2012 QUALITY AND RESOURCE USE REPORT AND PHYSICIAN QUALITY REPORTING SYSTEM FEEDBACK REPORT

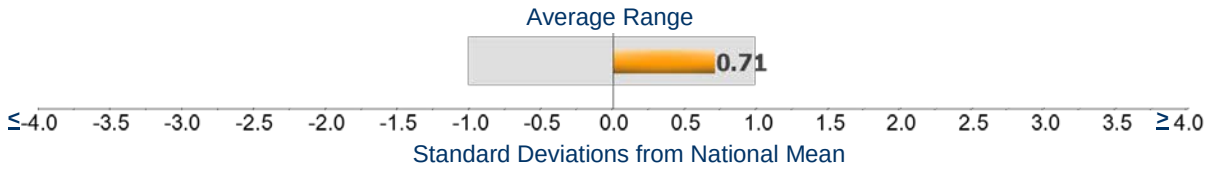
Medical Group C

Last Four Digits of Your Group's Taxpayer Identification Number (TIN): 0000

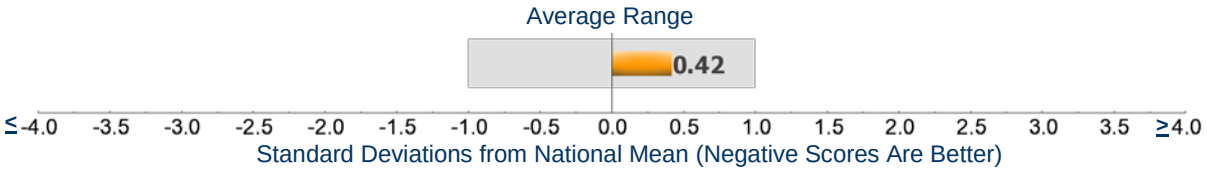
ABOUT THIS REPORT FROM MEDICARE	
WHY	• Medicare will apply a value-based payment modifier, starting in 2015, to medical group practices with 100 or more eligible professionals, based on participation in the Physician Quality Reporting System (PQRS) during 2013. Groups that do not participate in PQRS in 2013 will have their Medicare payments adjusted downward by 1.0%. • Groups that participate in PQRS through one of three PQRS group practice reporting mechanisms in 2013 and meet the minimum reporting requirements will have their value-based payment modifier set at 0.0%. They may also elect to have their value-based payment modifier calculated based on a quality tiering approach, which could result in an upward, downward, or no payment adjustment. • This report, using quality and cost information for 2012, is designed to show how your group would fare if you requested the quality tiering approach. • Performance information in this report will not affect your current Medicare payments.
WHAT	• A summary of your group's 2012 performance, and your quality tiering designation, are shown on the Performance Highlights page of this report. • Exhibits 1 and 2 show how Medicare beneficiaries were attributed to your medical group practice in 2012. • Exhibits 3 and 4 show your group's 2012 performance on quality measures and Exhibits 6–10 show your group's 2012 performance on the cost measures that will be used to compute the value-based payment modifier under the quality tiering approach.
WHO	• Medicare is providing 2012 Quality and Resource Use Reports to all groups of physicians with 25 or more eligible professionals (identified by a single Taxpayer Identification Number), so they can understand the methodologies used to calculate the value-based payment modifier. • By law, Medicare must apply the value-based payment modifier to all physicians starting January 1, 2017.
WHAT YOU CAN DO	• Participate in PQRS, if your group is not already doing so. Details and deadlines for 2013 participation can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html. • Share your thoughts about the content and format of these reports via e-mail, at pvhelpdesk@cms.hhs.gov.

PERFORMANCE HIGHLIGHTS

YOUR QUALITY COMPOSITE SCORE: AVERAGE



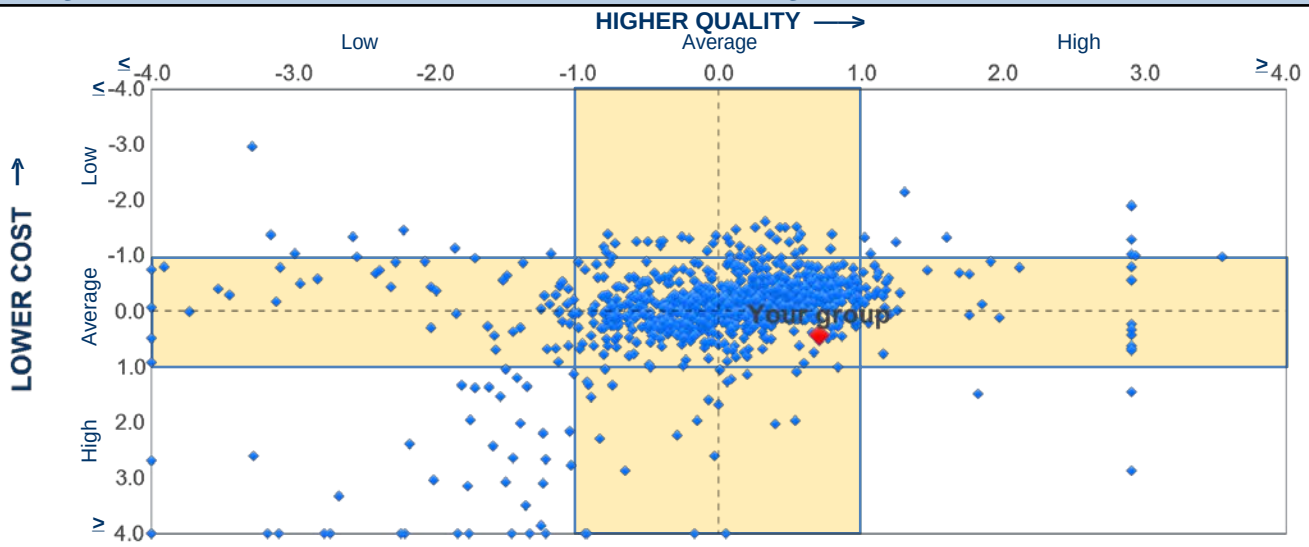
YOUR COST COMPOSITE SCORE: AVERAGE



YOUR BENEFICIARIES' AVERAGE RISK SCORE: 67TH PERCENTILE

- To account for differences in patient risk and reduce the influence of very high cost beneficiaries, the overall per capita costs of your beneficiaries were risk adjusted upward by 2.7 percent.
- Because your Medicare beneficiaries' average risk score is not at or above the 75th percentile of all beneficiary risk scores, your group would not be eligible for an additional upward adjustment under the quality tiering approach for serving high-risk beneficiaries.

YOUR QUALITY TIERING PERFORMANCE: AVERAGE QUALITY, AVERAGE COST



YOUR VALUE-BASED PAYMENT ADJUSTMENT BASED ON QUALITY TIERING

- Based on 2012 performance, electing the quality tiering approach would result in a payment adjustment of +0.0%.

Payment adjustments for each level of performance are shown below:

	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0x%	+2.0x%
Average Cost	-0.5%	+0.0%	+1.0x%
High Cost	-1.0%	-0.5%	+0.0%

Note: x refers to a payment adjustment factor yet to be determined due to budget neutrality requirements.

INTRODUCTION

This report provides information on the quality and costs of care provided to Medicare beneficiaries by your medical group practice, as identified by Taxpayer Identification Number (TIN), and on beneficiaries' utilization of hospital services, compared to the average for 1,032 medical group practices with 100 or more eligible professionals (peer group). Based on Medicare claims, a total of 102 eligible professionals, of whom 85 were physicians, billed to your medical group practice's TIN for services provided to Medicare fee-for-service (FFS) beneficiaries in 2012.

Terms and concepts underlined and in blue boldface are defined in the Glossary of Terms section of the report. Information underlined and in red boldface links to selected detailed data about the eligible professionals billing under your medical group practice's TIN and the beneficiaries attributed to your medical group practice.

Attribution of Medicare Beneficiaries to Your Medical Group Practice

For the purposes of this report, individual Medicare beneficiaries have been attributed to the single medical group practice whose primary care physicians or non-primary care specialists provided the most primary care services for that beneficiary, based on Medicare allowed charges.

