

## QUESTIONS AND ANSWERS ABOUT THE 2015 QUALITY AND RESOURCE USE REPORTS AND THE 2017 VALUE-BASED PAYMENT MODIFIER

### About the Frequently Asked Questions

*These Frequently Asked Questions include information about both the Annual and the Mid-Year Quality and Resource Use Reports (QRURs) for 2015. The Annual QRUR, disseminated each fall, serves as the final summary report of performance on quality and cost measures during the performance year and on the Value-Based Payment Modifier (Value Modifier) payment adjustment for those groups and solo practitioners to which the Value Modifier applies. The Mid-Year QRUR, disseminated each spring, provides interim information about performance on only those quality outcome and cost measures that the Centers for Medicare & Medicaid Services (CMS) calculates directly from Medicare administrative claims, based on the most recent 12 months of data that are available. The Annual QRURs are intended to help groups and solo practitioners understand the quality and efficiency of care provided to Medicare beneficiaries and to inform them about their performance on some of the measures that will be included in the Value Modifier. The Mid-Year QRURs do not estimate performance for the Value Modifier, because they do not include all of the quality and cost data included in the Value Modifier and are based on a performance period that precedes the calendar year performance period used for the Value Modifier.*

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### **A. THE VALUE-BASED PAYMENT MODIFIER PROGRAM**

#### **1. What is the Value-Based Payment Modifier Program?**

The Value-Based Payment Modifier Program is part of a larger effort by the Centers for Medicare & Medicaid Services (CMS) to improve the quality and efficiency of medical care by developing meaningful and actionable ways to measure physician performance. The program's main goal is to give providers information about the quality and cost of care furnished to their Medicare Fee-for-Service (FFS) beneficiaries. This program began under the Medicare Improvements for Patients and Providers Act of 2008 (formerly called the Physician Resource Use Measurement and Reporting Program) and was later extended and enhanced under the 2010 Patient Protection and Affordable Care Act (ACA). Confidential feedback reports, called Quality and Resource Use Reports (QRURs), are disseminated to groups and solo practitioners, as identified by their Medicare-enrolled Taxpayer Identification Numbers (TINs). See Section B, "Overview of the 2015 Quality and Resource Use Reports" for additional information.

The Value-Based Payment Modifier Program also supports Section 3007 of the ACA, which directs the secretary of the U.S. Department of Health & Human Services to develop and implement a budget-neutral Value-Based Payment Modifier (Value Modifier). The Value Modifier will be used to adjust Medicare Physician Fee Schedule (PFS) payments to TINs, based on the quality and cost of care delivered to the Medicare beneficiaries attributed to the TINs.

#### **2. How is TIN size determined for purposes of applying the 2017 Value Modifier?**

The magnitude of the Value Modifier payment adjustment depends, in part, on the number of eligible professionals in a TIN. To determine the size of a TIN for the purposes of applying the 2017 Value Modifier, CMS uses the lower of:

- the number of eligible professionals identified in the Provider Enrollment, Chain and Ownership System (PECOS) on July 10, 2015 as having reassigned their billing rights to the TIN; and
- the number of eligible professionals submitting claims to Medicare under the TIN during 2015.

Both full-time and part-time eligible professionals are included in the calculation.

#### **3. How are the QRURs related to the Value Modifier?**

For TINs to which the Value Modifier applies, the Annual QRURs, disseminated each fall, will serve as the final summary report on performance on the quality and cost measures used to



calculate the Value Modifier and the resulting payment adjustment. The Value Modifier is determined using a quality-tiering approach that can result in an upward, neutral, or downward payment adjustment to physicians, depending on a TIN's performance compared to its peers. The Mid-Year QRURs do not estimate performance for the Value Modifier, because they do not include all of the quality and cost data included in the Value Modifier and are based on different reporting periods: July 1, 2014 through June 30, 2015 for the 2015 Mid-year QRURs and calendar year 2015 for the 2015 Annual QRURs.

#### 4. Who has received a QRUR so far?

Since 2008, CMS has used a phased approach to create and disseminate physician feedback reports, in order to gain experience and obtain input from stakeholders. Throughout this process, CMS has used input from stakeholders, physician and medical specialty groups, QRUR recipients, and medical associations to guide changes to the QRURs.

In 2014, CMS began to make QRURs available to all physician groups and solo practitioners that had at least one physician who billed under the TIN during 2013. These were the first reports to include data used to determine Medicare PFS payment adjustments that would apply to some TINs, due to application of the Value Modifier starting in 2015. In 2015, CMS also began to make Mid-Year QRURs available, providing interim feedback about performance on claims-based quality outcome and cost measures (a subset of the measures used to calculate the Value Modifier), and continued to generate Annual QRURs for all groups and solo practitioners with at least one physician billing under the TIN during the period July 1, 2014 through June 30, 2015. Both Annual and Mid-Year QRURs provide feedback on a TIN's performance on cost and quality measures that are used to calculate the Value Modifier, regardless of whether the TIN will actually be subject to the Value Modifier in a given year.

In **April 2016**, CMS made Mid-Year QRURs available to all groups and solo practitioners that billed for Medicare-covered services under a single TIN, provided the TIN had at least one eligible case for at least one claims-based quality outcome or cost measure during the period July 1, 2014 through June 30, 2015.

In **September 2016**, CMS made Annual QRURs available to all groups and solo practitioners that billed for Medicare-covered services under a single TIN, provided the TIN had at least one eligible professional in the TIN in 2015. This includes TINs that will not be subject to the Value Modifier in 2017, namely, those with only non-physician eligible professionals in 2015 and TINs that participated in the Pioneer Accountable Care Organization (ACO) Model or the Comprehensive Primary Care (CPC) initiative in 2015. For TINs that will be subject to the 2017 Value Modifier (including, for the first time, all TINs that participated in the Shared Savings Program in 2015), the Annual QRURs will include their Value Modifier information based on care provided during 2015.

