



# **MLN Connects<sup>®</sup>**

*National Provider Call*

## **Overview of the 2014 Annual Quality and Resource Use Reports**

September 17, 2015



# Disclaimer

---

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

# Agenda and Learning Objectives

---

- Overview of the 2016 Value-Based Payment Modifier (VM)
- Overview of the 2014 Annual Quality and Resource Use Report (QRUR)
- How to Access the 2014 Annual QRUR
- Information Contained in the 2014 Annual QRUR
- Question and Answer Session

# Overview of the 2016 Value-Based Payment Modifier

---

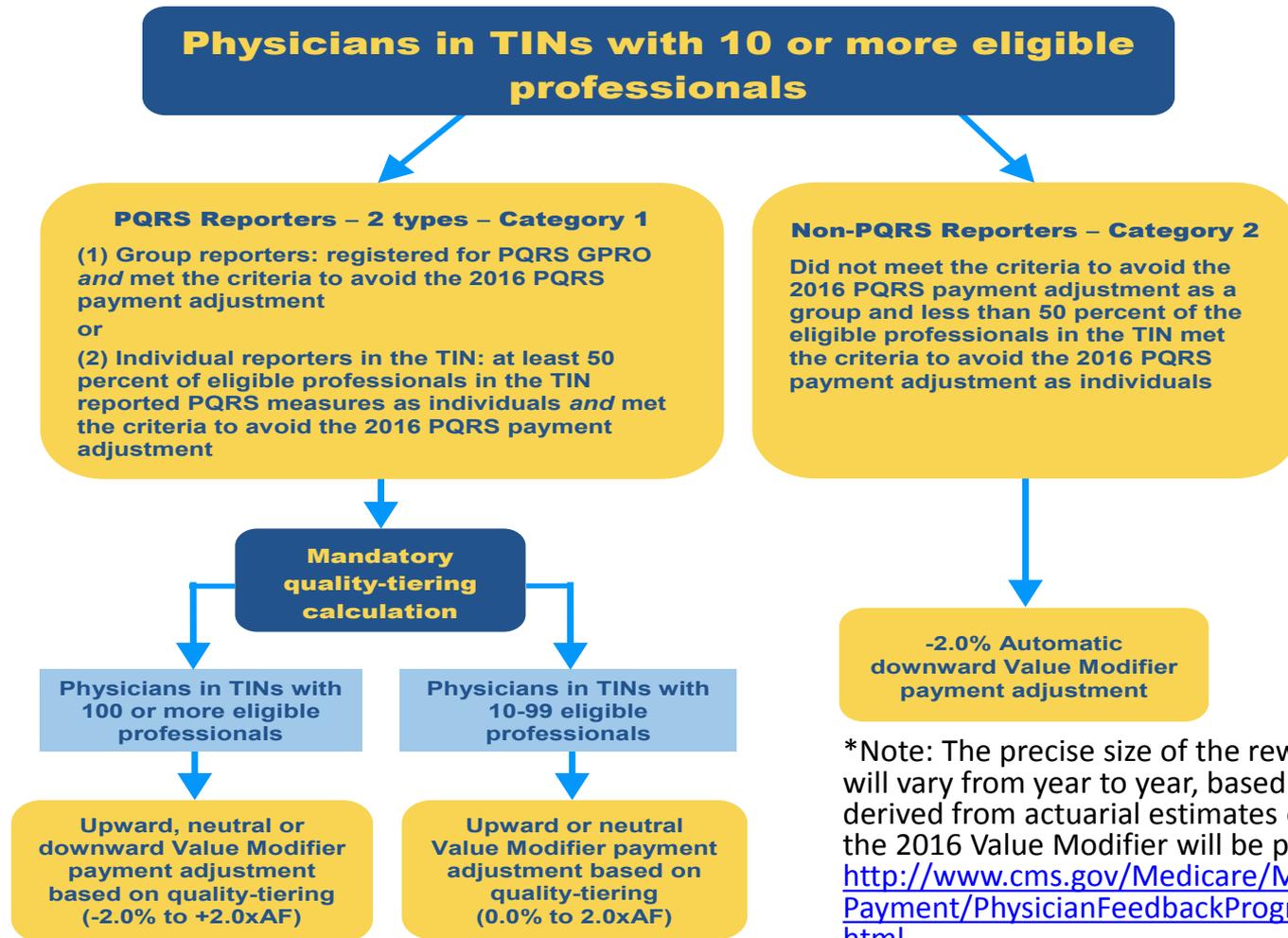
# What is the Value-Based Payment Modifier (VM)?

- The VM assesses the quality of care and cost of care furnished to Medicare Fee-for-Service beneficiaries during a performance period.
- The VM is an adjustment made on a per claim basis to Medicare payments for items and services furnished under the Medicare Physician Fee Schedule (PFS).
- The VM is calculated at the Taxpayer Identification Number (TIN) level, and in 2016, will apply to physicians in groups with 10 or more eligible professionals (EPs) based on performance in 2014.
- In 2016, the VM will not apply to groups with one or more physicians that participated in the Medicare Shared Savings Program (Shared Savings Program), the Pioneer ACO Model, or the Comprehensive Primary Care (CPC) initiative in 2014.

# What Is an Eligible Professional (EP)?

- Physician
  - Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Dental Surgery, Doctor of Dental Medicine, and Doctor of Chiropractic
- Practitioner
  - Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist (and Anesthesiologist Assistant), Certified Nurse Midwife, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Nutrition Professional, and Audiologist
- Therapist
  - Physical Therapist, Occupational Therapist, and Qualified Speech-Language Therapist

# Overview of the 2016 VM and the 2014 Physician Quality Reporting System (PQRS)



\*Note: 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>

# Overview of the 2014 Annual Quality and Resource Use Report (QRUR)

---

# What Is the 2014 Annual QRUR?

- The 2014 Annual QRUR, disseminated in September 2015, shows how groups and solo practitioners, as identified by their TIN, performed in 2014 on the quality and cost measures used to calculate the 2016 VM.
- A QRUR is provided for each TIN.
- For TINs with 10 or more EPs who are subject to the 2016 VM, the QRUR shows how the VM will apply to physician payments under the Medicare PFS for physicians who bill under the TIN in 2016.
- For all other TINs, the QRUR is for informational purposes only, and it will not affect the TIN's payments under the Medicare PFS in 2016.

# Who Received 2014 Annual QRURs?

- All TINs (groups and solo practitioners) nationwide that met the following two criteria received a full-length 2014 Annual QRUR:
  - At least one physician or non-physician EP billed under the TIN between January 1 and December 31, 2014, AND
  - The TIN had at least one eligible case for at least one quality or cost measure included in the Annual QRUR.
- TINs not meeting both of the above criteria received a one-page explanatory summary 2014 Annual QRUR.
- TINs that participated in the Shared Savings Program, the Pioneer ACO Model, or the CPC initiative in 2014 received a 2014 Annual QRUR.
- TINs consisting of non-physician EPs also received a 2014 Annual QRUR.

# How to Access the 2014 Annual QRUR

---

# How Can You Access Your TIN's Report?

- You can access a QRUR on behalf of a group or solo practitioner (as identified by its TIN) at <https://portal.cms.gov>.
- First, you or one person from your TIN will need to obtain an Enterprise Identity Data Management (EIDM) account with the correct role.
- For TINs with two or more EPs:
  - Security Official
  - Group Representative
- For solo practitioners (TINs with only one EP):
  - Individual Practitioner
  - Individual Practitioner Representative
- For more information on obtaining an EIDM account, refer to the “How to Obtain a QRUR” webpage:  
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html>.

# How Can You Access Your TIN's Report? (cont'd)

If you already have or after you establish an EIDM account with the correct role, follow these steps to access your TIN's 2014 Annual QRUR:

1. Navigate to the CMS Enterprise Portal: <https://portal.cms.gov>
2. Select "Login to CMS Secure Portal", accept the "Terms and Conditions", and enter your EIDM User ID and password to log in.
3. Select the "PV-PQRS" tab, and the "Feedback Reports" option.
4. Select "2014" and then "2014 Annual Quality and Resource Use Report (QRUR)".
5. Complete your role attestation.
6. Select your TIN.

For step-by-step instructions, refer to the "Quick Reference Guide for Accessing the 2014 Annual QRURs" on the "How to Obtain a QRUR" webpage <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html>.

