

2014 ANNUAL QUALITY AND RESOURCE USE REPORT

AND THE 2016 VALUE MODIFIER FOR PAYMENT UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE

Example TIN B

Last Four Digits of Your Taxpayer Identification Number (TIN): XXXX

PERFORMANCE PERIOD: 01/01/2014 – 12/31/2014

ABOUT THIS REPORT FROM MEDICARE

- The Centers for Medicare & Medicaid Services (CMS) is continuing to phase in a Value Modifier under the Medicare Physician Fee Schedule.
- This Annual Quality and Resource Use Report shows how your group or solo practice, as identified by its Medicare-enrolled Taxpayer Identification Number (TIN), performed in 2014 on the quality and cost measures used to calculate the Value Modifier in 2016. Any applicable Value Modifier payment adjustment is separate from payment adjustments made under the Physician Quality Reporting System (PQRS) or other Medicare programs.
- The information contained in this report is believed to be accurate at the time of production. The information may be subject to change at CMS' discretion, including, but not limited to, circumstances in which an error is discovered.

HOW THE 2016 VALUE MODIFIER APPLIES TO YOUR TIN

- The 2016 Value Modifier will apply to your TIN because
 - at least 10 eligible professionals (including at least one physician) were in your TIN in 2014, and
 - no physicians billing under your TIN participated in the Medicare Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care initiative in 2014.
- In 2014, your TIN registered to report quality data to the Physician Quality Reporting System (PQRS) through the Group Practice Reporting Option (GPRO) via the GPRO Web Interface, and your TIN met the criteria to avoid the PQRS payment adjustment in 2016.
- Your TIN's 2016 Value Modifier has been calculated based on your TIN's performance in 2014 on quality and cost measures, as shown on the Performance Highlights page of this report.

ABOUT THE 2016 VALUE MODIFIER

- Calendar year 2014 is the performance period for the Value Modifier that will be applied in 2016. The Value Modifier applies at the TIN level and is based on participation in the Physician Quality Reporting System (PQRS).
- In 2016, the Value Modifier will apply to physician payments under the Medicare Physician Fee Schedule for physicians billing under TINs with 10 or more eligible professionals (at least one of whom is a physician).
- The 2016 Value Modifier will not apply to TINs with one or more physicians who participated in the Medicare Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care initiative in 2014.
- If a TIN met the criteria as a group to avoid the PQRS payment adjustment in 2016, or if at least 50 percent of its eligible professionals met the criteria as individuals to avoid the PQRS payment adjustment in 2016, then its 2016 Value Modifier will be calculated based on the TIN's quality and cost performance in 2014, using CMS' quality tiering methodology. Depending on performance, this could result in an upward or neutral payment adjustment for TINs with between 10 and 99 eligible professionals, or an upward, neutral, or downward payment adjustment for TINs with 100 or more eligible professionals. The Value Modifier payment adjustment is in addition to any PQRS incentive the TIN, or eligible professionals in the TIN, may earn.
- If a TIN did not meet the criteria as a group to avoid the PQRS payment adjustment in 2016, or if at least 50 percent of its eligible professionals did not meet the criteria as individuals to avoid the PQRS payment adjustment in 2016, then its 2016 Value Modifier will be set at -2.0% (downward payment adjustment). Information on the PQRS reporting criteria for groups and individuals can be found at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>.

WHAT'S NEXT

- Beginning in 2017, the Value Modifier will apply to all physicians in groups with two or more eligible professionals, and to physicians who are solo practitioners who bill under the Medicare Physician Fee Schedule.

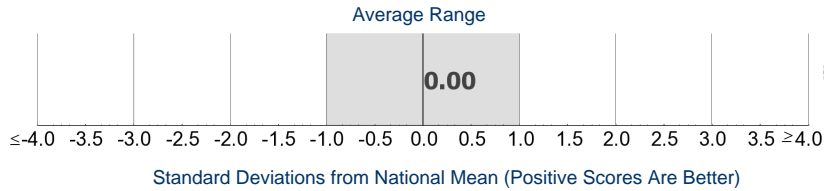
QUESTIONS?

- Contact the QRUR Help Desk at 1-888-734-6433 (select option 3) or at pvhelpdesk@cms.hhs.gov with questions or feedback about this report.
- For more information about the Value Modifier, please visit <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>.
- If your TIN is subject to the Value Modifier in 2016 and you disagree with the Value Modifier calculation indicated in the Performance Highlights section of this report, then an authorized representative of your TIN can submit a request for an Informal Review through the CMS Enterprise Portal within 60 days after the release of the 2014 Annual QRURs. Please refer to the 2014 QRUR website for more information about how to submit an informal review request: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html>.

PERFORMANCE HIGHLIGHTS

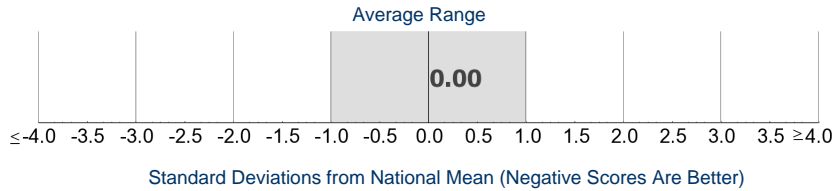
Your TIN's Quality Composite Score: Average

The graph below displays your TIN's standardized Quality Composite Score.