### 5. Will CMS continue to accept comments or suggestions about the QRURs?

Yes. You can submit comments about the content and format of the QRUR by calling the Physician Value Help Desk at 1-888-734-6433 (select option 3) or emailing the Help Desk at [pvhelpdesk@cms.hhs.gov](mailto:pvhelpdesk@cms.hhs.gov). Normal business hours are Monday–Friday, 8 a.m. to 8 p.m. Eastern Time.

## B. OVERVIEW OF THE 2015 QUALITY AND RESOURCE USE REPORTS

### 1. What are the Quality and Resource Use Reports?

Under the Value Modifier Program, QRURs provide information about the resources used and the quality of care furnished to a group's or solo practitioner's Medicare FFS beneficiaries. The 2015 QRURs will be generated for all groups and solo practitioners nationwide, as identified by their Medicare-enrolled TIN, regardless of whether the 2017 Value Modifier will apply to them. They can use their QRURs to see how their TIN compares with other TINs caring for Medicare beneficiaries.

Three types of QRURs are generated for 2015: the Mid-Year QRUR, the Annual QRUR, and the Supplemental QRUR.

- **Mid-Year QRURs** will provide interim information about performance on only those cost and quality outcomes measures that CMS calculates directly from Medicare claims, based on care provided from July 1, 2014 through June 30, 2015. The Mid-Year QRURs are distributed for informational purposes only to groups and solo practitioners. Quality data reported as part of the Physician Quality Reporting System (PQRS) are not included in the Mid-Year QRUR. The information contained in the Mid-Year QRUR will not affect Medicare PFS payments and is not intended to predict future value-based performance.
- **Annual QRURs** will provide information about performance on quality and cost measures during 2015. For physicians in TINs that are subject to the Value Modifier in 2017, the Annual QRURs will provide information on how the TIN's quality and cost performance will affect their Medicare PFS payments in 2017. The Value Modifier will be used to adjust Medicare PFS payments to physicians, based on the quality and cost of care delivered to Medicare beneficiaries during 2015. For TINs that are not subject to the 2017 Value Modifier, the Annual QRURs are for informational purposes only.
- **Supplemental QRURs** are confidential feedback reports provided to groups and solo practitioners with information on the management of their Medicare FFS beneficiaries based on episodes of care. An episode of care is defined as the set of services provided to treat a clinical condition or procedure. Section 3003 of the ACA requires the secretary of the U. S. Department of Health & Human Services to develop episode-based payment measurement,

and CMS is applying episode grouping algorithms specially designed for constructing episodes of care in the Medicare population. The Supplemental QRURs are currently generated for informational purposes only and complement the total per capita cost and quality information provided in the Annual QRURs. The information included in the Supplemental QRURs is not used to calculate TINs' 2017 Value Modifier results.

### **2. What information is in the 2015 Annual QRURs?**

The 2015 Annual QRUR, available in fall 2016, provides complete information about how the 2017 Value Modifier applies to each TIN. This includes information about a TIN's performance during 2015 on all quality and cost measures used in calculating the 2017 Value Modifier, provided the TIN had at least one eligible case for at least one quality or cost measure. For TINs that meet the criteria to have their Value Modifier calculated using the quality tiering approach, the Annual QRUR also indicates the quality tier designation (high, average, or low cost and quality), based on its 2015 performance. The Annual QRUR also includes benchmarks that allow each TIN to compare its performance on each measure to that of its peers.

Supplementing each TIN's Annual QRUR are detailed tables with information about the eligible professionals who billed to the TIN during 2015; the beneficiaries attributed to the TIN in 2015 for all claims-based quality outcome and total per capita cost measures; beneficiaries attributed to the TIN for the Medicare Spending per Beneficiary (MSPB) cost measure; beneficiaries' hospital admissions, primary diagnoses, and discharge disposition; TIN- and beneficiary-level total per capita cost breakdowns by category of service; and additional information on the quality measures that individual eligible professionals in a TIN reported through PQRS.

### **3. What information is in the 2015 Mid-Year QRURs?**

The 2015 Mid-Year QRUR was distributed in the spring of 2016 for informational purposes only. The Mid-Year QRUR contains performance data on CMS-calculated claims-based measures only. This includes three quality outcome measures based on Medicare FFS claims: hospital admissions for Acute and Chronic Ambulatory Care-Sensitive Condition (ACSC) Composite measures and one 30-day All-Cause Hospital Readmission measure.

To assess cost, the Mid-Year QRURs include performance information on two total per capita cost measures: the Per Capita Costs for All Attributed Beneficiaries measure and the MSPB measure. The Mid-Year QRURs also include the four Per Capita Costs for Beneficiaries with Specific Conditions measures: total per capita costs for beneficiaries with diabetes, coronary artery disease, chronic obstructive pulmonary disease, and heart failure. For all cost measures, beneficiary costs, as identified by allowed charges on Medicare Part A and Part B claims, are payment standardized to remove geographic Medicare payment differences, risk



adjusted to account for differences in beneficiaries' age or medical histories, and specialty adjusted to account for differences in TINs' specialty mix (described in Section C).

Additionally, the Mid-Year QRUR includes benchmarks that allow the TIN to compare its performance on these measures to that of all TINs in the peer group for each measure. The Mid-Year QRUR also includes information on the hospitals most often treating a TIN's attributed beneficiaries.

Detailed tables accompanying each Mid-Year QRUR provide information on each of the eligible professionals who billed under the TIN during the period of July 1, 2014 through June 30, 2015 or that were associated with the TIN in PECOS as of July 10, 2015, as well as information on each of the beneficiaries attributed to the TIN for claims-based cost and quality outcomes measures, their hospital stays, and the costs associated with delivering their care.

#### 4. What is the difference between the 2015 Mid-Year and 2015 Annual QRURs?

The 2015 Mid-Year QRUR was distributed in spring 2016 for informational purposes only. It is intended to provide TINs with up-to-date interim information on their performance on the claims-based quality outcome and cost measures. The 2015 Annual QRUR was distributed in fall 2016. It serves as the final report on the payment adjustment for all TINs subject to the 2017 Value Modifier and on the TIN's performance on the quality and cost measures during 2015 used to calculate the Value Modifier.