# Information Contained in the 2014 Annual QRUR

---

# What Information Is Contained in the 2014 Annual QRUR?

Annual QRUR Report Section	Exhibit	Use the Information in the Report to:
Cover Page	-	Understand how the 2016 Value-Based Payment Modifier applies to your TIN. This includes your TIN's PQRS participation status.
Performance Highlights	-	Identify how your TIN's performance in 2014 influenced your TIN's Value-Based Payment Modifier payment adjustment in 2016, if applicable.
About the Data in this Report	-	Read a summary of the report methodology and access links to supplementary exhibits and glossary items (if viewing the report dashboard). Download or print report as a PDF file.
Eligible Professionals In Your Taxpayer Identification Number (TIN)	1	Understand how many eligible professionals were in your TIN during the performance period based on PECOS and claims data
Attribution of Medicare Beneficiaries and Episodes to Your TIN for Claims-Based Measures	2 – 4	Understand how Medicare FFS beneficiaries and episodes of hospital care were attributed to your TIN for claims-based quality and cost measures

# What Information Is Contained in the 2014 Annual QRUR? (cont'd)

Annual QRUR Report Section	Exhibit	Use the Information in the Report to:
Performance on Quality (Composite and Domain Level)	5	Review your TIN's quality performance at the composite level, as reflected in the Performance Highlights section, and at the domain level
Performance on Quality (Measure Level)	6	Review your TIN's performance on PQRS measures, CMS-calculated outcome measures, and CAHPS measures (if applicable) within each quality domain
Hospitals Admitting Your Patients	7	Identify the hospitals that provided at least five percent of your TIN's attributed beneficiaries' inpatient stays during the performance period for the three claims-based quality outcome measures and the five per capita cost measures
	8	Identify the hospitals that provided at least five percent of the inpatient episodes of care surrounding a hospital admission attributed to your TIN during the performance period for the Medicare Spending per Beneficiary (MSPB) measure
Performance on Costs (Composite and Domain Level)	9	Review your TIN's cost performance at the composite level, as reflected in the Performance Highlights section, and at the domain level
Performance on Costs (Measure Level)	10	Review your TIN's performance on six cost measures across two domains
Per Capita and Per Episode Costs of Care for Specific Services	11 – 12	Understand the dollar difference between your TIN's attributed beneficiaries' payment-standardized, risk-adjusted, and specialty-adjusted per capita or per episode costs, by category of service, and the corresponding costs for your TIN's peer group for the six cost measures

# What Additional Supporting Information Is Available in the Supplementary Exhibits?

Report Section	Supplementary Exhibit	Use the Information in the Supplementary Exhibit to:
Physicians and Non-Physician Eligible Professionals Billing Under Your TIN, Selected Characteristics	1	Understand which physician and non-physician eligible professionals were in your TIN based on PECOS data and claims billed under your TIN during the performance period and their designated specialties
Beneficiaries Attributed to Your TIN for the Cost Measures (excluding MSPB) and Claims-Based Outcome Measures and the Care that You and Others Provided and Costs of Services Provided by You and Others	2A, 2B	Understand total Medicare costs of each attributed beneficiary, including costs of services furnished by eligible professionals inside and outside of your TIN, for the cost measures (excluding MSPB) and claims-based quality outcome measures
Beneficiaries Attributed to Your TIN for the Cost Measures (excluding MSPB) and Claims-Based Outcome Measures: Hospital Admissions for Any Cause	3	Identify hospital admissions, primary diagnoses, and discharge disposition for each beneficiary attributed to your TIN for the cost measures (excluding MSPB) and three claims-based quality outcome measures
Beneficiaries Attributed to Your TIN for the Medicare Spending per Beneficiary Measure	4	Understand which beneficiaries were attributed to your TIN for the Medicare Spending per Beneficiary (MSPB) measure

# What Additional Supporting Information Is Available in the Supplementary Exhibits? (cont'd)

Report Section	Supplementary Exhibit	Use the Information in the Supplementary Exhibit to:
Per Capita or Per Episode Costs, by Categories of Service, for the Six Cost Measures	5 – 10	Review costs by categories of services for the beneficiaries attributed to your TIN for the six cost measures
Individual Eligible Professional Performance on the 2014 PQRS Measures	11	Review the eligible professionals in your TIN who participated in the PQRS as individuals in 2014 and understand their performance on submitted PQRS measures
Summary of 2014 GPRO Earned Incentive	12	Review any incentive your TIN may have earned by participating in the PQRS GPRO in 2014
Beneficiaries Assigned to Your ACO and Attributed to Your TIN for the All-Cause Hospital Readmissions Measure: Hospital Admissions for Any Cause	13	<b>For MSSP ACOs only:</b> Identify hospital admissions, primary diagnoses, and discharge disposition for beneficiaries attributed to your TIN. Using the ACO assigned patient population, we attribute ACO patients to TINs using the VM two-step attribution process or plurality rule for MSPB attribution.

# What Information Is Included on the Performance Highlights Section?

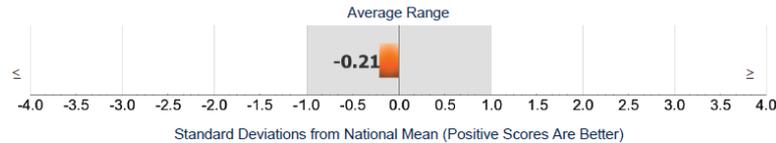
Your TIN's Quality Composite Score



## PERFORMANCE HIGHLIGHTS

Your TIN's Quality Composite Score: Average

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

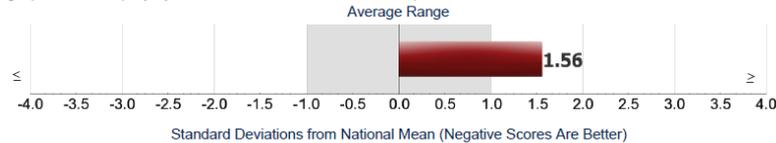


Your TIN's Cost Composite Score



Your TIN's Cost Composite Score: High

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



Your TIN's Quality Tying Performance



Your TIN's Performance: Average Quality, High 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.

# What Information Is Included on the Performance Highlights Section? (cont'd)

Your TIN's Eligibility for a High-Risk Bonus Adjustment



## High-Risk Bonus Adjustment: Not Eligible

The average beneficiary risk for your TIN is at the 90th 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 2016 Value-Based Payment Adjustment



## Your TIN's Value Modifier: Downward 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>.

# **Information on Your TIN's Attributed Beneficiaries and Medicare Spending per Beneficiary (MSPB) Episodes of Hospital Care**

---

# Exhibit 1. Eligible Professionals in Your TIN

- Exhibit 1 shows the number and percentage of physicians and non-physician EPs that were in your TIN during the performance period, based on October 16, 2014 PECOS data and Medicare claims submitted under your TIN during the performance period.
- The lower of these numbers is used to determine the size of your TIN for purposes of applying the VM.



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.



Review the EP composition  
of your TIN

# Exhibits 2 and 3. Attribution of Medicare Beneficiaries to Your TIN: Five Per Capita Cost and Three Quality Outcome Measures

- For the five per capita cost measures and three claims-based quality outcome measures, Medicare beneficiaries are attributed to a TIN using a two-step methodology.
  - Step 1: Assign a beneficiary to a TIN if the beneficiary receives the plurality of primary care services, as measured by Medicare-allowed charges, from primary care physicians within the TIN.
  - Step 2 (for beneficiaries who did not receive a primary care service from a primary care physician during the performance period): Assign a 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.
  - Primary care services include evaluation and management visits in an office, other outpatient services, skilled nursing facility services, and those services rendered in home settings.
  - Primary care physicians include Family Practice, Internal Medicine, General Practice, and Geriatric Medicine specialty codes.

# Exhibits 2 and 3. Attribution of Medicare Beneficiaries to Your TIN: Five Per Capita Cost and Three Quality Outcome Measures (cont'd)

- Exhibit 2 includes information on the number of beneficiaries attributed to your TIN and whether they were attributed in the first or second step of the attribution methodology.
- Exhibit 3 provides information on the average number of primary care services provided to beneficiaries attributed to your TIN.

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

	Basis for Attribution	Number	Percentage
	All attributed beneficiaries	77	100.00%
Step 1	Beneficiaries attributed because your TIN's primary care physicians provided the most primary care services	6	7.79%
Step 2	Beneficiaries attributed because your TIN's specialist physicians or non-physician practitioners provided the most primary care services	71	92.21%

Review the proportion of beneficiaries attributed during each step

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	25	100.00%
Provided by physicians or non-physician practitioners in your TIN	14	57.31%
Provided by physicians or non-physician practitioners outside of your TIN	11	42.69%

Understand the degree to which your TIN's attributed beneficiaries received care from EPs outside of your TIN during the performance period

# Exhibit 4. Attribution of MSPB Episodes to Your TIN: MSPB Measure

- Exhibit 4 provides information on the total episodes of hospital care attributed to your TIN, and the number of unique Medicare FFS beneficiaries associated with the attributed episodes for the MSPB measure.
- A hospitalization episode is attributed to a TIN if, during the hospitalization, the TIN provided more Part B-covered services (as measured by Medicare-allowed charges) to that beneficiary during the hospitalization than any other TIN.

