PQRS SOLUTIONS

PAY FOR PERFORMANCE SOLUTIONS

Avoiding Medicare Penalties

Part I, Sept. 29: Value-Based Modifier & Quality Tiering

Part II, Oct. 6: Unlocking the Quality and Resource Use Report

Part III, October 13: What We Know About MIPS AND Responding to Medicare's Request for Information

Dr. Dan Mingle, CEO

MINGLE ANALYTICS

Agenda

- Why are we here?
- Introduction to Mingle Analytics
- Review of PQRS 2015, Value-Based Modifier & Quality Tiering
- Understanding the QRUR Report

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You Avoided The PQRS and VBM Modifier Penalties for 2015

"You will be subject to a 2.0% downward payment adjustment against all of your Medicare payments for 2016 services due to failure to make a qualifying 2014 PQRS submission."

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Now you are subject to
Quality Tiering
In the
Value Based Modifier Program

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2 Quality Tiering Program Years Remain

-

Up to 4% per Year to Gain or Lose

Program Year	Service Year	Reporting Due	Adjustment Applied
2017	2015	March 31, 2016	2017 Medicare Part B Payments
2018	2016	March 31, 2017	2018 Medicare Part B Payments
2019	2017	→ MIPS is Here ←	

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PQRS Solutions™ from Mingle Analytics

Nobody knows PQRS like we do!

Over 30,000 Successful Submissions since 2012 with a 99.997% Success Rate

Qualified to Submit All Measures
Leading-Edge Tools and Processes
In Medicare's top 10 GPRO Registry Vendors for 2013

Your Quality Reporting Partner. We help:

- Practices of all Sizes—solo providers to 6,000 provider healthcare systems
- Providers of all Credentials and Specialties
- All 50 States

You will be receive personalized support from our knowledgeable PQRS Consultants backed by a full clinical team

PQRS Solutions™ from Mingle Analytics

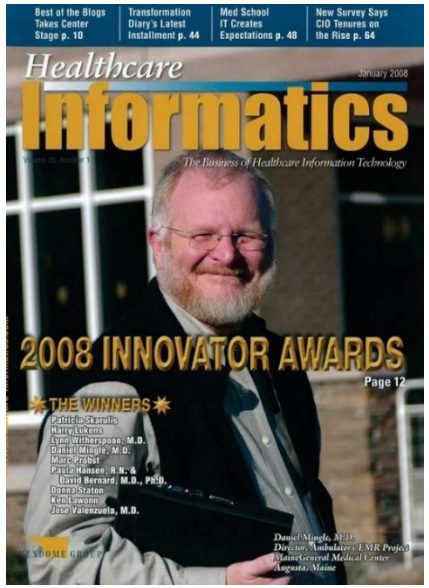
Nobody knows PQRS like we do!

Dr. Dan Mingle, MD, MS

- Family Physician
  - Group Practice owner-manager
  - Residency Faculty
  - Director of Clinical Informatics
- Feature in *Healthcare Informatics* magazine
- Reporting PQRS since 2008
- Principle Architect for nine registries

Kash Basavappa

- Thirty years in healthcare and healthcare informatics
- Recipient of multiple awards as Chief Information Officer
- Directed development of commercial healthcare information technology products



Assisted By

- PQRS Consultants providing
  - Client Support
  - Account Management
  - Project Management
- Data Analysts
- Software Development Staff

Gay De Hart

- Ten years in healthcare
- Practice Manager
- Business Writer – Grant Writer
- Reporting PQRS since 2012

Scott Larsen

- 27 years in Information Technology
- 6 years in healthcare informatics
- Web Applications, Software as a Service
- Security Infrastructures
- Building environments that scale