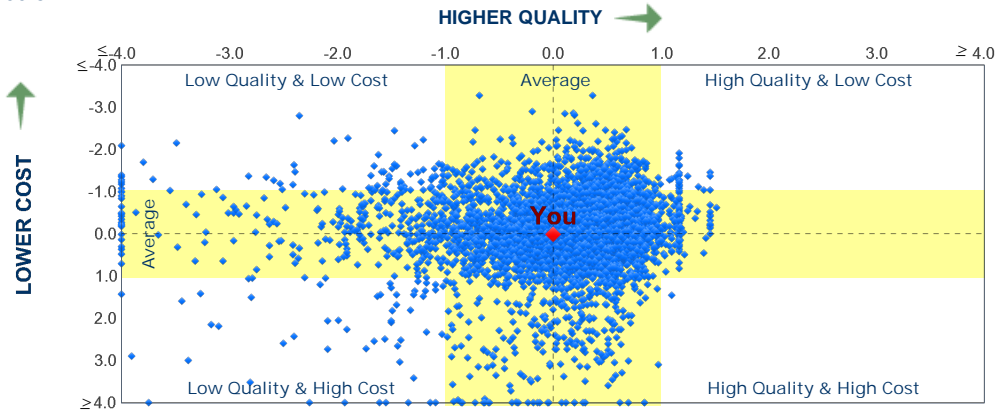
Your TIN's Cost Composite Score: Average

The graph below displays your TIN's standardized Cost Composite Score.



Your TIN's Performance: Average Quality, Average Cost

The scatter plot below displays your TIN's quality and cost performance ("You" diamond), relative to that of your peers.



Note: The scatter plot reflects the performance of a representative sample of your peers.

High-Risk Bonus Adjustment: Not Eligible

The average beneficiary risk for your TIN is at the 54th percentile of beneficiaries nationwide.

Medicare determined your TIN's eligibility for an additional upward adjustment for serving high-risk beneficiaries based on whether your TIN met (✓) or did not meet (✗) the following criteria in 2014:

- ✗ Your TIN's average beneficiary's risk is at or above the 75th percentile of beneficiaries nationwide.
- ✗ Your TIN had strong quality and cost performance.
- ✓ Your TIN met the criteria to avoid the PQRS payment adjustment as a group, or at least 50 percent of your TIN's eligible professionals met the criteria to avoid the PQRS payment adjustment as individuals in 2016.

Your TIN's Value Modifier: Neutral Adjustment

The highlighted payment adjustment will be applied to payments under the Medicare Physician Fee Schedule for physicians billing under in your TIN in 2016.

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

Note: Quality and Cost Composite Scores that could not be calculated due to insufficient data are categorized as "Average" for the purposes of determining the Value Modifier payment adjustment under quality tiering. The displayed payment adjustment includes the high-risk bonus adjustment, if applicable. The precise size of the reward for higher performing TINs will vary from year to year, based on an adjustment factor (AF) derived from actuarial estimates of projected billings. The AF for the 2016 Value Modifier will be posted at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>.

ABOUT THE DATA IN THIS REPORT

This report provides summary information on quality and cost measures that are used to calculate the 2016 Value Modifier based on care provided to the Medicare fee-for-service (FFS) beneficiaries attributed to your TIN during the performance period. The table below briefly describes the data included in each section. All of the data in this report are available in an exportable comma-separated values (CSV) data file {Link to CSV}, with accompanying data dictionary {Link to Data Dictionary}, in a downloadable portable document format (PDF) {Link to PDF report}, and in an exportable Excel format {Link to Excel File}. Additionally, CMS has made educational information about the Annual Quality and Resource Use Report available through the CMS Portal. For more information, and to understand the Annual Quality and Resource Use Report methodology, visit <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html>.

Overview of the Data, by Section	For More Information
<p><u>Eligible Professionals In Your Taxpayer Identification Number (TIN)</u></p> <p>A "TIN" (or "Taxpayer Identification Number") is defined as the single provider entity to which eligible professionals reassigned their Medicare billing rights in the performance period. In order to receive this Annual QRUR, at least one eligible professional must bill under your TIN.</p> <p>The number of eligible professionals in your TIN is determined based on the lower of the number of eligible professionals indicated by a query of the Provider Enrollment, Chain and Ownership System (PECOS) on October 16, 2014 and the number of eligible professionals based on claims submitted to Medicare under that TIN during the performance period (Exhibit 1).</p>	<p>Links on the CMS Portal:</p> <ul style="list-style-type: none"> ● Supplementary Exhibit 1. Physicians and Non-Physician Eligible Professionals Billing Under Your TIN, Selected Characteristics <p>Glossary</p> <ul style="list-style-type: none"> ● Eligible professional ● Provider Enrollment, Chain and Ownership System (PECOS) ● Taxpayer Identification Number (TIN) <p>Exhibit A-1 (listing of eligible professional specialties)</p>

Attribution of Medicare Beneficiaries and Episodes to Your TIN for Claims-Based Measures

Two methods of attribution are used in this report for measures calculated using administrative claims:

1. For the Per Capita Costs for All Attributed Beneficiaries measure, the four Per Capita Costs for Beneficiaries with Specific Conditions measures, and the three quality outcome measures, Medicare has attributed each beneficiary to the single TIN that provided the most primary care services to that beneficiary (as measured by Medicare-allowed charges) through a two-step attribution process (Exhibits 2 and 3).
 - a. The first step assigns a beneficiary to a TIN if the beneficiary received the plurality of primary care services from primary care physicians in the TIN.
 - b. If a beneficiary did not receive a primary care service from any primary care physician during the performance period, the second step assigns the beneficiary to a TIN if the beneficiary (a) received at least one primary care service from a physician of any specialty within the TIN, and (b) received a plurality of the primary care services from specialist physicians, nurse practitioners, physician assistants, and clinical nurse specialists within the TIN.
2. For the Medicare Spending per Beneficiary measure, an episode of care surrounding a hospital admission for a Medicare fee-for-service beneficiary is attributed to the TIN that provided the most Part B-covered services (as measured by Medicare-allowed charges) to that beneficiary during the hospitalization (Exhibit 4).