Exhibit 1. Number of Medicare Beneficiaries Attributed to Your Medical Group Practice and Basis for Attribution

	Total	Plurality of Primary Care Services Provided by Primary Care Physicians in your Group	Plurality of Primary Care Services Provided by Non-Primary Care Specialists in your Group
Number of Medicare patients attributed to your medical group practice	7,835	7,585	250
Average percentage of primary care services provided by your group, per attributed beneficiary	72.4%	72.2%	80.1%

Exhibit 2 shows how many different eligible professionals billed for services to 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 in your peer group.

Exhibit 2. Medicare Beneficiaries Attributed to Your Medical Group Practice in 2012 and the Eligible Professionals Treating Them, Compared to Peers

	Your Medical Group Practice	Mean Among All 1,032 Medical Group Practices with at Least 100 Eligible Professionals
Number of Medicare patients attributed to the medical group practice	7,835	7,130
Average percentage of primary care services provided by the medical group practice to each attributed beneficiary	72.4%	67.0%
Average number of eligible professionals in all care settings who treated each attributed beneficiary	12.0	11.0
Percentage of eligible professionals treating beneficiaries attributed to the medical group practice who did not bill under the group's TIN	57.0%	66.6%

PERFORMANCE ON QUALITY

The Quality Composite Score summarizes a medical group practice's performance on quality indicators across up to six equally-weighted quality domains: Clinical Process/Effectiveness, Patient and Family Engagement, Population/Public Health, Patient Safety, Care Coordination, and Efficient Use of Healthcare Resources. Standardized scores reflect how much a group's performance differs from the national mean performance on a measure-by-measure basis.

To be considered either a high-quality or low-quality performer for the purposes of the value-based payment modifier under the quality tiering approach in 2015, a group's performance in 2013 must be precisely measured and meaningfully different from average performance. Precise measurement means that a score must be statistically different from the mean at the five percent level of significance. Meaningful difference is performance at least one standard deviation above or below the benchmark mean. That is, a statistically significant standardized Quality Composite Score of +1.0 or higher would place a group in the high-quality performance category, while a score of -1.0 or lower would place it in the low-quality category.

Medical Group Practices Participating in the Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO)

Your medical group practice did not report PQRS data via the GPRO web interface in 2012. If physicians in your group participated in PQRS as individuals in 2012, detailed information about their PQRS performance at both the individual and group level will be available after December 23, 2013.

Medicare Administrative Claims-Based Quality Indicators

In 2013, medical group practices that do not select the PQRS web interface or registry group reporting mechanism will be able to request that Medicare compute their performance on a set of 17 administrative claims-based quality indicators, several of which are multi-part measures. Performance on these indicators is derived from FFS Medicare claims submitted for Medicare beneficiaries attributed to your group in 2012.

Please note that these indicators would only be used to calculate the value-based payment modifier using the quality tiering approach if your medical group chose the PQRS administrative claims option reporting mechanism.

Exhibit 3 shows your medical group practice's 2012 Quality Composite Score under the quality tiering approach based on the 17 CMS-calculated administrative claims-based quality indicators. The quality indicators are grouped in three quality domains. Standardized scores are calculated only for measures with at least 20 cases. Your Quality Composite Score of 0.71 was statistically different from the national mean.

Exhibit 3. Your Medical Group Practice's Performance by Quality Domain in 2012

Quality Domain	Number of Quality Indicators	Standardized Score
Standardized Quality Composite Score	**17**	**0.71* (Average)**
Average Domain Score	17	0.44
Clinical Process/Effectiveness	11	1.21
Patient Safety	2	-0.29
Care Coordination	4	0.41

Note: The standardized quality composite score is a standardized average of equally-weighted domain scores indicating within how many standard deviations of the national mean a medical group practice's performance rate falls; positive scores reflect performance better than the mean, and negative scores reflect performance worse than the mean. Each domain-level performance score is an equally-weighted average of the standardized scores for all measures in the domain with at least 20 cases; the standardized score is the difference between the raw score and the peer group benchmark, divided by the peer group standard deviation. Domain scores are not computed for domains with no measure with at least 20 cases.

* Significantly different from the mean at the five percent level.

The following exhibits display your group's performance on the administrative claims-based quality measures contributing to each domain score used to calculate the Quality Composite Score.

Only those measures for which benchmarks are available and you had 20 or more cases are included in the domain and quality composite scores.

Exhibits are displayed only for domains in which measures for your group could be calculated.

Exhibit 4-CPE. 2012 Performance on Claims-Based Quality Indicators in the Clinical Process/Effectiveness Domain
Clinical Process/Effectiveness Domain Score = 1.21

Performance Measures	Your Medical Group Practice's Performance		Performance of All 1,032 Groups with at Least 100 Eligible Professionals		
	Number of Eligible Cases	Performance Rate	Benchmark Rate	Average Range	
				Benchmark –1 Standard Deviation	Benchmark +1 Standard Deviation
Bone, Joint, and Muscle Disorders					
Osteoporosis Management in Women ≥ 67 Who Had a Fracture	23	21.7%	19.1%	13.0%	25.3%
Chronic Obstructive Pulmonary Disease (COPD)					
Use of Spirometry Testing to Diagnose COPD	358	46.4%	31.9%	23.8%	39.9%
Diabetes Mellitus					
Dilated Eye Exam for Beneficiaries ≤ 75 with Diabetes	685	69.8%	56.6%	48.0%	65.2%
Hba1c Testing for Beneficiaries ≤ 75 with Diabetes	685	92.1%	88.1%	79.3%	96.9%
Nephropathy Screening Test or Evidence of Existing Nephropathy for Beneficiaries ≤ 75 with Diabetes	685	86.9%	78.5%	71.9%	85.0%
Lipid Profile for Beneficiaries ≤ 75 with Diabetes	685	94.5%	82.4%	71.0%	93.7%
Ischemic Vascular Disease					
Lipid Profile for Beneficiaries with Ischemic Vascular Disease	1,584	92.3%	77.5%	68.1%	86.9%
Adherence to Statin Therapy for Beneficiaries with Coronary Artery Disease	51	74.5%	66.8%	59.8%	73.8%
Mental Health					
Antidepressant Treatment for Depression:					
1. Acute Phase Treatment (at least 12 weeks)	28	60.7%	57.1%	48.8%	65.3%
2. Continuation Phase Treatment (at least 6 months)	28	50.0%	39.8%	31.7%	47.9%
Medication Management					
Lipid Profile for Beneficiaries Who Started Lipid-Lowering Medications	1,017	53.5%	39.9%	33.4%	46.5%
Preventive Care Measures					
Breast Cancer Screening for Women Ages 40-69	964	74.7%	65.7%	57.9%	73.6%

Exhibit 4-PS. 2012 Performance on Claims-Based Quality Indicators in the Patient Safety Domain
Patient Safety Domain Score = -0.29

Performance Measures	Your Medical Group Practice's Performance		Performance of All 1,032 Groups with at Least 100 Eligible Professionals		
	Number of Eligible Cases	Performance Rate	Benchmark Rate	Average Range: Benchmark –1 Standard Deviation	Average Range: Benchmark +1 Standard Deviation
Medication Management					
Use of High-Risk Medications in the Elderly*					
*1. Patients Who Receive At Least One Drug to be Avoided**	2,521	21.9%	19.4%	14.6%	24.1%
*2. Patients Who Receive At Least Two Different Drugs to be Avoided**	2,521	6.7%	3.5%	1.7%	5.3%
Lack of Monthly INR Monitoring for Beneficiaries on Warfarin*	1,284	28.5%	32.5%	25.7%	39.2%

*Lower performance rates on these measures indicate better performance. Domain scores are calculated such that positive (+) scores indicate better performance and negative (-) scores indicate worse performance.

