MEDICARE FEE-FOR-SERVICE QUALITY AND RESOURCE USE REPORT

For Medical Group Practices Participating in the 2010 Group Practice Reporting Option-1 (GPRO I)

ABC HEALTHCARE ASSOCIATES

Last Four Digits of Your Group's Tax Identification Number:

This confidential Medicare Quality and Resource Use Report (QRUR) is being provided to the 35 medical group practices that participated in the group practice reporting option (GPRO I) of the Physician Quality Reporting System in 2010. Participating group practices had to meet the following criteria:

- The group practice, as defined by a single Tax Identification Number (TIN), had to have at least 200 individual physicians or other eligible professionals (identified by Individual National Provider Identifiers, or NPIs) who have reassigned their billing rights to the TIN.
- The group practice had to submit a self-nomination letter to the Centers for Medicare & Medicaid Services (CMS) to participate in the 2010 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.

This report is provided *for information purposes only*.

It *will not affect* Medicare payment or participation in the Medicare program.

ABC HEALTHCARE ASSOCIATES Highlights

QUALITY OF YOUR PATIENTS' CARE (PART I) **Compared to the average (mean) among medical groups participating in the 2010 GPRO I Physician Quality Reporting System, your group's quality indicators for the following chronic conditions were:**		
Disease	Better Than or Equal To Average for At Least 50% of the Indicators	Worse Than Average for More Than 50% of the Indicators
Diabetes	X	
Heart Failure		X
Coronary Artery Disease	X	
Hypertension		X
Preventive Care		X
HOSPITAL ADMISSIONS FOR AMBULATORY CARE SENSITIVE CONDITIONS (PART II) Compared to the average (mean) among medical groups participating in the 2010 GPRO I Physician Quality Reporting System, your group's patients were admitted to the hospital with the following conditions:		
Disease	Less Often Than or Equal To Average	More Often Than Average
Diabetes		X
Chronic Obstructive Pulmonary Disease		X
Heart Failure		X
Bacterial Pneumonia	X	
Urinary Tract Infection		X
Dehydration		X
COST OF YOUR PATIENTS' CARE (PARTS III & IV) Compared to the average (mean) among medical groups participating in the 2010 GPRO I Physician Quality Reporting System, your group's costs in the following categories of service were:		
	Lower Than or Equal To Average	Higher Than Average
Total Per Capita (Parts A & B)		X
Evaluation and Management Services	X	
Procedures	X	
Hospital Inpatient Services	X	
Hospital Outpatient and Emergency Care		X
Ancillary Services	X	
Post-Acute Care	X	
CHRONIC CONDITIONS PER CAPITA COSTS (PART V) Compared to the average (mean) among medical groups participating in the 2010 GPRO I Physician Quality Reporting System, your group's per capita costs for patients with the following chronic conditions were:		
Disease	Lower Than or Equal To Average	Higher Than Average
Diabetes	X	
Coronary Artery Disease	X	
Chronic Obstructive Pulmonary Disease	X	
Heart Failure	X	

INTRODUCTION

This report provides information on the quality and costs of care provided to Medicare beneficiaries in your medical group's practice, and on beneficiaries' utilization of hospital services, compared to the average for 35 medical group practices that participated in the 2010 GPRO I Physician Quality Reporting System.

- **Part I** presents summary information on your group's performance on 26 **quality indicators**, reflecting care for beneficiaries with diabetes, heart failure, coronary artery disease (CAD), hypertension, and preventive care measures, based on the sample data that your medical group practice provided to the Physician Quality Reporting System.
- **Part II** presents information about your Medicare fee-for-service (FFS) patients' **utilization of hospital services**, including their rate of acute care hospitalization for conditions where timely and effective ambulatory care can prevent or reduce the need for admission to the hospital (**ambulatory care sensitive conditions**).
- **Part III** presents summary information about your patients' total **per capita costs** (average annual costs per patient). This information is based on all 2010 Medicare Part A and B claims submitted by all providers (including those not affiliated with ABC HEALTHCARE ASSOCIATES) who treated all of the Medicare beneficiaries **attributed** to your group.
- **Part IV** provides a breakdown of Medicare FFS patients' **per capita costs by specific categories of service**.
- **Part V** provides summary information about the average annual per capita costs and hospital utilization rates of subgroups of Medicare FFS patients with specific **chronic conditions** common in the Medicare population, including heart failure, chronic obstructive pulmonary disease (COPD), CAD, and diabetes.

The quality information in this report is based on quality indicators you submitted as part of the 2010 GPRO I Physician Quality Reporting System.

The cost information in this report is derived from all Medicare Part A and B claims (excluding hospice) submitted by all providers who treated Medicare FFS patients attributed to ABC HEALTHCARE ASSOCIATES, including providers who are not affiliated with your group. To the extent that Medicare claims include such information, costs are comprised of payments to providers from Medicare, from beneficiaries (copayments and deductibles), and from third-party private payers. They do not include Part D outpatient prescription drug costs.