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	195
Unique Medicare beneficiaries associated with attributed episodes of care	185



Review your TIN's attributed MSPB episodes

# Quality Performance Section of the Annual QRUR

---

## Quality Measures Used for display in the 2014 Annual QRURs and to Calculate the 2016 VM for eligible TINs (those with 10 or more EPs)

- Groups with 2 or more EPs: Measures reported through the PQRS Group Practice Reporting Option (GPRO) **OR** individual PQRS measures reported by at least 50% of the EPs in the group (50% threshold option)
- Solo practitioners: Individual PQRS measures reported by the solo practitioner
- Three claims-based outcome measures: All-Cause Hospital Readmissions, Composite of Preventable Hospitalizations for Acute Conditions, and Composite of Preventable Hospitalizations for Chronic Conditions
- CAHPS for PQRS survey measures (applicable only for groups that elected to use their 2014 CAHPS for PQRS results in the calculation of their 2016 VM)
- Shared Savings Program participant TINs (for information only): ACO-level GPRO Web Interface measures and ACO-level All-Cause Hospital Readmissions measure
- Pioneer ACO Model and CPC initiative participant TINs (for information only): PQRS data reported outside of the Model or initiative are shown in the Annual QRUR, in addition to the outcome measures and CAHPS measures (if applicable)

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

- Exhibit 5 displays your TIN's domain score for each quality domain included in the VM and the resulting overall Quality Composite Score and Quality Tier Designation.
  - The Quality Composite Score summarizes the TIN's performance on quality measures across up to six equally-weighted domains.
  - Quality domain scores represent the equally-weighted average of standardized scores for all measures in the domain that have at least 20 eligible cases.
- Standardized scores reflect how many standard deviations a TIN's performance differs from the national mean.
- At the Quality Composite level, the peer group for TINs with 10 or more EPs is all TINs with 10 or more EPs subject to the VM. The peer group for TINs with between one and nine EPs is all TINs with one or more EPs and at least one physician, excluding TINs with physicians that participated in the Shared Savings Program, Pioneer ACO Model, or CPC initiative in 2014 and TINs with no physicians.

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 Designation)
<b>Quality Composite Score</b>	<b>11</b>	<b>0.43 (Average)</b>
Effective Clinical Care	4	-0.19
Person and Caregiver-Centered Experience and Outcomes	0	
Community/Population Health	3	0.05
Patient Safety	2	0.63
Communication and Care Coordination	2	0.63
Efficiency and Cost Reduction	0	

Note: The average performance range, -1.0 to 1.0, is shown in gray.

"1."

"2."

# Exhibit 5. Your TIN's Performance in 2014, by Quality Domain (cont'd)

- Exhibit 5 is populated only for TINs that meet one of the criteria described below:
  - TIN reported quality data via the PQRS GPRO and met the criteria to avoid the 2016 PQRS payment adjustment, or
  - At least 50 percent of the EPs in the TIN reported quality data under the PQRS as individuals and met the criteria to avoid the 2016 PQRS payment adjustment.
- For TINs with physicians that participated in the Shared Savings Program in 2014, this exhibit is displayed only if the ACO in which the TIN participated met the reporting criteria under the Shared Savings Program.

# Exhibit 6. Your TIN's Performance on Quality Measures, by Domain

- Exhibit 6 displays your TIN's performance on each quality measure, by domain, that was reported via the PQRS GPRO or individually by the EPs in the TIN, CAHPS measures (if applicable), and claims-based quality outcome measures, as long as there was at least one measure with at least one eligible case.
- Only the measures for which a benchmark is available and for which the TIN had 20 or more eligible cases are included in the domain scores.
- At the measure level, the benchmark is the case-weighted average performance rate for the peer group based on 2013 data. The peer group is defined as all TINs nationwide for which the measure is reported that had at least 20 eligible cases.
- For Shared Savings Program participant TINs: Exhibit 6 displays the ACO's performance on the GPRO Web Interface measures and the ACO-level all-cause hospital readmissions measure.

# Exhibit 6. Your TIN's Performance on Quality Measures, by Domain (cont'd)

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

Show All Measures       Show Only Measures Included in Domain Score

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, CMS147v2)	Preventive Care and Screening: Influenza Immunization	27,193	99.09%	40.89%	13.21%	68.58%	2.10	Yes
128 (GPRO Prev-9, CMS69v2)	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	37,465	99.31%	54.58%	31.28%	77.87%	1.92	Yes
131	Pain Assessment and Follow-Up	70,034	99.98%	93.70%	75.89%	100.00%	0.35	Yes
134 (GPRO Prev-12, CMS2v3)	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	1,459	85.2%	46.27%	10.26%	82.27%	1.08	Yes
173	Preventive Care and Screening: Unhealthy Alcohol Use - Screening	74,306	99.94%	54.08%	12.32%	95.84%	1.10	Yes
183	Hepatitis C: Hepatitis A Vaccination in Patients with Hepatitis C Virus (HCV)	11	90.91%	57.06%	25.26%	88.85%	1.06	No
226 (GPRO Prev-10, CMS138v2)	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	77,201	99.93%	83.11%	58.14%	100.00%	0.67	Yes
317 (GPRO Prev-11, CMS22v2)	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	47,451	99.91%	62.27%	32.29%	92.25%	1.26	Yes

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.

Compare your TIN's quality outcome performance to that of your TIN's peers

Identify those measures contributing to your TIN's domain score

# Information on the Hospitals Admitting Your TIN's Attributed Beneficiaries

---

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

- Exhibit 7 identifies the hospitals where at least five percent of your TIN’s attributed beneficiaries’ inpatient stays occurred.
- This exhibit includes only the beneficiaries attributed to your TIN for the three claims-based outcome measures and five per capita cost measures.
- Information about the quality of care at these hospitals can be found at <http://www.hospitalcompare.hhs.gov>.

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
<b>Total</b>			15	100%
QFSHFXYJW LJSJWFQ MTXQNYFQ	978088	QFSHFXYJW, QF	9	60.00%
JQMWFYF HTRRZSNYD MTXQNYFQ	978332	JQMWFYF, QF	3	20.00%
QFSHFXYJW WJLNTSFQ RJQNHFQ HJSYJW	978840	QFSHFXYJW, QF	2	13.33%
MJFWY TK QFSHFXYJW WJLNTSFQ RJQNHFQ HJSYJW	978846	QNYNYQ, QF	1	6.67%



Understand which hospitals most frequently admitted your TIN’s attributed beneficiaries



Review the number of your TIN’s attributed beneficiaries’ inpatient stays at these hospitals

# Exhibit 8. Hospitals Accounting for Episodes of Care Attributed to Your TIN for the MSPB Measure

- Exhibit 8 identifies the hospitals that account for at least five percent of attributed inpatient episodes of care surrounding a hospital admission during the performance period for your TIN for the MSPB measure.
- Information about the quality of care at these hospitals can be found at <http://www.hospitalcompare.hhs.gov>.

Exhibit 8. Hospitals Accounting for Episodes of Care Attributed to You for the Medicare Spending per Beneficiary Measure				
Hospital Name	Hospital CMS Certification Number	Hospital Location	Number of MSPB Episodes	Percentage of All MSPB Episodes
<b>Total</b>			49	100%
RJWHD MTXQNYFQ	240115	HTTS WFQNQX, RS	18	36.73%
QFWP SNHTQQJY RJYMTQNX MTXQNYFQ	240053	XFNSY QTZNX QFWP, RS	9	18.37%
KFNWQNJJB XTZYMCFQJ MTXQNYFQ	240078	JQNSF, RS	8	16.33%
ZSNYD MTXQNYFQ	240132	KWNQQJD, RS	6	12.24%
KFNWQNJJB WNQLJX MTXQNYFQ	240207	GZWSXQNNQJ, RS	5	10.20%
ZSNQJWXNYD TK RNSSJXTYF RJQNHFQ HJSYJW, KFNWQNJJB	240080	RNSSJFQTQNX, RS	3	6.12%



Understand the hospitals associated with your TIN's attributed MSPB episodes



Review the number of your TIN's attributed MSPB episodes at these hospitals

# **Cost Performance Section of the Annual QRUR**

---

# Cost Measures Used to Calculate the 2016 VM and Shown in the 2014 Annual QRURs

- Cost data for the Per Capita Costs for All Attributed Beneficiaries measure and the four Per Capita Costs for Beneficiaries with Specific Conditions measures (Chronic Obstructive Pulmonary Disease, Heart Failure, Coronary Artery Disease, and Diabetes) are based on charges for Medicare Parts A and B claims submitted by all providers for Medicare beneficiaries attributed to a TIN for these measures.
- For the MSPB measure, per episode costs are based on Medicare Parts A and B payments surrounding specified inpatient hospital stays (3 days prior to admission through 30 days post-discharge) for beneficiaries attributed to a TIN for this measure.
- Part D-covered prescription drug costs are not included.
- All cost measures have been payment-standardized, risk-adjusted, and adjusted for the TIN's mix of medical specialties (specialty-adjusted).

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

- Exhibit 9 displays your TIN's domain score for each cost domain included in the VM and the resulting overall Cost Composite Score and Cost Tier Designation.
  - The Cost Composite Score summarizes the TIN's performance on up to six cost measures across two equally-weighted cost domains.
  - Cost domain scores represent the equally-weighted average of standardized scores for all measures in the domain that have at least 20 eligible cases.
- Standardized scores shows by how many standard deviations a TIN's performance differs from the national mean.
- At the Cost Composite level, the peer group for TINs with 10 or more EPs is all TINs with 10 or more EPs subject to the VM. The peer group for TINs with between one and nine EPs is all TINs with one or more EPs and at least one physician, excluding TINs with physicians that participated in the Shared Savings Program, Pioneer ACO Model, or CPC initiative in 2014 and TINs with no physicians.

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)
<b>Cost Composite Score</b>	6	1.56 (High)
Per Capita Costs for All Attributed Beneficiaries	2	2.08
Per Capita Costs for Beneficiaries with Specific Conditions	4	2.12

Note: The average performance range, -1.0 to 1.0, is shown in gray.

"1."

"2."

