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Indiana Health Information Exchange Health Care Quality 646 Demonstration Performance Year One Financial Results

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OVERVIEW OF IHIE HEALTH CARE QUALITY 646 DEMONSTRATION PERFORMANCE YEAR ONE RESULTS

This package contains information regarding IHIE's financial results for the first performance year (July 1, 2009 – June 30, 2010) during the Health Care Quality 646 Demonstration. The results presented include: (1) assignment methodology, (2) intervention group profile tables for performance year one as well as the corresponding base year, (3) comparison group profile tables for performance year one as well as the corresponding base year, (4) an overview of expenditure calculations, and (5) performance payment results for performance year one.

All calculations have been performed according to the methods set forth in the IHIE Demonstration Protocols, MMA §646 Health Care Quality Demonstration (2010).

Beneficiary Assignment Methodology

Intervention Group

There are three steps involved in assigning beneficiaries to the performance year one (PY1) intervention group (IG). They involve, in turn, identifying participating practices, identifying participating physicians, and identifying IG beneficiaries. The three steps are:

1. Use the list of tax IDs (EINs), sent by IHIE to CMS, to identify participating practices.

2. Identify participating providers defined as any provider who, during PY1, provided a qualifying evaluation and management (E&M) visit to eligible Medicare beneficiaries that was billed through a participating practice within the 9-county Indianapolis area (as specified in the Protocol).

3. Identify PY1 IG beneficiaries as beneficiaries who have at least one qualifying evaluation and management (E&M) visit with a participating physician and who meet the general eligibility criteria for the demonstration IG.

The IG population consists of Indiana residents who meet general eligibility criteria (defined in Section 2 of the Protocol and shown in Table 1-1 (PY1) of this report) with at least one qualifying E&M visit with a participating physician, regardless of the tax ID or place of service zip code on that claim line item. The IG is identified using final action claims with dates of service falling within the start and end dates of the demonstration year and a paid-date within six months of the end of the demonstration year.

The same list of participating providers is used to assign beneficiaries to IHIE in the performance year and its corresponding base year (BY, which is July 1, 2008 to June 30, 2009). That is, the BY IG consists of beneficiaries who received a qualifying E&M visit during the BY from a physician who is a participating PY1 physician, and who meet general BY eligibility criteria for the demonstration (as shown in Table 1-1 (BY)).

Comparison Group

There are two steps involved in assigning beneficiaries to the comparison group (CG). They involve identifying beneficiaries residing in the comparison counties and identifying beneficiaries who meet the assignment criteria set forth in Section 2 of the Protocol. The comparison group beneficiaries must reside in a specified set of counties within the following three areas: Milwaukee, WI, Columbus, OH, and Louisville, KY. The two steps of assignment are:

1. Identify beneficiaries residing in the comparison counties who received at least one qualifying E&M visit during the demonstration year.

2. Among beneficiaries identified in 1, retain those who meet all other eligibility criteria for the demonstration CG during the demonstration year. Note that if a beneficiary resides in a comparison group county, but meets eligibility requirements for the intervention group, priority is given to the intervention group.

RTI defined two CGs: one for PY1 and one for the BY as shown in Tables 2-1 (PY1) and 2-1 (BY) of this report.

Calculating Medicare Expenditures

To calculate total Medicare expenditures for each beneficiary, the expenditures (Medicare payments) are summed from all of the beneficiary's claims at any provider (hospital outlier payments are excluded). The expenditures are then annualized by dividing them by the fraction the year (fraction of 12 months) each beneficiary was enrolled in Medicare Parts A and B. All further analyses weight the annualized expenditures by this same fraction. Annualization and weighting ensures that payments are correctly adjusted for months of beneficiary eligibility, including new Medicare enrollees and those who died. Weighted mean annualized expenditures divided by 12 yield the "per beneficiary per month" (PBPM) amount.

To prevent extremely costly beneficiaries from significantly affecting average expenditures, the annualized expenditures are capped. Annualized expenditures for covered services incurred by beneficiaries without end stage renal disease (ESRD) are capped at $100,000 and expenditures for covered services that are incurred by beneficiaries with ESRD are capped at an annualized value of $200,000.

Demographic Factor Calculation

Differences in the composition of the IG and CG may affect expected expenditures. To account for this, a demographic factor is used to adjust expenditures for the demographic composition of the IG and the CG:

Demographic Adjusted Expenditures = Expenditures / (Demographic Factor).[1]

[1] Medicare savings are specified on a per beneficiary per month (PBPM) basis as indicated in the section on *Performance Payment Results*.

The demographic factors are established each year for the set of beneficiaries based on age, sex, and ESRD entitlement status. To calculate the demographic factors RTI used 2007 Medicare claims for a 5% national sample of beneficiaries to estimate an ordinary least squares regression with expenditures as the dependent variable and independent variables representing age/gender categories. Separate regressions were run for ESRD and non-ESRD beneficiaries and the regression coefficients were restricted to be non-decreasing with increasing age within less than age 65 and age 65 or over subgroups. The coefficients from these regressions were then divided by the pooled (ESRD and non-ESRD) mean expenditures to generate age/gender demographic factors.

The demographic factors are shown in Table A-1 in the appendix. They are estimates of the ratio of a beneficiary's expected expenditures with the indicated enrollment characteristics relative to the mean expenditures for the entire Medicare fee-for-service (FFS) population. For example, a demographic factor of 1.0 indicates a beneficiary with expected costliness equal to the national FFS average. A factor of 1.10 indicates a beneficiary with expected costliness 10 percent above the FFS average, and a factor of 0.90 indicates a beneficiary with expected costliness 10 percent below the FFS average. The same factors were used for both the BY and the PY so that the demographic factor only measures changes in expected costliness due to changes in the demographic composition of a group.

To calculate the weighted demographic factor for a group, RTI multiplied each age/gender demographic factor by the proportion of group beneficiary months that fell into the age/gender category and summed across categories. This was done separately for the BY and PY1 for each group.

Minimum Savings Requirement Calculation

The minimum savings requirement (MSR) is used in determining shareable savings in each performance year. The minimum savings rate is based on the 95 percent confidence interval for the difference between actual expenditures for the intervention group and the expenditure target.

$$\text{Minimum Required Savings Rate} = 1.96 \times \text{CV}\sqrt{2 \times \left(\frac{1}{n_i} + \frac{1}{n_c}\right)}$$

where CV, the coefficient of variation, is the standard deviation of base year expenditures for the pooled IG and CG sample divided by the base year mean expenditures for the pooled sample, n_i is the number of beneficiary-years assigned to the IG in the performance period, and n_c is the number of beneficiary-years assigned to the CG in the performance period. The calculation of the MSR for the first performance year is shown below. The MSR for PY1 is 1.78%.

Calculation of Performance Year 1 MSR

Index	Component	Group	Year	Value
[A]	Person Years IGPY1	Intervention Group	Performance Year 1	119,470
[B]	Person Years CGPY1	Comparison Group	Performance Year 1	331,130
[C]	Standard Deviation of Demographic Adjusted Expenditures	Intervention Group and Comparison Group	Base Year	$17,834
[D]	Mean of Demographic Adjusted Expenditures	Intervention Group and Comparison Group	Base Year	$9,351

Index	Component	Calculation	Year	Value
[E]	Coefficient of Variation (CV)	=[C]/[D]	—	1.91
[F]	MSR	$= 1.96 \times [E] \sqrt{2 \times \left(\frac{1}{[A]} + \frac{1}{[B]} \right)}$	—	1.78%

NOTES:

[1] Numbers may not add exactly in any given column due to rounding error.

[2] The letters within the square brackets are references to rows within this table.

