional Pain Management	Medical Specialists
10	Gastroenterology	Medical Specialists
11	Internal Medicine	Primary Care Physicians
12	Osteopathic Manipulative Therapy	Medical Specialists
13	Neurology	Medical Specialists
14	Neurosurgery	Surgeons
15	Speech Language Pathologists	Other Medical Professionals
16	Obstetrics/Gynecology	Surgeons
17	Hospice and Palliative Care	Medical Specialists
18	Ophthalmology	Surgeons
19	Oral Surgery (Dentists Only)	Surgeons
20	Orthopedic Surgery	Surgeons
21	Cardiac Electrophysiology	Medical Specialists
22	Pathology	Other Physicians
23	Sports Medicine	Other Physicians
24	Plastic and Reconstructive Surgery	Surgeons
25	Physical Medicine and Rehabilitation	Medical Specialists
26	Psychiatry	Medical Specialists
27	Geriatric Psychiatry	Medical Specialists
28	Colorectal Surgery (Formerly Proctology)	Surgeons
29	Pulmonary Disease	Medical Specialists
30	Diagnostic Radiology	Other Physicians
31	Intensive Cardiac Rehabilitation	Other Physicians
32	Anesthesiologist Assistant	Other Medical Professionals
33	Thoracic Surgery	Surgeons
34	Urology	Surgeons
35	Chiropractor, Licensed	Other Medical Professionals
36	Nuclear Medicine	Other Physicians
37	Pediatric Medicine	Other Physicians
38	Geriatric Medicine	Primary Care Physicians
39	Nephrology	Medical Specialists
40	Hand Surgery	Surgeons
41	Optometrist	Other Medical Professionals
42	Certified Nurse Midwife	Other Medical Professionals
43	Certified Registered Nurse Anesthesiologist	Other Medical Professionals
44	Infectious Disease	Medical Specialists

HCFA Specialty Code	HCFA Specialty Description	Provider Stratification Category
45	Mammography Screening Center	Not Applicable
46	Endocrinology	Medical Specialists
47	Independent Diagnostic Testing Facility	Not Applicable
48	Podiatry	Other Medical Professionals
49	Ambulatory Surgical Center	Not Applicable
50	Nurse Practitioner	Other Medical Professionals
51	Medical Supply Company with Certified Orthotist	Not Applicable
52	Medical Supply Company with Certified Prosthetist	Not Applicable
53	Medical Supply Company with Certified Prosthetist-Orthotist	Not Applicable
54	Medical Supply Company For DMERC	Not Applicable
55	Individual Certified Orthotist	Other Medical Professionals
56	Individual Certified Prosthetist	Other Medical Professionals
57	Individual Certified Prosthetist-Orthotist	Other Medical Professionals
58	Medical Supply Company with Registered Pharmacist	Not Applicable
59	Ambulance Service Supplier (e.g., Private Ambulance Companies, Funeral Homes)	Not Applicable
60	Public Health or Welfare Agencies (Federal, State, and Local)	Not Applicable
61	Voluntary Health or Charitable Agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)	Not Applicable
62	Clinical Psychologist (Billing Independently)	Other Medical Professionals
63	Portable X-Ray Supplier	Not Applicable
64	Audiologist (Billing Independently)	Other Medical Professionals
65	Physical Therapist (Independently Practicing)	Other Medical Professionals
66	Rheumatology	Medical Specialists
67	Occupational Therapist (Independently Practicing)	Other Medical Professionals
68	Clinical Psychologist	Other Medical Professionals
69	Clinical Laboratory (Billing Independently)	Not Applicable
70	Single or Multispecialty Clinic or Group Practice	Other Physicians
71	Registered Dietician/Nutrition Professional	Other Medical Professionals
72	Pain Management	Other Physicians
73	Mass Immunization Roster Biller	Not Applicable
74	Radiation Therapy Centers	Not Applicable
75	Slide Preparation Facilities	Not Applicable
76	Peripheral Vascular Disease	Surgeons
77	Vascular Surgery	Surgeons
78	Cardiac Surgery	Surgeons
79	Addiction Medicine	Medical Specialists
80	Licensed Clinical Social Worker	Other Medical Professionals
81	Critical Care (Intensivists)	Medical Specialists
82	Hematology	Medical Specialists
83	Hematology/Oncology	Medical Specialists
84	Preventive Medicine	Primary Care Physicians
85	Maxillofacial Surgery	Surgeons
86	Neuropsychiatry	Medical Specialists

HCFA Specialty Code	HCFA Specialty Description	Provider Stratification Category
87	All Other Suppliers (e.g., Drug Stores)	Not Applicable
88	Unknown Supplier/Provider	Not Applicable
89	Certified Clinical Nurse Specialist	Other Medical Professionals
90	Medical Oncology	Medical Specialists
91	Surgical Oncology	Surgeons
92	Radiation Oncology	Other Physicians
93	Emergency Medicine	Emergency Medicine Physicians*
94	Interventional Radiology	Other Physicians
95	Unassigned	Not Applicable
96	Optician	Other Medical Professionals
97	Physician Assistant	Other Medical Professionals
98	Gynecologist/Oncologist	Surgeons
99	Unknown Physician	Other Physicians
A0	Hospital	Not Applicable
A1	Skilled Nursing Facility	Not Applicable
A2	Intermediate Care Nursing Facility (DMERCs Only)	Not Applicable
A3	Nursing Facility, Other (DMERCs Only)	Not Applicable
A4	Home Health Agency (DMERCs Only)	Not Applicable
A5	Pharmacy (DMERCs Only)	Not Applicable
A6	Medical Supply Company with Respiratory Therapist (DMERCs Only)	Not Applicable
A7	Department Store (For DMERC Use)	Not Applicable
A8	Grocery Store (For DMERC Use)	Not Applicable
B2	Pedorthic Personnel	Not Applicable
B3	Medical Supply Company with Pedorthic Personnel	Not Applicable
B4	Rehabilitation Agency	Not Applicable
B5	Ocularist	Not Applicable

* Emergency medicine specialists are classified as Other Professionals in Exhibit 12.

MEDICARE FEE-FOR-SERVICE QUALITY AND RESOURCE USE AND PHYSICIAN QUALITY REPORTING SYSTEM FEEDBACK REPORT

For Medical Group Practices Participating in the 2011 Group Practice Reporting Option I (GPRO I)

This confidential Medicare Quality and Resource Use Report (QRUR) is being provided to the medical group practices that participated in the group practice reporting option (GPRO I) of the Physician Quality Reporting System in 2011. Participating group practices met the following criteria:

- The physician group practice, as defined by a single Tax Identification Number (TIN), had at least 200 individual physicians or other eligible professionals (identified by individual National Provider Identifiers, or NPIs) who reassigned their billing rights to the TIN.
- The group practice submitted a self-nomination letter to the Centers for Medicare & Medicaid Services to participate in the 2011 GPRO I Physician Quality Reporting System.
- CMS determined that the self-nominating group practice met the program definition of a group practice and complied with other program requirements.

November 2012