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REVIEW OF PQRS 2015, VALUE-BASED MODIFIER & QUALITY TIERING

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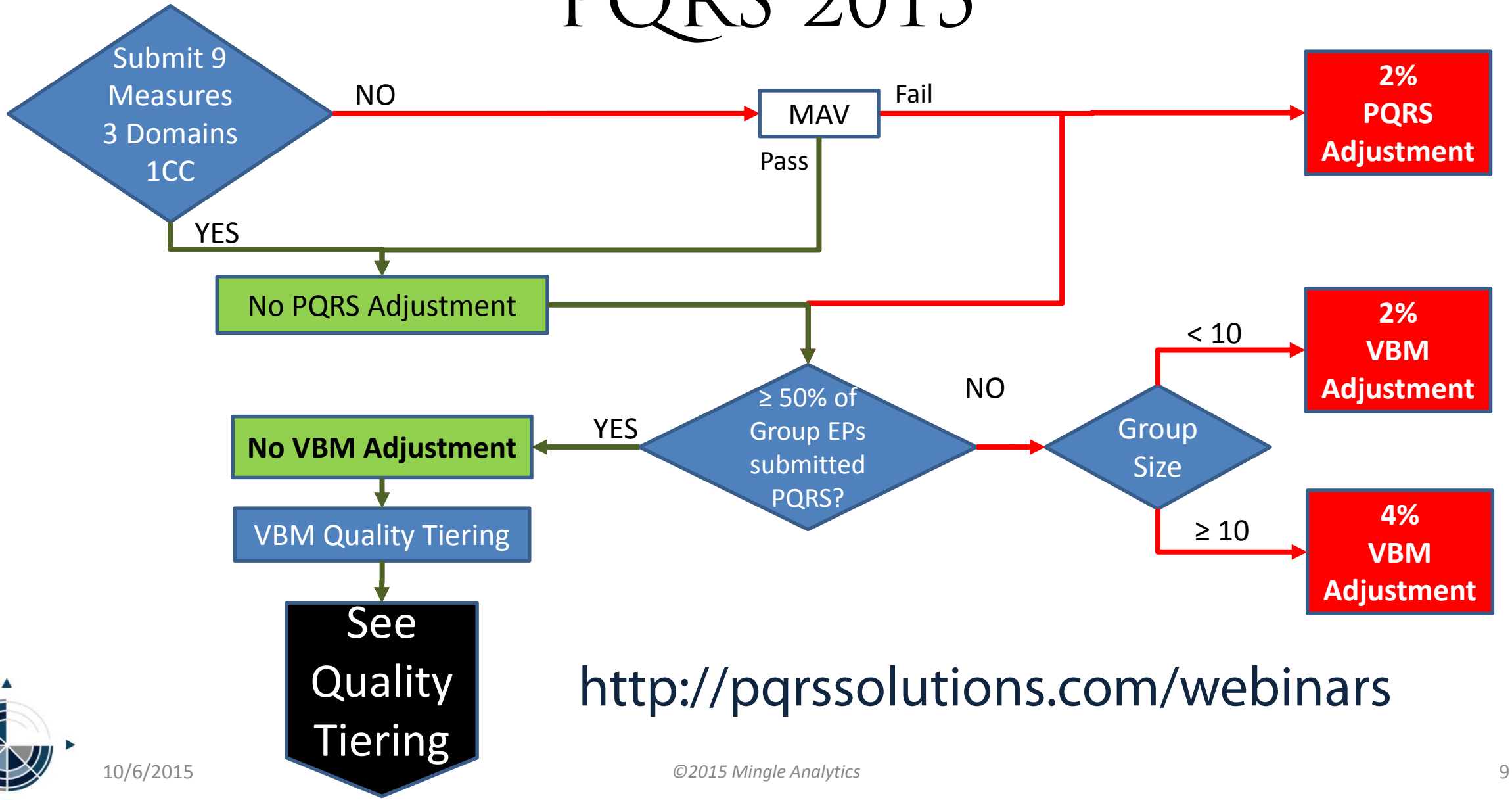
PQRS 2015



http://pqrssolutions.com/webinars

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The Future of PQRS – A System in Evolution

4/15/2015: The "Doc Fix Bill" repealed MC part B Sustainable Growth Rate Formula and …

2016 (2018) is the Final Year in their current form:

- Physician Quality Reporting System (PQRS)
- Value Based Modifier (VBM)
- Quality Tiering
- Meaningful Use

<u>Merit-Based Incentive Payment System (MIPS)</u>

- ((Quality Tiering + PQRS + VBM + EHR) + a – b) x N
  - Competition on a 100 point scale
    - 30 quality points
    - 30 resource use points
    - 25 meaningful use points
    - 15 practice improvement points
  - Increasing Adjustments
    - ±4% 2017 (2019)
    - ±9% 2020 (2022)

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We are Your Solution in Evolution

Today and Thru March 31, 2017	We are PQRS Solutions™ by Mingle Analytics	Your Solution for PQRS
As of January 1, 2017	We will be MIPS Solutions™ by Mingle Analytics	Your Solution for MIPS

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Register and access recordings:
http://pqrssolutions.com/webinars

Dr. Dan Mingle, CEO

MINGLE ANALYTICS

QUALITY TIERING

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About Quality Tiering

Quality Composite

A. PQRS Measures by Domain
B. Non – PQRS Measures

(Domain = Communication and Care Coordination)

1. Preventing Acute Illness Admissions
   - Bacterial Pneumonia
   - Urinary Tract Infections
   - Dehydration
2. Preventing Chronic Disease Admissions
   - Uncontrolled Diabetes
   - Short term diabetic complications
   - Long Term diabetic complications
   - Diabetic Lower Extremity Amputations
   - Acute COPD Exacerbations
   - Decompensated Heart Failure
3. All Cause Readmission

Cost Composite

- Attributed Patients – "Plurality of Care"
- Global Annual Per Capita Cost of Care in 5 Strata
  A. All Patients
  B. COPD
  C. Heart Failure
  D. Coronary Artery Disease
  E. Diabetes
- Modification requires careful selection of clinical partners and coordination of Care

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Quality Tiering

80% of Participants receive no adjustment

10% of Participants Penalty Range

10% of Participants Incentive Range

5%	90%	5%		
Low Quality	Avg Quality	High Quality		
0	+2x%	+4x%	Low Cost	5%
-2%	0	+2x%	Avg Cost	90%
-4%	-2%	0	High Cost	5%

High and Low Defined as 1 Standard Deviation above or below the mean

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Quality Tiering

VBM Program Year	Service Provided	Notes	Applies to	Reporting Complete	Adjustment Applied
2015	**2013**	First Year – QT Elective	Physicians in Groups of 100 or More	2014	2015
2016	**2014**	QT Expands and Mandatory	Physicians in Groups of 10 or More	2015	2016
2017	**2015**	QT Expands	All Physicians	2016	2017
2018	**2016**	QT Expands	All Physicians, PA, NP, CRNA, APN..	2017	2018

Physician = doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, optometry, and chiropracty

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YOUR BEST GUIDE TO HOW YOU WILL FARE IN 2017 QUALITY TIERING

IS YOUR 2014 QUALITY AND RESOURCE USE REPORT (QRUR)

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Access Your QRUR Report in your CMS Enterprise Portal (PV-PQRS)

HTTPS://PORTAL.CMS.GOV/WPS/PORTAL

IACS → EIDM Credentials

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3 QRUR Reports

Reports	Delivered	Content
Mid-Year QRUR	April	July 1 – June 30 Cost and Administrative Claims Performance No affect on Payments
Annual QRUR	September	Last Calendar Year Cost and Quality Performance Affect On Payments
Supplemental QRUR	September	Cost by Episode Grouper No affect on Payments