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

- Exhibit 10 shows the payment-standardized, risk-adjusted, and specialty-adjusted per capita or per episode costs for each cost measure based on the beneficiaries attributed to your TIN.
- Only the measures for which the TIN had 20 or more eligible cases or episodes are included in the domain scores.
- At the measure level, the benchmark is the case-weighted average cost for the peer group based on 2014 data. The peer group is defined as all TINs nationwide that had at least 20 eligible cases.

# Exhibit 10. Per Capita or Per Episode Costs for Your TIN's Attributed Medicare Beneficiaries (cont'd)

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	1,288	\$21,513	\$10,907	\$8,066	\$13,749	3.73	Yes
	Medicare Spending per Beneficiary	89	\$21,153	\$20,475	\$18,877	\$22,073	0.42	Yes
Per Capita Costs for Beneficiaries with Specific Conditions	Diabetes	711	\$25,911	\$15,825	\$11,466	\$20,185	2.31	Yes
	Chronic Obstructive Pulmonary Disease (COPD)	257	\$39,515	\$24,854	\$17,524	\$32,184	2.00	Yes
	Coronary Artery Disease (CAD)	846	\$30,425	\$18,234	\$13,132	\$23,336	2.39	Yes
	Heart Failure	566	\$43,009	\$28,033	\$19,606	\$36,460	1.78	Yes

Compare your TIN's cost performance to that of your TIN's peers

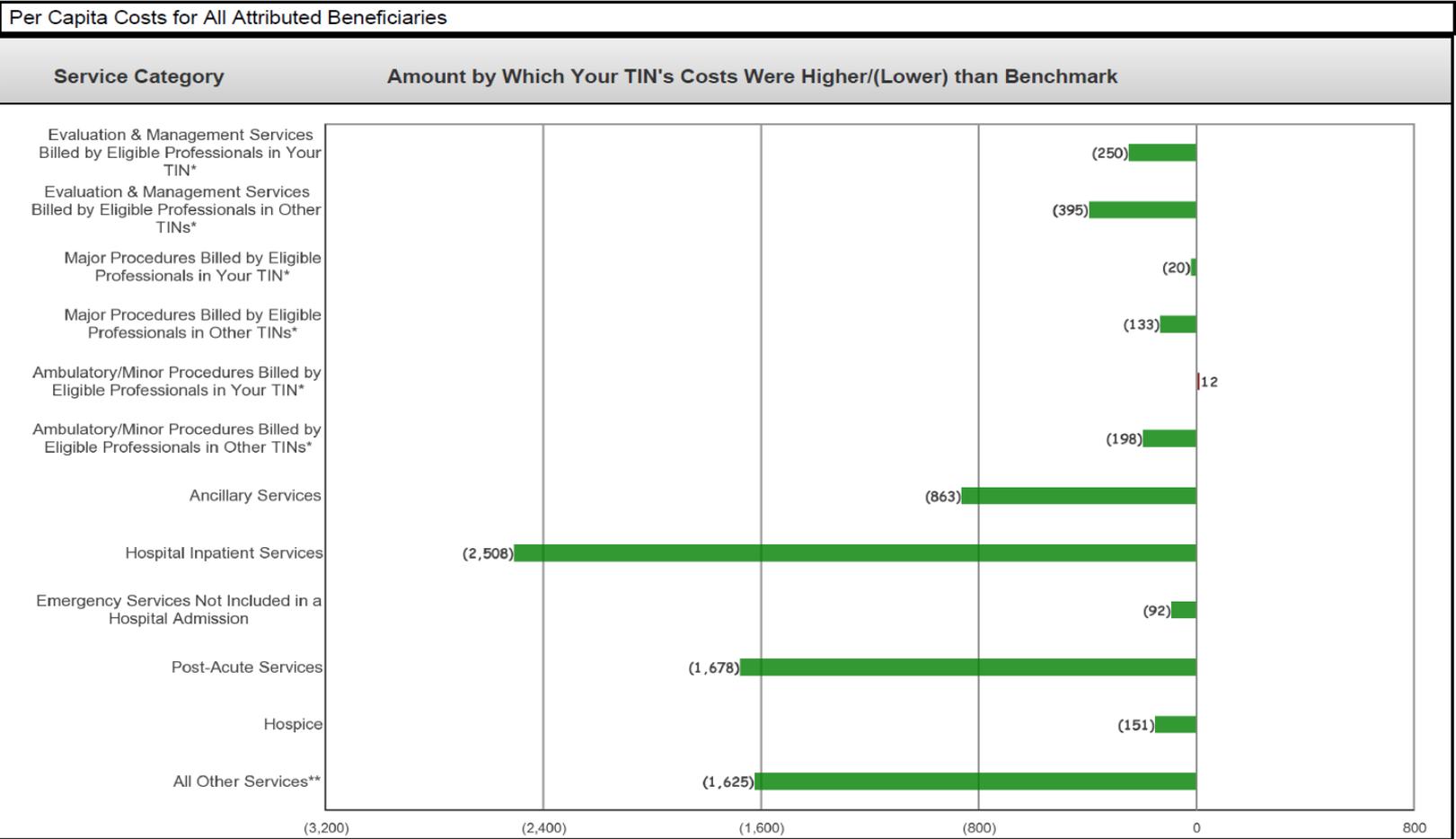
Identify those measures contributing to your TIN's domain score

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

- Exhibit 11 shows the difference between your TIN's attributed beneficiaries' per capita costs for specific services and the corresponding costs for your TIN's peer group.
- The peer group is defined for each cost category as all TINs that had at least 20 eligible cases for a measure in the given cost category.
- Compare your TIN's cost breakdowns to those of your TIN's peers to identify opportunities for improvement.

# Exhibit 11. Differences between Your Per Capita Costs for All Attributed Beneficiaries and Beneficiaries with Specific Conditions and Mean Per Capita Costs among TINs with these Measures, by Category of Service (cont'd)

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

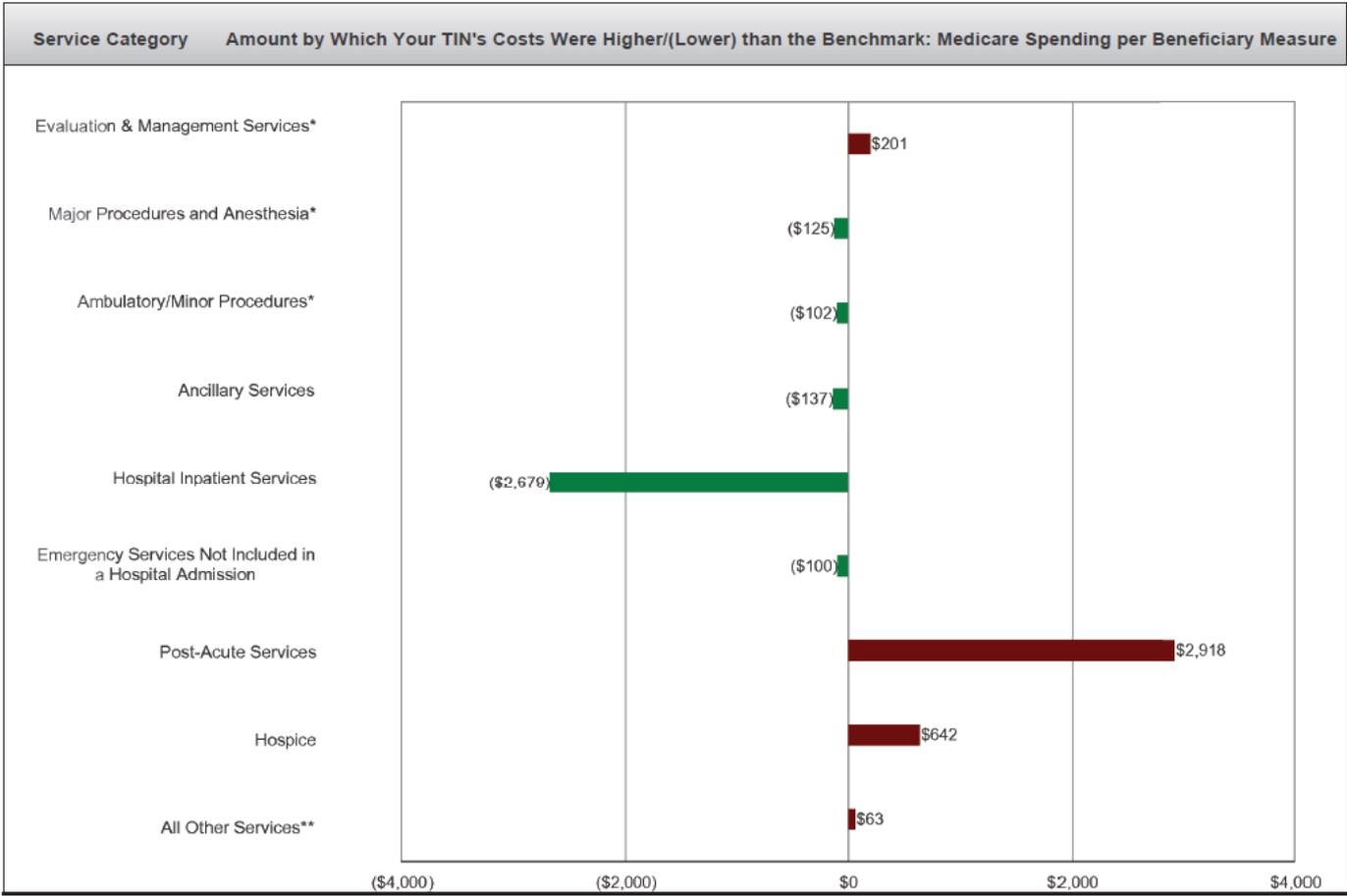


## Exhibit 12. Differences between Your Per Episode Costs for the MSPB Measure and Mean Per Episode Costs among TINs with this Measure, by Category of Service

- For the MSPB measure, Exhibit 12 shows the difference between your TIN's per episode costs for specific services and the corresponding costs for your TIN's peer group.
- The peer group is defined for each cost category as all TINs that had at least 20 eligible cases for a measure in the given cost category.
- Compare your TIN's cost breakdowns to those of your TIN's peers to identify opportunities for improvement

# Exhibit 12. Differences between Your Per Episode Costs for the MSPB Measure and Mean Per Episode Costs among TINs with this Measure, by Category of Service (cont'd)

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



# Additional Information Contained in the Annual QRUR

---

# Supplementary Exhibit 1. Physicians and Non-Physician Eligible Professionals Billing Under Your TIN, Selected Characteristics

- Supplementary Exhibit 1 provides a listing of the EPs that were in your TIN during the performance period, based on October 16, 2014 PECOS data and Medicare claims submitted under your TIN during the performance period.
- These data can be used to verify the EP counts in Exhibit 1 of the Annual QRUR.

