MID-YEAR QUALITY AND RESOURCE USE REPORT

Sample Medical Practice
Last Four Digits of Your Medicare Taxpayer Identification Number (TIN): 0000

PERFORMANCE PERIOD: 07/01/2014 - 06/30/2015

ABOUT THIS REPORT

- This Mid-Year Quality and Resource Use Report shows how your group or solo practice, as identified by its Medicare-enrolled Taxpayer Identification Number (TIN), performed during the performance period for this report (July 1, 2014 to June 30, 2015) on up to three quality outcome measures and six cost measures that the Centers for Medicare & Medicaid Services (CMS) calculates from Medicare fee-for-service claims data. These measures are a subset of the quality and cost measures CMS uses to calculate the 2017 Value Modifier. Quality data reported as part of the Physician Quality Reporting System (PQRS) are not included in this report.

- This report is provided for informational purposes only. It will not affect your TIN's Medicare Physician Fee Schedule payments. The data in this report reflect a performance period that is different than the one used to calculate the 2017 Value Modifier (January 1, 2015 to December 31, 2015) and may not represent actual performance during the later period. 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.

WHAT'S NEXT

- CMS will continue to phase in the Value Modifier for Medicare Physician Fee Schedule payments.

- In 2017, the Value Modifier will apply to physician payments under the Medicare Physician Fee Schedule for physicians billing under TINs with one or more eligible professionals. The 2017 Value Modifier will be based on a TIN's participation in the Physician Quality Reporting System (PQRS) and on quality and cost performance in calendar year 2015. It will not apply to eligible professionals who are not physicians.

- The 2017 Value Modifier will be waived for physicians in TINs, if at least one eligible professional billing under the TIN in 2015 participated in the Pioneer ACO Model or the Comprehensive Primary Care initiative in 2015.

- The 2015 Annual Quality and Resource Use Report, which will be available in fall 2016, will provide full information about your TIN's 2017 Value Modifier, as applicable. Because the Annual Quality and Resource Use Report will be based on a different performance period (January 1, 2015 to December 31, 2015), note that the measures and performance rates computed for each exhibit in this report may change.

QUESTIONS?

- Contact the QRUR Help Desk by email at pvhelpdesk@cms.hhs.gov or by phone at 1-888-734-6433 (select option 3) with questions or feedback about this report.

- For more information about the 2017 Value Modifier, please visit https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html.

ABOUT THE DATA IN THIS REPORT

This report provides summary information on selected quality outcomes and costs for care provided to the Medicare fee-for-service (FFS) beneficiaries attributed to your TIN during the performance period for this report (July 1, 2014 to June 30, 2015). The table below briefly describes the data included in each section of this report. All of the data in this report are available in the following formats: an exportable comma-separated values (CSV) data file {Link to CSV}, with accompanying data dictionary {Link to Data Dictionary}; a downloadable portable document format (PDF) {Link to PDF report}; and an exportable Excel format {Link to Excel File}. Additionally, CMS has made educational information about the Mid-Year Quality and Resource Use Report available through the CMS Enterprise Portal. For more information about the Physician Feedback/Value-Based Payment Modifier Program, and to understand the Mid-Year Quality and Resource Use Report methodology, visit https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html.

Section	Overview of the Data	For More Information
Eligible Professionals in Your Taxpayer Identification Number (TIN)	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 Mid-Year QRUR, at least one eligible professional must have billed under your TIN during the performance period for this report. The number of eligible professionals in your TIN is determined by the lower of the number of eligible professionals indicated by a query of the Provider Enrollment, Chain and Ownership System (PECOS) on July 10, 2015 and the number of eligible professionals submitting claims to Medicare under the TIN for the performance period for this report (Exhibit 1).	Links on the CMS Enterprise Portal: • Table 1. Physicians and Non-Physician Eligible Professionals in Your TIN, Selected Characteristics Glossary: • Eligible professional • Provider Enrollment, Chain and Ownership System (PECOS) • Taxpayer Identification Number (TIN) Exhibit A-1 (listing of eligible professional specialties)
Attribution of Medicare Beneficiaries and Episodes to Your TIN	Two methods of attribution are used in this report: 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 more primary care services to that beneficiary (as measured by Medicare-allowed charges during the performance period for this report) than did any other TIN, through a two-step attribution process (Exhibits 2 and 3). a. A beneficiary is assigned to a TIN in the first step if the beneficiary received more primary care services from primary care physicians, nurse practitioners, physician assistants, and clinical nurse specialists in that TIN than in any other TIN. b. If a beneficiary did not receive a primary care service from any primary care physician, nurse practitioner, physician assistant, or clinical nurse specialist during the performance period, the beneficiary is assigned to a TIN in the second step if the beneficiary received more primary care services from specialist physicians within the TIN than in any other 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 more Part B-covered services (as measured by Medicare-allowed charges) to that beneficiary during the hospitalization than did any other TIN (Exhibit 4).	Links on the CMS Enterprise Portal: For additional information about beneficiaries attributed to your TIN through both methods and their use of services, see: • Table 2A. Beneficiaries Attributed to Your TIN for the Cost Measures (except MSPB) and Claims-Based Quality Outcome Measures, and the Care that Your TIN and Others Provided • Table 2B. Beneficiaries Attributed to Your TIN for the Cost Measures (except MSPB) and Claims-Based Quality Outcome Measures: Costs of Services Provided by Your TIN and Others • Table 4. Beneficiaries Attributed to Your TIN for the Medicare Spending per Beneficiary Measure Glossary: • Attribution • Medicare Spending per Beneficiary • Per Capita Costs for All Attributed Beneficiaries • Per Capita Costs for Beneficiaries with Specific Conditions • Primary care services