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2-Step Attribution of patients

Step 1	beneficiary is attributed to the TIN whose primary care physicians provided the plurality (highest number) of allowed Medicare charges
Step 2	When there are no Primary Care Provider visits beneficiary is attributed to the TIN whose non-primary care providers provided the plurality (highest number) of allowed Medicare charges. There must be at least one Primary Care coded visit by a physician in the TIN

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Primary Care Visit Codes	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

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3 Cost Adjustments

Geographic	All Cost Measures adjusted to Geographic Allowable Cost differences
Specialty	All Cost Measures adjusted to Specialty Averages by Specialty Mix
Risk	70 High Risk Conditions by HCC methodology

There must be 20 cases to be included in any cost or quality measure comparison

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On Eligibility and Adjustment

Eligibility	2017 Adjustment
Count of Eligible Professionals	Applies only to Physicians

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Lets Dissect a De-Identified 2012 QRUR

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

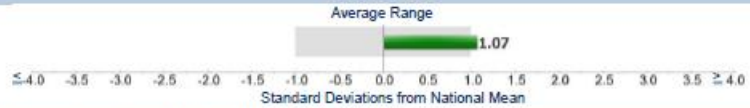
Best Practice Medical Group

Last Four Digits of Your Group's Taxpayer Identification Number (TIN): 1234

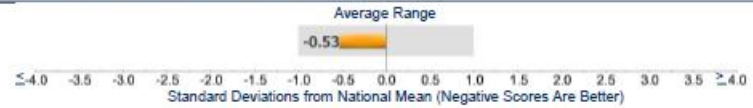
ABOUT THIS REPORT FROM MEDICARE	
WHY	• Medicare will apply a value-based payment modifier, starting in 2015, to medical group practices with 100 or more eligible professionals, based on participation in the Physician Quality Reporting System (PQRS) during 2013. Groups that do not participate in PQRS 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: HIGH



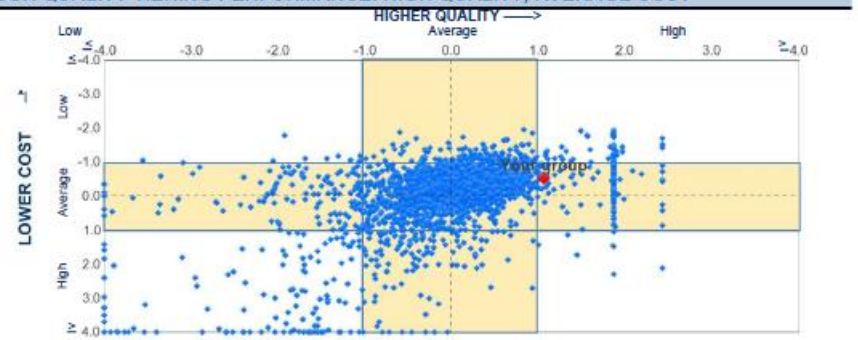
YOUR COST COMPOSITE SCORE: AVERAGE



YOUR BENEFICIARIES' AVERAGE RISK SCORE: 70TH 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 downward by 4.1 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: HIGH 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 +1.0x%.

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.

2

- Page 2
  - 4 Sections

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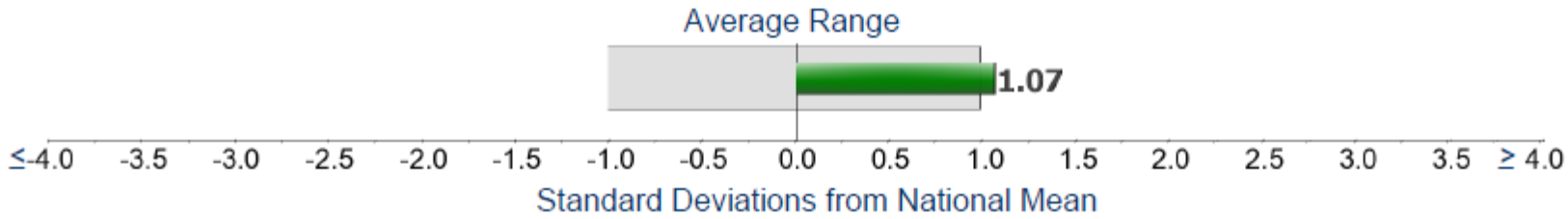
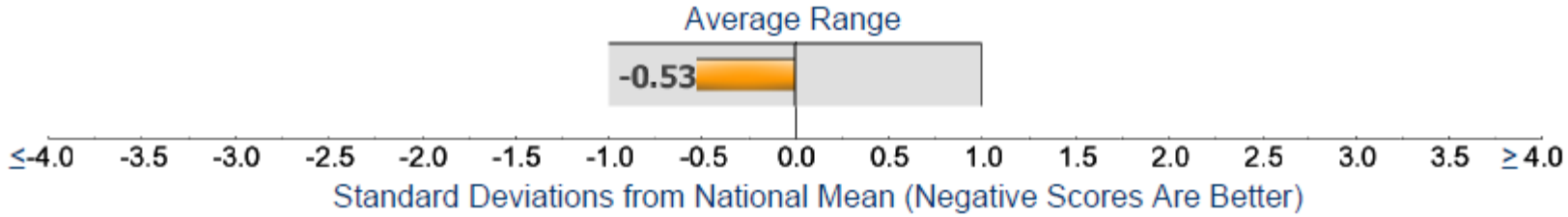
PERFORMANCE HIGHLIGHTS