Supplementary Exhibit 1. Physicians and Non-Physician Eligible Professionals Billing Under Your TIN, Selected Characteristics

NPI	Name	Physician †	Non-Physician Eligible Professional †	Specialty Designation †
1111111111	XHTYY WNJGJQ	X	-	Cardiology
1111111111	JQNXJ MFWYWFSKY	-	X	Nurse Practitioner

↑  
Verify the eligible professionals billing under your TIN and the data in Annual QRUR Exhibit 1

↑  
Verify your TIN's eligible professionals' specialty designations

Specialty Designation †	Identified via PECOS †	Identified via Billings †	Date of Last Claim Billed Under TIN
Cardiology	X	X	12/31/2014
Nurse Practitioner	X	X	10/19/2014

↗  
Understand how CMS determined eligible professional affiliation with your TIN

↑  
Confirm the date of the last claim billed by a given eligible professional

# Supplementary Exhibit 2A. Beneficiaries Attributed to Your TIN for the Cost Measures (excluding MSPB) and Claims-Based Outcome Measures and the Care that You and Others Provided

- Supplementary Exhibit 2A provides information about the Medicare beneficiaries attributed to your TIN for the five per capita cost and three quality outcome measures.
- This exhibit is divided into sections that describe beneficiary characteristics, specific Medicare claims data, the EPs that billed the most services for the beneficiary, the date of the last hospital admission, and whether the beneficiary had one or more of four chronic conditions requiring more integrative care.
- You can use these data as a starting point for examining systematic ways to improve and maintain delivery of high-quality and efficient care to beneficiaries.

Supplementary Exhibit 2A. Beneficiaries Attributed to Your TIN for the Cost Measures (excluding MSPB) and Claims-Based Outcome Measures, and the Care that You and Others Provided

Beneficiaries Attributed to Your TIN							Medicare FFS Claims Filed by Your TIN		
HIC	Gender	DOB	Index †	HCC Percentile Ranking †	Died in 2014	Basis for Attribution †	Date of Last Claim Filed by TIN	Number of Primary Care Services † Provided by TIN	Percent of Primary Care Services † Billed by TIN
111111111A	F	06/21/1939	111111111	11	-	Step 2	01/22/2014	1	100.00%
111111111B	M	06/18/1940	111111112	74	-	Step 2	03/21/2014	1	100.00%



Verify the beneficiaries attributed to your TIN



Identify those beneficiaries who received most of their services outside of your TIN

# Supplementary Exhibit 2A. Beneficiaries Attributed to Your TIN for the Cost Measures (excluding MSPB) and Claims-Based Outcome Measures and the Care that You and Others Provided (cont'd)

- You can use the data in this exhibit to identify the services your TIN furnished to these beneficiaries and identify the beneficiaries who are receiving the plurality of their primary care services and non-primary care services from a physician or non-physician EP under your TIN.
- Check the information in the column titled “Date of Last Claim Filed by TIN” to make sure that CMS captured this information correctly.

EP in TIN Billing Most Primary Care Services †				EP in TIN Billing Most Non-Primary Care Services †			
NPI	Name	Specialty	Date of Last Claim Filed by NPI	NPI	Name	Specialty	Date of Last Claim Filed by NPI
6550656433	HMWNXYTQMJW KFWFSFS	Emergency Medicine	01/22/2014	6550656433	HMWNXYTQMJW KFWFSFS	Emergency Medicine	01/22/2014
6921378085	BNQQNFR PJNL	Emergency Medicine	03/21/2014		STSJ		



Review information about the eligible professionals in your TIN providing the most primary and non-primary care services to your TIN’s attributed beneficiaries

Verify claims information

# Supplementary Exhibit 2A. Beneficiaries Attributed to Your TIN for the Cost Measures (excluding MSPB) and Claims-Based Outcome Measures and the Care that You and Others Provided (cont'd)

- Supplementary Exhibit 2A displays the eligible professionals outside your TIN who billed the most primary care services and non-primary care services for each beneficiary. These data offer an opportunity to better understand the full range of health care services your attributed beneficiaries receive beyond those that you provide.
- You can also use the exhibit to identify individual beneficiaries with chronic conditions who may benefit from improved chronic care management.

EP Outside of TIN Billing Most Primary Care Services †				EP Outside of TIN Billing Most Non-Primary Care Services †				Hospital Admission	Chronic Condition Subgroup †			
NPI	Name	Specialty	Date of Last Claim Filed by NPI	NPI	Name	Specialty	Date of Last Claim Filed by NPI	Date of Last Hospital Admission	Diabetes	Coronary Artery Disease	Chronic Obstructive Pulmonary Disease	Heart Failure
	STSJ				STSJ				-	-	-	-
	STSJ			6287707380	XZXS VZNHP	Ophthalmology	07/18/2014		◆	-	-	-



Review information about the eligible professionals outside of your TIN providing the most primary and non-primary care services to your TIN's attributed beneficiaries



Determine if beneficiaries were included in any of the per capita costs measures for beneficiaries with specific conditions

# 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 2B provides information about the costs of the care provided to the Medicare beneficiaries attributed to your TIN (as shown in Supplementary Exhibit 2A).
- It provides both the patient’s total payment-standardized FFS Medicare costs and the distribution of these costs across categories of service.

Beneficiaries Attributed to Your TIN				Included in Per Capita Costs for All Attributed Beneficiaries Measure †	Total Payment-Standardized † Medicare FFS Costs
HIC	Gender	DOB	Index †		
111111111B	F	12/6/1937	111111111	◆	\$937
111111111A	F	4/9/1965	111111112	◆	\$3,807
111111111C	F	2/17/1951	111111113	◆	\$413



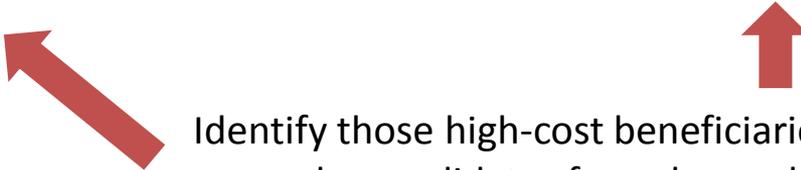
Identify your TIN’s cost drivers

# 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 (cont'd)

- Use this information to learn about the types of services used by your TIN’s attributed beneficiaries.
- Use this information, along with the information in Supplementary Exhibit 3 (hospitals admitting your TIN’s attributed beneficiaries), to identify specialty services and hospital-based services provided to each attributed beneficiary.

Percent of Total Costs, by Category of Services Furnished by All Providers

Evaluation & Management* Services Billed by Eligible Professionals in Your TIN	Evaluation & Management* Services Billed by Eligible Professionals in Other TINs	Other Facility-Billed** Evaluation & Management* Expenses	Major Procedures* Billed by Eligible Professionals in Your TIN	Major Procedures* Billed by Eligible Professionals in Other TINs	Other Facility-Billed** Expenses for Major Procedures*	Ambulatory/Minor Procedures* Billed by Eligible Professionals in Your TIN	Ambulatory/Minor Procedures* Billed by Eligible Professionals in Other TINs	Other Facility-Billed** Expenses for Ambulatory/Minor Procedures*	Outpatient Physical, Occupational, or Speech and Language Pathology Therapy*	Ancillary Services*	Inpatient Hospital Facility Services	Eligible Professional Services During Hospitalization Billed by Your TIN	Eligible Professional Services During Hospitalization Billed by Other TINs	Emergency Services that Did Not Result in a Hospital Admission	Post-Acute Services	Hospice	All Other Services
11.36%	35.84%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.56%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	48.24%
5.35%	6.05%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.73%	0.00%	61.88%	0.00%	0.00%	0.00%	15.11%	0.00%	0.00%	8.89%


  
 Identify those high-cost beneficiaries who may be candidates for enhanced care coordination and follow-up

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

- Supplementary Exhibit 3 provides details about your TIN's attributed beneficiaries' hospitalizations during the performance period.
- Data are broken down by beneficiary and the admitting hospital, along with the principal diagnosis associated with the admission and the discharge disposition.
- **Note:** This table does **not** include hospitalizations with a primary diagnosis of alcohol or substance abuse.