All cost data have been **risk adjusted** to account for differences in patient characteristics that may affect costs. All comparative cost data use **price standardization** to account for differences in Medicare payments across geographic regions due to such factors as wages or rents.

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

For the purposes of this report, a Medicare beneficiary is **attributed to the single physician group practice** that billed for more Evaluation & Management (E&M) services than any other physician practice in 2010, provided the practice billed for at least two of the beneficiary's office or other outpatient E&M services.

PART I: QUALITY OF CARE INDICATORS

Exhibit 1 summarizes your group's performance on 26 quality indicators reported for your patients as part of the GPRO I Physician Quality Reporting System.

Exhibit 1. Your Medical Group Practice's Performance on GPRO I Quality Indicators, 2010

Disease Modules and Preventive Care Measures		*ABC HEALTHCARE ASSOCIATES*	All Medical Group Practices Participating in GPRO I			
			Mean	Percentile		
				10th	50th	90th
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 < 140/80**					
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 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 is 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 a 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**					

**DM-2 is a measure of poorly controlled blood sugar. Higher scores on the measure reflect worse performance.*

PART II. HOSPITAL UTILIZATION

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 2 shows how 2010 hospital admission rates for ACSCs for all Medicare patients attributed to ABC HEALTHCARE ASSOCIATES compared to the mean admission rates among medical group practices participating in the 2010 GPRO I Physician Quality Reporting System.

Exhibit 2. Hospital Admission Rates for Ambulatory Care Sensitive Conditions, 2010

Condition	Admission Rates for Medicare Patients in ABC HEALTHCARE ASSOCIATES, Per 1,000 Beneficiaries	Mean Admission Rates Among GPRO I Medical Group Practices (n=35), Per 1,000 Beneficiaries
Total	**62**	**54**
Chronic Conditions*		
Diabetes	32	25
Chronic Obstructive Pulmonary Disease	104	95
Heart Failure	139	122
Acute Conditions **		
Bacterial Pneumonia	11	12
Urinary Tract Infection	10	8
Dehydration	4	3

* *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.*

Hospitals Admitting Your Patients

Based on all Medicare Part A claims submitted in 2010, at least ten percent of your patients' inpatient stays were at one of the hospitals shown in Exhibit 3. Information on hospital performance is available on the Hospital Compare website (http://www.hospitalcompare.hhs.gov).

Exhibit 3. Hospitals Admitting the Patients of ABC HEALTHCARE ASSOCIATES, 2010

Hospital	Medicare Patients in ABC HEALTHCARE ASSOCIATES	
	Number of Inpatient Stays	Percent of All Inpatient Stays
Total	**##**	**100%**
Barrett Hospital		
Gardner Hospital		
Hillside Hospital		

PART III: PER CAPITA COSTS OF CARE

This section provides summary information about the **per capita costs of care** provided to Medicare FFS patients attributed to ABC HEALTHCARE ASSOCIATES. This information is derived from all Medicare Part A and B claims (excluding hospice) submitted by all providers who treated Medicare FFS patients attributed to ABC HEALTHCARE ASSOCIATES, including providers who are not affiliated with your group. Outpatient prescription drug (Part D) costs are not included.

Exhibit 4 shows how many patients were attributed to your practice, how many different professionals (including nurse practitioners and physician assistants) treated your patients, on average, and what proportion of those professionals were outside of your medical group practice, compared to the average among all medical group practices participating in the 2010 GPRO I Physician Quality Reporting System.

Exhibit 4. Medicare Patients Attributed to Your Medical Group Practice in 2010

Medicare Patients and Eligible Professionals Treating Them	ABC HEALTHCARE ASSOCIATES	Mean Among GPRO I Medical Group Practices (n=35)
Number of Medicare patients attributed to your practice		
Average number of professionals in all care settings who treated each patient		
Percent of professionals who did not bill under the group's TIN who treated your patients		

Based on claims submitted for your Medicare patients in 2010, risk-adjusted and price-standardized per capita costs for the # Medicare patients attributed to ABC HEALTHCARE ASSOCIATES were **$14,189**. Exhibit 5 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 2010 GPRO I Physician Quality Reporting System.