Exhibit 4-CC. 2012 Performance on Quality Indicators in the Care Coordination Domain
Care Coordination Domain Score = 0.41

Performance Measures	Your Medical Group Practice's Performance		Performance of All 1,032 Groups with at Least 100 Eligible Professionals		
	Number of Eligible Cases	Performance Rate	Benchmark Rate	Average Range: Benchmark –1 Standard Deviation	Average Range: Benchmark +1 Standard Deviation
Mental Health					
Follow-Up After Hospitalization for Mental Illness					
1. Percentage of Patients Receiving Follow-Up Within 30 Days	39	64.1%	64.1%	52.3%	75.9%
2. Percentage of Patients Receiving Follow-Up Within 7 Days	39	33.3%	36.1%	24.9%	47.4%
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care Sensitive Conditions					
CMS-1 Acute Conditions Composite*	7,835	5.6	8.2	5.0	11.4
*PQI-11 Bacterial Pneumonia**	7,835	6.0	12.4	7.6	17.3
*PQI-12 Urinary Tract Infection**	7,835	7.1	7.5	3.5	11.4
*PQI-10 Dehydration**	7,835	3.7	4.7	2.7	6.8
CMS-2 Chronic Conditions Composite*	3,883	41.7	58.6	45.6	71.6
*Diabetes (Composite of 4 indicators)**	1,837	12.7	20.5	10.0	30.9
*PQI-5 COPD or Asthma**	1,086	61.9	82.5	58.4	106.5
*PQI-8 Heart Failure**	960	76.8	108.6	82.7	134.4
Hospital Readmissions					
CMS-3 **All-Cause Hospital Readmissions***	1,768	16.5%	16.1%	14.8%	17.3%

* Lower performance rates on these measures indicate better performance. However, the domain score for this domain has been calculated such that positive (+) scores indicate better performance and negative scores indicate worse performance.

Hospitals Admitting Your Patients

Based on all Medicare Part A claims submitted in 2012, at least five percent of your attributed Medicare beneficiaries' inpatient stays were at each of the hospitals shown in Exhibit 5. Information on hospital performance is available on the Hospital Compare website (http://www.hospitalcompare.hhs.gov).

Exhibit 5. Hospitals Admitting Medicare Beneficiaries Attributed to Your Medical Group Practice in 2012

Hospital		Medicare Beneficiaries Attributed to Your Medical Group Practice	
Name	**Location**	**Number of Inpatient Stays**	**Percentage of All Inpatient Stays**
Total		**2,498**	**100.0%**
QFWLT RJQNHFQ HJSYJW	QFWLT, KQ	1,242	49.7%
RTWYTS QQFSY MTXQNYFQ	HQJFWBFYJW, KQ	414	16.6%
RJFXJ HTZSYWDXNQJ MTXQNYFQ	XFKJYD MFWGTW, KQ	341	13.7%

PERFORMANCE ON COSTS

The Cost Composite Score summarizes a medical group practice's performance on costs across two equally-weighted cost domains: Per Capita Costs for All Attributed Beneficiaries and Per Capita Costs for Beneficiaries with Specific Conditions (diabetes, coronary artery disease, chronic obstructive pulmonary disease, and heart failure). Standardized scores reflect how much a group's performance differs from the national mean performance on a measure-by-measure basis.

All comparative cost data have been risk adjusted to account for differences in patient characteristics that may affect costs, including age, gender, Medicare eligibility status, history of medical conditions, and ESRD status. In addition, all comparative cost data use payment standardization to account for differences in Medicare payments across geographic regions due to differences in such factors as wages or rents. This information is derived from payments for all Medicare Parts A and B claims 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.

To be considered either a high-cost or low-cost performer for the purposes of calculating the value-based payment modifier under the quality tiering approach in 2015, a group's performance in 2013 must be precisely measured and meaningfully different from average performance. Precise measurement means that a score must be statistically different from the mean at the five percent level of significance. Meaningful difference is performance at least one standard deviation above or below the benchmark mean. That is, a statistically significant standardized Cost Composite Score of +1.0 or higher would place a group in the high-cost performance category, while a score of -1.0 or lower would place it in the low-cost category.

Your Cost Composite Score of 0.42 was statistically different from the national mean. Performance within each domain, expressed in terms of standardized scores, is shown in Exhibit 6.

Exhibit 6. Your Medical Group Practice's Performance by Cost Domain in 2012

Cost Domain	Standardized Score
Standardized Cost Composite Score	**0.42* (Average)**
Average Domain Score	0.87
Per Capita Costs for *All* Attributed Beneficiaries	1.02
Per Capita Costs for Beneficiaries *with Specific Conditions*	0.73

Note: The standardized cost composite score is a standardized average of equally-weighted domain scores indicating within how many standard deviations of the national mean a medical group practice's performance rate falls; positive scores reflect costs higher than the mean, and negative scores reflect costs lower than the mean. Each domain-level performance score is an equally-weighted average of the standardized scores for all measures in the domain with at least 20 cases; the standardized score is the difference between the raw score and the peer group benchmark, divided by the peer group standard deviation. Domain scores are not computed for domains with no measure with at least 20 cases.

* Significantly different from the mean at the five percent level.

Exhibit 7 shows how the payment standardized per capita costs of your Medicare patients, before and after risk adjustment, compared to the mean per capita costs among medical group practices with at least 100 eligible professionals, for each of the cost domains and categories.[1] **Only those measures for which you had 20 or more cases are included in the domain and cost composite scores.**

Exhibit 7. Per Capita Costs for Medicare Beneficiaries Attributed to Your Medical Group Practice in 2012

Cost Categories	Your Medical Group Practice's Performance			Performance of All 1,032 Groups with at Least 100 Eligible Professionals		
	Number of Eligible Cases	Per Capita Costs Before Risk Adjustment	Per Capita Costs After Risk Adjustment	Benchmark Per Capita Costs (Risk Adjustment)	Average Range	
					Benchmark –1 Standard Deviation	Benchmark +1 Standard Deviation
Per Capita Costs for All Attributed Beneficiaries (Domain Score = + 1.02)						
All Beneficiaries	7,313	$11,523	$11,835	$10,265	$8,722	$11,808
Per Capita Costs for Beneficiaries with Specific Conditions (Domain Score = + 0.73)						
Diabetes	1,697	$15,287	$16,244	$14,788	$12,379	$17,198
COPD	759	$26,700	$27,214	$24,153	$19,840	$28,466
Coronary Artery Disease	2,654	$17,740	$19,123	$17,265	$14,415	$20,115
Heart Failure	833	$29,417	$30,562	$26,013	$21,237	$30,788

Note: Per capita costs are based on payments for Medicare Part A and Part B claims submitted in 2012 by all providers (including medical professionals, hospitals, and post-acute care facilities) for Medicare beneficiaries attributed to a medical group practice. Outpatient prescription drug costs are not included.