Attributed Beneficiaries Admitted to the Hospital			
HIC	Gender	DOB	Index †
111111111A	F	07/21/1926	111111111
111111111B	M	03/03/1961	111111112

† Crosses indicate terms to be defined through the hover-over function.



Verify the beneficiaries attributed to your TIN

# Supplementary Exhibit 3. Beneficiaries Attributed to Your TIN for the Cost Measures (excluding MSPB) and Claims-Based Quality Outcome Measures: Hospital Admissions for Any Cause (cont'd)

- Supplementary Exhibit 3 also shows whether the hospital admission was the result of an emergency department evaluation, an ambulatory care sensitive condition, or a readmission within 30 days of prior admission. This exhibit also indicates the date of discharge and the subsequent care environment.

Characteristics of Hospital Admission										Discharge Disposition		
Date of Admission	Admitting Hospital					Principal Diagnosis †	Admission Via the ED	ACSC Admission †	Followed by Unplanned All-Cause Readmission within 30 Days of Discharge †	Date of Discharge	Discharge Status †	
10/12/2014	KFNWQNJ	B WNLJX	MTXQNYFQ	123456	ROCHESTER MN	81342 Fx distal radius NEC-cl	-	-	-	10/15/2014	06	Disch to Home Health
02/09/2014	MJFYQY	MJFYX	XY QTMS'X	123457	BLOOMINGTON MN	78650 Chest pain NOS	X	-	-	02/10/2014	01	Disch Home

Identify preventable hospital admissions



Verify the data in Annual QRUR Exhibit 6



Identify which diagnoses were the basis for hospitalization



Identify hospital readmissions



Identify where beneficiaries were discharged

# Supplementary Exhibit 4. Beneficiaries Attributed to Your TIN for the MSPB Measure

- Supplementary Exhibit 4 displays information on the beneficiaries attributed to your TIN for the MSPB measure.
- Data are presented at the beneficiary-episode level. A beneficiary that had more than one episode eligible to be counted for the MSPB measure will appear in the exhibit for each episode.

Understand where beneficiaries were hospitalized

Beneficiaries Attributed to Your TIN for the Medicare Spending per Beneficiary Measure					Apparent Lead Eligible Professional†			Total Payment-Standardized Episode Cost †	Characteristics of Hospital Admission				
HIC	Gender	DOB	Index †	HCC Percentile Ranking†	NPI	Name	Specialty		Date of Admission	Admitting Hospital	Principal Diagnosis †		
111111111A	M	05/31/1923	11111111	70	1111111111	YFYQFSF	Hfwqntqltd	\$22,427	08/23/2014	JQMWFYF HTRRZSNYD MTXQNYFQ	524779 EPHRATA PA	42823 Ac on chr syst hrt fail	
111111111B	M	04/25/1940	11111112	31	1111111112	QTPJXM LTBQF	Hfwqntqltd	\$40,943	11/02/2014	QFSHFXYJW LJSJWFQ MTXQNYFQ	524644 LANCASTER PA	41041 AMI inferior wall, init	

Identify the eligible professional associated with the plurality of the episode's Medicare Part B costs during the hospital stay

Displays the total of standardized Medicare Part A and Part B billings from all groups over the period, starting from 3 days before the index admission through 30 days after the discharge

Identify which diagnoses were the basis for hospitalization

# Supplementary Exhibit 4. Beneficiaries Attributed to Your TIN for the MSPB Measure (cont'd)

- The data presented in the columns below help you to understand the distribution of costs associated with your TIN's beneficiaries' hospitalizations for the MSPB measure. Higher costs in some of the cost categories presented in Supplementary Exhibit 4 may suggest ways to improve your TIN's performance on the MSPB measure.
- Note:** This table does **not** include hospitalizations with a primary diagnosis of alcohol or substance abuse.

Discharge Disposition		Medicare Spending per Beneficiary, by Category of Service Furnished by All Providers																					
Date of Discharge	Discharge Status †	Evaluation and Management Services*	Major Procedures and Anesthesia*	Ambulatory/ Minor Procedures*	Outpatient Physical, Occupational, or Speech and Language Pathology Therapy*	Ancillary Laboratory, Pathology, and Other Tests	Ancillary Imaging Services	Durable Medical Equipment and Supplies	Inpatient Hospital: Trigger	Inpatient Hospital: Readmission	Physician Services During Hospitalization	ER Evaluation & Management Services	ER Procedures	ER Laboratory, Pathology, and Other Tests	ER Imaging Services	Home Health	Skilled Nursing Facility	Inpatient Rehabilitation or Long-Term Care Hospital	Hospice	Ambulance Services	Chemotherapy and Other Part B-Covered Drugs	Dialysis	All Other Services Not Otherwise Classified
08/27/2014	03 Disch to Medicare SNF	\$585	\$0	\$0	\$0	\$74	\$0	\$0	\$5,673	\$0	\$943	\$0	\$0	\$0	\$0	\$0	\$14,652	\$0	\$0	\$495	\$0	\$0	\$6
11/05/2014	01 Disch Home	\$1,536	\$848	\$0	\$0	\$25	\$177	\$0	\$11,872	\$0	\$1,857	\$0	\$0	\$0	\$0	\$0	\$23,203	\$0	\$0	\$1,424	\$0	\$0	\$0



Understand where beneficiaries were discharged

Identify those high-cost beneficiaries who may be candidates for enhanced care coordination

# Supplementary Exhibit 5. Per Capita Costs, by Categories of Service, for the Per Capita Costs for All Attributed Beneficiaries Measure

- Supplementary Exhibit 5 summarizes your TIN's attributed beneficiaries' costs for various types of services performed by EPs both within and outside your TIN. The categories are the same as those shown at the beneficiary level in Supplementary Exhibit 2B.
- The exhibit shows the percentage of your TIN's attributed beneficiaries using a service in a given category; your TIN's payment-standardized, risk-adjusted per capita costs; and the difference between your TIN's beneficiary per capita costs and the per capita costs of your TIN's peers.

# Supplementary Exhibit 5. Per Capita Costs, by Categories of Service, for the Per Capita Costs for All Attributed Beneficiaries Measure (cont'd)

Service Category	Number of Your TIN's Attributed Beneficiaries Using any Service in this Category	Percentage of Your TIN's Attributed Beneficiaries Using any Service in this Category	Per Capita Costs for Your TIN's Attributed Beneficiaries	Benchmark Percentage of Beneficiaries Using Any Service in This Category	Benchmark Per Capita Costs	Amount by Which Your TIN's Costs Were Higher or (Lower) Compared to the Benchmark
<b>ALL SERVICES</b>	1,288	100.00%	\$21,513	100.00%	\$10,907	\$10,606
<b>Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)</b>	1,285	99.77%	\$2,047	100.00%	\$2,998	(\$951)
<b>Evaluation &amp; Management Services Billed by Eligible Professionals</b>	1,284	99.69%	\$1,307	100.00%	\$1,132	\$176
<b>Billed by Your TIN</b>	1,281	99.46%	\$627	99.99%	\$473	\$154
Primary Care Physicians	1,270	98.60%	\$352	67.50%	\$357	(\$4)
Medical Specialists	432	33.54%	\$43	20.91%	\$54	(\$11)
Surgeons	256	19.88%	\$16	9.24%	\$22	(\$6)
Other Eligible Professionals	819	63.59%	\$216	10.44%	\$40	\$175
<b>Billed by Other TINs</b>	1,195	92.78%	\$680	83.87%	\$658	\$22
Primary Care Physicians	822	63.82%	\$122	20.43%	\$47	\$75
Medical Specialists, Surgeons, and Other Eligible Professionals	1,163	90.30%	\$558	82.45%	\$611	(\$53)
Other Facility-Billed Evaluation & Management Expenses*	369	28.65%	\$60	17.71%	\$131	(\$71)
<b>Major Procedures Billed by Eligible Professionals</b>	123	9.55%	\$116	9.43%	\$170	(\$54)
<b>Billed by Your TIN</b>	0	0.00%	\$0	1.62%	\$20	(\$20)
Primary Care Physicians	0	0.00%	\$0	0.24%	\$1	(\$1)
Medical Specialists	0	0.00%	\$0	0.75%	\$7	(\$7)
Surgeons	0	0.00%	\$0	0.48%	\$6	(\$6)
Other Eligible Professionals	0	0.00%	\$0	0.25%	\$6	(\$6)
<b>Billed by Other TINs</b>	123	9.55%	\$116	8.07%	\$150	(\$35)
Primary Care Physicians	13	1.01%	\$16	0.19%	\$2	\$13
Medical Specialists, Surgeons, and Other Eligible Professionals	119	9.24%	\$100	7.95%	\$148	(\$48)
Other Facility-Billed Expenses for Major Procedures*	69	5.36%	\$125	6.47%	\$465	(\$340)

Understand how care provided outside of your TIN's control is contributing to beneficiaries' costs (Costs reflect care furnished by all providers)

Determine which costs contributed most to your TIN's performance on this measure

Understand the detailed services that influence the data in Annual QRUR Exhibit 11

# Supplementary Exhibit 6. Per Episode Costs, by Categories of Service, for the MSPB Measure

- For the beneficiaries attributed to your TIN for the MSPB measure, this exhibit shows the percentage of using a service in a given category; your TIN’s payment-standardized, risk-adjusted, specialty-adjusted per episode costs; and the difference between your TIN’s beneficiary per episode costs and the per episode costs of your TIN’s peers.