Computer Output: I07R18MH

Source: RTI Analysis of July 2009 through June 2010 100% Medicare Claims Files and Enrollment Dataset sets

Assigned Beneficiary Profile

The purpose of the assigned beneficiary profile tables is to enable IHIE staff to better understand the characteristics and utilization patterns of its IG beneficiaries. The tables should also help IHIE better understand its PY1 financial results.

The IG profile tables provide a broad range of information regarding IHIE's assigned beneficiaries. The tables present the results of the assignment process and data on office visits, hospital utilization, expenditures, demographics, Medicare and Medicaid eligibility, and geographic distribution. The IG beneficiary profile includes eight tables for each year.

- Table 1-1 shows the assignment and exclusion statistics for assigned beneficiaries.
- Table 1-2 shows the distribution of the proportion of allowed charges for office or other outpatient E&M visits provided by IHIE participating practices to assigned beneficiaries.
- Table 1-3 shows the distribution of the E&M visits as specified for Table 1-2.
  - Note that this demonstration utilizes a "one-touch" E&M visit assignment rule.

- Table 1-4 shows the distribution of hospital discharges for IHIE assigned beneficiaries.

- Table 1-5 shows the distribution of capped annualized Medicare expenditures per IHIE assigned beneficiary.

  – Note that the table shows frequencies for beneficiaries capped at $200,000 and $100,000 separately, as these are the caps for ESRD and non-ESRD beneficiaries, respectively.

- Table 1-6 presents the components of annualized Medicare expenditures per IHIE assigned beneficiary, which are not capped.

- Table 1-7 presents demographic and eligibility characteristics of the assigned population, including Medicare and Medicaid eligibility.

- Table 1-8 shows the geographic distribution of the IHIE assigned beneficiaries by county.

Comparison Group Profile

The purpose of the comparison group (CG) profile tables is to enable IHIE staff to document the characteristics and utilization patterns of its comparison group beneficiaries.

The CG profile tables provide a broad range of information regarding IHIE's CG beneficiaries. The tables present statistics on office visits, hospital utilization, expenditures, demographics, Medicare and Medicaid eligibility, and geographic distribution. The comparison profile includes seven tables each for the first PY as well as corresponding BY.

- Table 2-1 shows assignment and exclusion statistics for PY1 and the BY, broken out by geographic area.

- Table 2-2 shows the distribution of allowed charges for office or other outpatient E&M visits provided by IHIE to comparison group beneficiaries.

- Table 2-3 shows the distribution of hospital discharges for IHIE CG beneficiaries.

- Table 2-4 shows the distribution of capped annualized Medicare expenditures per IHIE CG beneficiary.

  – Note that the table shows frequencies for beneficiaries capped at $200,000 and $100,000 separately, as these are the caps for ESRD and non-ESRD beneficiaries, respectively.

- Table 2-5 presents the components of annualized Medicare expenditures per IHIE CG beneficiary, which are not capped.

- Table 2-6 presents demographic and eligibility characteristics of the population, including Medicare and Medicaid eligibility.

- Table 2-7 shows the geographic distribution of the IHIE CG beneficiaries by county.

Performance Payment Results

The performance payment results table provides information regarding shareable savings from the first performance year of the demonstration. Table 3-1 provides results for PBPM expenditures, demographic factors, the standardized target, actual assigned beneficiary expenditures, shareable savings, performance payments not contingent on quality performance, performance payments based on quality performance, and performance year one (PY1) earned performance payments (if any). In PY1, the maximum performance payment for efficiency is 50 percent of the shared savings and the maximum performance payment for quality is 50 percent of the shared savings.

The total performance payment that was earned by IHIE for PY1 is $0 because gross savings did not exceed the minimum savings requirement, as shown in Table 3-1.

IHIE INTERVENTION GROUP PROFILE TABLES PERFORMANCE YEAR ONE

Table 1-1 (PY1)
IHIE Beneficiary Assignments and Exclusions Performance Year One

Practices, Physicians, Beneficiaries, and Exclusions	Count
Practices	
1. Participating practices[1]	111
Physicians	
2. Physicians[2] with a qualifying patient visit[3] at a participating practice	1,120
3. Physicians with qualifying patient visits at participating practices outside of 9 country demonstration area only	20
4. Participating physicians (line 2 − line 3)	1,100
Beneficiaries	
5. Patients of participating physicians at participating practices	118,150
6. Patients of participating physicians at non-participating practices only	17,775
7. Assigned Beneficiaries before exclusions (line 5 + line 6)	135,925
8. Beneficiaries excluded from assignment (see "Beneficiary Exclusions by Criterion" below)	13,424
9. Assigned Beneficiaries (line 7 − line 8)	122,501
Exclusions - By Criterion4	
At least one month of Part A-only or Part B-only coverage	1,638
At least one month of Medicare Advantage enrollment	7,045
Did not reside in state of Indiana at end of calendar year in which performance year ends	882
Had coverage under employer-sponsored group health plan	4,931
No enrollment file record	86

NOTES:

[1] Unique practice tax IDs submitted by IHIE to CMS. Multiple tax IDs may be part of the same organization.

[2] Unique National Provider Identifiers (NPIs) as identified by RTI in Medicare physician/supplier Part B claims. "Physicians" may include professionals who bill Medicare independently.

[3] "Qualifying patient visit" is a specified evaluation and management visit code.

[4] Exclusions are not mutually exclusive. A beneficiary may be excluded for more than one reason.

Computer Output: i01tb1

SOURCE: RTI Analysis of July 2009 through June 2010 100% Medicare Claims Files and Enrollment Dataset sets

Table 1-2 (PY1)
Distribution of Proportion of Allowed Charges for Office or Other Outpatient E&M Visits Provided by IHIE Participating Practices to Assigned Beneficiaries, Performance Year One

Mean Proportion[1]	0.49	
Standard Deviation	0.33	
Standard Error	0.001	

Proportion Ranges[1]	Beneficiaries	Percentage
Total	122,501	100.0
0.80–1.0	26,518	21.6
0.60–0.79	18,435	15.0
0.40–0.59	24,286	19.8
0.20–0.39	25,211	20.6
0.00–0.19	28,051	22.9

NOTES:

[1] Proportion of all Office and Other Outpatient E&M allowed charges provided to the beneficiary that were provided by any IHIE participating practice.

Computer Output: i01tb2

SOURCE: RTI Analysis of July 2009 through June 2010 100% Medicare Claims Files and Enrollment Dataset sets

Table 1-3 (PY1)
Distribution of Office or Other Outpatient E&M Visits for IHIE Assigned Beneficiaries[1]
Performance Year One

Office Or Other Outpatient E&M Visits	
Mean	8.45
Standard Deviation	6.46
Standard Error	0.018

Count of Visits	Beneficiaries	Percentage
Total	122,501	100.0
21+	6,504	5.3
16–20	8,492	6.9
11–15	19,527	15.9
7–10	29,856	24.4
4–6	31,642	25.8
3	10,457	8.5
2	9,461	7.7
1	6,562	5.4
0	—	0.0

NOTES:

[1] Refers to E&M visits at any provider.

Computer Output: i01tb3

SOURCE: RTI Analysis of July 2009 through June 2010 100% Medicare Claims Files and Enrollment Dataset sets

Table 1-4 (PY1)
Distribution of Hospital Discharges for IHIE Assigned Beneficiaries[1]
Performance Year One

Mean	0.41
Standard Deviation	0.99
Standard Error	0.003

Count of Discharges	Beneficiaries	Percentage
Total	122,501	100.0
5 +	1,276	1.0
4	1,183	1.0
3	2,591	2.1
2	6,223	5.1
1	17,462	14.3
0	93,766	76.5

NOTES:

[1] Refers to hospital discharges at any provider.