The method of attributing patients to TINs for the PQRS quality measures (Exhibits 6) varies by measure type and reporting mechanism:

1. For individual PQRS measures reported via claims, qualified registries, or electronic health records, the TINs reporting the measures identify the Medicare Part B FFS beneficiaries seen during the reporting period to which each measure applies.
2. For PQRS measures reported through the Group Practice Reporting Option (GPRO) Web Interface, CMS assigns a ranked pool of eligible Medicare FFS beneficiaries for which the TINs must submit data.
3. For individual eligible professionals reporting PQRS measures groups via qualified registries, a majority (but not all) of the eligible patients included in the measures groups must be Medicare Part B FFS patients.
4. For individual eligible professionals satisfying PQRS reporting requirements through participation in a qualified clinical data registry in 2014, the registry identifies the applicable patients seen during the reporting period to which its measures apply. The registry may report measures for Medicare and non-Medicare patients combined.
5. For TINs electing to submit data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for PQRS in 2014, CMS provides the identified CAHPS Vendor with an appropriate sample frame of beneficiaries from the TIN.

Links on the CMS Portal:

For additional information about beneficiaries attributed to your TIN through both methods, and their use of services, see:

- Supplementary Exhibit 2A. Beneficiaries Attributed to Your TIN for the Cost Measures (excluding MSPB) and Claims-Based Quality Outcome Measures, and the Care that You and Others Provided
- Supplementary Exhibit 2B. Beneficiaries Attributed to Your TIN for the Cost Measures (excluding MSPB) and Claims-Based Quality Outcome Measures: Costs of Services Provided by You and Others
- Supplementary Exhibit 4. Beneficiaries Attributed to Your TIN for the Medicare Spending per Beneficiary Measure

Glossary

- Attribution
- Medicare Spending per Beneficiary
- Non-physician eligible professional
- Per Capita Costs for All Attributed Beneficiaries
- Per Capita Costs for Beneficiaries with Specific Conditions
- Primary care services

Performance on Quality

Quality Domain Performance and the Quality Composite: Exhibit 5 displays your overall Quality Composite Score and performance in each of the six Value Modifier quality domains, as applicable (Effective Clinical Care, Person and Caregiver-Centered Experience and Outcomes, Community/Population Health, Patient Safety, Communication and Care Coordination, and Efficiency and Cost Reduction):

1. The quality domain scores are equally weighted averages of quality measures in the domain with at least 20 eligible cases.
2. The applicable Quality Composite Score shows how much your average score differs from the national mean.

Quality Measures:

Please note that PQRS measures submitted in 2014 via the qualified clinical data registry or electronic health record reporting option are not included in the 2014 Annual QRUR and will not be used to calculate the 2016 Value Modifier because we are unable to determine the accuracy of these data. For eligible professionals reporting as individuals, information about performance on these measures is available in the PQRS feedback report.

Quality data (Exhibits 6) in this report are derived in four ways:

1. If your TIN satisfactorily reported data to the PQRS via the Group Practice Reporting Option (GPRO), the measures used in this report are the quality measures reported for your patients via the mechanism your TIN chose in 2014 (qualified registry or GPRO Web Interface). Please note that the quality data presented exclude any PQRS measures submitted through the electronic health record reporting option.
2. For TINs whose eligible professionals participated in the PQRS as individuals, CMS aggregated PQRS data, as applicable, reported by individual eligible professionals in the group, to calculate the TIN-level quality performance. Please note that the quality data presented exclude any PQRS measures submitted through the qualified clinical data registry or electronic health record reporting option.
3. For TINs that elected to supplement PQRS data with the CAHPS for PQRS survey, patient experience data for your patients are reported by the Medicare-certified CAHPS Survey Vendor. Groups that elected to include the results of their 2014 CAHPS for PQRS survey in the calculation of their 2016 Value Modifier have performance on these measures reflected in their Communication and Care Coordination domain quality indicator performance, and an indication of whether these measures are included as part of the 2016 Value Modifier computation (based on the TIN's election) is shown.
4. In addition, Medicare calculated three quality outcome measures based on FFS Medicare claims submitted for Medicare beneficiaries attributed to your TIN during the performance period (Exhibit 6-CCC-B (CMS-Calculated Outcome Measures)), as applicable.

Risk Adjustment: All claims-based quality measures are risk-adjusted based on the mix of patients attributed to your TIN. Because patient populations and risk adjustment models vary, the effects of risk adjustment on a TIN's performance may not be the same for different measures.

Peer Group and Benchmarking: Comparative quality benchmarks are the case-weighted average performance rates within your peer group during performance year 2013 (the year prior to the 2014 performance period). At the measure level, the peer group is defined as all TINs nationwide that had at least 20 eligible cases. At the Quality Composite level, the peer group for TINs with 10 or more eligible professionals is all TINs with 10 or more eligible professionals that are subject to the Value Modifier. The peer group for TINs with fewer than 10 eligible professionals is all TINs with one or more eligible professionals and at least one physician (excluding TINs that participated in the Medicare Shared Savings Program, Pioneer ACO Model, or the Comprehensive Primary Care initiative in 2014).

