DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

[GROUP NAME]
Last Four Digits of Your Group's Tax Identification Number: [LAST FOUR DIGITS OF TIN]

NOTICE FROM THE CENTERS FOR MEDICARE & MEDICAID SERVICES

Confidential Quality and Resource Use Report for Medicare Fee-for-Service Patients Included in the 2010 Physician Quality Reporting System Group Practice Reporting Option

September 26, 2011

The Centers for Medicare & Medicaid Services (CMS) is pleased to make available this Quality and Resource Use Report, a confidential report about the quality and costs of care provided to fee-for-service Medicare patients that your medical group practice included in its 2010 Physician Quality and Reporting System Group Practice Reporting Option (GPRO I). Under the provisions of the Patient Protection and Affordable Care Act of 2010, the Secretary of Health and Human Services is required to phase in furnishing confidential feedback reports to physicians. This report contains information about the resources your group used and the quality of care the group of your Medicare patients received in 2010. CMS is providing a confidential feedback report to each of the 35 medical group practices that participated in GPRO I in 2010.

The information in the accompanying report is based on clinical data you submitted to CMS and Medicare claims submitted in 2010 by all providers caring for the subset of fee-for-service patients attributed to your medical group practice for the Physician Quality Reporting System Group Practice Reporting Option in 2010. The report displays information on how the quality and costs of your Medicare patients' care compare with averages among the 35 GPRO I medical groups. Additional information about the Quality and Resource Use Reports and a description of the report methodology are available on the CMS website at http://www.cms.gov/physicianfeedbackprogram.

CMS is very interested in hearing your thoughts on the design and content of these reports. Your comments will help shape future physician feedback reports, value-based purchasing efforts across CMS, and the development of a value-based payment modifier for physician services. Section 3007 of the 2010 Affordable Care Act directs the Secretary of Health and Human Services to develop and implement a budget-neutral payment system that will employ a value-based payment modifier to adjust Medicare physician fee schedule payments based on the quality and cost of care physicians deliver to Medicare beneficiaries. The Secretary will phase in the new payment modifier over a two-year period beginning in 2015, with the initial performance period beginning in 2013. In 2015 and 2016, specific physicians and/or groups of physicians that the Secretary determines appropriate will participate. Beginning in 2017, all physicians are expected to be affected.

We plan to **convene two conference calls with report recipients** and CMS staff in the coming weeks to obtain your opinions on the reports. As we continue to test content and expand the number of physicians and medical group practices that receive a report in future years, we would greatly welcome your participation.

The first conference call will be held on **Wednesday, October 5, 2011 (from 12:00pm-1:30pm EDT; 1-877-267-1577; Meeting ID 8753),** and the second call will be held on **Thursday, October 13, 2011 (from 4:00pm -5:30pm EDT; 1-877-267-1577; Meeting ID 8616)**. Both calls will address **any technical questions** you may have about your report, as well as give you an opportunity to suggest **how these reports might be made more fair, actionable, and/or meaningful** in the future. We plan to address the following topics, in addition to listening to any other comments and suggestions that you may have:

- Whether you had any difficulty in interpreting your report
- The meaning of any terms or exhibits not explained in sufficient detail in the report
- The methods used to produce the reports, including, for example, methods of attributing patients to group practices, computing per capita costs of your patients, or risk adjusting per capita costs
- Whether the report accurately reflects the Medicare fee-for-service patients your medical group treated in 2010
- How you might use the report in your group's practice
- How the content, design, and methods of the reports could be enhanced for your group's use in quality and cost improvement activities
- How the reports could be used to support the value-based payment modifier for physician fee-for-service payments, to be phased into the Medicare program starting in 2015

We hope that members of your medical group practice will be able to participate in either of the two identical calls. **Please let us know the name of persons (and date each is planning to participate) by sending an e-mail to** CMS_Medicare_Physician_Feedback_Program@mathematica-mpr.com at least 5 days before the call so we can be sure to have enough call-in lines and can distribute the call-in information to you. In addition, please feel free to e-mail any comments or questions to CMS_Medicare_Physician_Feedback_Program@mathematica-mpr.com, either before or after the scheduled calls.