YOUR QUALITY COMPOSITE SCORE: HIGH



YOUR COST COMPOSITE SCORE: AVERAGE



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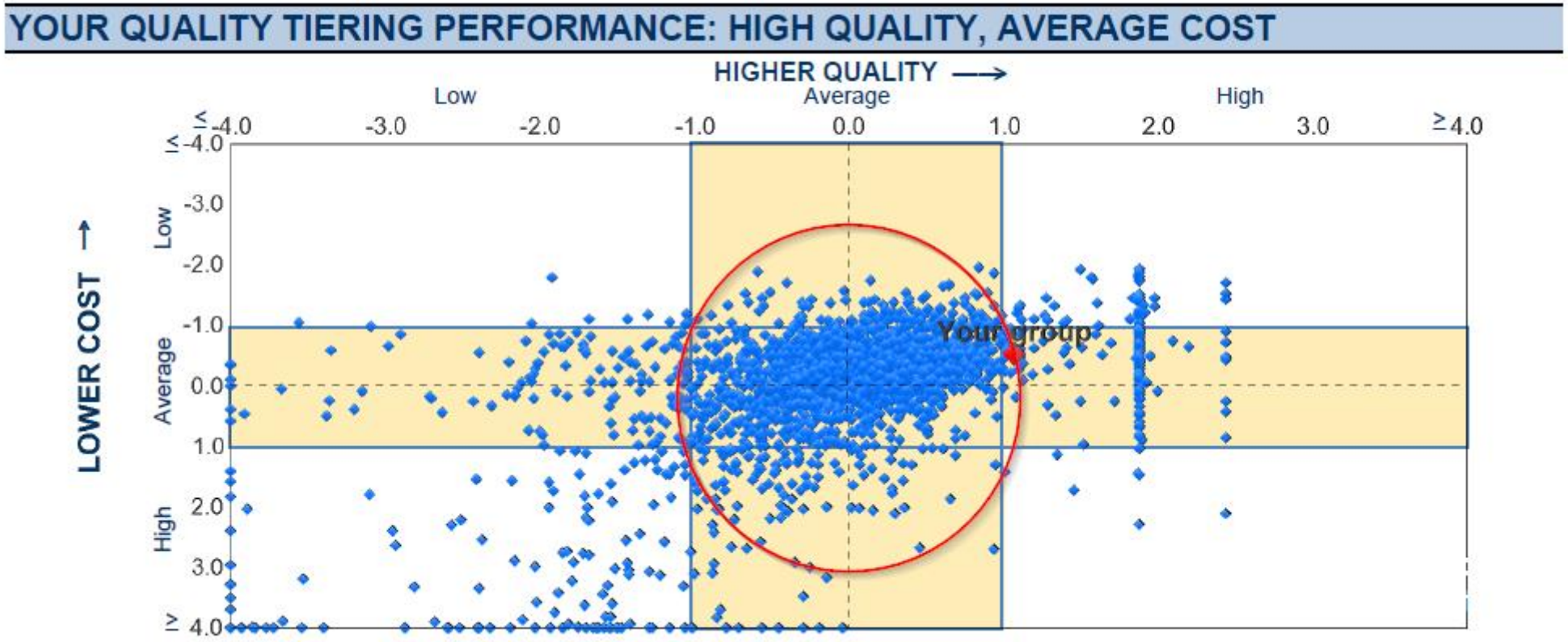
QRUR Regional Report



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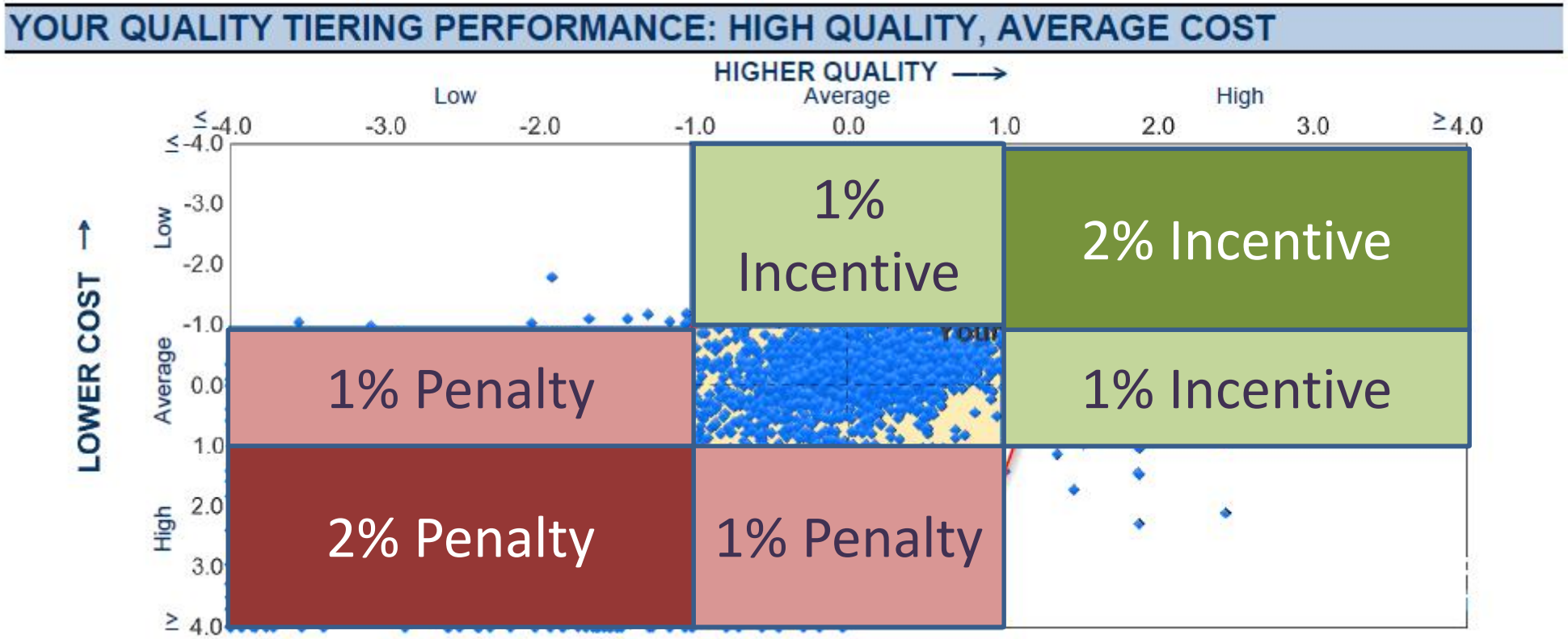
QRUR Regional Report