Computer Output: i01tb4

SOURCE: RTI Analysis of July 2009 through June 2010 100% Medicare Claims Files and Enrollment Dataset sets

Table 1-5 (PY1)
Distribution of Annualized Medicare Expenditures[1, 2, 3] per IHIE Assigned Beneficiary
Performance Year One

Summary Statistic	PBPY	PBPM
Mean[4]	$10,011	$834
Standard Deviation[4]	$18,681	—
Standard Error[4]	$54	—

Range	Beneficiaries	Percentage
Total	122,501	100.0
$200,000	72	0.1
$100,001–199,999	268	0.2
$100,000	1,423	1.2
$50,000–99,999	4,829	3.9
$25,000–49,999	8,711	7.1
$10,000–24,999	14,253	11.6
$5,000–9,999	14,279	11.7
$2,000–4,999	26,041	21.3
$500–1,999	34,621	28.3
$0–499 [5]	18,004	14.7

NOTES:

1 Annualized Medicare expenditures per beneficiary are calculated by dividing actual expenditures by the fraction of the year the beneficiary is alive and are capped at $100,000 for non ESRD beneficiaries and $200,000 for ESRD beneficiaries.

2 Expenditures have been rounded to the nearest dollar for presentation purposes. Performance payment calculations will use additional precision, i.e., expenditures will not be rounded to the nearest dollar.

3 Inpatient pass through amounts (e.g., direct graduate medical education and organ acquisition costs) are not included in total annualized Medicare expenditures.

4 Weighted by the eligibility fraction.

5 Some assigned beneficiaries have positive allowed charges but zero expenditures, because of the Medicare Part B deductible.

Computer Output: i01tb5

SOURCE: RTI Analysis of July 2009 through June 2010 100% Medicare Claims Files and Enrollment Dataset sets

Table 1-6 (PY1)
Components of Annualized Medicare Expenditures [1, 2, 3] per IHIE Assigned Beneficiary
Performance Year One

Expenditure component	Mean	Standard deviation	Standard error	Percentage of total $	Percentage of beneficiaries with zero $ for component
Inpatient	4,048	13,380	38.7	38.3	76.5
Hospital Outpatient	1,842	4,974	14.4	17.4	14.1
Part B Physician/Supplier[4,5]	2,730	48,561	140.5	25.8	0.9
Skilled Nursing Facility	975	4,841	14.0	9.2	93.8
Home Health	477	2,058	6.0	4.5	90.9
Durable Medical Equipment	379	1,887	5.5	3.6	61.8
Hospice	114	1,626	4.7	1.1	98.4

NOTES:

[1] Annualized Medicare expenditures per beneficiary are calculated using eligibility fractions. Component expenditures are not capped as total expenditures are in Table 5.

[2] Expenditures have been rounded to the nearest dollar for presentation purposes. Performance payment calculations will use additional precision, i.e., expenditures will not be rounded to the nearest dollar.

[3] Inpatient pass through amounts (e.g., direct graduate medical education and kidney acquisition costs) are not included in components of annualized Medicare expenditures.

[4] An Assigned Beneficiary may have zero Part B Physician/Supplier payments if he or she has a qualifying visit, but is below the Part B deductible so that Medicare payments are zero.

[5] There is an extreme expenditure outlier in Part B Physician/Supplier payments of $16,924,724. After capping each assigned beneficiary's total Part B payments at $100,000, the associated Part B payment statistics are: mean of $2,585; standard deviation of $4,433; standard error of $13; percent of total of 24.5; percentage of beneficiaries with zero $ for component of 0.9.

Computer Output: i01tb6

SOURCE: RTI Analysis of July 2009 through June 2010 100% Medicare Claims Files and Enrollment Dataset sets

Table 1-7 (PY1)
Demographic and Eligibility Characteristics of
IHIE's Assigned Beneficiaries, Performance Year One

Population:	Beneficiaries	Percent
Total Assigned Beneficiaries	122,501	100.0
Beneficiary Deaths	3,826	3.1
Beneficiary Survived	118,675	96.9
Medicare Eligibility:		
Total	122,501	100.0
Aged	100,414	82.0
ESRD	1,317	1.1
Disabled	20,770	17.0
Original Reason for Entitlement Among Current Aged[1]:		
Total	101,132	100.0
Originally Disabled	7,306	7.2
Not Originally Disabled	93,826	92.8
Medicaid Eligibility:		
Total	122,501	100.0
Not Medicaid Eligible for Any Months	103,269	84.3
Medicaid Eligible at Least One Month	19,232	15.7
Hospice Status:		
Total	122,501	100.0
Hospice	1,983	1.6
Non-Hospice	120,518	98.4
Gender:		
Total	122,501	100.0
Male	48,448	39.5
Female	74,053	60.5
Age:		
Total	122,501	100.0
Age < 65	21,369	17.4
Age 65–74	51,863	42.3
Age 75–84	36,030	29.4
Age 85 +	13,239	10.8

(continued)

Table 1-7 (PY1) (continued)
Demographic and Eligibility Characteristics of
IHIE's Assigned Beneficiaries, Performance Year One

Population:	Beneficiaries	Percent
Race:		
Total	122,501	100.0
White	109,047	89.0
Black	11,982	9.8
Unknown	123	0.1
Asian	454	0.4
Hispanic	185	0.2
North American Natives	50	0.0
Other	660	0.5

NOTES:

[1] Original reason for Medicare entitlement among beneficiaries currently entitled to Medicare by age and includes beneficiaries eligible by both age and ESRD.

Computer Output: i01tb7

SOURCE: RTI Analysis of July 2009 through June 2010 100% Medicare Claims Files and Enrollment Dataset sets

Table 1-8 (PY1)
Distribution of IHIE Assigned Beneficiary Residents by Demo Area Counties
Performance Year One

County name	County number [1]	Beneficiaries	Percentage
Total	—	122,501	100.0
Boone	15050	1,799	1.5
Hamilton	15280	8,677	7.1
Hancock	15290	3,555	2.9
Hendricks	15310	5,219	4.3
Johnson	15400	6,888	5.6
Madison	15470	13,798	11.3
Marion	15480	45,684	37.3
Morgan	15540	3,465	2.8
Shelby	15720	1,758	1.4
Other Indiana Counties	—	31,658	25.8

NOTES:

[1] State and county codes used by the Social Security Administration (SSA)

Computer Output: i01tb8

SOURCE: RTI Analysis of July 2009 through June 2010 100% Medicare Claims Files and Enrollment Dataset sets

IHIE INTERVENTION GROUP PROFILE TABLES BASE YEAR

Table 1-1 (BY)
IHIE Beneficiary Assignments and Exclusions
Base Year

Physicians, Beneficiaries, and Exclusions	Count
Physicians	
1. Participating physicians in PY1[1]	1,100
2. Physicians[2] with a qualifying patient visit[3] at a participating practice in BY	1,001
3. Physicians with qualifying patient visits at participating practices outside of 9 country demonstration area only	135
4. Participating physicians (line 2 − line 3)	866
Beneficiaries	
5. Patients of participating physicians at participating practices	101,056
6. Patients of participating physicians at non-participating practices only	30,034
7. Assigned Beneficiaries before exclusions (line 5 + line 6)	131,090
8. Beneficiaries excluded from assignment (see "Beneficiary Exclusions by Criterion" below)	13,019
9. Assigned Beneficiaries (line 7 − line 8)	118,071
Exclusions - By Criterion[4]	
At least one month of Part A-only or Part B-only coverage	1,623
At least one month of Medicare Advantage enrollment	6,594
Did not reside in state of Indiana at end of calendar year in which baseline ends	1,074
Had coverage under employer-sponsored group health plan	4,663
No enrollment file record	92

NOTES:

[1] The same list of participating physicians used to assign beneficiaries in PY1 is used to assign beneficiaries in the base year per the protocol.