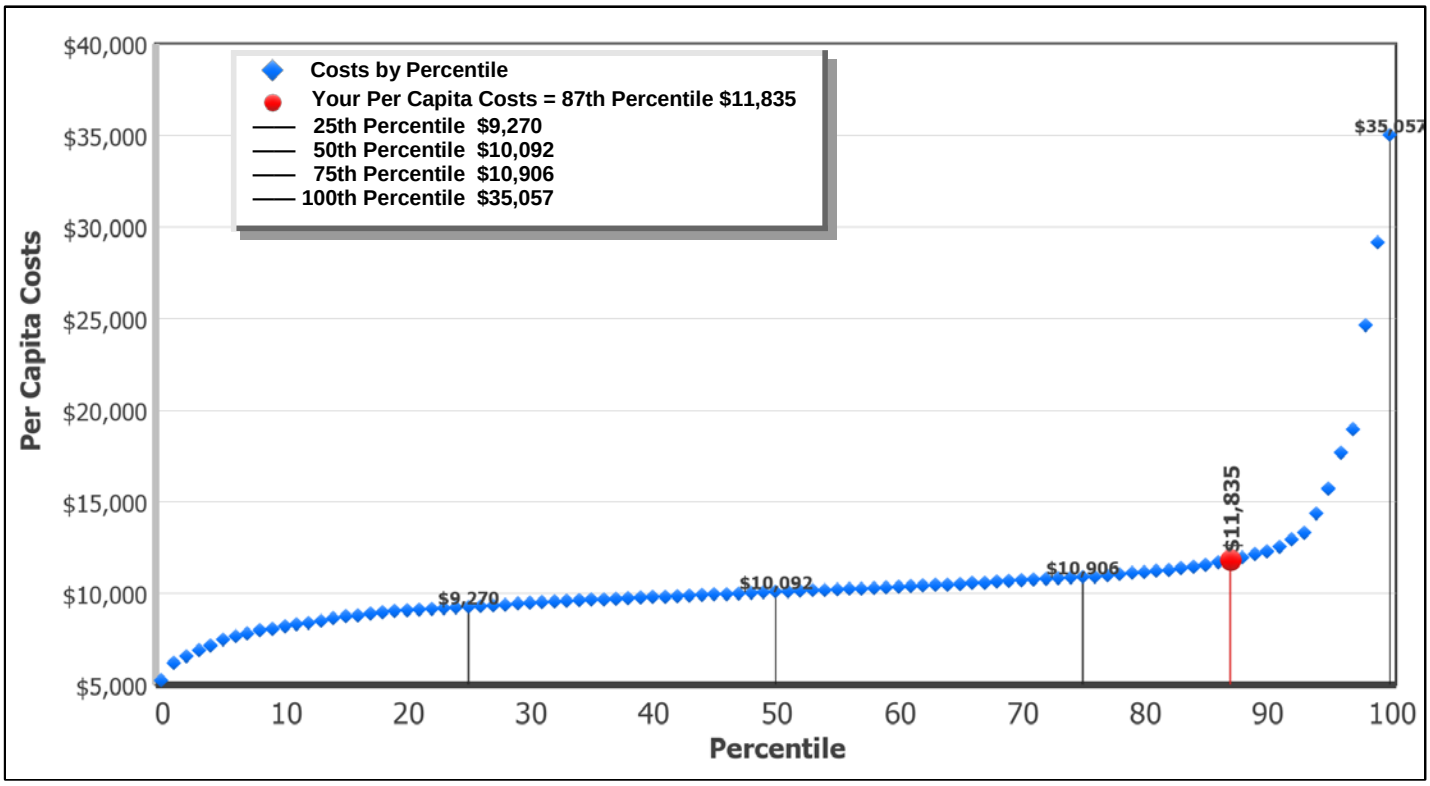
1 For medical group practices that have a higher than average proportion of patients with costly medical conditions or other risk factors, unadjusted costs will be higher than adjusted costs. For medical group practices with a healthier patient population, unadjusted costs will be lower than adjusted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

Per Capita Costs for All Attributed Beneficiaries

This section provides more detailed information about the total per capita costs of care provided to all Medicare FFS patients attributed to your medical group practice.

Per capita costs for the medical group practices in your peer group ranged from a low of $2,207 to a high of $35,057. Total per capita costs for your group were at the 87th percentile of total per capita costs among all groups with at least 100 eligible professionals (Exhibit 8).

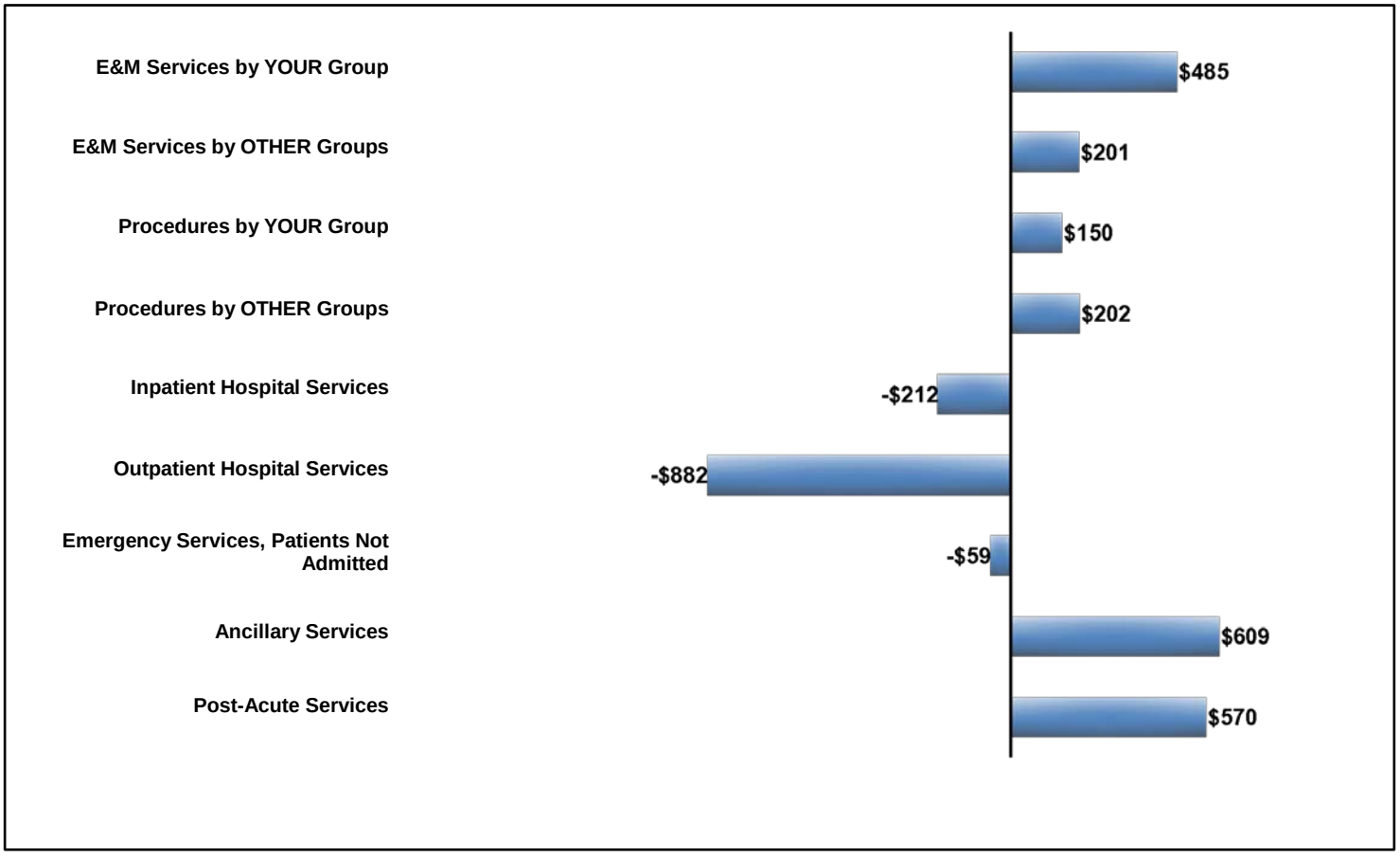
Exhibit 8. Per Capita Costs of Medicare Beneficiaries Attributed to Your Medical Group Practice in 2012, Compared to All 1,032 Medical Group Practices with at Least 100 Eligible Professionals



Note: Per capita costs are risk adjusted and payment standardized and are based on payments for Medicare Part A and Part B claims submitted in 2012 by all providers (including medical 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.

Exhibit 9 shows the difference between the per capita costs of specific types of services for all Medicare patients attributed to your medical group practice and the mean among all medical group practices in your peer group.

Exhibit 9. Difference Between Per Capita Costs for Specific Services for Your Group's Attributed Beneficiaries in 2012 and Mean Per Capita Costs Among All 1,032 Groups with at Least 100 Eligible Professionals



Note: Per capita costs are based on payments for Medicare Part A and Part B claims submitted in 2012 by all providers (including medical 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 10 on the following page 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 in your peer group.