Section	Overview of the Data	For More Information
Performance on Quality Outcome Measures	Medicare calculated three quality outcome measures based on Medicare FFS claims submitted for services provided to Medicare beneficiaries attributed to your TIN during the performance period for this report (Exhibit 5). Physician Quality Report System (PQRS) measures your TIN may have reported during the performance period are not included in this report but will be included in your TIN's 2015 Annual Quality and Resource Use Report, available in fall 2016. **Risk Adjustment:** All claims-based quality outcome measures are risk-adjusted based on the mix of beneficiaries attributed to your TIN. Because beneficiary 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 the peer group during performance year 2014. The peer groups for the CMS-1 Acute Conditions Composite and the CMS-2 Chronic Conditions Composite measures are defined as all TINs nationwide that had at least 20 eligible cases for each measure. The peer group for the CMS-3 All-Cause Hospital Readmissions measure is defined as all TINs nationwide with 10 or more eligible professionals that had at least 200 eligible cases.	Glossary: • Attribution • Benchmark • Peer group • Quality Outcome measures • Risk adjustment
Hospitals Admitting Your TIN's Beneficiaries	Medicare identified the hospitals that provided at least five percent of inpatient stays to the beneficiaries attributed to your TIN for the cost measures (except Medicare Spending Per Beneficiary) and claims-based quality outcome measures during the performance period for this report (the first attribution method described above) (Exhibit 6). 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 7). Information on hospital performance is available on the Hospital Compare website (http://www.hospitalcompare.hhs.gov)	Links on the CMS Enterprise Portal: • Table 3. Beneficiaries Attributed to Your TIN for the Cost Measures (excluding MSPB) and Claims-Based Quality Outcome Measures: Hospital Admissions for Any Cause • Table 4. Beneficiaries Attributed to Your TIN for the Medicare Spending per Beneficiary Measure Glossary: • Attribution • CMS Certification Number (CCN) • Medicare Spending per Beneficiary

Section	Overview of the Data	For More Information
Performance on 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 beneficiaries attributed to your TIN for each measure during the performance period for this report, including providers who do not bill under your TIN (Exhibits 8 and 9). 2. Costs for the Medicare Spending per Beneficiary measure are based on payments for all Medicare Parts A and B claims submitted by all providers for care surrounding specified inpatient hospital stays (3 days prior through 30 days post-discharge) attributed to your TIN during the performance period for this report (Exhibits 8 and 10). **Risk Adjustment:** All cost measures are risk-adjusted based on the mix of beneficiaries attributed to your TIN. Beneficiary 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 specialties among eligible professionals within a TIN. **Peer Group and Benchmarking:** Comparative cost benchmarks are the case-weighted average costs within the peer group during the performance period for this report. For all cost measures except Medicare Spending per Beneficiary, the peer group is defined as all TINs nationwide that had at least 20 eligible cases for the measure. For the Medicare Spending per Beneficiary measure, the peer group is defined as all TINs nationwide with at least 125 eligible episodes.	Links on the CMS Enterprise Portal: • Tables 5 - 10. Per Capita or Per Episode Costs, by Categories of Service, for the Six Cost Measures Glossary: • Attribution • Medicare claims data used in the cost measures • 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, based on July 10, 2015 PECOS data and claims data from the performance period for this report.

Exhibit 1. Your TIN's Eligible Professionals

	Number Identified in PECOS	Percentage Identified in PECOS	Number Identified in Claims	Percentage Identified in Claims
All eligible professionals	0	0%	0	0%
Physicians	0	0%	0	0%
Non-physicians	0	0%	0	0%

Note: To determine the size of your TIN for the 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 submitting claims to Medicare under your TIN for the performance period for this report. Because the 2015 Annual Quality and Resource Use Report, which will be available in fall 2016, will be based on a different performance period, the number of eligible professionals billing for services under your TIN may change.