Exhibit 5. Medicare FFS Patients' Per Capita Costs*, 2010

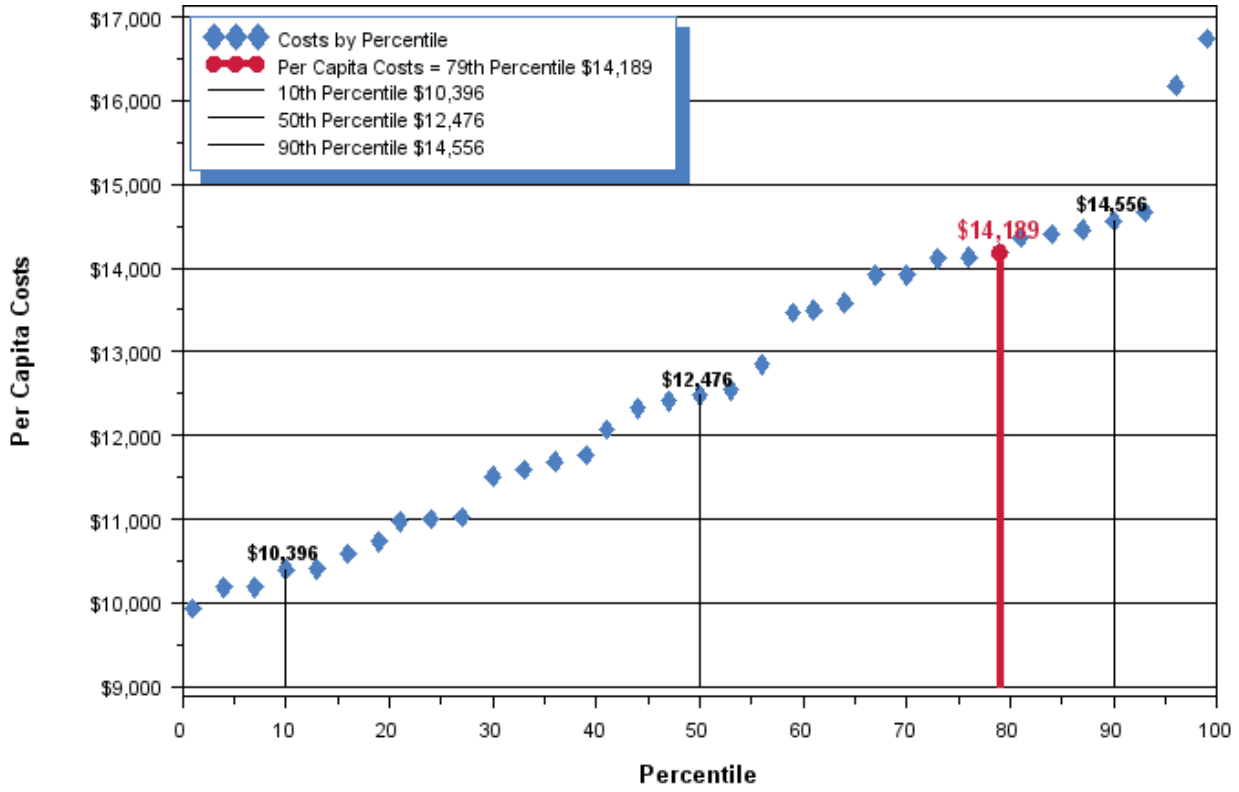
Per Capita Costs for ABC HEALTHCARE ASSOCIATES (Price Standardized)		Mean Per Capita Costs Among GPRO I Medical Group Practices (n=35)
Before Risk Adjustment	**After Risk Adjustment**	**Price Standardized and Risk Adjusted**
$XX,XXX	$14,189	$12,652

**Per capita costs are based on all Medicare Part A and Part B (excluding hospice) claims submitted in 2010 by all providers (including 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 the medical group practices participating in the 2010 GPRO I Physician Quality Reporting System ranged from a low of $9,932 to a high of $16,736. Average patient costs for your group were at the **79th percentile** of average costs among all 35 practices (Exhibit 6).

Exhibit 6. Medicare Patients' Per Capita Costs* Among Medical Group Practices Participating in GPRO I (n=35), by Percentile, 2010