Exhibit 10. Medicare Patients' Per Capita Costs for Specific Services in 2012

Service Category	Your Medical Group Practice			Mean for All 1,032 Groups with at Least 100 Eligible Professionals		Amount by Which Your Group's Costs Were Higher or (Lower) than Peer Group Mean
	Your Medicare Patients Using Any Service in This Category		Risk-Adjusted Per Capita Costs	Medicare Patients Using Any Service in This Category	Risk-Adjusted Per Capita Costs	
	Number	Percentage				
All Services	**7,313**	**100.0%**	**$11,835**	**100.0%**	**$10,265**	**$1,570**
Evaluation and Management (E&M) Services in All Non-Emergency Settings						
All E&M Services Provided by YOUR Group	**7,313**	**100.0%**	**$1,025**	**100.0%**	**$541**	**$485**
Primary Care Physicians	7,120	97.4%	$463	78.6%	$338	$126
Medical Specialists	4,146	56.7%	$242	32.3%	$106	$136
Surgeons	3,762	51.4%	$135	22.4%	$42	$93
Other Eligible Professionals	3,299	45.1%	$185	27.2%	$54	$131
All E&M Services Provided by OTHER Groups	**6,120**	**83.7%**	**$823**	**81.0%**	**$622**	**$201**
Primary Care Physicians	2,087	28.5%	$124	24.6%	$88	$35
Medical Specialists, Surgeons, and Other Eligible Professionals	5,958	81.5%	$699	78.9%	$534	$166
Procedures in All Non-Emergency Settings						
All Procedures Performed by YOUR Group	**4,253**	**58.2%**	**$330**	**30.0%**	**$180**	**$150**
Primary Care Physicians	969	13.3%	$15	9.4%	$15	$1
Medical Specialists	2,320	31.7%	$124	9.3%	$54	$70
Surgeons	2,232	30.5%	$164	11.2%	$84	$80
Other Eligible Professionals	743	10.2%	$27	8.1%	$27	($1)
All Procedures Performed by OTHER Groups	**4,492**	**61.4%**	**$832**	**54.3%**	**$631**	**$202**
Primary Care Physicians	230	3.1%	$10	3.2%	$10	$1
Medical Specialists, Surgeons, and Other Eligible Professionals	4,430	60.6%	$822	53.5%	$621	$201
Hospital Services (Excluding Emergency Outpatient)						
Inpatient Hospital Facility Services	**1,268**	**17.3%**	**$2,262**	**20.6%**	**$2,474**	**($212)**
Outpatient Hospital Facility Services	**4,754**	**65.0%**	**$1,470**	**87.1%**	**$2,352**	**($882)**
Emergency Services That Did Not Result in a Hospital Admission						
All Emergency Services	**2,100**	**28.7%**	**$184**	**38.1%**	**$243**	**($59)**
Emergency Visits	2,083	28.5%	$155	37.7%	$208	($52)
Procedures	677	9.3%	$12	12.9%	$18	($6)
Laboratory and Other Tests	846	11.6%	$2	13.7%	$2	$0
Imaging Services	1,664	22.8%	$14	24.0%	$15	$0
Services in Non-Emergency Ambulatory Settings						
All Ancillary Services	**7,256**	**99.2%**	**$1,596**	**93.3%**	**$987**	**$609**
Laboratory and Other Tests	7,198	98.4%	$663	82.1%	$297	$365
Imaging Services	6,082	83.2%	$589	75.9%	$283	$306
Durable Medical Equipment	2,167	29.6%	$344	33.4%	$407	($62)
Post-Acute Care						
All Post-Acute Services	**1,207**	**16.5%**	**$2,189**	**13.7%**	**$1,619**	**$570**
Skilled Nursing Facility	330	4.5%	$832	4.9%	$707	$125
Home Health	1,103	15.1%	$836	10.1%	$457	$378
Psychiatric, Rehabilitation, or Other Post-Acute Care	190	2.6%	$521	2.9%	$455	$66
Other Services Billed by Non-Institutional Providers						
All Other Services	**6,328**	**86.5%**	**$1,123**	**69.4%**	**$616**	**$507**
Ambulance Services	962	13.2%	$117	14.7%	$130	($13)
Chemotherapy and Other Part B–Covered Drugs	2,767	37.8%	$773	18.9%	$323	$449
All Other Services Not Otherwise Classified	5,902	80.7%	$234	60.3%	$163	$71

Note: 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 a list of physician specialties assigned to each specialty category.

APPENDIX A

Exhibit A-1. Specialties Associated with Eligible Professional, Physician, and Provider Stratification Categories

Provider or Supplier Specialty Description	CMS Specialty Code	Eligible Professional?	Physician?	Provider Stratification Category
Primary Care Specialties				
Family Practice	08	Yes	Yes	Primary Care Physicians
General Practice	01	Yes	Yes	Primary Care Physicians
Geriatric Medicine	38	Yes	Yes	Primary Care Physicians
Internal Medicine	11	Yes	Yes	Primary Care Physicians
All Other Specialties				
Addiction Medicine	79	Yes	Yes	Medical Specialists
All Other Suppliers (e.g., Drug Stores)	87	No	No	Not Applicable
Allergy/Immunology	03	Yes	Yes	Medical Specialists
Ambulance Service Supplier (e.g., Private Ambulance Companies, Funeral Homes)	59	No	No	Not Applicable
Ambulatory Surgical Center	49	No	No	Not Applicable
Anesthesiologist Assistant	32	Yes	No	Other Eligible Professionals
Anesthesiology	05	Yes	Yes	Other Eligible Professionals
Audiologist (Billing Independently)	64	Yes	No	Other Eligible Professionals
Cardiac Electrophysiology	21	Yes	Yes	Medical Specialists
Cardiac Surgery	78	Yes	Yes	Surgeons
Cardiology	06	Yes	Yes	Medical Specialists
Certified Clinical Nurse Specialist	89	Yes	No	Other Eligible Professionals
Certified Nurse Midwife	42	Yes	No	Other Eligible Professionals
Certified Registered Nurse Anesthesiologist	43	Yes	No	Other Eligible Professionals
Chiropractor, Licensed	35	Yes	Yes	Other Eligible Professionals
Clinical Laboratory (Billing Independently)	69	No	No	Not Applicable
Clinical Psychologist	68	Yes	No	Other Eligible Professionals
Clinical Psychologist (Billing Independently)	62	Yes	No	Other Eligible Professionals
Colorectal Surgery (Formerly Proctology)	28	Yes	Yes	Surgeons
Critical Care (Intensivists)	81	Yes	Yes	Medical Specialists
Department Store (For DMERC Use)	A7	No	No	Not Applicable
Dermatology	07	Yes	Yes	Medical Specialists
Diagnostic Radiology	30	Yes	Yes	Other Eligible Professionals
Emergency Medicine	93	Yes	Yes	Other Eligible Professionals
Endocrinology	46	Yes	Yes	Medical Specialists
Gastroenterology	10	Yes	Yes	Medical Specialists
General Surgery	02	Yes	Yes	Surgeons
Geriatric Psychiatry	27	Yes	Yes	Medical Specialists
Grocery Store (For DMERC Use)	A8	No	No	Not Applicable
Gynecologist/Oncologist	98	Yes	Yes	Surgeons
Hand Surgery	40	Yes	Yes	Surgeons
Hematology	82	Yes	Yes	Medical Specialists
Hematology/Oncology	83	Yes	Yes	Medical Specialists
Home Health Agency (DMERCs Only)	A4	No	No	Not Applicable
Hospice and Palliative Care	17	Yes	Yes	Medical Specialists
Hospital	A0	No	No	Not Applicable
Independent Diagnostic Testing Facility	47	No	No	Not Applicable
Individual Certified Orthotist	55	No	No	Not Applicable
Individual Certified Prosthetist	56	No	No	Not Applicable
Individual Certified Prosthetist-Orthotist	57	No	No	Not Applicable
Infectious Disease	44	Yes	Yes	Medical Specialists
Intensive Cardiac Rehabilitation	31	No	No	Not Applicable
Intermediate Care Nursing Facility (DMERCs Only)	A2	No	No	Not Applicable
Interventional Pain Management	09	Yes	Yes	Medical Specialists
Interventional Radiology	94	Yes	Yes	Other Eligible Professionals
Licensed Clinical Social Worker	80	Yes	No	Other Eligible Professionals