Links on the CMS Portal:

For information about your incentive payment for participation in the PQRS GPRO, see:

- Supplementary Exhibit 12. Summary of 2014 GPRO Earned Incentive

For information about the performance of eligible professionals in your TIN reporting PQRS measures individually, see:

- Supplementary Exhibit 11. Individual Eligible Professional Performance on the 2014 PQRS Measures

Glossary

- Attribution
- Benchmark
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Group Practice Reporting Option (GPRO)
- Outcome measures
- Peer group
- Physician Quality Reporting System
- Quality Composite Score
- Risk adjustment

Hospitals Admitting Your Patients

Medicare identified the hospitals that provided at least five percent of inpatient stays to the beneficiaries attributed to your TIN based on primary care services provided during the performance period (the first attribution method described above) (Exhibit 7). In addition, Medicare identified the hospitals that provided at least five percent of episodes of care to your TIN's attributed beneficiaries for the Medicare Spending per Beneficiary measure (the second attribution method described above) (Exhibit 8). Information on hospital performance is available on the Hospital Compare website (<http://www.hospitalcompare.hhs.gov>).

Links on the CMS Portal:

- Supplementary Exhibit 3A. Beneficiaries Attributed to Your TIN for the Cost Measures (excluding MSPB) and Claims-Based Quality Outcome Measures: Hospital Admissions for Any Cause
- Supplementary Exhibit 3B. Beneficiaries Attributed to Your TIN for the Cost Measures (excluding MSPB) and Claims-Based Quality Outcome Measure: Hospital Admissions for Any Cause (MSSP ACO TINs Only)
- (For MSSP ACOs only) Supplementary Exhibit 13. Beneficiaries Assigned to Your ACO and Attributed to Your TIN for the All-Cause Hospital Readmissions Measure: Hospital Admissions for Any Cause

Glossary

- Attribution
- CMS Certification Number (CCN)
- Medicare Spending per Beneficiary

Performance on Costs

Cost Domain Performance and the Cost Composite: Exhibit 9 displays your overall Cost Composite Score and performance in the two Value Modifier cost domains (Per Capita Costs for All Attributed Beneficiaries and Per Capita Costs for Beneficiaries with Specific Conditions):

1. The cost domain scores are equally-weighted averages of cost measures in the domain with at least 20 eligible cases.
2. The standardized cost score shows how much your average score differs from the national mean.

Cost Measures: Cost information in this report is derived in two ways:

1. For the Per Capita Costs for All Attributed Beneficiaries measure and the four Per Capita Costs for Beneficiaries with Specific Conditions measures, costs reflect payments for all Medicare Parts A and B claims submitted by all providers who treated Medicare FFS patients attributed to your TIN for each measure, including providers who do not bill under your TIN (Exhibits 10 and 11). Part D prescription drug costs are not included.
2. Costs for the Medicare Spending per Beneficiary measure are based on Parts A and B expenditures surrounding specified inpatient hospital stays (3 days prior through 30 days post-discharge) (Exhibits 10 and 12). Part D prescription drug costs are not included.

Risk Adjustment: All cost measures are risk-adjusted based on the mix of patients attributed to your TIN. Patient populations and risk adjustment models vary, and the effects of risk adjustment on a TIN's performance may not be the same across all measures.

Payment Standardization: All comparative cost data are payment-standardized to account for differences in Medicare payments across geographic regions due to variations in local input prices.

Specialty Adjustment: In addition to being payment-standardized and risk-adjusted, cost measures are also adjusted to reflect the mix of physician specialties within a TIN.

Peer Group and Benchmarking: Comparative cost benchmarks are the case-weighted average performance rates within your peer group during the 2014 performance period. At the measure level, the peer group is defined as all TINs nationwide that had at least 20 eligible cases. At the Cost Composite level, the peer group for TINs with 10 or more eligible professionals is all TINs with 10 or more eligible professionals that are subject to the Value Modifier. The peer group for TINs with fewer than 10 eligible professionals is all TINs with one or more eligible professionals and at least one physician (excluding TINs that participated in the Medicare Shared Savings Program, Pioneer ACO Model, or the Comprehensive Primary Care initiative in 2014).

Links on the CMS Portal:

- Supplementary Exhibits 5 - 10. Per Capita or Per Episode Costs, by Categories of Service, for the Six Cost Measures

Glossary

Attribution

- Cost Composite Score

Medicare Spending per Beneficiary

Payment standardization

Peer group

- Per Capita Costs for All Attributed Beneficiaries

Per Capita Costs for Beneficiaries with Specific Conditions

Risk adjustment

Specialty adjustment

ELIGIBLE PROFESSIONALS IN YOUR TAXPAYER IDENTIFICATION NUMBER (TIN)

The table below shows how many eligible professionals (physicians and non-physicians) were in your TIN during the performance period, based on October 16, 2014 PECOS data and claims data from the performance period.

Exhibit 1. Your TIN's Eligible Professionals

Eligible Professionals in Your TIN	Number Identified in PECOS	Percentage Identified in PECOS	Number Identified in Claims	Percentage Identified in Claims
All eligible professionals	0	—	0	100.00%
Physicians	0	—	0	100.00%
Non-physicians	0	—	0	100.00%

Note: To determine the size of your TIN for purposes of the Value Modifier, CMS uses the lower of the number of eligible professionals identified in PECOS as having re-assigned their billing rights to your TIN, and the number of eligible professionals identified in the claims data for the performance period.

ATTRIBUTION OF MEDICARE BENEFICIARIES AND EPISODES TO YOUR TIN FOR CLAIMS-BASED MEASURES

Two methods of attribution are used in this report for measures calculated from administrative claims. Exhibits 2, 3, and 4 provide information about beneficiaries attributed to your TIN under these methods.

Exhibits 2 and 3 provide information on beneficiaries attributed to your TIN based on primary care services provided. This attribution method is used for the Per Capita Costs for All Attributed Beneficiaries measure, the four Per Capita Costs for Beneficiaries with Specific Conditions measures, and the three quality outcome measures.