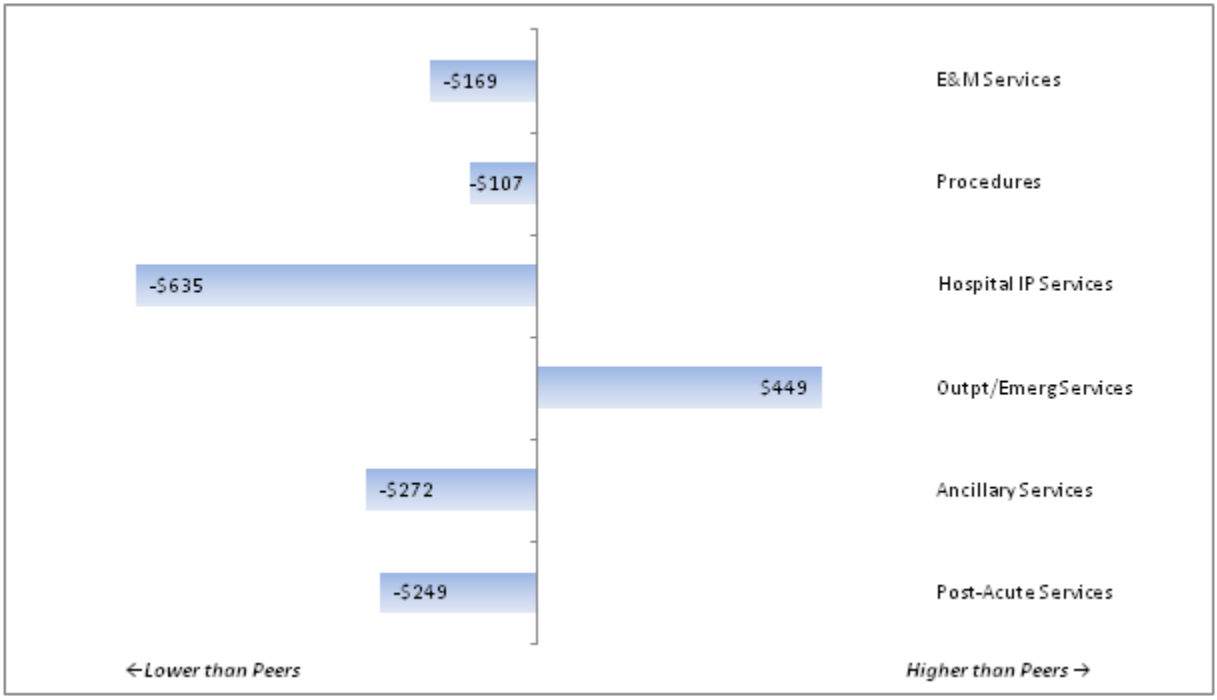


**Per capita costs are risk adjusted and price standardized and are based on all Medicare Part A and Part B claims (excluding hospice) submitted in 2010 by all providers (including professionals, hospitals, and post-acute care facilities) for Medicare beneficiaries attributed to a medical group practice. Outpatient prescription drug costs are not included.*

PART IV. PER CAPITA COSTS FOR SPECIFIC SERVICES

Exhibit 7 shows the difference between the per capita costs of specific categories of service for Medicare patients attributed to ABC HEALTHCARE ASSOCIATES and the mean among all medical group practices participating in the 2010 GPRO I Physician Quality Reporting System.

Exhibit 7. Difference Between Per Capita Costs* of Services for Your Group's Patients and Mean Per Capita Patient Costs Among Medical Group Practices Participating in GPRO I, 2010**



**Per capita costs are based on all Medicare Part A and Part B claims (excluding hospice) submitted in 2010 by all providers (including professionals, hospitals, and post-acute care facilities) for Medicare beneficiaries attributed to your group. Outpatient prescription drug costs are not included. All per capita costs are price 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 8 shows additional detail on per capita costs of services for Medicare patients attributed to ABC HEALTHCARE ASSOCIATES, compared to average costs of the group practices participating in the 2010 GPRO I Physician Quality Reporting System.

Exhibit 8. Medicare Patients' Per Capita Costs* for Specific Services, 2010

Service Category	ABC HEALTHCARE ASSOCIATES			Mean for GPRO I Medical Group Practices		Amount by Which Your Group's Costs are Higher or (Lower) than GPRO I Mean
	Medicare Patients Using Any Service in This Category		Per Capita Costs for Medicare Patients	Medicare Patients Using Any Service in This Category	Per Capita Costs for Medicare Patients	
	Number	Percent				
TOTAL	##	100%	$14,189	100%	$12,652	$1,537
Evaluation & Management Services in All Settings						
All Professional Evaluation & Management Services	##	100%	$1,128	%	$1,297	($169)
Primary Care Physicians	##	100%	$391	%	$452	
Medical Specialists	##	65%	$413	%	$372	
Surgeons	##	40%	$186	%	$210	
Emergency Department Physicians	##	22%	$106	%	$84	
Other Professionals**	##	%	$33	%	$179	
Procedures in All Settings						
All Procedures	##	65%	$769	%	$876	($107)
Primary Care Physicians	##	42%	$289	%	$31	
Medical Specialists	##	38%	$138	%	$229	
Surgeons	##	56%	$100	%	$389	
Emergency Department Physicians	##	18%	$47	%	$4	
Other Professionals**	##	%	$195	%	$222	
Hospital Services						
Inpatient Hospital Facility Services	##	44%	$3,277	%	$3,912	($635)
Outpatient and Emergency Services	##	30%	$2,989	%	$2,540	$449
Clinic or Emergency Visits			$936	%	$416	
Procedures			$880	%	$1,378	
Laboratory Tests			$626	%	$327	
Imaging Services			$548	%	$420	
Services in Ambulatory Settings						
All Ancillary Services	##	80%	$784	%	$1,056	($272)
Laboratory Tests			$364	%	$188	
Imaging Services			$263	%	$350	
Durable Medical Equipment			$156	%	$518	
Post-Acute Care						
All Post-Acute Services	##	20%	$1,412	%	$1,661	($249)
Skilled Nursing Facility			$607	%	$713	
Psychiatric or Rehab Facility			$384	%	$357	
Home Health			$136	%	$590	
Other Services						
All Other Services* **	##	100%	$3,830	100%	$1,310	$2,520