The Mid-Year QRURs differ from the Annual QRURs in three ways:

- 1. Performance period.** The Mid-Year QRUR is based on care provided from July 1, 2014 through June 30, 2015. The Annual QRUR and 2017 Value Modifier is based on performance from January 1, 2015 through December 31, 2015.
- 2. Quality measures included in the reports.** The Mid-Year QRUR contains performance data on CMS-calculated claims-based measures only. These include three quality outcome measures based on Medicare FFS claims submitted for Medicare beneficiaries attributed to the TIN from July 1, 2014 through June 30, 2015. The three measures are hospital admissions for Acute and Chronic ACSC Composite measures, and 30-day All-Cause Hospital Readmission measure. The Mid-Year QRUR does not contain performance information on quality measures submitted through PQRS, because these data are only calculated on an annual basis. The Annual QRUR, by contrast, will include all quality measures used to calculate a TIN's Quality Composite Score, including PQRS data. The same benchmarks will be used for the quality measures in the Mid-Year and Annual QRURs, based on performance on these measures between January 1, 2014 and December 31, 2014.

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**3. Information related to the Value Modifier and reporting format.** The Mid-Year QRUR does not include a Value Modifier calculation, and information reported will not affect the TIN's payments under the Medicare PFS. The Mid-Year QRUR is intended to provide timely, actionable information to help TINs understand and improve the quality and efficiency of care provided to Medicare beneficiaries and their performance on the claims-based measures quality outcome and cost measures that are a subset of the measures that will be used to calculate the 2017 Value Modifier. Because the performance period and quality measures differ from those used to calculate the 2017 Value Modifier, the Mid-Year QRUR may not be indicative of a TIN's future Value Modifier performance. As noted above, the format of the 2015 Annual QRUR has also been revised, to focus more clearly on the 2017 Value Modifier.

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Table A below outlines the metrics included in the 2015 Mid-Year QRURs and the 2015 Annual QRURs.

Table A. Comparison of metrics displayed in the 2015 Mid-Year QRURs and 2015 Annual QRURs

QRUR Component	2015 Mid-Year QRUR (Performance Period: July 1, 2014–June 30, 2015)		2015 Annual QRUR (Performance Period: January 1, 2015–December 31, 2015)	
	Included?	Relevant Exhibits	Included?	Relevant Exhibits
Value Modifier Calculation	No	-	Yes	Cover Page and Exhibit 1
Quality Tier Designation	No	-	Yes	Cover Page and Exhibit 1
Quality Composite Score	No	-	Yes	Exhibit 2
Quality Domain Scores	No	-	Yes	Exhibit 3
CMS-Calculated Quality Outcome Measures	Yes	Exhibit 5	Yes	Exhibit 3-CCC-B
PQRS Quality Measures	No	-	Yes	Exhibits 3, Table 7
CAHPS Survey Measures	No	-	Yes, if available	Exhibit 3-PCE
Cost Composite Score	No	-	Yes	Exhibit 4
Cost Domain Scores	No	-	Yes	Exhibit 5
Per Capita Costs for All Attributed Beneficiaries	Yes	Exhibit 8	Yes	Exhibit 5-AAB
Per Capita Costs for Beneficiaries with Specific Conditions	Yes	Exhibit 8	Yes	Exhibit 5-BSC
Medicare Spending per Beneficiary	Yes	Exhibit 8	Yes	Exhibit 5-AAB
Eligible Professionals in Your TIN	Yes	Exhibit 1; Table 1	Yes	Table 1
Medicare Beneficiaries Attributed to your TIN	Yes	Exhibit 2; Tables 2A, 2B, and 4	Yes	Tables 2A and 5B
Beneficiary-Level Cost and Utilization Data	Yes	Exhibits 3 and 4; Tables 3, 4, and 5	Yes	Tables 2C, 3B, 5D, 6A, and 6B
Hospitals Admitting Beneficiaries Attributed to your TIN	Yes	Exhibits 6 and 7	Yes	Tables 2B and 5A

### **5. How can I download my 2015 Annual QRUR and Tables from the CMS Enterprise Portal?**

The 2015 Annual QRUR and Tables can now be downloaded directly from the CMS Enterprise Portal at <https://portal.cms.gov> using an Enterprise Identity Management (EIDM) account with the correct role. Please note, the Annual QRURs and Tables contain sensitive information including protected health information (PHI) and personally identifiable information (PII). Therefore users should follow the appropriate protocols for saving and printing this information securely.

For instructions on downloading the 2015 Annual QRUR and Tables, refer to Section VI of the Guide for Accessing the 2015 Annual QRURs and Tables available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html>. Instructions for obtaining an EIDM account is also available on this website.

### **6. Who received a 2015 QRUR?**

The 2015 Mid-Year and Annual QRURs are provided to groups and solo practitioners, as identified by their Medicare-enrolled TIN, with at least one eligible professional (defined in Section B, FAQ number 12 below) who billed Medicare Part B during July 1, 2014 through June 30, 2015 for the Mid-Year QRURs and during 2015 for the Annual QRURs regardless of whether they will be subject to the 2017 Value Modifier.

### **7. How were beneficiaries attributed to TINs in the 2015 QRURs?**

Beneficiaries are considered for attribution to a group or solo practitioner, as identified by their Medicare-enrolled TIN, and other entities identified by a CMS Certification Number (Federally Qualified Health Centers, Rural Health Clinics, Critical Access Hospitals Billing under Method II, and Electing Teaching Amendment Hospitals). The method of attribution is different for different types of quality and cost measures.