Provider or Supplier Specialty Description	CMS Specialty Code	Eligible Professional?	Physician?	Provider Stratification Category
Mammography Screening Center	45	No	No	Not Applicable
Mass Immunization Roster Biller	73	No	No	Not Applicable
Maxillofacial Surgery	85	Yes	Yes	Surgeons
Medical Oncology	90	Yes	Yes	Medical Specialists
Medical Supply Company For DMERC	54	No	No	Not Applicable
Medical Supply Company with Certified Orthotist	51	No	No	Not Applicable
Medical Supply Company with Certified Prosthetist	52	No	No	Not Applicable
Medical Supply Company with Certified Prosthetist-Orthotist	53	No	No	Not Applicable
Medical Supply Company with Pedorthic Personnel	B3	No	No	Not Applicable
Medical Supply Company with Registered Pharmacist	58	No	No	Not Applicable
Medical Supply Company with Respiratory Therapist (DMERCs Only)	A6	No	No	Not Applicable
Nephrology	39	Yes	Yes	Medical Specialists
Neurology	13	Yes	Yes	Medical Specialists
Neuropsychiatry	86	Yes	Yes	Medical Specialists
Neurosurgery	14	Yes	Yes	Surgeons
Nuclear Medicine	36	Yes	Yes	Other Eligible Professionals
Nurse Practitioner	50	Yes	Yes	Other Eligible Professionals
Nursing Facility, Other (DMERCs Only)	A3	No	No	Not Applicable
Obstetrics/Gynecology	16	Yes	Yes	Surgeons
Occupational Therapist (Independently Practicing)	67	Yes	No	Other Eligible Professionals
Ocularist	B5	No	No	Not Applicable
Ophthalmology	18	Yes	Yes	Surgeons
Optician	96	No	No	Not Applicable
Optometrist	41	Yes	Yes	Other Eligible Professionals
Oral Surgery (Dentists Only)	19	Yes	Yes	Surgeons
Orthopedic Surgery	20	Yes	Yes	Surgeons
Osteopathic Manipulative Therapy	12	Yes	Yes	Medical Specialists
Otolaryngology	04	Yes	Yes	Surgeons
Pain Management	72	Yes	Yes	Other Eligible Professionals
Pathology	22	Yes	Yes	Other Eligible Professionals
Pediatric Medicine	37	Yes	Yes	Other Eligible Professionals
Pedorthic Personnel	B2	No	No	Not Applicable
Peripheral Vascular Disease	76	Yes	Yes	Surgeons
Pharmacy (DMERCs Only)	A5	No	No	Not Applicable
Physical Medicine and Rehabilitation	25	Yes	Yes	Medical Specialists
Physical Therapist (Independently Practicing)	65	Yes	No	Other Eligible Professionals
Physician Assistant	97	Yes	No	Other Eligible Professionals
Plastic and Reconstructive Surgery	24	Yes	Yes	Surgeons
Podiatry	48	Yes	Yes	Other Eligible Professionals
Portable X-Ray Supplier	63	No	No	Not Applicable
Preventive Medicine	84	Yes	Yes	Medical Specialists
Psychiatry	26	Yes	Yes	Medical Specialists
Public Health or Welfare Agencies (Federal, State, and Local)	60	No	No	Not Applicable
Pulmonary Disease	29	Yes	Yes	Medical Specialists
Radiation Oncology	92	Yes	Yes	Other Eligible Professionals
Radiation Therapy Centers	74	No	No	Not Applicable
Registered Dietician/Nutrition Professional	71	Yes	No	Other Eligible Professionals
Rehabilitation Agency	B4	No	No	Not Applicable
Rheumatology	66	Yes	Yes	Medical Specialists
Single or Multispecialty Clinic or Group Practice	70	Yes	Yes	Other Eligible Professionals
Skilled Nursing Facility	A1	No	No	Not Applicable
Sleep Medicine	C0	Yes	Yes	Medical Specialists

Provider or Supplier Specialty Description	CMS Specialty Code	Eligible Professional?	Physician?	Provider Stratification Category
Slide Preparation Facilities	75	No	No	Not Applicable
Speech Language Pathologists	15	Yes	No	Other Eligible Professionals
Sports Medicine	23	Yes	Yes	Other Eligible Professionals
Surgical Oncology	91	Yes	Yes	Surgeons
Thoracic Surgery	33	Yes	Yes	Surgeons
Unassigned	95	No	No	Not Applicable
Unknown Physician	99	Yes	Yes	Other Eligible Professionals
Unknown Supplier/Provider	88	No	No	Not Applicable
Urology	34	Yes	Yes	Surgeons
Vascular Surgery	77	Yes	Yes	Surgeons
Voluntary Health or Charitable Agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)	61	No	No	Not Applicable

GLOSSARY OF TERMS

ALL-CAUSE HOSPITAL READMISSIONS.

The all-cause hospital readmissions measure is a MEDICAL GROUP PRACTICE–specific all-cause 30-day rate of acute care hospital readmissions (defined as an unplanned readmission for any cause within 30 days from the date of discharge of an index admission in 2012) for beneficiaries discharged from an acute care or critical access hospital. The measure does not apply to ATTRIBUTED beneficiaries who were under age 18 on January 1, 2012, discharged against medical advice, or transferred to another acute care hospital. Beneficiaries who died within 30 days of discharge and those without continuous enrollment in Medicare Part A for at least one month following discharge are likewise excluded. Certain hospitalizations, such as those related to treatment of cancer or primary psychiatric disease, are excluded from the set of index admissions considered. Index admissions are grouped into five specialty cohorts—surgery/gynecology, cardiorespiratory, cardiovascular, neurology, and medicine—based on the presumption that admissions treated by similar teams of clinicians are likely to have similar risks of readmission. Readmissions are RISK ADJUSTED via hierarchical logistic regression models that estimate a series of ratios (one for each specialty cohort) of the number of readmissions predicted for the specific medical group practice, given its case mix, to the number of readmissions expected among all medical group practices in the peer group with a similar case mix. A case-weighted geometric mean of these ratios is then computed and multiplied by the overall readmission rate for all beneficiaries across all groups.

ALL OTHER SERVICES.

Exhibit 10 displays seven categories of Medicare-covered services: evaluation and management (E&M) provided by eligible professionals in non-emergency settings, procedures performed by eligible professionals in non-emergency settings, inpatient hospital, outpatient hospital (excluding emergency outpatient), emergency services provided by eligible professionals and not resulting in a hospital admission, ancillary services in non-emergency ambulatory settings, and post-acute care services. All other Medicare-covered services (with the exception of Medicare Part D prescription drug costs) not included in those seven categories are captured in Exhibit 10 as “All Other Services.” This includes anesthesia, ambulance services, chemotherapy, other Part B drugs, chiropractic, enteral and parenteral nutrition, some vision services, some hearing and speech services, and influenza immunization. This also includes any charges for services rendered by non-institutional providers and suppliers not considered eligible professionals. Specialties not associated with eligible professionals are listed in Appendix A.

AMBULATORY CARE SENSITIVE CONDITIONS (ACSCS).

ACSCs are conditions for which good outpatient care can prevent complications or more serious disease. 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.

The Care Coordination quality domain includes two composite measures of hospital admissions for acute and chronic ACSCs, as shown in Exhibit 4-CC. The admission rates are calculated from 2012 Medicare Part A claims data, based on the individual PQIs shown in Exhibit G-1.

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

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

Source: Agency for Healthcare Research and Quality and Mathematica Policy Research.

The ACSC measures are RISK ADJUSTED by comparing the MEDICAL GROUP PRACTICE's actual rate of potentially avoidable hospitalizations to an expected rate. The numerator of the actual rate 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 2012. Only those admissions where the measure of interest is listed as the primary diagnosis are counted. The denominators for the rates have been modified from the original PQI population-based measures to include only those Medicare beneficiaries attributed to the medical group practice being assessed. The denominator for measures in the Chronic Conditions Composite (diabetes, COPD/asthma, heart failure) is restricted to patients diagnosed with the specific condition. For measures in the Acute Conditions Composite (bacterial pneumonia, urinary tract infection, dehydration), the denominator includes all Medicare patients attributed to the medical group practice.

For each measure, the expected rate reflects the average experience of Medicare beneficiaries in the same age category and of the same gender as those attributed to the group. The risk-adjusted rate is calculated as the ratio of the actual rate to the expected rate multiplied by the average actual rate per 1,000 beneficiaries. Each of the composite rates is the weighted sum of the component rates, with each component's weight equal to the percentage of all attributed beneficiaries included in the component rate's denominator. The 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 are considered for assignment to a MEDICAL GROUP PRACTICE, identified by Taxpayer Identification Number (TIN), in a two-step process based on primary care services (Exhibit G-2) provided by the group, as captured in 2012 Part B Medicare claims.