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Adjustment/Incentive Results

YOUR VALUE-BASED PAYMENT ADJUSTMENT BASED ON QUALITY TIERING

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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.

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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 3,876 medical group practices with 25 or more eligible professionals (peer group). Based on Medicare claims, a total of 51 eligible professionals, of whom 48 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	271	271	0
Average percentage of primary care services provided by your group, per attributed beneficiary	49.3%	49.3%	

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 3,876 Medical Group Practices with at Least 25 Eligible Professionals
Number of Medicare patients attributed to the medical group practice	271	3,007
Average percentage of primary care services provided by the medical group practice to each attributed beneficiary	49.3%	65.0%
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	89.8%	75.0%

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

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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 whodid not bill under the group's TIN	89.8%	75.0%

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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 1.07 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	**12**	**1.07* (High)**
Average Domain Score	12	1.12
Clinical Process/Effectiveness	7	-0.11
Patient Safety	2	2.45
Care Coordination	3	1.02

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.

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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	**12**	**1.07* (High)**
Average Domain Score	12	1.12
Clinical Process/Effectiveness	7	-0.11
Patient Safety	2	2.45
Care Coordination	3	1.02

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Exhibit 4-CPE. 2012 Performance on Claims-Based Quality Indicators in the Clinical Process/Effectiveness Domain Clinical Process/Effectiveness Domain Score = -0.11

Performance Measures	Your Medical Group Practice's Performance		Performance of All 3,876 Groups with at Least 25 Eligible Professionals		
				Average Range	
	Number of Eligible Cases	Performance Rate	Benchmark Rate	Benchmark –1 Standard Deviation	Benchmark +1 Standard Deviation
Bone, Joint, and Muscle Disorders					
Osteoporosis Management in Women _> 67 Who Had a Fracture	1	0.0%	18.9%	12.3%	25.4%
Chronic Obstructive Pulmonary Disease (COPD)					
Use of Spirometry Testing to Diagnose COPD	10	20.0%	31.6%	22.2%	41.0%
Diabetes Mellitus					
Dilated Eye Exam for Beneficiaries < 75 with Diabetes	42	52.4%	55.9%	46.8%	64.9%
Hba1c Testing for Beneficiaries < 75 with Diabetes	42	92.9%	87.8%	79.0%	96.6%
Nephropathy Screening Test or Evidence of Existing Nephropathy for Beneficiaries< 75 with Diabetes	42	73.8%	77.0%	69.6%	84.4%
Lipid Profile for Beneficiaries < 75 with Diabetes	42	69.0%	82.3%	71.3%	93.3%
Ischemic Vascular Disease					
Lipid Profile for Beneficiaries with Ischemic Vascular Disease	31	77.4%	77.9%	68.5%	87.2%
Adherence to Statin Therapy for Beneficiaries with Coronary Artery Disease	2	50.0%	66.6%	59.1%	74.1%
Mental Health					
Antidepressant Treatment for Depression:					
1. Acute Phase Treatment (at least 12 weeks)	0		57.1%	48.5%	65.7%
2. Continuation Phase Treatment (at least 6 months)	0		39.9%	31.4%	48.4%
Medication Management					
Lipid Profile for Beneficiaries Who Started Lipid-Lowering Medications	33	36.4%	40.4%	33.5%	47.3%
Preventive Care Measures					
Breast Cancer Screening for Women Ages 40-69	64	76.6%	65.0%	56.2%	73.9%

Exhibit 4-PS. 2012 Performance on Claims-Based Quality Indicators in the Patient Safety Domain Patient Safety Domain Score = 2.45

Performance Measures	Your Medical Group Practice's Performance		Performance of All 3,876 Groups with at Least 25 Eligible Professionals		
				Average Range	
	Number of Eligible Cases	Performance Rate	Benchmark Rate	Benchmark –1 Standard Deviation	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**	70	11.4%	19.8%	14.8%	24.9%
*2. Patients Who Receive At Least Two Different Drugs to be Avoided**	70	1.4%	3.6%	1.7%	5.6%
Lack of Monthly INR Monitoring for Beneficiaries on Warfarin*	56	5.4%	33.0%	25.1%	40.8%

*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.