For five of the six cost measures (the Per Capita Costs for All Attributed Beneficiaries measure and the four Per Capita Costs for Beneficiaries with Specific Conditions measures) and for the three claims-based quality outcome measures that are calculated from Medicare administrative claims data, beneficiaries are attributed to a TIN using a two-step approach similar to the approach used to assign beneficiaries to ACOs under the Shared Savings Program. This two-step approach takes into account the level of primary care services received (as measured by Medicare allowed charges during 2015) and the provider specialties that performed these services. Only beneficiaries who received a primary care service (as defined in Table B of Section B, FAQ number 8 below) during 2015 are considered in attribution. A beneficiary is

attributed to a TIN in the first step if the beneficiary received more primary care services from primary care physicians<sup>1</sup> (PCPs), nurse practitioners (NPs), physician assistants (PAs), or clinical nurse specialists (CNSs) within the TIN than from any other TIN. If a beneficiary did not receive a primary care service from any PCP, NP, PA, or CNS during 2015, the beneficiary is attributed to a TIN in the second step if the beneficiary received more primary care services from specialist physicians within the TIN than from any other TIN. Beneficiaries are excluded from this attribution process if, for any month during 2015, any of the following situations applied to them: they were enrolled in Medicare Part A only or Medicare Part B only; they were enrolled in a private Medicare health plan (for example, a Medicare Advantage HMO/PPO, or a Medicare private FFS plan); or they resided outside the United States, its territories, and its possessions.

For specialty definitions and more details regarding attribution, please see the document titled “Two-Step Attribution for Claims-Based Quality Outcome Measures and Per Capita Cost Measures Included in the Value Modifier”, available at the following URL:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-03-25-Attribution-Fact-Sheet.pdf>.

Because the MSPB cost measure is based on care surrounding an episode of inpatient hospitalization, beneficiaries are attributed to TINs in a different manner. For the MSPB measure, an episode of care surrounding a hospital admission for a Medicare FFS 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.

### **8. What are considered primary care services for the purposes of the QRURs?**

For the purposes of the 2015 QRURs and the 2017 Value Modifier, primary care services are defined as Medicare Part B services billed under one of the Healthcare Common Procedure Coding System (HCPCS) codes listed in Exhibit G-1 of the 2015 QRUR. Please see Table B below for the list of HCPCS codes and descriptions. Only beneficiaries who received a primary care service as defined by these HCPCS codes during 2015 are considered in attribution.

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<sup>1</sup> Primary care physicians are physicians with one of four specialty designations: internal medicine, general practice, family practice, or geriatric medicine.



**Table B. Healthcare Common Procedure Coding System (HCPCS) Primary Care Service Codes**

HCPCS codes	Brief description
99201–99205	New patient, office, or other outpatient visit
99211–99215	Established patient, office, or other outpatient visit
99304–99306	New patient, nursing facility care
99307–99310	Established patient, nursing facility care
99315–99316	Established patient, discharge day management service
99318	Established patient, other nursing facility service
99324–99328	New patient, domiciliary, or rest home visit
99334–99337	Established patient, domiciliary, or rest home visit
99339–99340	Established patient, physician supervision of patient (patient not present) in home, domiciliary, or rest home
99341–99345	New patient, home visit
99347–99350	Established patient, home visit
G0402	Initial Medicare visit
G0438	Annual wellness visit, initial
G0439	Annual wellness visit, subsequent
G0463	Hospital outpatient clinic visit (ETA hospitals only)

Note: Labels are approximate. For detailed definitions, see the American Medical Association’s Current Procedural Terminology available at:  
[http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS\\_Quarterly\\_Update.html](http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html)

## 9. Could beneficiaries who received most of their primary care services from a Federally Qualified Health Center or Rural Health Clinic be attributed to my TIN?

No. Beneficiaries who received more primary care services (as measured by Medicare-allowed charges) during 2015 from a Federally Qualified Health Center or Rural Health Clinic than any other TIN will be attributed to that entity and not to a group or solo practitioner billing under a TIN. Although Federally Qualified Health Centers and Rural Health Clinics will be attributed beneficiaries, they and other entities not paid under the Medicare PFS did not receive 2015 QRURs, and the 2017 Value Modifier will not apply to them.

### **10. If a TIN consists solely of specialists, how could the TIN have attributed beneficiaries?**

If a beneficiary did not receive a primary care service from any PCPs, NPs, PAs, or CNSs, the beneficiary is attributed to a TIN in the second step if the beneficiary received more primary care services (as measured by Medicare-allowed charges) from specialist physicians within the TIN than in any other TIN. (Please refer to Table B above for a list of primary care service codes used for attribution.)

Therefore, a TIN made up solely of specialists may be attributed beneficiaries through the second step of the attribution process if: (1) the beneficiary did not receive any primary care services from a PCP, NP, PA, or CNS, and (2) the TIN's specialists provided more primary care services than any other TIN's specialists. For more information about two-step attribution, please see the document titled "Two-Step Attribution for Claims-Based Quality Outcome Measures and Per Capita Cost Measures Included in the Value Modifier", available at the following URL:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-03-25-Attribution-Fact-Sheet.pdf>.

Additional information on attribution is also available in FAQ number 7 in Section B of this document.

### **11. If patients receive primary care services from primary care physicians, nurse practitioners, physician assistants or certified nurse specialists, can they be attributed in Step 2 of the attribution process?**

No. Patients are attributed in Step 2 of the attribution process only if the patients did not receive any primary care services from primary care physicians (PCPs), NPs, PAs, or CNSs. A beneficiary would be attributed in Step 1 of the attribution process if he or she received a primary care service from a PCP, NP, PA, or CNS, even if the PCP, NP, PA, or CNS provided a smaller share of the total Medicare-allowed charges for primary care services than did specialist physicians.

For more information about the two-step process CMS uses to attribute beneficiaries to TINs, please see the document titled "Two-Step Attribution for Claims-Based Quality Outcome Measures and Per Capita Cost Measures Included in the Value Modifier", available at the following URL: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-03-25-Attribution-Fact-Sheet.pdf>. Additional information on attribution is also available in FAQ number 7 in Section B of this document.