Exhibit 4 provides information about beneficiaries attributed to your TIN for the Medicare Spending per Beneficiary measure, described in the "About the Data in this Report" section, based on services provided during episodes of hospital care.

For more information about attribution methods, please see the "About the Data in this Report" section.

Exhibit 2. Medicare Beneficiaries Attributed to Your TIN Based on Primary Care Services Provided

Basis for Attribution	Number	Percentage
All attributed beneficiaries	0	100.00%
Beneficiaries attributed because your TIN's primary care physicians provided the most primary care services	0	—
Beneficiaries attributed because your TIN's specialist physicians or non-physician practitioners provided the most primary care services	0	—

Exhibit 3. Primary Care Services Provided to Medicare Beneficiaries Attributed to Your TIN

Primary Care Services for Attributed Beneficiaries	Average Number	Average Percentage
Primary care services provided to each attributed beneficiary	0	100.00%
Provided by physicians or non-physician practitioners in your TIN	0	—
Provided by physicians or non-physician practitioners outside of your TIN	0	—

Note: Because the beneficiaries attributed to your TIN may receive different numbers of services, the average percentage of services will not necessarily equal the average number of services divided by the average total number of services. If no beneficiaries are attributed to your TIN in Exhibit 2, this exhibit will be populated with dashes.

Exhibit 4. Hospital Episodes and Medicare Beneficiaries Attributed to Your TIN for the Medicare Spending per Beneficiary Measure

Hospital Episodes and Beneficiaries	Number
Total episodes of hospital care attributed to your TIN	0
Unique Medicare beneficiaries associated with attributed episodes of care	0

PERFORMANCE ON QUALITY

Exhibit 5 summarizes your TIN's 2014 quality performance. Quality Composite Scores are calculated only for domains for which your TIN had at least 20 eligible cases for at least one quality measure. Calculations are based on the following data for your TIN:

- Quality measures your TIN reported to the PQRS as a group in 2014 through the Group Practice Reporting Option (GPRO) using the reporting mechanism indicated in the "How the 2016 Value Modifier Applies to Your TIN" section (with the exception for a TIN that reported using the electronic health record option as noted below), and
- Patient experience data for your patients, as reported by a Medicare-certified CAHPS Survey Vendor, and
- Three quality outcome measures that Medicare calculates from FFS Medicare claims submitted for beneficiaries attributed to your TIN during the performance period (as applicable).

Please note that PQRS measures submitted in 2014 via the qualified clinical data registry or electronic health record reporting option are not included in the 2014 Annual QRUR and will not be used to calculate the 2016 Value Modifier because we are unable to determine the accuracy of these data. For eligible professionals reporting as individuals, information about performance on these measures is available in the PQRS feedback report.

Exhibit 5. Your TIN's Performance in 2014, by Quality Domain

Quality Domain	Number of Quality Measures Included in Composite Score	Standardized Performance Score (Quality Tier Designation)
Quality Composite Score	0	
Effective Clinical Care	0	—
Person and Caregiver-Centered Experience and Outcomes	0	—
Community/Population Health	0	—
Patient Safety	0	—
Communication and Care Coordination	0	—
Efficiency and Cost Reduction	0	—

Note: A TIN's quality tier designation is "Average" if the Quality Composite Score falls within one standard deviation of the mean. The quality tier designation is "High" or "Low" only if the Quality Composite Score is at least one standard deviation above or below the mean and statistically different from the mean at the five percent level. A score outside the "Average" range that is not statistically different from the mean has an "Insufficient Data to Determine" quality tier designation. If a Quality Composite Score cannot be calculated because the TIN did not have at least one quality measure with at least 20 eligible cases, then no Quality Composite Score is reported (as indicated by a dash) and there is an "Insufficient Data to Determine" quality tier designation. For all TINs that met the criteria to avoid the 2016 PQRS payment adjustment, but have an "Insufficient Data to Determine" tier designation, quality performance will be considered "Average" for the 2016 Value Modifier. Assigning an "Average" quality tier designation to a TIN that does not have at least one quality measure with at least 20 eligible cases reflects a proposal that was included in the 2016 Medicare Physician Fee Schedule Proposed Rule (80 FR 41907) and is subject to change. In cases where a TIN reported PQRS measures only through the qualified clinical data registry or electronic health record reporting option and would otherwise have received a quality tier designation that is "Low," the TIN will instead be assigned a quality tier designation that is "Average". In cases where a TIN reported PQRS measures only through the qualified clinical data registry or electronic health record reporting option and the TIN's quality tier designation is "Average" or "High", the TIN will retain the calculated quality tier designation. Quality tiering does not apply to TINs that did not meet the reporting criteria to avoid the 2016 PQRS payment adjustment, and no domain or Quality Composite Scores or tier designations are calculated for these TINs.

Exhibits 6. Performance on Quality Measures, by Domain

Exhibits 6 display information on your TIN's performance on quality measures that were reported for your TIN through a PQRS reporting mechanism, provided your TIN had at least one measure with at least one eligible case. Only those measures for which benchmarks are available and for which your TIN had 20 or more eligible cases are included in the domain scores and the Quality Composite Score. Additionally, Exhibit 6-CCC-B provides information on the three claims-based quality outcome measures calculated by CMS, if your TIN had at least one eligible case for at least one outcome measure.