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Exhibit 4-CC. 2012 Performance on Quality Indicators in the Care Coordination Domain
Care Coordination Domain Score = 1.02

Performance Measures	Your Medical Group Practice's Performance		Performance of All 3,876 Groups with at Least 25 Eligible Professionals		
				Average Range	
	Number of Eligible Cases	Performance Rate	Benchmark Rate	Benchmark –1 Standard Deviation	Benchmark +1 Standard Deviation
Mental Health					
Follow-Up After Hospitalization for Mental Illness					
1. Percentage of Patients Receiving Follow-Up Within 30 Days	1	100.0%	63.3%	50.5%	76.1%
2. Percentage of Patients Receiving Follow-Up Within 7 Days	1	100.0%	35.6%	23.7%	47.5%
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care Sensitive Conditions					
CMS-1 Acute Conditions Composite*	271	3.7	8.4	4.6	12.1
*PQI-11 Bacterial Pneumonia**	271	11.1	12.7	6.7	18.7
*PQI-12 Urinary Tract Infection**	271	0.0	7.6	3.0	12.2
*PQI-10 Dehydration**	271	0.0	4.8	2.2	7.3
CMS-2 Chronic Conditions Composite*	151	41.8	58.5	42.9	74.0
*Diabetes (Composite of 4 indicators)**	74	25.2	20.4	7.9	32.8
*PQI-5 COPD or Asthma**	45	0.0	83.4	54.9	111.9
*PQI-8 Heart Failure**	32	137.0	107.6	76.5	138.8
Hospital Readmissions					
CMS-3 All-Cause Hospital Readmissions*	58	15.2%	16.2%	14.9%	17.4%

* 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		**88**	**100.0%**
BIGGEST MEMORIAL HOSPITAL	Anytown, USA	59	67.0%
OTHER LOCAL HOSPITAL	Anytown, USA	17	19.3%

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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 -0.53 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	**-0.53* (Average)**
Average Domain Score	-0.98
Per Capita Costs for *All* Attributed Beneficiaries	-0.67
Per Capita Costs for Beneficiaries *with Specific Conditions*	-1.28

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

Cost Domain	Standardized Score
Standardized Cost Composite Score	**-0.53* (Average)**
Average Domain Score	-0.98
Per Capita Costs for *All* Attributed Beneficiaries	-0.67
Per Capita Costs for Beneficiaries *with Specific Conditions*	-1.28

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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 3,876 Groups with at Least 25 Eligible Professionals		
	Number of Eligible Cases	Per Capita Costs Before Risk Adjustment	Per Capita Costs After Risk Adjustment	Benchmark Per Capita Costs (Risk-Adjusted)	Average Range	
					Benchmark –1 Standard Deviation	Benchmark +1 Standard Deviation
Per Capita Costs for All Attributed Beneficiaries (Domain Score = - 0.67)						
All Beneficiaries	259	$9,485	$9,091	$10,337	$8,481	$12,194
Per Capita Costs for Beneficiaries with Specific Conditions (Domain Score = - 1.28)						
Diabetes	70	$14,380	$13,927	$14,923	$12,082	$17,764
COPD	25	$13,916	$12,431	$24,249	$19,319	$29,179
Coronary Artery Disease	70	$13,098	$12,993	$17,315	$13,937	$20,693
Heart Failure	28	$19,986	$20,083	$26,189	$20,652	$31,725

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Exhibit 8. Per Capita Costs of Medicare Beneficiaries Attributed to Your Medical Group Practice in 2012, Compared to All 3,876 Medical Group Practices with at Least 25 Eligible Professionals