### 12. Is the same population of Medicare beneficiaries included in all of the quality and cost measures?

No. Although the populations in the quality and cost measures used to calculate the Value Modifier are intended to be broadly representative of the Medicare FFS beneficiaries in each TIN, the methods for defining those populations differ as follows:

- **Per Capita Costs for All Attributed Beneficiaries measure.** This cost measure is based on the same population of Medicare FFS beneficiaries attributed to a TIN in the two-step process (described in further detail in FAQ number 7 above). This attribution method is based on primary care services received (as measured by Medicare-allowed charges) and the provider types that performed these services. Any beneficiary attributed to a TIN is eligible to be included in any or all total per capita cost measures.
- **Per Capita Costs for Beneficiaries with Specific Conditions** (four measures). For each of these cost measures calculated from Medicare claims, CMS uses a subset of the population of Medicare FFS beneficiaries attributed to a TIN for the Per Capita Costs for All Attributed Beneficiaries measure. Specifically, for each of the four condition-specific measures, the beneficiary population (also referred to as eligible cases) included in the measure is the subset of attributed beneficiaries that have the relevant condition. For example, the beneficiaries included in the Per Capita Costs for Beneficiaries with Diabetes measure will include all beneficiaries in the Per Capita Costs for All Attributed Beneficiaries measure that were identified as having Diabetes.
- **Hospital admissions for Acute and Chronic ACSC Composite measures** (Acute Conditions Composite and Chronic Conditions Composite). For each of these quality outcome measures calculated from Medicare claims, CMS uses the same population of Medicare FFS beneficiaries attributed to a TIN for the Per Capita Costs for All Attributed Beneficiaries measure, with the same exclusions. However, while the population included in the denominator for the Acute Conditions Composite includes all Medicare beneficiaries attributed to the TIN, the denominator for measures in the Chronic Conditions Composite is restricted to beneficiaries diagnosed with the given chronic condition (diabetes, chronic obstructive pulmonary disease/asthma, and heart failure). For more detailed specifications for these measures, please see the document titled “2015 Measure Information about the Hospital Admissions for Acute and Chronic Ambulatory Care–Sensitive Condition (ACSC) Composite Measures, Calculated for the 2017 Value-Based Payment Modifier Program”, available at the following URL: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-ACSC-MIF.pdf>.
- **30-day All-Cause Hospital Readmission.** For this quality outcome measure calculated from Medicare claims, CMS uses the same population of Medicare FFS beneficiaries attributed to a TIN for the Per Capita Costs for All Attributed Beneficiaries measure, with the same exclusions. For a more detailed description of exclusions specific to this measure, please see

the document titled “2015 Measure Information about the 30-Day All-Cause Hospital Readmission Measure, Calculated for the Value-Based Payment Modifier Program”, available at the following URL: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-ACR-MIF.pdf>.

- **Medicare Spending per Beneficiary (MSPB).** The population of beneficiaries included in the MSPB measure is comprised of those Medicare FFS beneficiaries hospitalized during 2015 and for whom the TIN provided more Medicare Part B-covered services (as measured by Medicare-allowed charges) during the hospital stay than did any other TIN. This measure is based on episodes of care surrounding hospitalization for Medicare beneficiaries who were discharged from short-term acute hospitals during the period of performance. Medicare Part A and Part B claims are included in the MSPB episode if the beneficiary has been enrolled in Medicare Part A and Part B for the period 90 days prior to the start of an episode and for 30 days after discharge. Only claims for beneficiaries discharged from short-term acute hospitals paid under Medicare’s inpatient prospective payment system during the period of performance are included. Populations excluded from the MSPB calculation are beneficiaries who, at any time 90 days before or during the episode, were enrolled in a Medicare Advantage plan, covered by the Railroad Retirement Board, or for whom Medicare was the secondary payer. For more detailed information, please see the document titled “Measure Information about the Medicare Spending Per Beneficiary, Calculated for the 2017 Value Modifier and 2015 Annual QRURs”, available at the following URL: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2017-MSPBM-MIF.pdf>.
- **Quality measures reported through PQRS.** Note that no PQRS measures are reported in the 2015 Mid-Year QRUR, but are included in the 2015 Annual QRUR.

The populations included in PQRS quality measures reflect the patients for whom a TIN submitted quality data. Please refer to the 2015 PQRS Implementation Guide for more information on the eligible measure population for each reporting method. [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/downloads/2015\\_PQRS\\_ImplementationGuide.pdf?agree=yes&next=Accept?agree=yes&next=Accept](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/downloads/2015_PQRS_ImplementationGuide.pdf?agree=yes&next=Accept?agree=yes&next=Accept). The measure population for TINs electing to submit data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS Survey in 2015 reflects the sample frame of beneficiaries in the TIN, as identified by CMS.

For additional information on the PQRS measures, please refer to the PQRS website at the following URL: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>.

### **13. How are episodes of care attributed to a TIN for the Medicare Spending per Beneficiary (MSPB) measure?**

For the MSPB measure, an episode of care includes all Medicare Part A and Part B claims with a start date falling between three days prior to an inpatient prospective payment system (IPPS) hospital admission (index admission) through thirty days following hospital discharge. Each MSPB episode is attributed to the TIN responsible for the plurality of Medicare Part B services, as measured by Medicare allowed amounts, performed by eligible professionals during the episode's index hospitalization. Medicare Part B services are defined as all physician services that are billed on non-institutional claims. Medicare Part B services during the episode's index hospitalization include Medicare Part B services conducted in the period between the admission date and discharge date of the hospital stay. CMS considers any Medicare Part B services billed by eligible professionals on the admission date and in a hospital setting, with place of service restricted to inpatient, outpatient, or emergency room hospital; or during the index hospital stay, regardless of place of service; or on the discharge date and in an inpatient hospital.