** 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, not just those who used the service.*

*** Other Professionals include, for example, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse anesthetists, clinical social workers, clinical psychologists, dieticians, audiologists, physical therapists, and speech therapists. (See Appendix A for specialty codes included.)*

PART V: COSTS AND HOSPITAL UTILIZATION FOR SUBGROUPS OF PATIENTS WITH CHRONIC CONDITIONS

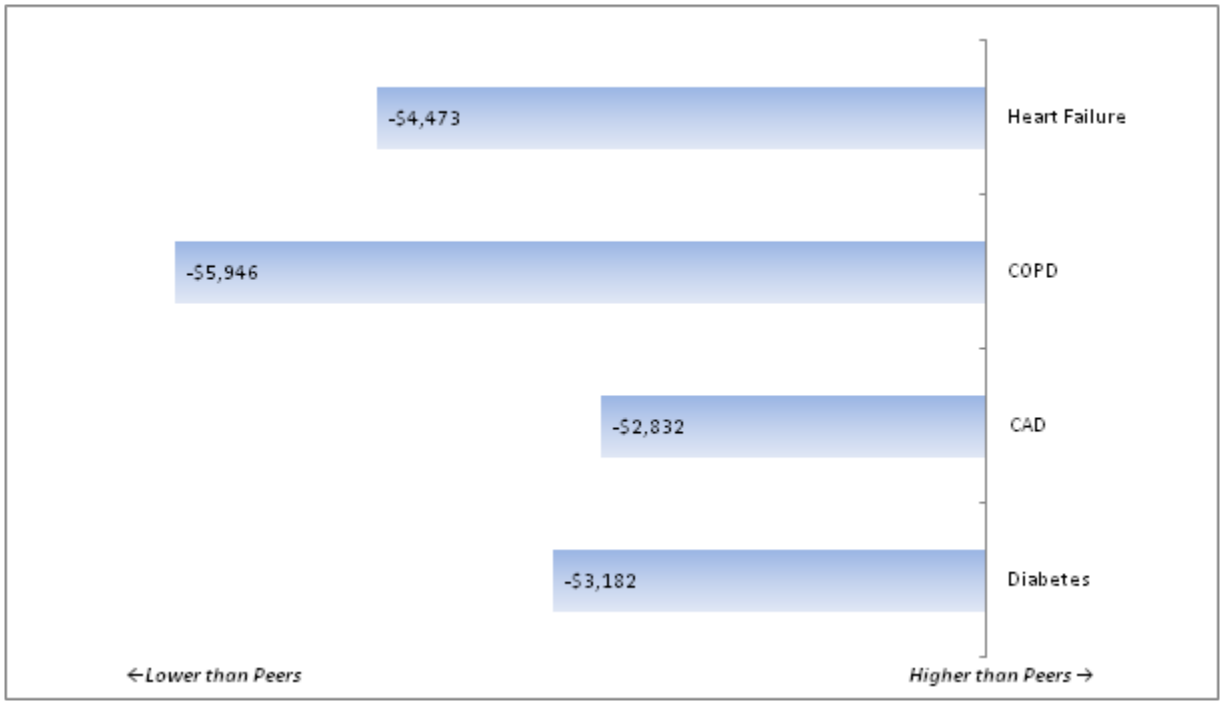
This section provides information on the total risk-adjusted and price-standardized per capita costs incurred by subgroups of your Medicare patients identified as having specific **chronic health conditions** in 2009. It also provides information on hospital utilization by subgroup.

Total Per Capita Costs by Subgroup

Exhibit 9 shows the difference between the per capita costs of Medicare patients attributed to ABC HEALTHCARE ASSOCIATES by chronic condition subgroup and mean costs for each subgroup among all medical group practices participating in the 2010 GPRO I Physician Quality Reporting System.

The subgroups are not mutually exclusive, which means that 100 percent of the 2010 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 9. Difference Between Your Group's Per Capita Costs* of Care for Patient Subgroups and Mean Among Medical Group Practices Participating in GPRO I, 2010



**Per capita costs are based on all Medicare Part A and Part B claims (excluding hospice) submitted by all providers in 2010 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 costs are not included. All costs are price standardized and risk adjusted.*

Hospital Utilization by Subgroup

Exhibit 10 shows the number of your group's Medicare patients in each chronic condition subgroup in 2010 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 10. Use of Inpatient and Emergency Hospital Services,* by Chronic Condition Subgroup, 2010

Chronic Condition Subgroup	Medicare Patients in ABC HEALTHCARE ASSOCIATES			Medicare Patients in GPRO I Medical Group Practices (n=35)		
	Number of Patients with This Condition	Hospital Admissions per 1,000 Patients with This Condition	Hospital ED Visits** per 1,000 Patients with This Condition	Mean Number of Patients with This Condition	Mean Number of Inpatient Hospital Admissions per 1,000 Patients with This Condition	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 Diabetes