[2] Unique National Provider Identifiers (NPIs) as identified by RTI in Medicare physician/supplier Part B claims. "Physicians" may include professionals who bill Medicare independently.

[3] "Qualifying patient visit" is a specified evaluation and management visit code.

[4] Exclusions are not mutually exclusive. A beneficiary may be excluded for more than one reason.

Computer Output: i02tb1

SOURCE: RTI Analysis of July 2008 through June 2009 100% Medicare Claims Files and Enrollment Dataset sets

Table 1-2 (BY)
Distribution of Proportion of Allowed Charges for Office or Other Outpatient E&M Visits Provided by IHIE Participating Practices to Assigned Beneficiaries, Base Year

Mean Proportion[1]	0.50
Standard Deviation	0.34
Standard Error	0.001

Proportion Ranges[1]	Beneficiaries	Percentage
Total	118,071	100.0
0.80–1.00	28,441	24.1
0.60–0.79	18,918	16.0
0.40–0.59	22,438	19.0
0.20–0.39	20,155	17.1
0.00–0.19	28,119	23.8

NOTES:

[1] Proportion of all Office and Other Outpatient E&M allowed charges provided to the beneficiary that were provided by any IHIE participating practice

Computer Output: i02tb2

SOURCE: RTI Analysis of July 2008 through June 2009 100% Medicare Claims Files and Enrollment Dataset sets

Table 1-3 (BY)
Distribution of Office or Other Outpatient E&M Visits for IHIE Assigned Beneficiaries[1]
Base Year

Office Or Other Outpatient E&M Visits		
Mean	8.15	
Standard Deviation	6.19	
Standard Error	0.018	

Count of Visits	Beneficiaries	Percentage
Total	118,071	100.0
21+	5,482	4.6
16–20	7,484	6.3
11–15	18,213	15.4
7–10	28,951	24.5
4–6	31,323	26.5
3	10,517	8.9
2	9,578	8.1
1	6,523	5.5
0	—	0.0

NOTES:

[1] Refers to E&M visits at any provider.

Computer Output: i02tb3

SOURCE: RTI Analysis of July 2008 through June 2009 100% Medicare Claims Files and Enrollment Dataset sets

Table 1-4 (BY)
Distribution of Hospital Discharges for IHIE Assigned Beneficiaries[1] Base Year

Mean	0.41		
Standard Deviation	0.98		
Standard Error	0.003		

Count of Discharges	Beneficiaries	Percentage
Total	118,071	100.0
5 +	1,235	1.0
4	1,123	1.0
3	2,480	2.1
2	6,065	5.1
1	16,336	13.8
0	90,832	76.9

NOTES:

[1] Refers to hospital discharges at any provider.

Computer Output: i02tb4

SOURCE: RTI Analysis of July 2008 through June 2009 100% Medicare Claims Files and Enrollment Dataset sets

Table 1-5 (BY)
Distribution of Annualized Medicare Expenditures[1, 2, 3] per IHIE Assigned Beneficiary
Base Year

Summary Statistic	PBPY	PBPM
Mean[4]	$9,527	$794
Standard Deviation[4]	$17,778	—
Standard Error[4]	$52	—

Range	Beneficiaries	Percentage
Total	118,071	100.0
$200,000	32	0.0
$100,001–199,999	226	0.2
$100,000	1,233	1.0
$50,000–99,999	4,443	3.8
$25,000–49,999	7,993	6.8
$10,000–24,999	13,461	11.4
$5,000–9,999	13,749	11.6
$2,000–4,999	25,583	21.7
$500–1,999	34,024	28.8
$0–499 [5]	17,327	14.7

NOTES:

[1] Annualized Medicare expenditures per beneficiary are calculated by dividing actual expenditures by the fraction of the year the beneficiary is alive and are capped at $100,000 for non ESRD beneficiaries and $200,000 for ESRD beneficiaries.

[2] Expenditures have been rounded to the nearest dollar for presentation purposes. Performance payment calculations will use additional precision, i.e., expenditures will not be rounded to the nearest dollar.

[3] Inpatient pass through amounts (e.g., direct graduate medical education and organ acquisition costs) are not included in total annualized Medicare expenditures.

[4] Weighted by the eligibility fraction.

[5] Some assigned beneficiaries have positive allowed charges but zero expenditures, because of the Medicare Part B deductible.

Computer Output: i02tb5

SOURCE: RTI Analysis of July 2008 through June 2009 100% Medicare Claims Files and Enrollment Dataset sets

Table 1-6 (BY)
Components of Annualized Medicare Expenditures [1, 2, 3] per IHIE Assigned Beneficiary
Base Year

Expenditure Component	Mean	Standard deviation	Standard error	Percentage of total $	Percentage of beneficiaries with zero $ for component
Inpatient	3,826	12,662	37.3	38.1	76.9
Hospital Outpatient	1,786	4,788	14.1	17.8	13.3
Part B Physician/ Supplier [4,5]	2,610	55,527	163.6	26.0	0.8
Skilled Nursing Facility	901	4,608	13.6	9.0	94.0
Home Health	445	1,961	5.8	4.4	91.2
Durable Medical Equipment	375	1,719	5.1	3.7	62.0
Hospice	102	1,500	4.4	1.0	98.5

NOTES:

[1] Annualized Medicare expenditures per beneficiary are calculated using eligibility fractions. Component expenditures are not capped as total expenditures are in Table 5.

[2] Expenditures have been rounded to the nearest dollar for presentation purposes. Performance payment calculations will use additional precision, i.e., expenditures will not be rounded to the nearest dollar.

[3] Inpatient pass through amounts (e.g., direct graduate medical education and kidney acquisition costs) are not included in components of annualized Medicare expenditures.

[4] An Assigned Beneficiary may have zero Part B Physician/Supplier payments if he or she has a qualifying visit, but is below the Part B deductible so that Medicare payments are zero.

[5] There is an extreme expenditure outlier in Part B Physician/Supplier payments of $19,022,992. After capping each assigned beneficiary's total Part B payments at $100,000, the associated Part B payment statistics are: mean of $2,441; standard deviation of $4,134; standard error of $12; percent of total of 24.3; percentage of beneficiaries with zero $ for component of 0.8.

Computer Output: i02tb6

SOURCE: RTI Analysis of July 2008 through June 2009 100% Medicare Claims Files and Enrollment Dataset sets

Table 1-7 (BY)
Demographic and Eligibility Characteristics of
IHIE's Assigned Beneficiaries, Base Year

Population:	Beneficiaries	Percent
Total Assigned Beneficiaries	118,071	100.0
Beneficiary Deaths	3,654	3.1
Beneficiary Survived	114,417	96.9
Medicare Eligibility:		
Total	118,071	100.0
Aged	98,023	83.0
ESRD	1,206	1.0
Disabled	18,842	16.0
Original Reason for Entitlement Among Current Aged[1]:		
Total	98,733	100.0
Originally Disabled	6,984	7.1
Not Originally Disabled	91,749	92.9
Medicaid Eligibility:		
Total	118,071	100.0
Not Medicaid Eligible for Any Months	100,979	85.5
Medicaid Eligible at Least One Month	17,092	14.5
Hospice Status:		
Total	118,071	100.0
Hospice	1,771	1.5
Non-Hospice	116,300	98.5
Gender:		
Total	118,071	100.0
Male	46,437	39.3
Female	71,634	60.7
Age:		
Total	118,071	100.0
Age < 65	19,338	16.4
Age 65–74	50,256	42.6
Age 75–84	36,071	30.6
Age 85 +	12,406	10.5

(continued)

Table 1-7 (BY) (continued)
Demographic and Eligibility Characteristics of
IHIE's Assigned Beneficiaries, Base Year

Population:	Beneficiaries	Percent
Race:		
Total	118,071	100.0
White	105,306	89.2
Black	11,476	9.7
Unknown	72	0.1
Asian	427	0.4
Hispanic	175	0.1
North American Natives	48	0.0
Other	567	0.5

NOTES:

[1] Original reason for Medicare entitlement among beneficiaries currently entitled to Medicare by age and includes beneficiaries eligible by both age and ESRD.