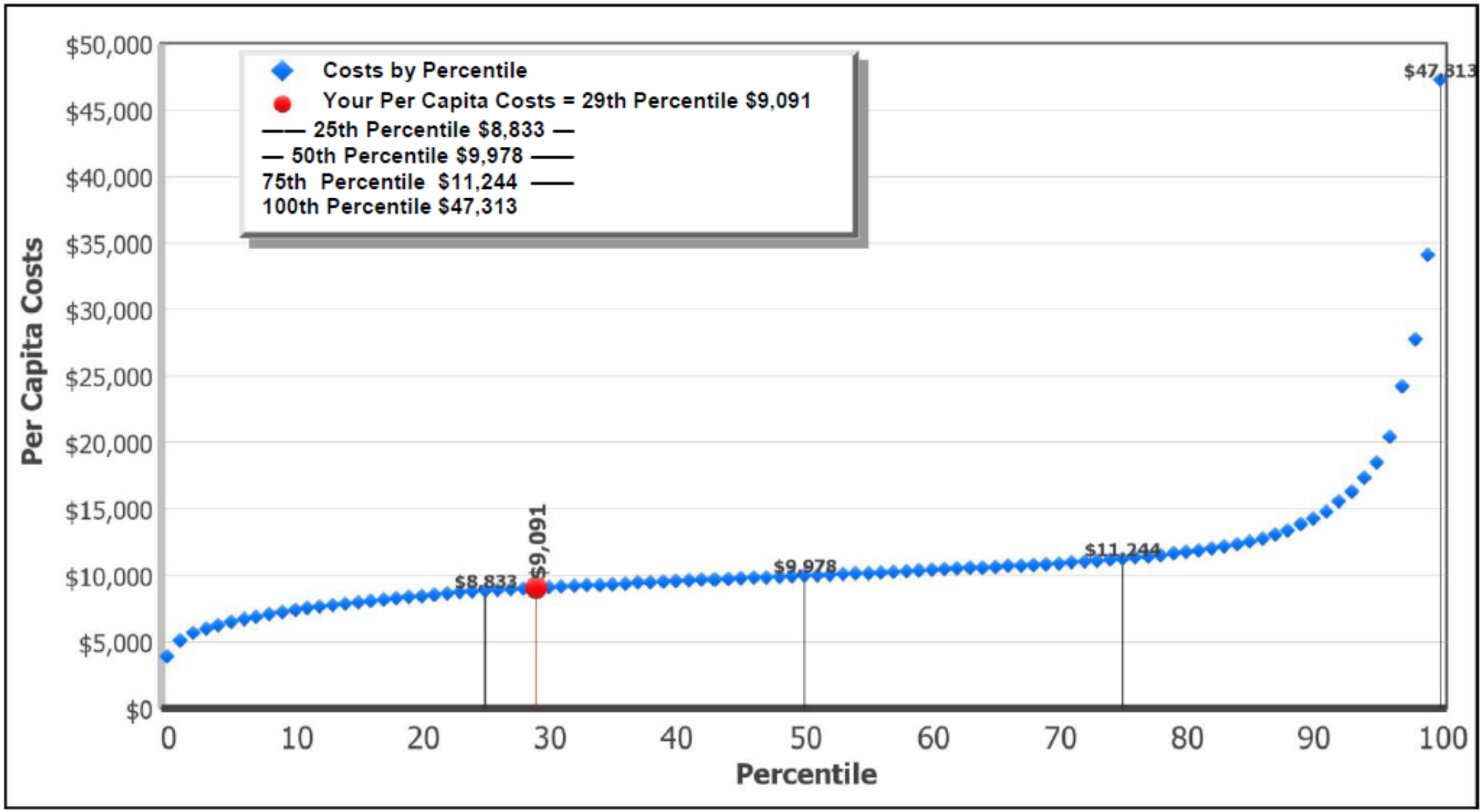

Exhibit 9. Difference Between Per Capita Costs for Specific Services for Your Group's Attributed Beneficiaries in 2012 and Mean Per Capita Costs Among All 3,876 Groups with at Least 25 Eligible Professionals