Exhibit 6-ECC. Effective Clinical Care Domain Quality Indicator Performance

Measure Reference	Measure Name	Your TIN's Eligible Cases	Your TIN's Performance Rate	Benchmark	Benchmark -1 Standard Deviation	Benchmark +1 Standard Deviation	Standardized Score	Included In Domain Score?
111 (GPRO Prev-8, CMS127 v2)	Preventive Care and Screening: Pneumococcal Vaccination for Older Adults	0	0.00%	0.00%	0.00%	0.00%	0.00	No
113 (GPRO Prev-6, CMS130 v2)	Preventive Care and Screening: Colorectal Cancer Screening	0	0.00%	0.00%	0.00%	0.00%	0.00	No
197 (GPRO CAD-2)	Coronary Artery Disease (CAD): Lipid Control	0	0.00%	0.00%	0.00%	0.00%	0.00	No
236 (GPRO HTN-2, CMS165 v2)	Hypertension (HTN): Controlling High Blood Pressure	0	0.00%	0.00%	0.00%	0.00%	0.00	No
-	Coronary Artery Disease (CAD): Composite (All or Nothing Scoring)	0	0.00%	0.00%	0.00%	0.00%	0.00	No

Note: If an asterisk (*) appears in the 'Measure Reference' column, it indicates that the measure is an inverse measure, and a lower performance rate for this measure means better performance. This is taken into account when calculating the domain score. Within the Quality Composite, all domain scores are calculated such that positive (+) domain scores indicate better performance and negative (-) domain scores indicate worse performance, as shown in Exhibit 5.

Exhibit 6-PCE. Person and Caregiver-Centered Experience and Outcomes Domain Quality Indicator Performance

Exhibit 6-PCE is not displayed because your TIN did not have at least one eligible case for at least one measure in this domain.

Exhibit 6-CPH. Community/Population Health Domain Quality Indicator Performance

Measure Reference	Measure Name	Your TIN's Eligible Cases	Your TIN's Performance Rate	Benchmark	Benchmark -1 Standard Deviation	Benchmark +1 Standard Deviation	Standardized Score	Included In Domain Score?
110 (GPRO Prev-7, CMS147 v2)	Preventive Care and Screening: Influenza Immunization	0	0.00%	0.00%	0.00%	0.00%	0.00	No
128 (GPRO Prev-9, CMS69v2)	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	0	0.00%	0.00%	0.00%	0.00%	0.00	Yes
134 (GPRO Prev-12, CMS2v3)	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	0	0.00%	0.00%	0.00%	0.00%	0.00	No
226 (GPRO Prev-10, CMS138 v2)	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	0	0.00%	0.00%	0.00%	0.00%	0.00	Yes

Measure Reference	Measure Name	Your TIN's Eligible Cases	Your TIN's Performance Rate	Benchmark	Benchmark -1 Standard Deviation	Benchmark +1 Standard Deviation	Standardized Score	Included In Domain Score?
317 (GPRO Prev-11, CMS22v 2)	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	0	0.00%	0.00%	0.00%	0.00%	0.00	No

Note: If an asterisk (*) appears in the 'Measure Reference' column, it indicates that the measure is an inverse measure, and a lower performance rate for this measure means better performance. This is taken into account when calculating the domain score. Within the Quality Composite, all domain scores are calculated such that positive (+) domain scores indicate better performance and negative (-) domain scores indicate worse performance, as shown in Exhibit 5.

Exhibit 6-PS. Patient Safety Domain Quality Indicator Performance

Measure Reference	Measure Name	Your TIN's Eligible Cases	Your TIN's Performance Rate	Benchmark	Benchmark -1 Standard Deviation	Benchmark +1 Standard Deviation	Standardized Score	Included In Domain Score?
318 (GPRO CARE-2, CMS139 v2)	Falls: Screening for Future Fall Risk	0	0.00%	0.00%	0.00%	0.00%	0.00	No

Note: If an asterisk (*) appears in the 'Measure Reference' column, it indicates that the measure is an inverse measure, and a lower performance rate for this measure means better performance. This is taken into account when calculating the domain score. Within the Quality Composite, all domain scores are calculated such that positive (+) domain scores indicate better performance and negative (-) domain scores indicate worse performance, as shown in Exhibit 5.

Exhibit 6-CCC-A. Communication and Care Coordination Domain Quality Indicator Performance

Exhibit 6-CCC-A is not displayed because your TIN did not have at least one eligible case for at least one PQRS measure in this domain.

Exhibit 6-CCC-B. Communication and Care Coordination Domain Quality Indicator Performance (CMS-Calculated Outcome Measures)

Performance Category	Measure Reference	Measure Name	Your TIN's Eligible Cases	Your TIN's Performance Rate	Benchmark	Benchmark -1 Standard Deviation	Benchmark +1 Standard Deviation	Standardized Score	Included In Domain Score?
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care-Sensitive Conditions	CMS-1	Acute Conditions Composite	0	0.00	0.00	0.00	0.00	0.00	Yes
	-	Bacterial Pneumonia	0	0.00	0.00	0.00	0.00	0.00	No
		Urinary Tract Infection	0	0.00	0.00	0.00	0.00	0.00	No
		Dehydration	0	0.00	0.00	0.00	0.00	0.00	No
	CMS-2	Chronic Conditions Composite	0	0.00	0.00	0.00	0.00	0.00	No
	-	Diabetes (composite of 4 indicators)	0	0.00	0.00	0.00	0.00	0.00	No
		Chronic Obstructive Pulmonary Disease (COPD) or Asthma	0	0.00	0.00	0.00	0.00	0.00	No
Heart Failure		0	0.00	0.00	0.00	0.00	0.00	No	
Hospital Readmissions	CMS-3	All-Cause Hospital Readmissions	0	0.00%	0.00%	0.00%	0.00%	0.00	No

Note: CMS-1, CMS-2, and CMS-3 are calculated by CMS using administrative claims data. Lower performance rates for these measures mean better performance. This is taken into account when calculating the domain score. Within the Quality Composite, all domain scores are calculated such that positive (+) domain scores indicate better performance and negative (-) domain scores indicate worse performance, as shown in Exhibit 5.