Based on all Medicare Part A and Part B claims (excluding hospice) submitted in 2010 for ## patients in the diabetes subgroup attributed to ABC HEALTHCARE ASSOCIATES, per capita costs for Medicare patients with this condition were **$15,410.**

Exhibit 11.Diabetes shows how the per capita costs of your Medicare patients with diabetes, before and after risk adjustment,[2] compared to the mean per capita costs of diabetes patients in the 35 medical group practices participating in the 2010 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 11.Diabetes. Per Capita Costs* of Medicare Patients with Diabetes, 2010

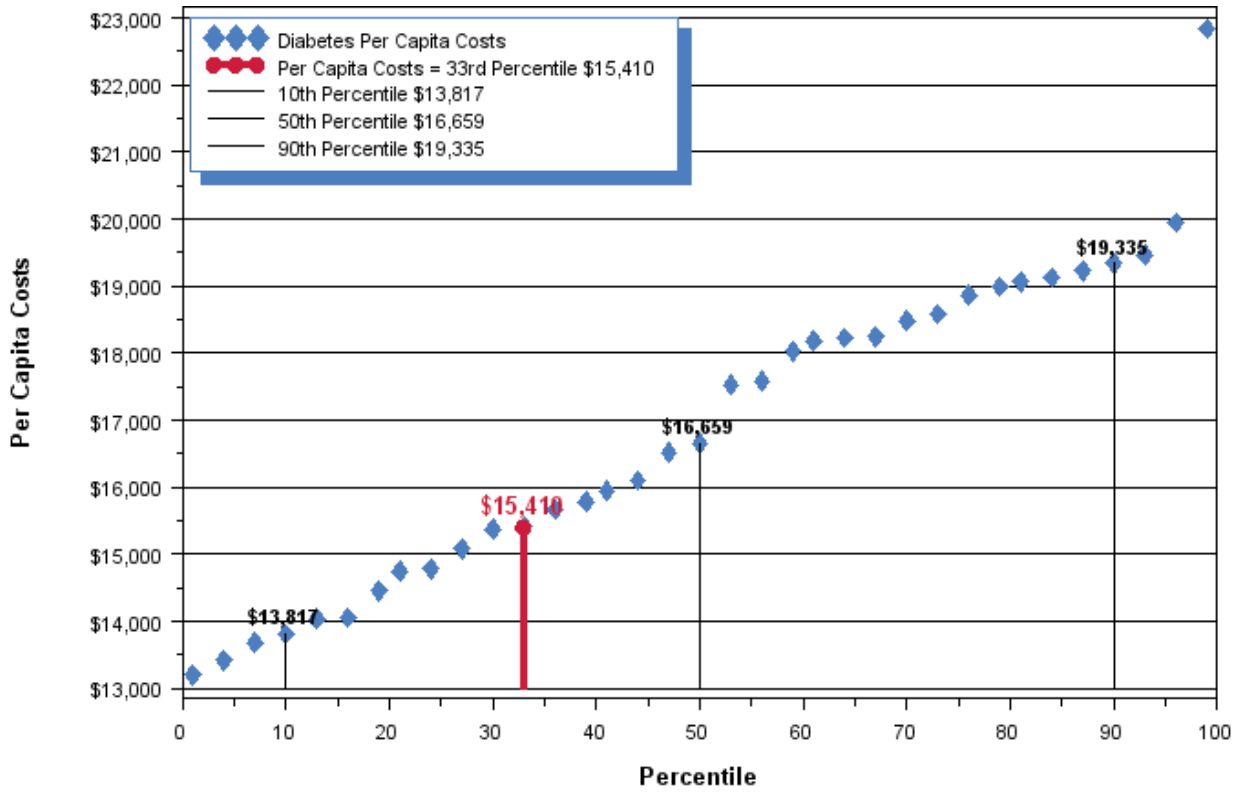
Per Capita Costs for ABC HEALTHCARE ASSOCIATES (Price Standardized)		Mean Per Capita Costs Among GPRO I Medical Group Practices that Treat Patients with This Condition (n=xx)
Before Risk Adjustment	**After Risk Adjustment**	**Price Standardized and Risk Adjusted**
$XX,XXX	$15,410	$18,592

**Per capita costs are based on all Medicare Part A and Part B claims (excluding hospice) submitted in 2010 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 costs are not included.*

[2] 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 the ## medical group practices participating in the 2010 GPRO I Physician Quality Reporting System that treat patients with diabetes, per capita costs for patients with diabetes ranged from a low of $13,204 to a high of $22,839. Your group's per capita costs for patients with this condition were at the **33rd percentile** among GPRO I medical group practices (Exhibit 12.Diabetes).