Computer Output: i02tb7

SOURCE: RTI Analysis of July 2008 through June 2009 100% Medicare Claims Files and Enrollment Dataset sets

Table 1-8 (BY)
Distribution of IHIE Assigned Beneficiary Residents by Demo Area Counties
Base Year

County name	County number [1]	Beneficiaries	Percentage
Total	—	118,071	100
Boone	15050	1,734	1.5
Hamilton	15280	8,238	7.0
Hancock	15290	3,512	3.0
Hendricks	15310	4,907	4.2
Johnson	15400	6,630	5.6
Madison	15470	13,448	11.4
Marion	15480	44,958	38.1
Morgan	15540	3,335	2.8
Shelby	15720	1,667	1.4
Other Indiana Counties	—	29,642	25.1

NOTES:

[1] State and county codes used by the Social Security Administration (SSA)

Computer Output: i02tb8

SOURCE: RTI Analysis of July 2008 through June 2009 100% Medicare Claims Files and Enrollment Dataset sets

IHIE COMPARISON GROUP PROFILE TABLES PERFORMANCE YEAR ONE

Table 2-1 (PY1)
IHIE Comparison Group Beneficiary Assignments and Exclusions
Performance Year One Beneficiaries

Beneficiary Assignments and Exclusions	Total	Milwaukee, WI area	Columbus, OH area	Louisville, KY area
Beneficiaries[1] Provided At Least One Office or Other Outpatient E&M	395,331	145,403	127,465	122,463
Comparison group beneficiaries excluded from comparison group (see "Exclusions by Criterion" below).	53,694	13,009	27,881	12,804
Comparison group beneficiaries	341,637	132,394	99,584	109,659
Exclusions - By Criterion[2]				
At least one month of Part A-only or Part B-only coverage	8,225	1,717	4,316	2,192
At least one month of Medicare Advantage enrollment	34,432	7,695	19,988	6,749
Had coverage under employer-sponsored group health plan	14,984	4,651	5,513	4,820
Assigned to Intervention Group	200	—	—	200

NOTES:

[1] Beneficiaries must reside in one of comparison group counties specified in Table 2-7.

[2] Exclusions are not mutually exclusive. A beneficiary may be excluded for more than one reason.

Computer Output: i04tb1

SOURCE: RTI Analysis of July 2009 through June 2010 100% Medicare Claims Files and Enrollment Dataset sets

Table 2-2 (PY1)
Distribution of Office or Other Outpatient E&M Visits for IHIE Comparison Group Beneficiaries Performance Year One

Office Or Other Outpatient E&M Visits		
Mean	7.74	
Standard Deviation	6.35	
Standard Error	0.011	

Count of Visits	Beneficiaries	Percentage
Total	341,637	100.0
21+	15,523	4.5
16–20	20,694	6.1
11–15	47,381	13.9
7–10	76,192	22.3
4–6	88,309	25.8
3	32,512	9.5
2	32,218	9.4
1	28,808	8.4
0	—	0.0

Computer Output: i04tb2

SOURCE: RTI Analysis of July 2009 through June 2010 100% Medicare Claims Files and Enrollment Dataset sets

Table 2-3 (PY1)
Distribution of Hospital Discharges for IHIE Comparison Group Beneficiaries
Performance Year One

Mean	0.41
Standard Deviation	1.00
Standard Error	0.002

Count of Discharges	Beneficiaries	Percentage
Total	341,637	100.0
5 +	3,634	1.1
4	3,282	1.0
3	7,033	2.1
2	17,137	5.0
1	48,163	14.1
0	262,388	76.8

Computer Output: i04tb3

SOURCE: RTI Analysis of July 2009 through June 2010 100% Medicare Claims Files and Enrollment Dataset sets

Table 2-4 (PY1)
Distribution of Annualized Medicare Expenditures[1, 2, 3] per IHIE Comparison Group Beneficiary Performance Year One

Mean[4]	$9,862
Standard Deviation[4]	$18,760
Standard Error[4]	$33

Range	Frequency	Percent
Total	341,637	100.0
$200,000	249	0.1
$100,001–199,999	894	0.3
$100,000	4,278	1.3
$50,000–99,999	13,596	4.0
$25,000–49,999	24,048	7.0
$10,000–24,999	38,588	11.3
$5,000–9,999	36,922	10.8
$2,000–4,999	68,170	20.0
$500–1,999	97,900	28.7
$0–499 [5]	56,992	16.7

NOTES:

[1] Annualized Medicare expenditures per beneficiary are calculated by dividing actual expenditures by the fraction of the year the beneficiary is alive and are capped at $100,000 for non ESRD beneficiaries and $200,000 for ESRD beneficiaries.

[2] Expenditures have been rounded to the nearest dollar for presentation purposes. Performance payment calculations will use additional precision, i.e., expenditures will not be rounded to the nearest dollar.

[3] Inpatient pass through amounts (e.g., direct graduate medical education and organ acquisition costs) are not included in total annualized Medicare expenditures.

[4] Weighted by the eligibility fraction.

[5] Some comparison group beneficiaries have positive allowed charges but zero expenditures, because of the Medicare Part B deductible.

Computer Output: i04tb4

SOURCE: RTI Analysis of July 2009 through June 2010 100% Medicare Claims Files and Enrollment Dataset sets

Table 2-5 (PY1)
Components of Annualized Medicare Expenditures [1, 2, 3] per IHIE Comparison Group Beneficiary Performance Year One

Expenditure Component	Mean	Standard deviation	Standard error	Percentage of total $	Percentage of beneficiaries with zero $ for component
Inpatient	4,095	14,063	24.4	39.6	76.8
Hospital Outpatient	1,677	4,930	8.6	16.2	22.9
Part B Physician/ Supplier	2,593	6,664	11.6	25.1	1.0
Skilled Nursing Facility	978	4,684	8.1	9.5	93.2
Home Health	477	2,101	3.7	4.6	90.4
Durable Medical Equipment	340	2,039	3.5	3.3	66.7
Hospice	183	2,219	3.9	1.8	97.9

NOTES:

[1] Annualized Medicare expenditures per beneficiary are calculated using eligibility fractions. Component expenditures are not capped as total expenditures are in Table 2-4.

[2] Expenditures have been rounded to the nearest dollar for presentation purposes. Performance payment calculations will use additional precision, i.e., expenditures will not be rounded to the nearest dollar.

[3] Inpatient pass through amounts (e.g., direct graduate medical education and kidney acquisition costs) are not included in components of annualized Medicare expenditures.