Exhibit 6-ECR. Efficiency and Cost Reduction Domain Quality Indicator Performance

Exhibit 6-ECR is not displayed because your TIN did not have at least one eligible case for at least one measure in this domain.

HOSPITALS ADMITTING YOUR PATIENTS

The hospitals in Exhibit 7 each account for at least five percent of inpatient hospital stays associated with beneficiaries attributed to your TIN for three claims-based quality outcome measures and for five of the six per capita cost measures. This includes only beneficiaries attributed to your TIN based on primary care services provided. For more information about this attribution method and the measures to which it applies, please see the “About the Data in this Report” section.

Exhibit 7. Hospitals Admitting Medicare Beneficiaries Attributed to Your TIN Based on Primary Care Services Provided

Hospital Name	Hospital CMS Certification Number	Hospital Location	Number of Stays	Percentage of All stays
Total			0	—
Sample Hospital	999999	CITY, STATE	0	—
Sample Hospital	999999	CITY, STATE	0	—
Sample Hospital	999999	CITY, STATE	0	—
Sample Hospital	999999	CITY, STATE	0	—

Note: CMS uses the Provider of Services file (<http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/NonIdentifiableDataFiles/ProviderofServicesFile.html>) to identify the full name and location of the hospital associated with the provider number indicated on a given Medicare claim. For information on this methodology, see the Performance Year 2014 Frequently Asked Questions (FAQs) available here (<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html>).

The hospitals in Exhibit 8 each account for at least five percent of the episodes of care attributed to your TIN for the Medicare Spending per Beneficiary (MSPB) measure. For more information about the attribution method for this measure, please see the “About the Data in this Report” section.

Exhibit 8. Hospitals Accounting for Episodes of Care Attributed to Your TIN for the Medicare Spending per Beneficiary Measure

Hospital Name	Hospital CMS Certification Number	Hospital Location	Number of MSPB Episodes	Percentage of All MSPB Episodes
Total			0	—
Sample Hospital	999999	CITY, STATE	0	—
Sample Hospital	999999	CITY, STATE	0	—
Sample Hospital	999999	CITY, STATE	0	—
Sample Hospital	999999	CITY, STATE	0	—
Sample Hospital	999999	CITY, STATE	0	—
Sample Hospital	999999	CITY, STATE	0	—
Sample Hospital	999999	CITY, STATE	0	—

Note: CMS uses the Provider of Services file (<http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/NonIdentifiableDataFiles/ProviderofServicesFile.html>) to identify the full name and location of the hospital associated with the provider number indicated on a given Medicare claim. For information on this methodology, see the Performance Year 2014 Frequently Asked Questions (FAQs) available here (<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html>).

PERFORMANCE ON COSTS

Exhibit 9 summarizes your TIN's 2014 cost performance. Cost Composite Scores are calculated for domains for which your TIN had at least 20 eligible cases for at least one cost measure.

Exhibit 9. Your TIN's Performance in 2014, by Cost Domain

Cost Domain	Number of Cost Measures Included in Composite Score	Standardized Performance Score (Cost Tier Designation)
Cost Composite Score	0	0.00 (Average)
Per Capita Costs for All Attributed Beneficiaries	0	—
Per Capita Costs for Beneficiaries with Specific Conditions	0	—

Note: A TIN's cost tier designation is "Average" if the Cost Composite Score falls within one standard deviation of the mean. The cost tier designation is "High" or "Low" only if Cost Composite Score is at least one standard deviation above or below the mean and statistically different from the mean at the five percent level. A score outside the "Average" range that is not statistically different from the mean has an "Insufficient Data to Determine" cost tier designation. If a Cost Composite Score cannot be computed because the TIN did not have at least one cost measure with at least 20 eligible cases, then no Cost Composite Score is reported (as indicated by a dash) and there is an "Insufficient Data to Determine" cost tier designation. For all TINs that met the criteria to avoid the 2016 PQRS payment adjustment, but have an "Insufficient Data to Determine" tier designation, cost performance will be considered "Average" for the 2016 Value Modifier. Domain scores are not computed for domains that do not have at least one measure with at least 20 eligible cases.

Exhibit 10 displays your TIN's payment-standardized, risk-adjusted, and specialty-adjusted per capita or per episode costs for each cost measure. Only those measures for which your TIN had 20 or more eligible cases or episodes are included in the domain scores and the Cost Composite Score.

Exhibit 10. Per Capita or Per Episode Costs for Your TIN's Attributed Medicare Beneficiaries

Cost Domain	Cost Measure	Your TIN's Eligible Cases or Episodes	Your TIN's Per Capita or Per Episode Costs	Benchmark	Benchmark - 1 Standard Deviation	Benchmark + 1 Standard Deviation	Standardized Score	Included in Domain Score?
Per Capita Costs for All Attributed Beneficiaries	Per Capita Costs for All Attributed Beneficiaries	0	—	\$0	\$0	\$0	—	Yes
	Medicare Spending per Beneficiary	0	—	\$0	\$0	\$0	—	No
Per Capita Costs for Beneficiaries with Specific Conditions	Diabetes	0	—	\$0	\$0	\$0	—	No
	Chronic Obstructive Pulmonary Disease (COPD)	0	—	\$0	\$0	\$0	—	No
	Coronary Artery Disease (CAD)	0	—	\$0	\$0	\$0	—	No
	Heart Failure	0	—	\$0	\$0	\$0	—	No

Note: For the Per Capita Costs for All Attributed Beneficiaries measure and the four Per Capita Costs for Beneficiaries with Specific Conditions measures, per capita costs are based on payments for Medicare Parts A and B claims submitted by all providers (including medical professionals, hospitals, and post-acute care facilities) for Medicare beneficiaries attributed to a TIN for a given measure. For the Medicare Spending per Beneficiary measure, per episode costs are based on Parts A and B expenditures surrounding specified inpatient hospital stays (3 days prior through 30 days post-discharge). Part D prescription drug costs are not included.