Exhibit 12. Diabetes. Per Capita Costs* for Medicare Patients with Diabetes Among Medical Group Practices Participating in GPRO I that Treat Patients with This Condition (n=##), by Percentile, 2010



**Per capita costs are based on all Medicare Part A and Part B claims (excluding hospice) submitted by all providers in 2010 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 price standardized and risk adjusted. Outpatient prescription drug costs are not included.*

Total Per Capita Costs for Coronary Artery Disease

Exhibit 11.CAD
Exhibit 12.CAD

Total Per Capita Costs for Chronic Obstructive Pulmonary Disease

Exhibit 11.COPD
Exhibit 12.COPD

Total Per Capita Costs for Heart Failure

Exhibit 11.CHF
Exhibit 12.CHF

GLOSSARY OF TERMS

(2010 GPRO I Physician Quality Reporting System Medical Group Practices)

AMBULATORY CARE SENSITIVE CONDITIONS (ACSCS) are conditions for which good outpatient care can prevent complications or more serious disease. These conditions include diabetes, chronic obstructive pulmonary disease, 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. 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) includes rates of hospital admission per thousand Medicare beneficiaries attributed to GPRO I Physician Quality Reporting System medical group practices, calculated from 2010 Medicare Part A claims data, for the following six ACSCs:

(1) Diabetes – a composite measure, based on short term diabetes complications; uncontrolled diabetes; long term diabetes complications; and lower extremity amputation for diabetes

(2) Chronic Obstructive Pulmonary Disease (COPD)

(3) Heart Failure

(4) Bacterial Pneumonia

(5) Urinary Tract Infection (UTI)

(6) Dehydration

In calculating ACSC rates, the numerator is the number of beneficiaries attributed to the medical group who were identified as having been hospitalized for that condition as the primary reason for the hospital admission in 2010. The denominator for the chronic conditions (diabetes, COPD, heart failure) is restricted to patients diagnosed with the specific condition. For the acute conditions (pneumonia, UTI, dehydration), the denominator includes all Medicare patients attributed to the medical group practice. The quotient (numerator divided by denominator) is then multiplied by 1,000, to yield rates per thousand. A medical group practice's hospital admission rate for each ACSC is compared to the mean admission rate among all medical group practices participating in the 2010 GPRO I Physician Quality Reporting System.

ATTRIBUTION OF BENEFICIARIES TO MEDICAL GROUP PRACTICES. Medicare beneficiaries were attributed to the single physician 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-1 below) and a larger number of E&M services for the beneficiary (measured by Medicare allowed charges) than any other physician practice,[3] based on 2010 Carrier (Part B) Medicare claims (i.e., the plurality of E&M services).

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

Beneficiaries who were not enrolled in both Medicare Parts A and B for the entire 2010 calendar year were not attributed to any physician practice. Thus, beneficiaries were excluded if, for any months from January 1, 2010 through December 31, 2010, 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, 2010; they died in 2010; 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 to report clinical data for the first 411 beneficiaries on their list of assigned beneficiaries drawn for all attributed 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.

Table G-1: 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		

Excluded
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 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 Centers for Medicare & Medicaid Services' (CMS's) Chronic Condition Warehouse were used to identify patients with the four conditions of interest.

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 QRURs, 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 2009

(2) The number of inpatient hospital admissions per 1,000 attributed beneficiaries with the chronic condition in 2009 (whether or not the hospital admissions were specifically related to that chronic condition)

(3) The number of hospital emergency department (ED) visits (that did not lead to an inpatient admission) per 1,000 attributed beneficiaries with the chronic condition in 2009 (whether or not the ED visits were specifically related to that chronic condition)

At the time the reports were prepared, chronic health condition indicators for GPRO-attributed beneficiaries were not yet available for 2010. A medical group practice's count of beneficiaries and their utilization statistics are presented in the QRUR relative to the average (mean) performance of all 35 GPRO I Physician Quality Reporting System medical group practices.

MEASURE POPULATIONS. Per capita cost measures, utilization statistics, and ACSC rates in this report are calculated based on all Medicare 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 to report clinical data for the first 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 refers to a single provider entity, identified by its tax identification number (TIN), which met the criteria for participation in the 2010 GPRO I Physician Quality Reporting System. These include the following:

- The 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 2010 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 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 TIN in 2010. A professional's medical specialty was determined based on the HCFA medical specialty code listed most often on those 2010 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 2010 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 2010 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 and hospital utilization among subgroups of patients who have chronic conditions. Calculations for the 2010 per capita cost and hospital utilization measures include all beneficiaries who were enrolled in both Parts A and B of original FFS Medicare for all of the calendar year.

PEER GROUPS. To provide a comparative context for the information in this QRUR, 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 QRUR, the peer group is defined as medical group practices participating in the 2010 GPRO I Physician Quality Reporting System. 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 are the average (mean) of all 2010 Medicare 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 QRUR compared to the mean (average) performance of all medical group practices participating in the 2010 GPRO I Physician Quality Reporting System.