Computer Output: i04tb5

SOURCE: RTI Analysis of July 2009 through June 2010 100% Medicare Claims Files and Enrollment Dataset sets

Table 2-6 (PY1)
Demographic and Eligibility Characteristics of IHIE's Comparison Group Beneficiaries, Performance Year One

Population:	Beneficiaries	Percent
Total Comparison Group Beneficiaries	341,637	100.0
Beneficiary Deaths	12,769	3.7
Beneficiary Survived	328,868	96.3
Medicare Eligibility:		
Total	341,637	100.0
Aged	273,058	79.9
ESRD	4,502	1.3
Disabled	64,077	18.8
Original Reason for Entitlement Among Current Aged[1]:		
Total	275,174	100.0
Originally Disabled	21,753	7.9
Not Originally Disabled	253,421	92.1
Medicaid Eligibility:		
Total	341,637	100.0
Not Medicaid Eligible for Any Months	287,014	84.0
Medicaid Eligible at Least One Month	54,623	16.0
Hospice Status:		
Total	341,637	100.0
Hospice	7,330	2.1
Non-Hospice	334,307	97.9
Gender:		
Total	341,637	100.0
Male	139,590	40.9
Female	202,047	59.1
Age:		
Total	341,637	100.0
Age < 65	66,463	19.5
Age 65–74	130,565	38.2
Age 75–84	101,907	29.8
Age 85 +	42,702	12.5

(continued)

Table 2-6 (PY1) (continued)
Demographic and Eligibility Characteristics of IHIE's Comparison Group Beneficiaries, Performance Year One

Population:	Beneficiaries	Percent
Race:		
Total	341,637	100.0
White	300,937	88.1
Black	34,051	10.0
Unknown	497	0.1
Asian	1,999	0.6
Hispanic	1,411	0.4
North American Natives	345	0.1
Other	2,397	0.7

NOTES:

[1] Original reason for Medicare entitlement among beneficiaries currently entitled to Medicare by age and includes beneficiaries eligible by both age and ESRD.

Computer Output: i04tb6

SOURCE: RTI Analysis of July 2009 through June 2010 100% Medicare Claims Files and Enrollment Dataset sets

Table 2-7 (PY1)
Distribution of IHIE Comparison Group Beneficiaries by County of Residence
Performance Year One

County name (state)	County code [1]	Beneficiaries	Percentage
Total	—	341,637	100.0
Milwaukee, WI Area (total)	—	132,394	38.8
Milwaukee (WI)	52390	74,487	21.8
Ozaukee (WI)	52440	8,612	2.5
Washington (WI)	52650	11,514	3.4
Waukesha (WI)	52660	37,781	11.1
Columbus, OH Area (total)	—	99,584	29.1
Delaware (OH)	36210	6,866	2.0
Fairfield (OH)	36230	9,437	2.8
Franklin (OH)	36250	61,567	18.0
Licking (OH)	36460	12,856	3.8
Madison (OH)	36500	2,776	0.8
Morrow (OH)	36600	2,253	0.7
Pickaway (OH)	36660	3,829	1.1
Louisville, KY Area (total)	—	109,659	32.1
Bullitt (KY)	18140	5,081	1.5
Jefferson (KY)	18550	73,262	21.4
Oldham (KY)	18920	3,480	1.0
Clark (IN)	15090	11,845	3.5
Floyd (IN)	15210	8,521	2.5
Harrison (IN)	15300	4,401	1.3
Scott (IN)	15710	3,069	0.9

NOTES:

[1] State and county codes used by the Social Security Administration (SSA)

Computer Output: i04tb7

SOURCE: RTI Analysis of July 2009 through June 2010 100% Medicare Claims Files and Enrollment Dataset sets

IHIE COMPARISON GROUP PROFILE TABLES BASE YEAR

Table 2-1 (BY)
IHIE Comparison Group Beneficiary Assignments and Exclusions Base Year Beneficiaries

Beneficiary Assignments and Exclusions	Total	Milwaukee, WI area	Columbus, OH area	Louisville, KY area
Beneficiaries[1] Provided At Least One Office or Other Outpatient E&M	394,603	146,939	126,740	120,924
Comparison group beneficiaries excluded from comparison group (see "Exclusions by Criterion" below).	39,251	13,342	15,348	10,561
Comparison group beneficiaries	355,352	133,597	111,392	110,363
Exclusions - By Criterion[2]				
At least one month of Part A-only or Part B-only coverage	7,702	1,581	4,144	1,977
At least one month of Medicare Advantage enrollment	19,304	7,922	6,992	4,390
Had coverage under employer-sponsored group health plan	14,978	4,826	5,381	4,771
Assigned to Intervention Group	215	—	—	215

NOTES:

[1] Beneficiaries must reside in one of comparison group counties specified in Table 2-7.

[2] Exclusions are not mutually exclusive. A beneficiary may be excluded for more than one reason.

Computer Output: i03tb1

SOURCE: RTI Analysis of July 2008 through June 2009 100% Medicare Claims Files and Enrollment Dataset sets

Table 2-2 (BY)
Distribution of Office or Other Outpatient E&M Visits for IHIE Comparison Group Beneficiaries Base Year

Office Or Other Outpatient E&M Visits	
Mean	7.52
Standard Deviation	6.17
Standard Error	0.010

Count of Visits	Beneficiaries	Percentage
Total	355,352	100.0
21+	14,635	4.1
16–20	20,025	5.6
11–15	47,387	13.3
7–10	79,010	22.2
4–6	94,184	26.5
3	35,044	9.9
2	34,203	9.6
1	30,864	8.7
0	—	0.0

Computer Output: i03tb2

SOURCE: RTI Analysis of July 2008 through June 2009 100% Medicare Claims Files and Enrollment Dataset sets

Table 2-3 (BY)
Distribution of Hospital Discharges for IHIE Comparison Group Beneficiaries Base Year

Mean	0.41
Standard Deviation	0.99
Standard Error	0.002

Count of Discharges	Beneficiaries	Percentage
Total	355,352	100.0
5 +	3,691	1.0
4	3,381	1.0
3	7,367	2.1
2	17,711	5.0
1	49,651	14.0
0	273,551	77.0

Computer Output: i03tb3

SOURCE: RTI Analysis of July 2008 through June 2009 100% Medicare Claims Files and Enrollment Dataset sets

Table 2-4 (BY)
Distribution of Annualized Medicare Expenditures[1, 2, 3] per IHIE Comparison Group Beneficiary Base Year

Mean[4]	$9,473
Standard Deviation[4]	$18,202
Standard Error[4]	$31

Range	Frequency	Percent
Total	355,352	100.0
$200,000	204	0.1
$100,001–199,999	826	0.2
$100,000	3,985	1.1
$50,000–99,999	13,680	3.9
$25,000–49,999	24,350	6.9
$10,000–24,999	38,924	11.0
$5,000–9,999	37,765	10.6
$2,000–4,999	71,237	20.0
$500–1,999	103,186	29.0
$0–499 [5]	61,195	17.2

NOTES:

[1] Annualized Medicare expenditures per beneficiary are calculated by dividing actual expenditures by the fraction of the year the beneficiary is alive and are capped at $100,000 for non ESRD beneficiaries and $200,000 for ESRD beneficiaries.

[2] Expenditures have been rounded to the nearest dollar for presentation purposes. Performance payment calculations will use additional precision, i.e., expenditures will not be rounded to the nearest dollar.

[3] Inpatient pass through amounts (e.g., direct graduate medical education and organ acquisition costs) are not included in total annualized Medicare expenditures.

[4] Weighted by the eligibility fraction.

[5] Some comparison group beneficiaries have positive allowed charges but zero expenditures, because of the Medicare Part B deductible.

Computer Output: i03tb4

SOURCE: RTI Analysis of July 2008 through June 2009 100% Medicare Claims Files and Enrollment Dataset sets

Table 2-5 (BY)
Components of Annualized Medicare Expenditures [1, 2, 3] per IHIE Comparison Group Beneficiary Base Year

Expenditure Component	Mean	Standard deviation	Standard error	Percentage of total $	Percentage of beneficiaries with zero $ for component
Inpatient	3,936	13,206	23	39.8	77.0
Hospital Outpatient	1,532	4,592	8	15.5	22.8
Part B Physician/ Supplier	2,525	6,679	11	25.6	1.0
Skilled Nursing Facility	964	4,620	8	9.8	93.3
Home Health	429	1,947	3	4.3	91.0
Durable Medical Equipment	331	1,856	3	3.4	67.3
Hospice	163	2,080	4	1.7	98.0

NOTES:

[1] Annualized Medicare expenditures per beneficiary are calculated using eligibility fractions. Component expenditures are not capped as total expenditures are in Table 2-4.