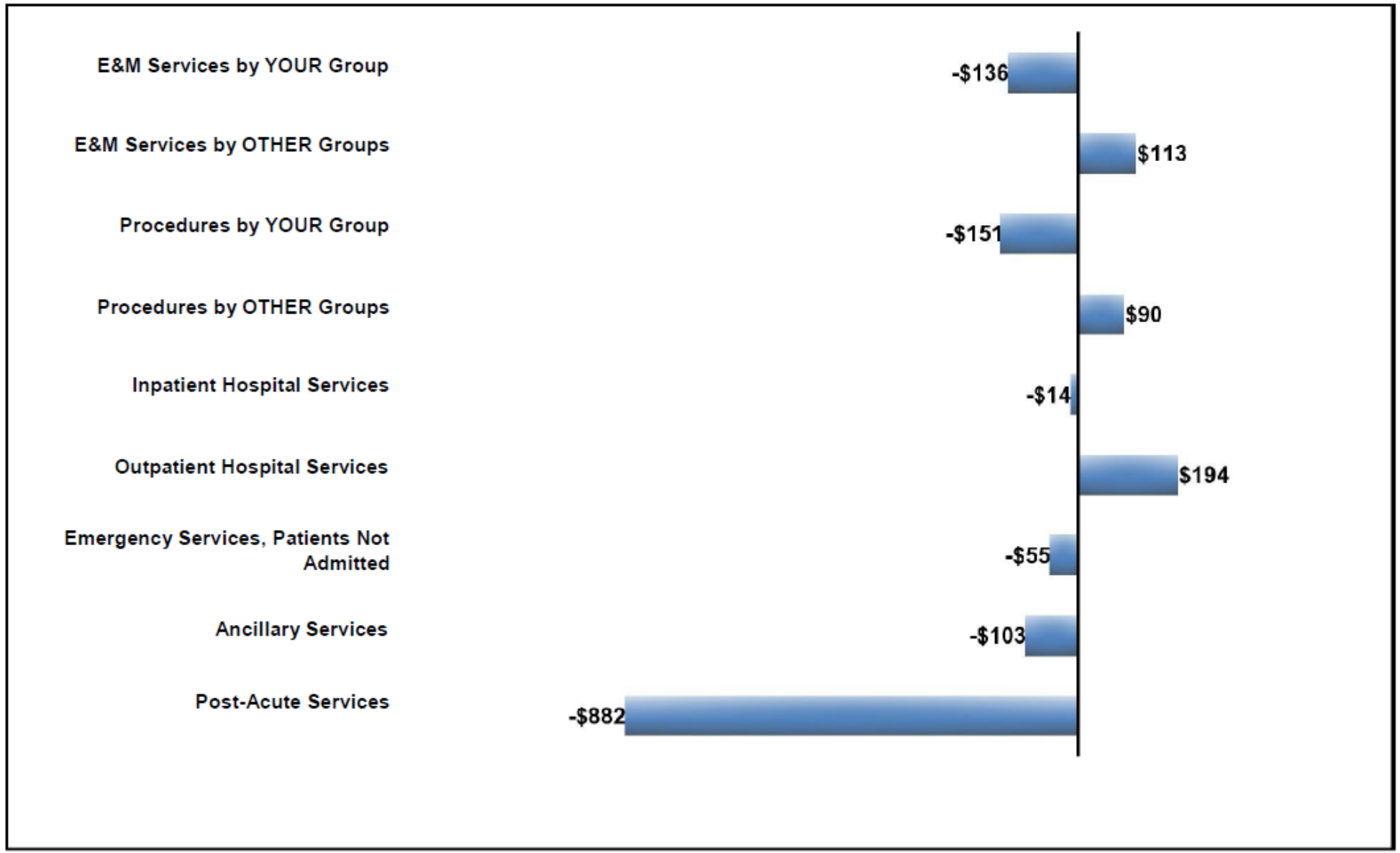

Exhibit 10. Medicare Patients' Per Capita Costs for Specific Services in 2012

Service Category	Your Medical Group Practice			Mean for All 3,876 Groups with at Least 25 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	259	100.0%	$9,091	100.0%	$10,337	($1,246)
Evaluation and Management (E&M) Services in All Non-Emergency Settings						
All E&M Services Provided by YOUR Group	259	100.0%	$374	100.0%	$510	($136)
Primary Care Physicians	259	100.0%	$374	64.4%	$332	$42
Medical Specialists	0	0.0%	$0	27.6%	$93	($93)
Surgeons	0	0.0%	$0	23.1%	$37	($37)
Other Eligible Professionals	2	0.8%	$0	23.3%	$48	($48)
All E&M Services Provided by OTHER Groups	247	95.4%	$701	82.8%	$588	$113
Primary Care Physicians	97	37.5%	$107	25.7%	$97	$10
Medical Specialists, Surgeons, and Other Eligible Professionals	243	93.8%	$674	80.9%	$570	$103
Procedures in All Non-Emergency Settings						
All Procedures Performed by YOUR Group	11	4.2%	$6	29.0%	$158	($151)
Primary Care Physicians	9	3.5%	$4	6.3%	$15	($11)
Medical Specialists	0	0.0%	$0	7.2%	$46	($46)
Surgeons	0	0.0%	$0	11.9%	$70	($70)
Other Eligible Professionals	2	0.8%	$1	7.1%	$24	($23)
All Procedures Performed by OTHER Groups	182	70.3%	$780	56.1%	$670	$90
Primary Care Physicians	12	4.6%	$11	3.6%	$10	$1
Medical Specialists, Surgeons, and Other Eligible Professionals	180	69.5%	$757	55.2%	$667	$90
Hospital Services (Excluding Emergency Outpatient)						
Inpatient Hospital Facility Services	52	20.1%	$2,464	20.7%	$2,468	($14)
Outpatient Hospital Facility Services	250	96.5%	$2,486	95.1%	$2,292	$194
Emergency Services That Did Not Result in a Hospital Admission						
All Emergency Services	82	31.7%	$187	38.4%	$242	($55)
Emergency Visits	82	31.7%	$165	37.9%	$207	($42)
Procedures	15	5.8%	$11	13.6%	$19	($8)
Laboratory and Other Tests	44	17.0%	$3	12.6%	$2	$1
Imaging Services	43	16.6%	$8	23.6%	$15	($7)
Services in Non-Emergency Ambulatory Settings						
All Ancillary Services	240	96.9%	$909	93.1%	$1,012	($103)
Laboratory and Other Tests	215	83.0%	$162	81.6%	$312	($150)
Imaging Services	204	78.8%	$290	75.1%	$396	($5)
Durable Medical Equipment	76	29.3%	$456	32.9%	$404	$52
Post-Acute Care						
All Post-Acute Services	39	15.1%	$789	14.2%	$1,681	($892)
Skilled Nursing Facility	8	3.1%	$186	5.7%	$735	($549)
Home Health	37	14.3%	$586	9.9%	$472	$114
Psychiatric, Rehabilitation, or Other Post-Acute Care	1	0.4%	$27	3.3%	$473	($446)
Other Services Billed by Non-Institutional Providers						
All Other Services	211	81.5%	$320	69.1%	$631	($303)
Ambulance Services	41	15.8%	$115	14.6%	$131	($15)
Chemotherapy and Other Part B–Covered Drugs	47	18.1%	$97	20.7%	$335	($238)
All Other Services Not Otherwise Classified	189	73.0%	$115	58.6%	$165	($50)

Service Category	Your Medical Group Practice			Mean for All 3,876 Groups with at Least 25 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	**259**	**100.0%**	**$9,091**	**100.0%**	**$10,337**	**($1,246)**
Evaluation and Management (E&M) Services in All Non-Emergency Settings						
All E&M Services Provided by YOUR Group	**259**	**100.0%**	**$374**	**100.0%**	**$510**	**($136)**
Primary Care Physicians	259	100.0%	$374	64.4%	$332	$42
Medical Specialists	0	0.0%	$0	27.6%	$93	($93)
Surgeons	0	0.0%	$0	23.1%	$37	($37)
Other Eligible Professionals	2	0.8%	$0	23.3%	$48	($48)
All E&M Services Provided by OTHER Groups	**247**	**95.4%**	**$781**	**82.8%**	**$668**	**$113**
Primary Care Physicians	97	37.5%	$107	25.7%	$97	$10
Medical Specialists, Surgeons, and Other Eligible Professionals	243	93.8%	$674	80.9%	$570	$103
Procedures in All Non-Emergency Settings						
All Procedures Performed by YOUR Group	**11**	**4.2%**	**$5**	**29.0%**	**$156**	**($151)**
Primary Care Physicians	9	3.5%	$4	8.3%	$15	($11)
Medical Specialists	0	0.0%	$0	7.2%	$46	($46)
Surgeons	0	0.0%	$0	11.9%	$70	($70)
Other Eligible Professionals	2	0.8%	$1	7.1%	$24	($23)
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Hospital Services (Excluding Emergency Outpatient)						
Inpatient Hospital Facility Services	**52**	**20.1%**	**$2,454**	**20.7%**	**$2,468**	**($14)**
Outpatient Hospital Facility Services	**250**	**96.5%**	**$2,486**	**85.1%**	**$2,292**	**$194**
Emergency Services That Did Not Result in a Hospital Admission						
All Emergency Services	**82**	**31.7%**	**$187**	**38.4%**	**$242**	**($55)**
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All Ancillary Services	**248**	**95.8%**	**$908**	**93.1%**	**$1,012**	**($103)**
Laboratory and Other Tests	215	83.0%	$162	81.6%	$312	($150)
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Ambulance Services	41	15.8%	$115	14.8%	$131	($15)
Chemotherapy and Other Part B–Covered Drugs	47	18.1%	$97	20.7%	$335	($238)
All Other Services Not Otherwise Classified	189	73.0%	$115	58.8%	$165	($50)

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Questions and Discussion

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