For more information on the MSPB measure, please see the document titled "Measure Information about the Medicare Spending Per Beneficiary, Calculated for the 2017 Value Modifier and 2015 Annual QRURs", available at the following URL:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2017-MSPBM-MIF.pdf>

### **14. How are specialty designations that are reported in the TIN's QRUR assigned to a TIN's eligible professionals?**

For calculations in the QRURs, CMS needs to determine which healthcare providers (that is, physicians, non-physician practitioners, and other suppliers) billing under a TIN are "eligible professionals." This determination is, in general, based on each healthcare provider's self-reported "primary specialty" for the performance period, as reflected in the CMS PECOS enrollment and claims systems.<sup>2</sup> To account for any changes in the primary specialty that a physician might have made during a performance year, or to account for multiple PECOS enrollments for non-physician healthcare providers, the specialty that appears in the QRUR is based on the primary specialty that is associated with the plurality of allowed charges for

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<sup>2</sup> While physicians may select multiple secondary specialties in PECOS, they may select only one primary specialty. If non-physician healthcare providers want to enroll in PECOS under more than one non-physician specialty type, they must submit a separate CMS enrollment application for each specialty type.



Medicare Part B services furnished by the healthcare provider under the TIN during the performance year.<sup>3</sup>

It is important that healthcare providers keep their specialty code(s) current in PECOS. CMS encourages healthcare providers to contact the Medicare Administrative Contractor that processes their claims to obtain additional details, if necessary, regarding their PECOS specialty codes. Healthcare providers may change their primary specialty, and/or any other applicable secondary specialty code(s), through PECOS. Recognize, however, that there is processing time for changes to be updated and reflected in future CMS enrollment and claims files. As a result, the methodology used to define eligible professionals' specialties for the purposes of the QRUR can, at times, produce results that are different from what a TIN or eligible professional might have expected, such as when an eligible professional updates his/her PECOS information during or after the performance period. For further details about the QRUR specialty designation methodology, please see the document titled "Detailed Methodology for the 2017 Value Modifier and 2015 Quality and Resource Use Report", available at the following URL: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Detailed-Methodology-for-the-2017-Value-Modifier-and-2015-Quality-and-Resource-Use-Report-.pdf>. For more information on PECOS, please visit <https://pecos.cms.hhs.gov/pecos/login.do#headingLv1>.

15. If the eligible professionals in a TIN are participating in PQRS as individuals, rather than as a group, how does CMS determine whether 50 percent of the eligible professionals in the TIN met the criteria as individuals to avoid the 2017 PQRS payment adjustment?

The percent of eligible professionals in a TIN that met the criteria as individuals to avoid the 2017 PQRS payment adjustment is calculated by taking the total number of eligible professionals in the TIN who met the criteria to avoid the 2017 PQRS payment adjustment as individuals, divided by the total number of eligible professionals in the TIN, and then multiplying the result by 100. Both full-time and part-time eligible professionals are included in the calculations. Specifically:

- The numerator is the number of eligible professionals in the TIN who avoided the 2017 PQRS payment adjustment and either: (a) billed under the TIN for services furnished during 2015, or (b) were associated with the TIN in PECOS as of July 10, 2015 and reported PQRS data in 2015.

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<sup>3</sup> As a technical note, if a healthcare provider's specialty is not included in the CMS Medicare Part B claims files, then for purposes of the QRUR, CMS uses the healthcare provider's PECOS specialty listed as of the date when PECOS data are downloaded to produce the QRURs.

- The denominator is based on the lower of the number of eligible professionals indicated by a query of PECOS on July 10, 2015 as having reassigned their billing rights to the TIN and the number of eligible professionals who submitted claims to Medicare under the TIN during 2015.

### **16. Does the 2017 Value Modifier apply to a TIN that participates in a Shared Savings Program ACO?**

Yes. TINs that participated in a Shared Savings Program ACO in 2015 will be subject to the 2017 Value Modifier based on the ACO's performance in 2015. In 2017, the Value Modifier will apply to payments under the Medicare PFS for physicians in groups with two or more eligible professionals and to physician solo practitioners, as identified by their Medicare-enrolled TIN.

If the ACO successfully reported on quality measures via the GPRO Web Interface in 2015, then the 2017 Value Modifier for the participant TINs under the ACO will be calculated using the quality-tiering methodology. For TINs that participated in a Shared Savings Program ACO in 2015, the Cost Composite will be classified as "Average Cost," and the Quality Composite Score will be calculated based on the quality data submitted by the ACO via the GPRO Web Interface and the ACO's performance on the claims-based 30-day All-Cause Hospital Readmission measure calculated by Medicare for 2015.

If a TIN participated in more than one Shared Savings Program ACO in 2015, then the TIN's Quality Composite Score will be based on the performance of whichever ACO had the highest numerical Quality Composite Score.

The maximum upward adjustment under quality-tiering for the 2017 Value Modifier is:

- +2.0 x AF for physicians in TINs containing 10 or more eligible professionals ('AF' is an adjustment factor derived from actuarial estimates of projected billings that will determine the precise size of the reward for higher performing TINs in a given year).
- +1.0 x AF for physicians in TINs containing between 2 and 9 eligible professionals and physician solo practitioners.
- All TINs receiving an upward adjustment are eligible for an additional +1.0 x AF if the ACO in which the TIN participated during 2015 has an attributed patient population with an average beneficiary CMS Hierarchical Condition Category (CMS-HCC) risk score in the top 25 percent of all beneficiary CMS-HCC risk scores nationwide under the Value Modifier methodology.
  - The maximum upward adjustment for TINs containing 10 or more eligible professionals would be +3.0 x AF and the maximum upward adjustment for TINs containing between 2 and 9 eligible professionals and physician solo practitioners would be +2.0 x AF.

The maximum downward adjustment under quality-tiering for the 2017 Value Modifier is:

- Negative two percent (-2.0%) for physicians in TINs containing 10 or more eligible professionals.
  - Physicians in TINs containing between 2 and 9 eligible professionals and physician solo practitioners are held harmless from downward adjustments for poor performance.

If the Shared Savings Program ACO failed to successfully report on quality measures via the Group Practice Reporting Option (GPRO) Web Interface in 2015, then the participant TINs will be subject to the automatic downward adjustment under the 2017 Value Modifier. In 2017, the automatic downward Value Modifier adjustment is:

- Negative four percent (-4.0%) for physicians in TINs containing 10 or more eligible professionals.
- Negative two percent (-2.0%) for physicians in TINs containing between 2 and 9 eligible professionals and physician solo practitioners.