[2] Expenditures have been rounded to the nearest dollar for presentation purposes. Performance payment calculations will use additional precision, i.e., expenditures will not be rounded to the nearest dollar.

[3] Inpatient pass through amounts (e.g., direct graduate medical education and kidney acquisition costs) are not included in components of annualized Medicare expenditures.

Computer Output: i03tb5

SOURCE: RTI Analysis of July 2008 through June 2009 100% Medicare Claims Files and Enrollment Dataset sets

Table 2-6 (BY)
Demographic and Eligibility Characteristics of IHIE's Comparison Group Beneficiaries, Base Year

Population:	Beneficiaries	Percent
Total Comparison Group Beneficiaries	355,352	100.0
Beneficiary Deaths	12,877	3.6
Beneficiary Survived	342,475	96.4
Medicare Eligibility:		
Total	355,352	100.0
Aged	289,332	81.4
ESRD	4,465	1.3
Disabled	61,555	17.3
Original Reason for Entitlement Among Current Aged[1]:		
Total	291,585	100.0
Originally Disabled	21,502	7.4
Not Originally Disabled	270,083	92.6
Medicaid Eligibility:		
Total	355,352	100.0
Not Medicaid Eligible for Any Months	303,849	85.5
Medicaid Eligible at Least One Month	51,503	14.5
Hospice Status:		
Total	355,352	100.0
Hospice	7,105	2.0
Non-Hospice	348,247	98.0
Gender:		
Total	355,352	100.0
Male	144,501	40.7
Female	210,851	59.3
Age:		
Total	355,352	100.0
Age < 65	63,767	17.9
Age 65–74	139,592	39.3
Age 75–84	109,265	30.7
Age 85 +	42,728	12.0

(continued)

Table 2-6 (BY) (continued)
Demographic and Eligibility Characteristics of IHIE's Comparison Group Beneficiaries, Base Year

Population:	Beneficiaries	Percent
Race:		
Total	355,352	100.0
White	314,783	88.6
Black	34,383	9.7
Unknown	298	0.1
Asian	1,843	0.5
Hispanic	1,400	0.4
North American Natives	334	0.1
Other	2,311	0.7

NOTES:

[1] Original reason for Medicare entitlement among beneficiaries currently entitled to Medicare by age and includes beneficiaries eligible by both age and ESRD.

Computer Output: i03tb6

SOURCE: RTI Analysis of July 2008 through June 2009 100% Medicare Claims Files and Enrollment Dataset sets

Table 2-7 (BY)
Distribution of IHIE Comparison Group Beneficiaries by County of Residence Base Year

County name (state)	County Code [1]	Beneficiaries	Percentage
Total	—	355,352	100.0
Milwaukee, WI Area (total)	—	133,597	37.6
Milwaukee (WI)	52390	76,508	21.5
Ozaukee (WI)	52440	8,510	2.4
Washington (WI)	52650	11,483	3.2
Waukesha (WI)	52660	37,096	10.4
Columbus, OH Area (total)	—	111,392	31.3
Delaware (OH)	36210	7,544	2.1
Fairfield (OH)	36230	10,417	2.9
Franklin (OH)	36250	69,620	19.6
Licking (OH)	36460	13,826	3.9
Madison (OH)	36500	3,262	0.9
Morrow (OH)	36600	2,401	0.7
Pickaway (OH)	36660	4,322	1.2
Louisville, KY Area (total)	—	110,363	31.1
Bullitt (KY)	18140	5,147	1.4
Jefferson (KY)	18550	73,936	20.8
Oldham (KY)	18920	3,515	1.0
Clark (IN)	15090	11,972	3.4
Floyd (IN)	15210	8,395	2.4
Harrison (IN)	15300	4,404	1.2
Scott (IN)	15710	2,994	0.8

NOTES:

[1] State and county codes used by the Social Security Administration (SSA)

Computer Output: i03tb7

SOURCE: RTI Analysis of July 2008 through June 2009 100% Medicare Claims Files and Enrollment Dataset sets

IHIE PERFORMANCE PAYMENT RESULTS PERFORMANCE YEAR ONE

Table 3-1
Health Care Quality Demonstration Performance Payment Results IHIE, Performance Year 1

Index	Component	Baseline, Panel 1	PY1, Panel 1
Intervention Group (IG) Beneficiaries			
[A]	PBPM Expenditures	$793.89	$834.27
[B]	Demographic Factor	0.99561	0.99858
[C]	Standardized PBPM Expenditures	$797.39	$835.46
[D]	Number of Beneficiary Months	1,383,022	1,433,639
Comparison Group (CG) Beneficiaries			
[E]	PBPM Expenditures	$789.40	$821.82
[F]	Demographic Factor	1.02103	1.02710
[G]	Standardized PBPM Expenditures	$773.15	$800.14
[H]	Number of Beneficiary Months	4,138,824	3,973,556
Performance Payment Results			
[I]	Standardized Expenditure Ratio	1.031	
[J]	Standardized Target	—	$825.23
[K]	PBPM Standardized Actual Expenditures	—	$835.46
[L]	Beneficiary Month Weight	—	1
[M]	Combined Standardized Target	—	$825.23
[N]	Combined Actual Expenditures	—	$835.46
[O]	Target Minus Actual (Gross Savings)	—	−$10.23
[P]	Minimum Savings Requirement Percentage	—	1.78%
[Q]	Minimum Savings Requirement	—	$14.72
[R]	Net Savings	—	−$24.95
[S]	Net Savings Cap	—	−$19.96
[T]	Gross Savings Cap	—	−$5.12
[U]	Target Cap	—	$41.26
[V]	Shared Savings	—	$0.00
[W]	Performance Payment Not Contingent on Performance	—	$0.00
[X]	Maximum Performance Payment for Quality	—	$0.00
[Y]	Percentage of Quality Targets Met	—	57.14%
[Z]	Performance Payment for Quality	—	$0.00
[AA]	Earned Performance Payment (PBPM)	—	$0.00
[AB]	Total Earned Performance Payment	—	$0.00
[AC]	Medicare Savings Before Award	—	—
[AD]	Medicare Savings After Award	—	—

NOTES:

Intervention Group (IG) Beneficiaries

[A] RTI calculations with BY, PY1 Medicare claims and enrollment data for beneficiaries assigned to the intervention group in panel 1 and their baseline.

[B] Demographic factor calculated by factors provided by OACT.

[C] Expenditures divided by Demographic Factor. [A] / [B].

[D] Number of Beneficiaries Assigned to the Intervention Group in Panel 1 in Baseline period and Performance period.

Comparison Group (CG) Beneficiaries

[E] RTI calculations with BY, PY1 Medicare claims and enrollment data for beneficiaries assigned to comparison group in panel 1 and baseline.

[F] Demographic factor calculated by factors provided by OACT.

[G] Expenditures divided by Demographic Factor. [E] / [F].

[H] Number of Beneficiaries Assigned to the Comparison Group in Panel 1 in Baseline period and Performance period.

Performance Payment Results

[I] The ratio of Standardized Intervention Group Expenditures in Baseline Period over Standardized Comparison Group Expenditures in Baseline Period [C for Baseline]/[G for Baseline].

[J] The product of the Standardized Expenditure Ratio and Standardized Expenditures of the Comparison Group in the performance period [I] x [G in Performance Period]

[K] Expenditures divided by Demographic Factor. [A] / [B].

[L] For PY1 this value is 1 since there is only one physician panel.

[M] For PY1 this value is equal to [J] since there is only one physician panel.

[N] For PY1 this value is equal to [K] since there is only one physician panel.