Service Category	Number of Your TIN's Episodes with Costs in This Category	Percentage of Your TIN's Episodes with Costs in This Category	Your TIN's Per Episode Costs	Benchmark Percentage of Episodes with Costs in This Category	Benchmark Per Episode Costs	Amount by Which Your TIN's Episode Costs Were Higher or (Lower) Compared to the Benchmark
<b>ALL SERVICES</b>	15	100.00%	\$19,418	100.00%	\$20,475	(\$1,058)
<b>Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)</b>	15	100.00%	\$1,584	91.78%	\$892	\$691
Evaluation & Management Services	15	100.00%	\$544	89.08%	\$510	\$34
Major Procedures and Anesthesia	2	13.33%	\$796	9.54%	\$188	\$609
Ambulatory/Minor Procedures	9	60.00%	\$199	31.50%	\$164	\$35
Outpatient Physical, Occupational, Speech/Language Therapy	2	13.33%	\$44	6.23%	\$31	\$13
<b>Ancillary Services</b>	15	100.00%	\$493	84.54%	\$356	\$138
Laboratory, Pathology, and Other Tests	13	86.67%	\$186	64.27%	\$97	\$89
Imaging Services	11	73.33%	\$210	55.84%	\$144	\$67
Durable Medical Equipment	4	26.67%	\$96	28.41%	\$115	(\$19)
<b>Hospital Inpatient Services</b>	15	100.00%	\$12,234	100.00%	\$12,784	(\$550)
Inpatient Hospital: Trigger	15	100.00%	\$6,122	100.00%	\$9,161	(\$3,038)
Inpatient Hospital: Readmission	4	26.67%	\$5,187	15.62%	\$1,687	\$3,500
Physician Services During Hospitalization	15	100.00%	\$924	100.00%	\$1,936	(\$1,012)
<b>Emergency Services Not Included in a Hospital Admission</b>	4	26.67%	\$161	15.56%	\$150	\$11
Emergency Visits	4	26.67%	\$151	15.55%	\$128	\$24
Procedures	0	0.00%	\$0	6.76%	\$17	(\$17)
Laboratory, Pathology, and Other Tests	2	13.33%	\$1	4.15%	\$1	\$1
Imaging Services	2	13.33%	\$9	8.32%	\$5	\$4
<b>Post-Acute Services</b>	7	46.67%	\$3,179	47.81%	\$5,316	(\$2,137)
Home Health	6	40.00%	\$1,062	26.72%	\$808	\$254
Skilled Nursing Facility	2	13.33%	\$2,117	25.21%	\$3,431	(\$1,314)
Inpatient Rehabilitation and Long-Term Care	0	0.00%	\$0	5.32%	\$1,077	(\$1,077)
<b>Hospice</b>	0	0.00%	\$0	2.00%	\$131	(\$131)
<b>All Other Services</b>	12	80.00%	\$1,767	66.45%	\$842	\$925
Ambulance Services	7	46.67%	\$384	47.45%	\$456	(\$72)
Chemotherapy and Other Part B-Covered Drugs	6	40.00%	\$297	13.35%	\$169	\$127
Dialysis	5	33.33%	\$1,068	5.62%	\$191	\$877
All Other Services Not Otherwise Classified	2	13.33%	\$18	24.36%	\$26	(\$8)

Note: In calculating service-specific per episode 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. See Exhibit A-1 (available online) for a list of physician specialties assigned to each specialty category.

Understand how care provided outside of your TIN’s control is contributing to beneficiaries’ episode costs (Episode costs reflect care furnished by all providers)

Determine which costs contributed most to your TIN’s performance on this measure

Understand the detailed services that influence the data in Annual QRUR Exhibit 12

# Supplementary Exhibits 7 - 10. Per Capita Costs, by Categories of Service, for Beneficiaries with Specific Conditions

- For beneficiaries attributed to the TIN's chronic condition per capita cost measures for diabetes (exhibit 7), chronic obstructive pulmonary disease (exhibit 8), coronary artery disease (exhibit 9), and heart failure (exhibit 10), these exhibits show the percentage using a service in a given category; your TIN's payment-standardized, risk-adjusted, specialty-adjusted per capita costs; and the difference between your TIN's beneficiaries' per capita costs and the per capita costs of your TIN's peers.

# Supplementary Exhibits 7 - 10. Per Capita Costs, by Categories of Service, for Beneficiaries with Specific Conditions (cont'd)

Service Category	Number of Your TIN's Attributed Beneficiaries Using any Service in this Category	Percentage of Your TIN's Attributed Beneficiaries Using any Service in this Category	Per Capita Costs for Your TIN's Attributed Beneficiaries	Benchmark Percentage of Beneficiaries Using Any Service in This Category	Benchmark Per Capita Costs	Amount by Which Your TIN's Costs Were Higher or (Lower) Compared to the Benchmark
<b>ALL SERVICES</b>	2,354	100.00%	\$15,374	100.00%	\$15,825	(\$452)
<b>Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)</b>	2,354	100.00%	\$4,696	100.00%	\$3,685	\$1,011
<b>Evaluation &amp; Management Services Billed by Eligible Professionals</b>	2,354	100.00%	\$984	100.00%	\$1,407	(\$423)
<b>Billed by Your TIN</b>	2,354	100.00%	\$594	100.00%	\$589	\$5
Primary Care Physicians	2,187	92.91%	\$310	89.63%	\$464	(\$154)
Medical Specialists	1,386	58.88%	\$157	9.75%	\$58	\$100
Surgeons	850	36.11%	\$49	2.78%	\$18	\$31
Other Eligible Professionals	1,105	46.94%	\$77	8.18%	\$49	\$28
<b>Billed by Other TINs</b>	1,833	77.87%	\$390	90.65%	\$818	(\$427)
Primary Care Physicians	232	9.86%	\$27	27.79%	\$67	(\$40)
Medical Specialists, Surgeons, and Other Eligible Professionals	1,793	76.17%	\$363	89.29%	\$751	(\$388)
Other Facility-Billed E&M Expenses	2,352	99.92%	\$1,000	21.00%	\$169	\$831
<b>Major Procedures Billed by Eligible Professionals</b>	325	13.81%	\$127	12.02%	\$224	(\$96)
<b>Billed by Your TIN</b>	213	9.05%	\$71	0.97%	\$18	\$53
Primary Care Physicians	0	0.00%	\$0	0.28%	\$1	(\$1)
Medical Specialists	117	4.97%	\$32	0.48%	\$7	\$25
Surgeons	97	4.12%	\$35	0.19%	\$5	\$29
Other Eligible Professionals	35	1.49%	\$4	0.10%	\$4	\$0
<b>Billed by Other TINs</b>	137	5.82%	\$56	11.23%	\$206	(\$150)
Primary Care Physicians	0	0.00%	\$0	0.30%	\$4	(\$4)
Medical Specialists, Surgeons, and Other Eligible Professionals	137	5.82%	\$56	11.06%	\$202	(\$146)
Other Facility-Billed Expenses for Major Procedures	323	13.72%	\$966	8.63%	\$630	\$336



Understand how care provided outside of your TIN's control is contributing to beneficiaries' costs (Costs reflect care furnished by all providers)



Determine which costs contributed most to your TIN's performance on this measure



Understand the detailed services that influence the data in Annual QRUR Exhibit 11

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

- This exhibit displays performance on PQRS measures for each EP who participated in the PQRS as an individual under your TIN in 2014.
- It also indicates whether each EP met the criteria to avoid the 2016 PQRS payment adjustment.

Identify the 2014 PQRS measure information and Value-Based Payment Modifier domain classifications for measures reported by a given eligible professional

Supplementary Exhibit 11. Individual Eligible Professional Performance on the 2014 PQRS Measures: XHTYY WNJGJQ(6166258909), Met the criteria to avoid the 2016 PQRS payment adjustment: Yes

Performance Measure		Domain	Eligible Professional Performance			Benchmark Rate
			Reporting Mechanism †	Number of Eligible Cases †	Performance Rate	
110 (CMS147v2)	Preventive Care and Screening:	Community/Population Health	Claims	95	20.00%	40.89%
111 (CMS127v2)	Preventive Care and Screening:	Effective Clinical Care	Claims	194	3.09%	45.42%
128 (CMS69v2)	Preventive Care and Screening: Body	Community/Population Health	Claims	218	42.66%	54.58%
130 (CMS68v3)	Documentation of Current Medications	Patient Safety	Claims	229	99.56%	87.36%
204 (CMS164v2)	Ischemic Vascular Disease (IVD): Use of	Effective Clinical Care	Claims	258	94.57%	70.56%
226 (CMS138v2)	Preventive Care and Screening:	Community/Population Health	Claims	218	96.79%	83.11%
46	Medication Reconciliation:	Patient Safety	Claims	4	100.00%	81.63%
6	Coronary Artery Disease (CAD):	Effective Clinical Care	Claims	254	93.70%	83.89%

\* Lower performance rates on this measure indicate better performance.  
 † Crosses indicate terms to be defined through the hover-over function.