1. The first step assigns a beneficiary to a group if the beneficiary receives the plurality of his or her primary care services from primary care physicians within the group. Primary care physicians are those with one of four specialty designations: family practice, general practice, geriatric medicine, or internal medicine.

2. The second step applies only to beneficiaries who did not receive a primary care service from any primary care physician in 2012. Under this second step, a beneficiary is assigned to a group if the beneficiary (a) received at least one primary care service from a physician within the group and (b) received a plurality of his or her primary care services from specialist physicians and certain non-physician practitioners (nurse practitioners, clinical nurse specialists, and physician assistants) within the group.

Beneficiaries were not attributed to any medical group practice if, for any month in 2012, 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 resided outside the United States, its territories, and its possessions; or they did not have any Medicare allowed charges in 2012.

The same population of beneficiaries attributed to a medical group practice is used for calculating the denominators of all non–PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) quality and cost measures displayed in this report. Performance on any displayed GROUP PRACTICE REPORTING OPTION (GPRO) quality indicators, however, is based on a sample of beneficiaries who had at least two office or other outpatient visits with the medical group practice and for whom the medical group practice provided the plurality of all office and other outpatient services during approximately the first ten months of 2012; Medicare Advantage enrollees and beneficiaries for whom Medicare was not the primary payer for all of 2012 are excluded.

Exhibit G-2. Healthcare Common Procedure Coding System (HCPCS) Primary Care Service Codes Criteria

HCPCS Codes	Brief Description
99201–99205	New patient, office or other outpatient visit
99211–99215	Established patient, office or other outpatient visit
99304–99306	New patient, nursing facility care
99307–99310	Established patient, nursing facility care
99315–99316	Established patient, discharge day management service
99318	Established patient, other nursing facility service
99324–99328	New patient, domiciliary or rest home visit
99334–99337	Established patient, domiciliary or rest home visit
99339–99340	Established patient, physician supervision of patient (patient not present) in home, domiciliary or rest home
99341–99345	New patient, home visit
99347–99350	Established patient, home visit
G0402	Initial Medicare visit
G0438	Annual wellness visit, initial
G0439	Annual wellness visit, subsequent

Note: Labels are approximate. See the American Medical Association's Current Procedural Terminology and the Centers for Medicare & Medicaid Services website (http://www.cms.gov) for detailed definitions.

BENCHMARKS.

The benchmark for each Physician Quality Reporting System (PQRS) measure is the measure's case-weighted national mean performance rate among all individual physicians and participating Group Practice Reporting Option (GPRO) groups in 2011 (the year prior to the performance year). A medical group practice's benchmark for each administrative claims-based quality indicator, ambulatory care sensitive condition measure, or all-cause readmissions measure is the measure's case-weighted mean performance rate of the medical group practice's peer group in 2011. (See PEER GROUP.) A medical group practice's benchmark for each cost measure is the measure's case-weighted mean performance rate of the medical group practice's peer group in 2012 (the performance year). Benchmarks are not available for quality measures without a comparable measure in the year preceding, the performance period and are designated as such in the report exhibits.

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, PER CAPITA COSTS FOR BENEFICIARIES WITH SPECIFIC CONDITIONS were calculated for four conditions common to the Medicare population: diabetes, coronary artery disease, chronic obstructive pulmonary disease, and heart failure.

COST COMPOSITE SCORE.

The Cost Composite Score is one of two composite scores used to calculate the VALUE-BASED PAYMENT MODIFIER under the QUALITY TIERING option. It standardizes a MEDICAL GROUP PRACTICE'S average performance on costs across two equally-weighted cost domains: PER CAPITA COSTS FOR ALL ATTRIBUTED BENEFICIARIES and PER CAPITA COSTS FOR BENEFICIARIES WITH SPECIFIC CONDITIONS (diabetes, coronary artery disease, chronic obstructive pulmonary disease, and heart failure). Standardized scores reflect how much a group's performance differs from the national mean performance on a measure-by-measure basis within each domain. For groups attributed fewer than 20 beneficiaries with diabetes, coronary artery disease, chronic obstructive pulmonary disease, or heart failure, the Cost Composite Score is based solely on Per Capita Costs for All Attributed Beneficiaries. The standardized Cost Composite Score used for quality tiering indicates how much a group's average score across domains differs from the national mean.

ELIGIBLE PROFESSIONALS.

An eligible professional is an individual provider, as identified by his or her individual National Provider Identifier (NPI), who is either a physician, a practitioner, a physical or occupational therapist or qualified speech-language pathologist, or a qualified audiologist. A physician is one of the following: doctor of medicine, doctor of osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry, or chiropractor. A practitioner is any of the following: certified registered nurse anesthetist, anesthesiology assistant, certified nurse midwife, clinical social worker, clinical psychologist, nurse practitioner, physician assistant, or registered dietician or nutrition professional. An eligible professional's medical specialty was determined from the specialty listed by the provider in the Provider Enrollment, Chain, and Ownership System (PECOS); in cases where multiple specialties are listed for a provider in PECOS, the provider is assigned the specialty recorded most often on those 2012 Part B claims for which the professional was the performing provider.

GROUP PRACTICE REPORTING MECHANISMS.

MEDICAL GROUP PRACTICES participating in the PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) through the GROUP PRACTICE REPORTING OPTION (GPRO) may report quality measures for 2013 through one of three options: (1) a qualified registry, (2) the GPRO web interface, or (3) the administrative claims reporting method. Only group practices with 25 or more ELIGIBLE PROFESSIONALS may use the web interface as a reporting method. Under the administrative claims reporting method, the Centers for Medicare & Medicaid Services (CMS) will calculate performance on quality measures based on Medicare Part B claims data submitted by the group. Groups may elect the administrative claims reporting option in 2013 for the purpose of 2015 value-based payment adjustment, but not for 2013 GPRO incentive payments.

GROUP PRACTICE REPORTING OPTION (GPRO).

In accordance with section 1848(m)(3)(C) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) created a new group practice reporting option (GPRO) for the PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) in 2010. MEDICAL GROUP PRACTICES that satisfactorily report data on specified PQRS quality indicators 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 2012, each selected GPRO participant is required to report 29 quality measures. More complete information about GPRO, including descriptions of each of the 29 measures, is available from the GPRO website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html.

MEASURE POPULATIONS.

All administrative claims-based measures—including any claims-based quality measures, AMBULATORY CARE SENSITIVE CONDITION (ACSC) rates, ALL-CAUSE HOSPITAL READMISSION RATES, and PER CAPITA COST measures—in this report are calculated based on all Medicare fee-for-service (FFS) beneficiaries ATTRIBUTED to the medical group practice. In contrast, any PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) quality measures are calculated based on a sample of Medicare FFS beneficiaries attributed to the MEDICAL GROUP PRACTICE. Each participating medical group practice is required to report clinical data for at least the first 218 or 411 beneficiaries (depending on the group's size) on their list of assigned beneficiaries that the Centers for Medicare & Medicaid Services (CMS) has determined meet criteria for specific measures, or on 100 percent of the beneficiaries on their list for that measure, whichever is smaller.

MEDICAL GROUP PRACTICE.

Medical group practice refers to a single provider entity, identified by its Taxpayer Identification Number (TIN), to which at least 25 ELIGIBLE PROFESSIONALS reassigned their billing rights in 2012.

MEDICARE CLAIMS DATA USED IN THE COST MEASURES.

The cost measures displayed in this report use 2012 Part A and Part B Medicare claims data to provide feedback to MEDICAL GROUP PRACTICES about selected cost measures related to the care provided to Medicare beneficiaries ATTRIBUTED to their group. These data include inpatient hospital, outpatient hospital, hospice, skilled nursing facility, home health, and durable medical equipment claims, as well as claims submitted by individual (non-institutional) providers and suppliers to their Part B Medicare Administrative Contractors (MACs). Part D prescription drug costs are not included in the cost measures.

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 this report 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 GROUP.