[O] Target Minus Actual Expenditures, which is equal to Gross Savings [M] - [N].

[P] Minimum savings requirement percentage is based on the 95% confidence interval for the difference between actual expenditures for the intervention group and the expenditure target.

[Q] The product of the Minimum Savings Requirement Percentage and Target Expenditures [M] x [P].

[R] The difference between gross savings and the minimum savings requirement [O] - [Q].

[S] Equal to 80% of net savings. 0.80 x [R].

[T] Equal to 50% of gross savings. 0.50 x [O].

[U] Equal to 5% of Target expenditures 0.05x [M].

[V] If Net Savings [R] are positive, the lesser of the gross savings cap, net savings cap, and target cap (Lesser of [S], [T], and [U]). If Net Savings [R] are negative, 0.

[W] Equal to 50% of shared savings in PY1 [V] x 0.50.

[X] Equal to 50% of shared savings in PY1 [V] x 0.50.

[Y] Calculated based on quality performance.

[Z] Product of the percentage of quality targets met and the maximum performance payment for quality [Y] x [X].

[AA] Sum of performance payment for efficiency and performance payment for quality [W] + [Z].

[AB] Equal to total earned performance payment (PBPM) multiplied by the number of beneficiary-months incurred by beneficiaries assigned to IG during the performance period. [AA]x[D for PY1 IG].

[AC] Equal to PBPM gross savings multiplied by the number of beneficiary-months incurred by beneficiaries assigned to IG during the performance period. [O]x[D for PY1 IG].

[AD] Equal to Medicare savings before award minus the award amount [AC]-[AB].

SOURCE: RTI Analysis of July 2008 through June 2010 100% Medicare Claims Files and Enrollment Dataset sets

APPENDIX
Table A-1
Demographic Factors Used in Calculations

Gender/Age category	Unweighted factor[2]	Base year intervention group: Percent of sample	Base year intervention group: Weighted factor[3]	Performance year intervention group: Percent of sample	Performance year intervention group: Weighted factor[3]	Base year comparison group: Percent of sample	Base year comparison group: Weighted factor[3]	Performance year comparison group: Percent of sample	Performance year comparison group: Weighted factor[3]
Non-ESRD									
F0_34	0.68407	0.6%	0.00435	0.7%	0.00499	0.8%	0.00531	0.9%	0.00587
F35_44	0.78739	1.3%	0.00991	1.3%	0.01034	1.3%	0.01054	1.5%	0.01144
F45_54	0.93398	2.5%	0.02358	2.7%	0.02541	2.5%	0.02289	2.7%	0.02547
F55_59	1.04095	1.7%	0.01778	1.8%	0.01898	1.6%	0.01694	1.8%	0.01848
F60_64	1.12008	2.1%	0.02340	2.1%	0.02376	1.9%	0.02129	2.1%	0.02299
F65_69	0.63333	13.9%	0.08826	13.9%	0.08780	12.6%	0.07952	12.1%	0.07645
F70_74	0.79224	11.8%	0.09361	11.7%	0.09271	10.9%	0.08661	10.7%	0.08455
F75_79	0.96019	10.5%	0.10036	10.0%	0.09637	10.1%	0.09745	9.7%	0.09281
F80_84	1.14478	8.6%	0.09830	8.3%	0.09447	8.8%	0.10112	8.7%	0.10014
F85_89	1.34466	5.0%	0.06687	5.1%	0.06919	5.6%	0.07497	5.8%	0.07840
F90_94	1.52770	1.9%	0.02856	1.9%	0.02875	2.2%	0.03384	2.3%	0.03447
F95_GT	1.52770	0.4%	0.00652	0.4%	0.00670	0.5%	0.00834	0.6%	0.00898
M0_34	0.51544	0.4%	0.00231	0.5%	0.00278	0.8%	0.00400	0.8%	0.00438
M35_44	0.67594	1.0%	0.00664	1.0%	0.00663	1.2%	0.00838	1.3%	0.00881
M45_54	0.78119	1.9%	0.01461	2.1%	0.01608	2.3%	0.01766	2.5%	0.01951
M55_59	0.86700	1.1%	0.00963	1.2%	0.01027	1.3%	0.01154	1.5%	0.01280
M60_64	0.95974	1.3%	0.01249	1.4%	0.01321	1.5%	0.01441	1.6%	0.01552
M65_69	0.66663	10.1%	0.06751	10.1%	0.06725	9.4%	0.06266	9.3%	0.06198
M70_74	0.83935	8.2%	0.06848	8.2%	0.06923	7.9%	0.06656	7.7%	0.06501
M75_79	1.03509	6.8%	0.07032	6.4%	0.06640	6.9%	0.07106	6.5%	0.06764
M80_84	1.23652	4.8%	0.05924	4.8%	0.05940	5.0%	0.06244	5.1%	0.06255
M85_89	1.41613	2.4%	0.03362	2.4%	0.03397	2.6%	0.03676	2.7%	0.03792
M90_94	1.64527	0.7%	0.01104	0.7%	0.01192	0.8%	0.01349	0.8%	0.01389
M95_GT	1.82027	0.1%	0.00193	0.1%	0.00211	0.1%	0.00232	0.1%	0.00263
ESRD									
F0_44	6.86781	0.1%	0.00412	0.1%	0.00380	0.1%	0.00509	0.1%	0.00569
F45_54	7.29478	0.1%	0.00377	0.1%	0.00484	0.1%	0.00561	0.1%	0.00635
F55_59	7.72635	0.0%	0.00298	0.1%	0.00394	0.1%	0.00419	0.1%	0.00442
F60_64	7.83336	0.1%	0.00476	0.1%	0.00517	0.1%	0.00396	0.1%	0.00428
F65_69	8.26461	0.1%	0.00616	0.1%	0.00634	0.1%	0.00604	0.1%	0.00579
F70_74	8.26461	0.1%	0.00775	0.1%	0.00582	0.1%	0.00588	0.1%	0.00542
F75_GT	8.26461	0.1%	0.01115	0.2%	0.01267	0.1%	0.01152	0.1%	0.01174
M0_44	6.34766	0.0%	0.00263	0.1%	0.00327	0.1%	0.00574	0.1%	0.00680
M45_54	6.95106	0.1%	0.00541	0.1%	0.00628	0.1%	0.00836	0.1%	0.00913
M55_59	6.97072	0.0%	0.00296	0.0%	0.00336	0.1%	0.00488	0.1%	0.00531

(continued)

Table A-1 (continued)
Demographic Factors Used in Calculations

Gender/Age category	Unweighted factor[2]	Base year intervention group		Performance year intervention group		Base year comparison group		Performance year comparison group	
		Percent of sample	Weighted factor[3]	Percent of sample	Weighted factor[3]	Percent of sample	Weighted factor[3]	Percent of sample	Weighted factor[3]
M60_64	7.19628	0.0%	0.00261	0.0%	0.00298	0.1%	0.00426	0.1%	0.00525
M65_69	7.47249	0.1%	0.00463	0.1%	0.00502	0.1%	0.00551	0.1%	0.00537
M70_74	8.01869	0.1%	0.00498	0.1%	0.00530	0.1%	0.00628	0.1%	0.00588
M75_GT	8.01869	0.2%	0.01240	0.1%	0.01110	0.2%	0.01360	0.2%	0.01301
Final Factor	—	0.99561		0.99858		1.02103		1.02710	

NOTES:

[1] Numbers may not add exactly in any given column due to rounding error.

[2] The unweighted factors are centered on 1 and reflect the relative costliness of beneficiaries in a given category to the average beneficiary across all categories.

[3] The weighted factor is the product of the percent of the sample that falls into each category and the unweighted factor.

SOURCE: RTI International.

Computer Output: Req_16_Factors