For more information about the eligible professionals in your TIN, please refer to the following table on the CMS Enterprise Portal:

- Table 1. Physicians and Non-Physician Eligible Professionals in Your TIN, Selected Characteristics.

ATTRIBUTION OF MEDICARE BENEFICIARIES AND EPISODES TO YOUR TIN

Two methods of attribution are used in this report.

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

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

Basis for Attribution	Number	Percentage
All attributed beneficiaries	0	—
Beneficiaries attributed because your TIN's primary care physicians, nurse practitioners, physician assistants, or clinical nurse specialists provided the most primary care services	0	—
Beneficiaries attributed because your TIN's specialist physicians 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	—
Provided by any physicians, nurse practitioners, physician assistants, or clinical nurse specialists in your TIN	0	—
Provided by any physicians, nurse practitioners, physician assistants, or clinical nurse specialists 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 dashes (–) appear in this table, this indicates that the statistics are not applicable to your TIN, because no beneficiaries were attributed to your TIN by this method (as shown in Exhibit 2).

Exhibit 4 provides information about beneficiaries attributed to your TIN for the Medicare Spending per Beneficiary measure, based on services provided during episodes of hospital care. For more information about this attribution method, please see the “About the Data in This Report” section of this report.

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 hospital care	0

For more information about attribution of Medicare beneficiaries and episodes to your TIN, please refer to the following tables on the CMS Enterprise Portal:

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

PERFORMANCE ON QUALITY OUTCOME MEASURES

Exhibit 5 displays your TIN's performance on the three quality outcome measures that CMS calculates from Medicare FFS claims submitted for services provided to beneficiaries attributed to your TIN during the performance period for this report. Please note that lower rates on these measures indicate better performance.

Quality measures reported through the Physician Quality Reporting System (PQRS) will be included in your TIN's 2015 Annual Quality and Resource Use Report (available in fall 2016), but are not included in this report. Because the Annual Quality and Resource Use Report will be based on the calendar year 2015 performance period, your TIN's performance on the quality outcome measures and the average ranges shown in this report may change.

Exhibit 5. CMS-Calculated Quality Outcome Measure Performance

Performance Category	Measure Number	Measure Name	Your TIN's Eligible Cases	Your TIN's Performance Rate	Benchmark Rate	Reference Range
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care Sensitive Conditions	CMS-1	**Acute Conditions Composite**	0	-	0.00	0.00 - 0.00
	-	Bacterial Pneumonia	0	-	0.00	0.00 - 0.00
	-	Urinary Tract Infection	0	-	0.00	0.00 - 0.00
	-	Dehydration	0	-	0.00	0.00 - 0.00
	CMS-2	**Chronic Conditions Composite**	0	-	0.00	0.00 - 0.00
	-	Diabetes (composite of 4 indicators)	0	-	0.00	0.00 - 0.00
	-	Chronic Obstructive Pulmonary Disease (COPD) or Asthma	0	-	0.00	0.00 - 0.00
	-	Heart Failure	0	-	0.00	0.00 - 0.00
Hospital Readmissions	CMS-3	**All-Cause Hospital Readmissions**	0	-	0.00%	0.00 - 0.00

Note: Lower performance rates on these measures indicate better performance. The lower limit of the reference range for a measure is defined as one standard deviation below the measure's benchmark rate, and the upper limit is one standard deviation above the measure's benchmark rate. The reference range is shown for informational purposes only and is not used to determine whether a measure is included in the Quality Composite Score for the Value Modifier. If dashes (–) appear in this table, this indicates that the performance rate could not be calculated for your TIN because there were no eligible cases for that measure.

HOSPITALS ADMITTING YOUR TIN'S BENEFICIARIES

The hospitals listed in Exhibit 6 each account for at least five percent of inpatient hospital stays associated with beneficiaries attributed to your TIN for the three claims-based quality outcome measures and for five of the six 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 of this report.

Exhibit 6. 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	0.00**%**
Hospital Name 1	111111	City 1, State 1	0	0.00%
Hospital Name 2	222222	City 2, State 2	0	0.00%

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 hospitals using the provider number contained on a given Medicare claim. Information on this methodology is available here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html.

For more information on hospital admissions for beneficiaries attributed to your TIN, please refer to the following table on the CMS Enterprise Portal:

- Table 3. Beneficiaries Attributed to Your TIN for the Cost Measures (except MSPB) and Claims-Based Quality Outcome Measures: Hospital Admissions for Any Cause.

The hospitals listed in Exhibit 7 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 of this report.

Exhibit 7. Hospitals Accounting for Episodes of Care Attributed to Your TIN for the Medicare Spending per Beneficiary (MSPB) Measure

Hospital Name	Hospital CMS Certification Number	Hospital Location	Number of MSPB Episodes	Percentage of All MSPB Episodes
Total			0	0.00%
Hospital Name 1	111111	City 1, State 1	0	0.00%

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. Information on this methodology is available here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html.