Please note, CMS has proposed a special secondary PQRS quality reporting period in the 2017 Medicare Physician Fee Schedule (PFS) Proposed Rule. The proposal, if adopted, will allow eligible professionals who participated in a Shared Savings Program ACO that failed to report quality data for the previously established reporting period for the 2017 PQRS payment adjustment (that is, January 1, 2015, through December 31, 2015) to subsequently avoid the 2017 PQRS downward adjustment and 2017 Value Modifier automatic downward adjustment. These eligible professionals must report PQRS data separately from the ACO under one of the allowed options for this special secondary reporting period during January 1, 2016 through December 31, 2016.<sup>4</sup>

### **17. Will the 2017 Value Modifier apply to a TIN that participates in the Pioneer ACO Model or the Comprehensive Primary Care initiative?**

The 2017 Value Modifier will be waived for groups and solo practitioners, as identified by their Medicare-enrolled TIN, if at least one eligible professional who billed for Medicare PFS items and services under the TIN during 2015 participated in the Pioneer ACO Model or the CPC initiative and none of the TINs eligible professionals participated in a Shared Savings Program ACO in 2015.

<sup>4</sup> Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2017 Proposed Rule (81 Federal Register 46408-46409 and 46446-46448).

### 18. If a TIN is new in calendar year 2016, how will the TIN's 2017 and 2018 Value Modifier be affected?

If a TIN is newly enrolled in the Medicare program in calendar year 2016 and did not exist during calendar year 2015 (the performance period for the 2015 Annual QRURs and 2017 Value Modifier), the TIN will not be affected by the 2017 Value Modifier since there would be no data for this TIN during 2015. However, the TIN's performance during 2016 may affect its Value Modifier payment adjustment in 2018. Specifically, if the TIN billed the Medicare PFS during calendar year 2016 and had at least one eligible professional, then the TIN will be evaluated based on its performance on quality and cost measures during 2016 for the 2018 Value Modifier. Information on the TIN's performance during 2016 and on its 2018 Value Modifier will be provided in the 2016 Annual QRUR (available in fall 2017).

Table C below shows four different scenarios for applying the Value Modifier based on TIN's creation or billing activity. For example, if TIN A existed in 2015, but it is no longer billing under the Medicare PFS from 2016 to 2018, then the TIN would not be subject to the Value Modifier in 2016, 2017, or 2018. If TIN B existed in 2015 and 2016, but it did not bill under the Medicare PFS from 2017 on, then TIN B would not be subject to the Value Modifier in 2017 and 2018. For TIN C, which billed the Medicare PFS between 2015 and 2017, the TIN could be subject to the Value Modifier in 2017, based on performance during calendar year 2015. Finally, TIN D is an example of a TIN that was newly enrolled in the Medicare program during calendar year 2016. For this TIN, the first year in which the TIN could be subject to the Value Modifier would be calendar year 2018, based on its performance during 2016.

**Table C. Year in Which TINs are Subject to the Value Modifier, Based on the Existence of a TIN**

TIN Index	TIN Existed and Billed the Medicare Physician Fee Schedule?				Year in Which TIN is Affected by Value Modifier
	2015	2016	2017	2018	
A	Yes	No	No	No	Not affected
B	Yes	Yes	No	No	Not affected
C	Yes	Yes	Yes	No	2017 (Based on Performance in 2015)
D	No	Yes	Yes	Yes	2018 (Based on performance in 2016)

### **19. Does the Value Modifier apply to physicians providing services at a Rural Health Clinic, Federally Qualified Health Center or Critical Access Hospital?**

The Value Modifier payment adjustment applies to physician payments (and, starting in 2018, to payments for services furnished by Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, or Certified Registered Nurse Anesthetists) under the Medicare PFS. The Value Modifier does not apply to payments that are not made under the Medicare PFS. Therefore, the Value Modifier does not apply to payments for Rural Health Clinic services and Federally Qualified Health Center services.

In regard to the application of the Value Modifier for services furnished in Critical Access Hospitals (CAHs), the Value Modifier applies in limited circumstances. Payments for professional services are separately billed and paid under the Medicare PFS when the eligible professional's services are furnished in a CAH that bills under the standard payment methodology (Method I). Therefore, the Value Modifier payment adjustment applies to the Medicare PFS payments for professional services furnished in a Method I CAH.

The Value Modifier payment adjustment does not apply to payments for professional services furnished in CAHs when the services are billed and paid under the CAH Method II payment methodology. That is, CAH Method II payments for professional services are not paid under the Medicare PFS, so the Value Modifier payment adjustment does not apply. However, please note that even if a TIN's physicians typically furnish services in a CAH that bills for physician services under the CAH Method II payment methodology, the payments for services that these physicians furnish in other settings may still be subject to the Value Modifier if the services are billed and paid under the Medicare PFS (such as in an office or in a CAH that bills for its services under the standard payment methodology or Method I).

### **20. Does the Value Modifier apply to physicians providing services in an Independent Diagnostic Testing Facility or an Independent Lab?**

Yes, the Value Modifier payment adjustment could apply to physician payments (and, starting in 2018, to payments for services furnished by Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, or Certified Registered Nurse Anesthetists) under the Medicare PFS in an Independent Diagnostic Testing Facility (IDTF) or Independent Lab (IL). Any Medicare PFS services which a physician (and starting in 2018 a Nurse Practitioner, Physician Assistant, Clinical Nurse Specialist, or Certified Registered Nurse Anesthetist) bills using his/her individual National Provider Identifier (NPI), regardless of setting, could be subject to the Value Modifier. However, the Value Modifier payment adjustment does not apply to Medicare PFS services furnished and billed *by* IDTFs or ILs. IDTFs and ILs are not included in the definition of an



eligible professional and are therefore not subject to the Value Modifier. For more information about IDTF and IL billings, please contact your Medicare Administrative Contractor (MAC).