Per capita cost measures in this QRUR were calculated using 2010 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 2010 administrative claims data using inpatient, outpatient, skilled nursing facility, home health, durable medical equipment, and Medicare Carrier (non-institutional provider) claims. Part D (Outpatient Prescription Drug) claims were not included in the 2010 cost measure calculations. To the extent that Medicare claims include such information, costs are comprised of payments to providers from Medicare, from beneficiaries (copayments and deductibles), and from third-party private payers.

Per capita costs were calculated by first summing the price-standardized or (as labeled for a given Exhibit in the report) both price-standardized and risk-adjusted Medicare Parts A and B costs during the 2010 calendar year for all Medicare beneficiaries who were attributed to the medical group (the numerator). This numerator was then divided 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.

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

- All professional E&M services provided by primary care physicians, medical specialists, surgeons, emergency department physicians, and other professionals (Appendix A shows how medical professionals were grouped into one of these five categories)
- All procedures performed by primary care physicians, medical specialists, surgeons, emergency department physicians, and other professionals
- Inpatient hospital facility services
- Hospital outpatient and emergency services, including clinic or emergency visits, procedures, laboratory tests, and imaging services
- All ancillary services provided in ambulatory settings, including laboratory tests, imaging services, and durable medical equipment
- Post-acute services including skilled nursing care, psychiatric or rehabilitation 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 2010 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 calculated 1) by summing the price-standardized risk-adjusted Medicare Part A and Part B costs for attributed beneficiaries identified as having the given chronic condition and 2) by dividing that sum by the number of attributed 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, a separate risk adjustment model for subgroup per capita costs captures other chronic and acute co-morbidities associated with beneficiaries in the particular subgroup.

PRICE 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 or differences in Medicare payment rates among facilities. 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 price standardized to allow for comparisons to peers who may practice in locations or facilities where reimbursement rates are higher or lower. Price standardization is performed prior to calculating per capita price-adjusted and risk-adjusted cost measures.

RISK ADJUSTMENT takes into account differences in patient characteristics that can affect their medical costs, 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, we used 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 2010, the HCC model generates a 2009 score based on the presence of these conditions in 2009—and on sex, age, original reason for Medicare entitlement (either age or disability), and Medicaid entitlement—as a predictor of beneficiary costs in 2010. Risk adjustment of 2010 costs also takes into account the presence of end-stage renal disease (ESRD) in 2009.

A statistical risk adjustment model estimates the independent effects of these factors on absolute beneficiary costs and adjusts 2010 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.

APPENDIX A
HCFA (CMS) SPECIALTY CODES FOR DETERMINING PROVIDER STRATIFICATION CATEGORY IN EXHIBIT 8

HCFA Specialty Code	HCFA 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
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 Medicine	Medical Specialists
13	Neurology	Medical Specialists
14	Neurosurgery	Surgeons
15	Speech Language Pathologists	Other
16	Obstetrics/Gynecology	Surgeons
17	Hospice and Palliative Care	Medical Specialists
18	Ophthalmology	Surgeons
19	Oral Surgery (dental only)	Surgeons
20	Orthopedic Surgery	Surgeons
22	Pathology	Other
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
31	Intensive Cardiac Rehabilitation	Other
32	Anesthesiologist Assistant	Other
33	Thoracic Surgery	Surgeons
34	Urology	Surgeons
35	Chiropractor, Licensed	Other
36	Nuclear Medicine	Other
37	Pediatric Medicine	Other
38	Geriatric Medicine	Primary Care Physicians
39	Nephrology	Medical Specialists
40	Hand Surgery	Surgeons
41	Optometry	Other
42	Certified Nurse Midwife	Other
43	Certified Registered Nurse Anesthesiologist	Other
44	Infectious Disease	Medical Specialists

HCFA Specialty Code	HCFA Specialty Description	Provider Stratification Category
46	Endocrinology	Medical Specialists
48	Podiatry	Other
50	Nurse Practitioner	Other
55	Individual certified orthotist	Other
56	Individual certified prosthetist	Other
57	Individual certified prosthetist-orthotist	Other
62	Clinical Psychologist	Other
64	Audiologist	Other
65	Physical Therapist	Other
66	Rheumatology	Medical Specialists
67	Occupational Therapy	Other
68	Clinical Psychologist	Other
70	Multispecialty Clinic or Group Practice	Other
71	Registered dietician/nutritional professional	Other
72	Pain Management	Other
76	Peripheral Vascular Disease	Surgeons
77	Vascular Surgery	Surgeons
78	Cardiac Surgery	Surgeons
79	Addiction Medicine	Medical Specialists
80	Licensed Clinical Social Worker	Other
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
89	Certified Clinical Nurse Specialist	Other
90	Medical Oncology	Medical Specialists
91	Surgical Oncology	Surgeons
92	Radiation Oncology	Other
93	Emergency Medicine	Emergency Medicine Physicians
94	Interventional Radiology	Other
96	Optician	Other
97	Physician Assistant	Other
98	Gynecology/Oncology	Surgeons
99	Unknown Physician	Other