Identify the mechanisms through which PQRS measures were reported by individual eligible professionals

Identify the number of eligible cases in the performance denominator, by reporting mechanism

Compare your TIN's performance to that of its peers

# Supplementary Exhibit 12. Summary of 2014 GPRO Earned Incentive

- Supplementary Exhibit 12 provides details about any incentive your TIN may have earned by participating in the PQRS GPRO in 2014.
- This table reports your TIN's total incentive amount and your TIN's incentive as a percentage of its total Part B PFS allowed charges.

Summarizes your TIN's 2014 GPRO earned incentive, if your TIN is eligible to receive one



Total Earned Incentive Amount	Total Estimated Allowed Medicare Part B Physician Fee Schedule Charges	Incentive as a Percentage of Total Part B Physician Fee Schedule Charges
\$42,068	\$8,585,259	0.49%

# Supplementary Exhibit 13. Beneficiaries Attributed to Your TIN and Assigned to Your ACO for the All-Cause Hospital Readmissions Measure: Hospital Admissions for Any Cause

- For TINs participating in the Shared Savings Program, Supplementary Exhibit 13 provides details about hospitalizations during the performance period (if applicable). Using the ACO assigned patient population, we attribute the ACO’s patients to the individual participant TINs using the VM two-step attribution process or plurality attribution rule for MSPB.
- Like Supplementary Exhibit 3, data are broken down by beneficiary and the admitting hospital, along with the principal diagnosis associated with the admission, the date of discharge, and the subsequent care environment.
- The exhibit also shows whether the hospital admission was a readmission within 30 days of prior admission.

Attributed Beneficiaries Admitted to the Hospital				Characteristics of Hospital Admission					Discharge Disposition	
HIC	Gender	DOB	Index †	Date of Admission	CMS Certification Number	Principal Diagnosis † (Code, Description)	Followed by Unplanned All-Cause Readmission within 30 Days of Discharge †	Date of Discharge	Discharge Status † (Code, Description)	
111111111A	F	06/05/1933	11111111	03/19/2014	000000	5849 Acute kidney failure NOS	-	03/27/2014	01 Disch Home	
111111111B	M	12/02/1987	11111112	07/09/2014	000000	25013 DMI ketoacd uncontrol	-	07/14/2014	01 Disch Home	


 Identify which diagnoses were the basis for hospitalization
     
 
 Identify hospital readmissions
     
 
 Understand where beneficiaries were discharged

# VM Informal Review Request

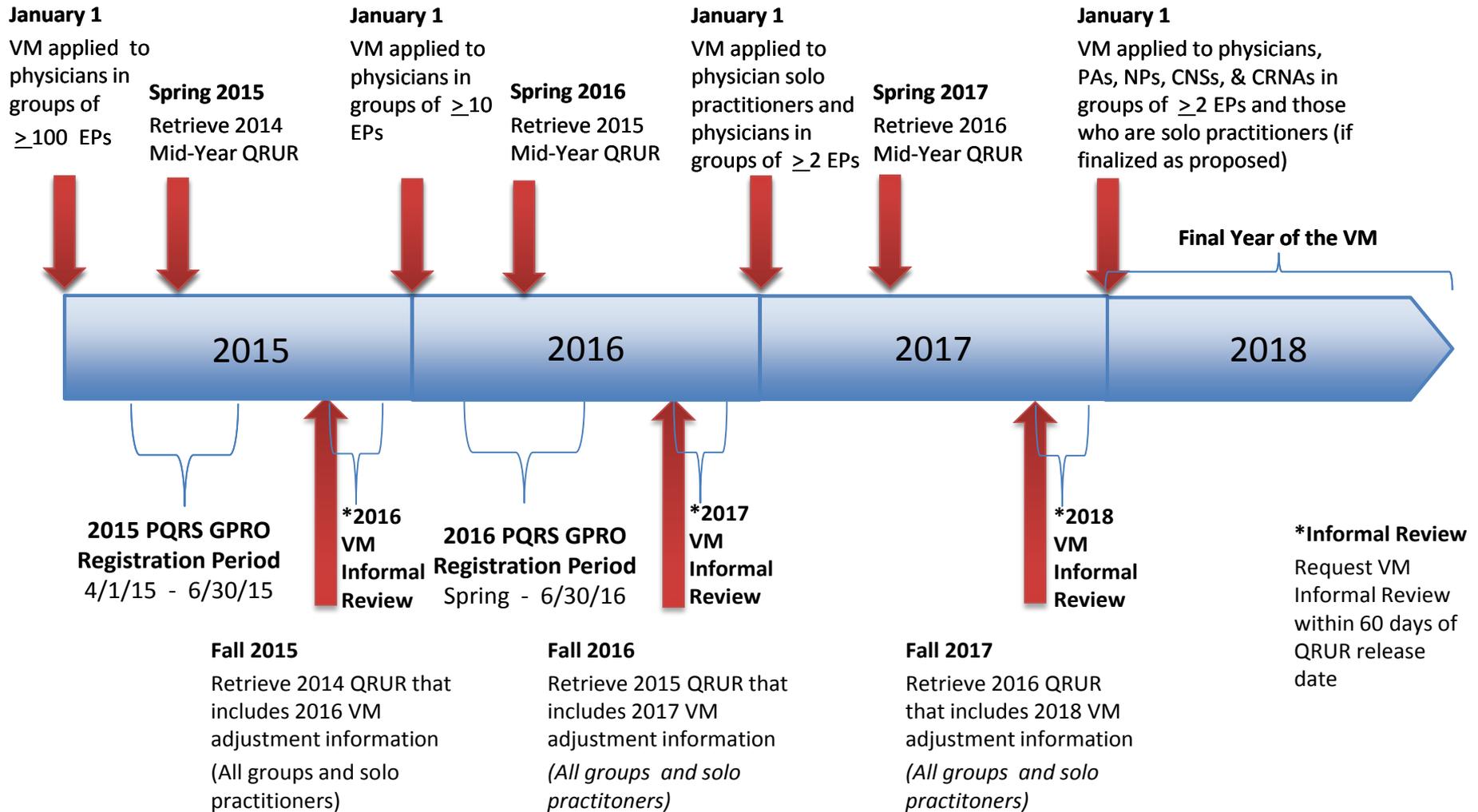
- For the VM that will be applied in 2016, CMS established a 60-day Informal Review Period, to request a correction of a perceived error, that begins after the release of the 2014 Annual QRURs for TINs with 10 or more EPs that are subject to the 2016 VM.
- Between September 9, 2015 and November 9, 2015, a TIN that is subject to the 2016 VM may request an informal review via the CMS Enterprise Portal at <https://portal.cms.gov>.
- For information on how a TIN that is subject to the 2016 VM can request an informal review, refer to <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html>.

# Next Steps: What You Can Do

---

- Download your TIN's QRUR at: <https://portal.cms.gov>
- Review the detailed methodology, tips sheet, FAQs, fact sheets, and other QRUR supporting documents at:  
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html>.

# Timeline for Phasing in the VM



# Technical Assistance Information

- For QRUR and VM questions or to provide feedback on the content and format of the QRUR, contact the Physician Value Help Desk:
  - Phone: 1-888-734-6433 (select option 3)
  - Monday – Friday: 8:00 am – 8:00 pm EST
  - Email: [pvhelpdesk@cms.hhs.gov](mailto:pvhelpdesk@cms.hhs.gov)
- For PQRS and EIDM questions, contact the QualityNet Help Desk:
  - Phone: 1-866-288-8912 (TTY 1-877-715-6222)
  - Monday – Friday: 8:00 am – 8:00 pm EST
  - Email: [gnetsupport@hcqis.org](mailto:gnetsupport@hcqis.org)
- 2014 QRUR Educational Documents: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html>
- How to Obtain a QRUR: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html>
- VM Program: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>
- PQRS Program: <http://www.cms.gov/PQRS>

# Acronyms in this Presentation

- ACO: Accountable Care Organization
- CAHPS: Consumer Assessment of Healthcare Providers & Systems
- CPC: Comprehensive Primary Care
- EIDM: Enterprise Identity Management
- FFS: Fee-for-Service
- GPRO: Group Practice Reporting Option
- MSPB: Medicare Spending per Beneficiary
- PFS: Physician Fee Schedule
- PQRS: Physician Quality Reporting System
- QRUR: Quality and Resource Use Report
- TIN: Taxpayer Identification Number
- VM: Value-Based Payment Modifier

# Question & Answer Session

---

# Evaluate Your Experience

---

- Please help us continue to improve the MLN Connects® National Provider Call Program by providing your feedback about today's call.
- To complete the evaluation, visit <http://npc.blhtech.com> and select the title for today's call.

# CME and CEU

---

This call is being evaluated by CMS for CME and CEU continuing education credit. For more information about continuing education credit, review the *CE Activity Information & Instructions* document available at the link below for specific details:

<https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/TC-L09172015-Marketing-Materials.pdf>

# Thank You

---

- For more information about the MLN Connects® National Provider Call Program, please visit <http://cms.gov/Outreach-and-Education/Outreach/NPC/index.html>.
- For more information about the Medicare Learning Network®, please visit <http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html>.

The Medicare Learning Network® and MLN Connects® are registered trademarks of the Centers for Medicare & Medicaid Services.