For more information on hospital episodes attributed to your TIN, please refer to the following table on the CMS Enterprise Portal:

- Table 4. Beneficiaries Attributed to Your TIN for the Medicare Spending per Beneficiary Measure.

PERFORMANCE ON COSTS MEASURES

Exhibit 8 displays your TIN's payment-standardized, risk-adjusted, and specialty-adjusted per capita or per episode costs for each cost measure during the performance period for this report. For more information about the costs included in these measures, please see the "About the Data in this Report" section of this report.

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 services provided to Medicare beneficiaries attributed to a TIN for a given measure. For the Medicare Spending per Beneficiary measure, 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).

Because the 2015 Annual Quality and Resource Use Report (which will be available in fall 2016) will be based on the calendar year 2015 performance period, your TIN's performance on the cost measures, the benchmarks, and the average ranges shown in this report may change.

Exhibit 8. Per Capita or Per Episode Costs for Your TIN's Attributed Medicare Beneficiaries

Performance Category	Cost Measure	Your TIN's Eligible Cases or Episodes	Your TIN's Per Capita or Per Episode Costs	Benchmark	Reference Range
Per Capita Costs for All Attributed Beneficiaries	Per Capita Costs for All Attributed Beneficiaries	0	-	$0	$0 - $0
	Medicare Spending per Beneficiary	0	-	$0	$0 - $0
Per Capita Costs for Beneficiaries with Specific Conditions	Diabetes	0	-	$0	$0 - $0
	Chronic Obstructive Pulmonary Disease (COPD)	0	-	$0	$0 - $0
	Coronary Artery Disease (CAD)	0	-	$0	$0 - $0
	Heart Failure	0	-	$0	$0 - $0

Note: The lower limit of the reference range for a measure is defined as one standard deviation below the measure's benchmark, and the upper limit is one standard deviation above the measure's benchmark. The reference range is shown for informational purposes only and is not used to determine whether a measure is included in the Cost Composite Score for the Value Modifier. If dashes (–) appear in this table, this indicates that per capita or per episode costs could not be calculated for your TIN because there were no eligible cases or episodes for that measure.

Per Capita and Per Episode Costs of Care for Specific Services

Exhibits 9 and 10 show the dollar difference, by category of service, between your TIN's costs and the mean costs among TINs with at least 20 eligible cases for each of the per capita cost measures indicated in the column headings (Exhibit 9) or at least 125 eligible episodes of care for the Medicare Spending per Beneficiary measure (Exhibit 10).

Exhibit 9. Differences between Your TIN's Per Capita Costs and Mean Per Capita Costs among TINs with these Measures, by Service Category: 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
TOTAL PER CAPITA COSTS	**$0**	**—**	**—**	**—**	**—**
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	—	—	—	—
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	$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: Service-specific per capita costs are based on the total number of Medicare beneficiaries attributed to a TIN for that measure, rather than only those who used the service. If dashes (–) appear in this table, this indicates that there were no beneficiaries attributed to your TIN for a specific condition.

* Refers to services in non-emergency settings.

** The "All Other Services" cost of service category includes all costs not captured in the other categories shown in this exhibit.

For more information on per capita costs for your TIN by categories of service, please refer to the following tables on the CMS Enterprise Portal:

- Table 5. Per Capita Costs, by Categories of Service, for the Per Capita Costs for All Attributed Beneficiaries Measure.
- Table 7. Per Capita Costs, by Categories of Service, for Beneficiaries with Diabetes.
- Table 8. Per Capita Costs, by Categories of Service, for Beneficiaries with Chronic Obstructive Pulmonary Disease (COPD).
- Table 9. Per Capita Costs, by Categories of Service, for Beneficiaries with Coronary Artery Disease (CAD).
- Table 10. Per Capita Costs, by Categories of Service, for Beneficiaries with Heart Failure.

Exhibit 10. Differences between Your TIN's Per Episode Costs and Mean Per Episode Costs among TINs with this Measure, by Service Category:
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
TOTAL PER EPISODE COSTS	**$0**
Evaluation & Management Services*	$0
Major Procedures and Anesthesia*	$0
Ambulatory/Minor Procedures*	$0
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	$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: Service-specific per episode costs are based on the total number of episodes attributed to a TIN for this measure, rather than only those in which the specific service was used.

* Refers to services in non-emergency settings.

** The "All Other Services" cost of service category includes all costs not captured in the other categories shown in this exhibit.

For more information on per episode costs for your TIN by categories of service, please refer to the following table on the CMS Enterprise Portal:

- Table 6. Per Episode Costs, by Categories of Service, for the Medicare Spending per Beneficiary Measure.