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 PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) GROUP PRACTICE REPORTING OPTION (GPRO) quality indicators displayed in this report, the peer group is defined as all medical group practices participating in GPRO in 2012. For all other measures displayed in this report, medical group practices with at least 25 but less than 100 ELIGIBLE PROFESSIONALS are compared to all medical group practices nationwide with at least 25 eligible professionals; medical group practices with at least 100 eligible professionals are compared to all medical group practices nationwide with at least 100 eligible professionals. All peer group totals include data for the specific medical group practice profiled in the QRUR.

PER CAPITA COSTS FOR ALL ATTRIBUTED BENEFICIARIES.

Per capita costs are the average (mean) of all 2012 Medicare fee-for-service (FFS) Parts A and B payments 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 all other medical group practices nationwide of similar size (see PEER GROUP).

Per capita cost measures in this report were calculated using 2012 Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) claims for all FFS Medicare beneficiaries attributed to the medical group practice. Medicare costs were obtained from 2012 administrative claims data using inpatient, outpatient, skilled nursing facility, home health, hospice, durable medical equipment, and non-institutional provider/supplier claims. Outpatient prescription drug (Part D) claims were not included in the 2012 cost measure calculations. Payments to providers from Medicare are the primary component of costs. 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 2012 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). Attributed beneficiaries who were enrolled in both Medicare Parts A and B for only part of the year and attributed beneficiaries who died during the year were excluded, as were the costs associated with their care.

Payment-standardized and risk-adjusted per capita costs were computed 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) 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 practices in the sample.

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

- All professional evaluation and management (E&M) services provided by primary care physicians, medical specialists, surgeons, and other eligible professionals in non-emergency settings (Appendix A shows how eligible 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 eligible 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, chiropractic, enteral and parenteral nutrition, vision services, hearing and speech services, and influenza immunization

PER CAPITA COSTS FOR BENEFICIARIES WITH SPECIFIC CONDITIONS.

Per capita costs for Medicare beneficiaries with specific conditions are the average of 2012 Medicare FFS Parts A and B standardized payments per attributed beneficiary with one of four specific CHRONIC HEALTH CONDITIONS: diabetes, coronary artery disease, chronic obstructive pulmonary disease, and heart failure.

The per capita costs for beneficiaries with each condition were computed in the same manner as the PER CAPITA COSTS FOR ALL ATTRIBUTED BENEFICIARIES, except that expected costs for beneficiaries with a specific condition were computed based on a risk adjustment model that included only beneficiaries with that condition. These condition-specific 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. 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 QUALITY REPORTING SYSTEM (PQRS).

The PQRS is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by ELIGIBLE PROFESSIONALS. The program provides an incentive payment to practices with eligible professionals who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B FFS beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). Beginning in 2015, the program also applies a negative payment adjustment to eligible professionals who do not satisfactorily report data on quality measures for covered professional services (see VALUE-BASED PAYMENT MODIFIER). Physicians may participate in PQRS as individuals or, at the group level, through the GROUP PRACTICE REPORTING OPTION (GPRO). Physician quality reporting is mandated by federal legislation. CMS implements the program through regulations published in the Federal Register.

QUALITY COMPOSITE SCORE.

The Quality Composite Score is one of two composite scores used to calculate the VALUE-BASED PAYMENT MODIFIER under the QUALITY TIERING option. It standardizes a MEDICAL GROUP PRACTICE'S average performance on quality across up to six equally-weighted quality domains: Clinical Process/Effectiveness, Patient and Family Engagement, Population/Public Health, Patient Safety, Care Coordination, and Efficient Use of Healthcare Resources. Only domains containing at least one quality measure with at least 20 eligible cases are included in the quality composite score. Standardized scores reflect how much a group's performance differs from the national mean performance on a measure-by-measure basis within each quality domain. The standardized Quality Composite Score used for quality tiering indicates how much a group's average score across domains differs from the national mean.

QUALITY TIERING.

MEDICAL GROUP PRACTICES participating in the PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) will have the option of having their 2015 VALUE-BASED PAYMENT MODIFIER calculated using a quality-tiering approach based on 2013 performance. Groups electing this option will have the opportunity to earn an upward payment adjustment for performance in the higher quality and lower cost tiers but will also be at risk for a downward payment adjustment for lower quality and higher cost performance. To be considered either a high or a low performer, a qualifying group's score must be at least one standard deviation above or below the national mean performance score and statistically different from the mean score at the five percent level of significance. The QUALITY COMPOSITE SCORE and COST COMPOSITE SCORE used to calculate the value-based payment modifier under the quality tiering option indicate how much a group's average performance differs from the national mean. To be considered either a high or a low performer, a qualifying group's performance must be at least one standard deviation above or below the national mean and statistically different from the mean score at the five percent level of significance.

The basic structure of value-based payment modification under the quality tiering option is displayed below. Because the modifier must be budget neutral, the precise size of the reward for higher performing groups—those that are at least average on both quality and cost and better than average on at least one—will depend on the projected billings of these groups relative to lower performing groups (as captured in the table by the variable x), which will vary from year to year with differences in actuarial estimates and in the number and relative performance of medical group practices electing the quality tiering option. Higher performing groups treating beneficiaries with an average risk exceeding the risk of the 75th percentile beneficiary in the Medicare population receive an additional 1.0 percent incentive payment on top of the standard upward adjustment.

	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0x%*	+2.0x%*
Average Cost	-0.5%	+0.0%	+1.0x%*
High Cost	-1.0%	-0.5%	+0.0%

Note: x refers to a payment adjustment factor yet to be determined.

* Higher performing groups serving high-risk beneficiaries (based on average risk scores) are eligible for an additional adjustment of +1.0x%.

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 GROUP 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 and admissions (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 the Centers for Medicare & Medicaid Services (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 2012, the HCC model generates a 2012 RISK SCORE based on the presence of these conditions in 2011—and on sex, age, original reason for Medicare entitlement (either age or disability), and Medicaid entitlement—as a predictor of beneficiary costs in 2012. Risk adjustment of 2012 costs also takes into account the presence of end-stage renal disease (ESRD) in 2011.

A statistical risk adjustment model estimates the independent effects of these factors on absolute beneficiary costs and adjusts 2012 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.

RISK SCORE.

The risk score assigned to each Medicare beneficiary predicts how that beneficiary's medical costs in 2012 would be expected to compare to average (mean) costs among all Medicare FFS beneficiaries (where a score of 1.0 represents average risk and average predicted costs), based on the presence of factors known to affect costs and utilization. Risk scores for all beneficiaries ATTRIBUTED to a MEDICAL GROUP PRACTICE are used to estimate, and adjust for, the independent effects of these factors on beneficiary costs in calculating RISK-ADJUSTED cost measures for the group. In addition, medical group practices with average beneficiary risk scores at or above the 75th percentile of all beneficiary risk scores nationwide are eligible for an additional upward payment adjustment in the VALUE-BASED PAYMENT MODIFIER under the QUALITY TIERING approach.

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. As described in the 2013 Physician Fee Schedule Notice of Final Rulemaking, the Centers for Medicare & Medicaid Services (CMS) will initially 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) as of October 15, 2012. CMS will separate these groups into two categories, based on their registration and participation in the PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) in 2013. Groups may participate under one of three PQRS reporting options: (1) the GROUP PRACTICE REPORTING OPTION (GPRO) web interface, (2) a qualified registry, or (3) CMS-calculated administrative claims. Groups choosing not to register and participate in PQRS in one of these three ways will have a value-based payment modifier set at -1.0 percent, applied to all of the group's Medicare physician fee schedule payments in 2015. Groups that register and participate in PQRS via one of the three reporting options will have their value-based payment modifier set at 0.0 percent, meaning that they will incur no negative adjustment to their 2015 physician fee schedule payments. During the registration period, groups participating in PQRS can request, instead, that CMS calculate their 2015 value-based payment modifier using a QUALITY TIERING approach based on 2013 performance.

CMS will not apply the value-based payment modifier for 2015 and 2016 to groups of physicians that are participating in the Medicare Shared Savings Program, the testing of the Pioneer ACO Model, or the Comprehensive Primary Care Initiative.