Per Capita and Per Episode Costs of Care for Specific Services

Exhibits 11 and 12 show the dollar difference between your per capita and per episode costs and the mean among TINs with at least 20 eligible cases for the measure (benchmark), by category of service. Detailed cost of services breakdowns for these measures are available via the CMS Portal in downloadable supplementary exhibits (see the “About the Data in this Report” section).

**Exhibit 11. Differences between Your TIN’s Per Capita Costs and Mean Per Capita Costs among TINs with these Measures, by Category of Service:
Per Capita Costs for All Attributed Beneficiaries and Beneficiaries with Specific Conditions**

Service Category	Amount by Which Your TIN’s Costs Were Higher/(Lower) than Benchmark:Per Capita Costs for All Attributed Beneficiaries	Amount by Which Your TIN’s Costs Were Higher/(Lower) than Benchmark:Per Capita Costs for Beneficiaries with Diabetes	Amount by Which Your TIN’s Costs Were Higher/(Lower) than Benchmark:Per Capita Costs for Beneficiaries with Chronic Obstructive Pulmonary Disease	Amount by Which Your TIN’s Costs Were Higher/(Lower) than Benchmark:Per Capita Costs for Beneficiaries with Coronary Artery Disease	Amount by Which Your TIN’s Costs Were Higher/(Lower) than Benchmark:Per Capita Costs for Beneficiaries with Heart Failure
Evaluation & Management Services Billed by Eligible Professionals in Your TIN*	\$0	—	—	—	—
Evaluation & Management Services Billed by Eligible Professionals in Other TINs*	\$0	—	—	—	—
Major Procedures Billed by Eligible Professionals in Your TIN*	\$0	—	—	—	—
Major Procedures Billed by Eligible Professionals in Other TINs*	\$0	—	—	—	—
Ambulatory/Minor Procedures Billed by Eligible Professionals in Your TIN*	\$0	—	—	—	—
Ambulatory/Minor Procedures Billed by Eligible Professionals in Other TINs*	\$0	—	—	—	—
Ancillary Services	\$0	—	—	—	—
Hospital Inpatient Services	\$0	—	—	—	—
Emergency Services Not Included in a Hospital Admission	\$0	—	—	—	—
Post-Acute Services	\$0	—	—	—	—
Hospice	\$0	—	—	—	—
All Other Services**	\$0	—	—	—	—

Note: Per capita costs are based on payments for Medicare Parts A and B claims submitted by all providers (including medical professionals, hospitals, and post-acute care facilities) for Medicare beneficiaries attributed to your TIN. Part D prescription drug costs are not included. All per capita costs are payments that have been payment-standardized, risk-adjusted, and specialty-adjusted. In calculating service-specific per capita costs, the numerator is the total costs for a category of service used by attributed patients; the denominator is the total number of Medicare patients attributed to a TIN, not only those who used the service. Dashes in the exhibit indicate that there were no beneficiaries with a particular chronic condition attributed to your TIN.

* Refers to services in non-emergency settings.

** “All Other Services” represents a subtotal composed of the particular miscellaneous expenses detailed in Supplementary Exhibits 5, 7, 8, 9, and 10 (available via the CMS Portal; see the “About the Data in this Report” section), as well as the expenses in the following categories of these supplementary exhibits: “Other Facility-Billed Evaluation & Management Expenses,” “Other Facility-Billed Expenses for Major Procedures,” “Other Facility-Billed Expenses for Ambulatory/Minor Procedures,” and “Outpatient Physical, Occupational, or Speech and Language Pathology Therapy”. Accordingly, “All Other Services” is defined differently in this exhibit than in the supplementary exhibits. For a more detailed cost of services breakdown, please refer to the aforementioned supplementary exhibits.

**Exhibit 12. Differences between Your TIN's Per Episode Costs and Mean Per Episode Costs among TINs with this Measure, by Category of Service:
Medicare Spending per Beneficiary Measure**

Service Category	Amount by Which Your TIN's Costs Were Higher/(Lower) than the Benchmark: Medicare Spending per Beneficiary Measure
Evaluation & Management Services*	\$0
Major Procedures and Anesthesia*	\$0
Ambulatory/Minor Procedures*	\$0
Ancillary Services	\$0
Hospital Inpatient Services	\$0
Emergency Services Not Included in a Hospital Admission	\$0
Post-Acute Services	\$0
Hospice	\$0
All Other Services**	\$0

Note: Per episode costs are based on Medicare Parts A and B expenditures surrounding specified inpatient hospital stays (3 days prior through 30 days post-discharge) for Medicare beneficiaries attributed to your TIN. Part D prescription drug costs are not included. For comparison with peers, per episode costs were payment-standardized, risk-adjusted, and specialty-adjusted.

* Refers to services in non-emergency settings.

** "All Other Services" represents a subtotal composed of the particular miscellaneous expenses detailed in Supplementary Exhibit 6 (available via the CMS Portal; see the "About the Data in this Report" section), as well as the expenses in the following category of Supplementary Exhibit 6: "Outpatient Physical, Occupational, or Speech and Language Pathology Therapy". Accordingly, "All Other Services" is defined differently in this exhibit than in Supplementary Exhibit 6. For a more detailed cost of services breakdown, please refer to the aforementioned supplementary exhibit.