### **21. Could a TIN with a hardship exemption under the Electronic Health Records (EHR) Incentive Program receive a downward 2017 Value Modifier payment adjustment?**

Yes. While hardship exemptions apply under CMS Electronic Health Record (EHR) Incentive Programs, there is no hardship exemption under the Value Modifier program. A TIN does not avoid the PQRS payment adjustment or the automatic downward Value Modifier payment adjustment simply by receiving a hardship exemption under CMS EHR Incentive Programs.

### **22. What is the most frequent reason for a TIN to receive a downward payment adjustment?**

There are two primary reasons that a TIN would receive a downward payment adjustment under the 2017 Value Modifier: 1) a TIN fails to meet the criteria to avoid the PQRS payment adjustment in 2017 by reporting quality data to the PQRS through the Group Practice Reporting Option (GPRO) and less than 50 percent of the eligible professionals in the TIN meet the criteria to avoid the PQRS payment adjustment in 2017 as individuals, and therefore receives an automatic downward adjustment under the Value Modifier; or 2) a TIN avoids the PQRS payment adjustment and consequently the Value Modifier automatic downward adjustment, but receives a downward payment adjustment based on their performance on quality and cost measures in 2015 under quality-tiering.

Based on the 2016 Value Modifier results, the most frequent reason for receiving a downward payment adjustment under the Value Modifier was failure to meet the requirements to avoid the PQRS payment adjustment. For more information on how to report through PQRS, please see the document titled “2015 Physician Quality Reporting System (PQRS) Implementation Guide”, available at the following URL, [https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/downloads/2015\\_pqrs\\_implementationguide.pdf](https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/downloads/2015_pqrs_implementationguide.pdf).

### **23. How could a TIN with 1 to 9 eligible professionals receive a downward 2017 Value Modifier payment adjustment?**

A TIN with between 1 and 9 eligible professionals would only receive the automatic downward 2017 Value Modifier payment adjustment if it fails to avoid the PQRS payment adjustment in 2017. A TIN can avoid the PQRS payment adjustment either:

- 1) as a group through the Group Practice Reporting Option (GPRO); or

- 2) by having at least 50 percent of its eligible professionals avoid the adjustment as individuals.

TINs with between 1 and 9 eligible professionals that meet one of these criteria will receive either a neutral or an upward 2017 Value Modifier payment adjustment under quality-tiering. If TINs with 1 to 9 eligible professionals are designated as “Low Quality” or “High Cost,” they are subject to a neutral payment adjustment instead of a downward payment adjustment, due to their TIN size.

### **24. Why are there unpopulated cells in some exhibits in my QRUR?**

Table cells include dashes, or are otherwise unpopulated, if it is not possible to calculate a particular statistic or performance measure because there are zero eligible cases.

### **25. Does CMS provide beneficiary-level data (with beneficiary identifiers) to TINs, so that the TINs can see which beneficiaries have been attributed to them and what services the beneficiaries used?**

Yes. Tables 2A, 2B, 3, and 4 accompanying the 2015 Mid-Year QRURs and Tables 2A, 2C, 3B, 5B and 5D (as well as 6A and 6B for Shared Savings Program ACO TINs) in the 2015 Annual QRURs include information on the beneficiaries attributed to the TIN, including sex, date of birth, risk status, Medicare FFS claims filed and services provided, chronic conditions, and hospital admissions. Tables 2A, 2B, and 3 in the Mid-Year QRUR and Tables 2A and 3B in the Annual QRUR list the beneficiaries attributed to the TIN for the cost measures (except MSPB) and claims-based quality outcome measures, and detail the care that the TIN and others provided. Table 4 in the 2015 Mid-Year QRURs and Table 5B in the 2015 Annual QRURs list beneficiaries attributed to the TIN for the MSPB measure.

### **26. Do the total per capita costs of patients attributed to a given TIN reflect costs from Medicare providers and suppliers outside of the TIN?**

Yes. The Per Capita Costs for All Attributed Beneficiaries and Per Capita Costs for Beneficiaries with Specific Conditions measures include *all* Medicare FFS Part A and Part B allowed charges for a TIN’s attributed beneficiaries during the performance period, regardless of whether the claims were billed by eligible professionals in the given TIN, or by other providers and suppliers. Similarly, MSPB episode costs attributed to a TIN include all Part A and Part B payments during the period from three days prior to hospital admission through thirty days after discharge.

### **C. QUALITY AND COST SECTIONS OF THE QUALITY AND RESOURCE USE REPORTS**

#### **1. What quality measures does CMS display in the Quality and Resource Use Reports?**

In both the Mid-Year and the Annual QRURs for 2015, CMS displays three quality outcome measures calculated from administrative claims: hospital admissions for Acute and Chronic ACSC Composite measures and the 30-day All-Cause Hospital Readmission measure.

In the 2015 Annual QRUR only, performance based on quality measures submitted through PQRS is also reported. The particular measures reported will depend on the TIN's participation in PQRS, as follows:

- For TINs that satisfactorily reported data to the PQRS via GPRO, the measures shown in the QRUR are the quality measures reported for the TIN's beneficiaries via the mechanism the TIN chose in 2015 (qualified registry, electronic health record, or GPRO Web Interface).
- For TINs whose eligible professionals participated in PQRS as individuals and solo practitioners, CMS aggregated PQRS data reported by individual eligible professionals in the TIN, to calculate TIN-level quality performance.
- For TINs that elected to supplement PQRS data with the 2015 CAHPS for PQRS survey, patient experience data are reported by the Medicare-certified CAHPS Survey Vendor.

For purposes of calculating the 2017 Value Modifier, CMS will consider quality data reported by a TIN through PQRS reporting mechanisms other than the one initially selected. If a TIN registered as a GPRO but failed as a group to meet the criteria to avoid the 2017 PQRS payment adjustment, CMS will use quality data reported by the individual eligible professionals in the TIN for purposes of applying the 2017 Value Modifier. Similarly, CMS will use GPRO data reported through a mechanism other than the mechanism for which the TIN registered, but failed to meet the criteria to avoid the 2017 PQRS payment adjustment, for purposes of applying the 2017 Value Modifier. In addition, if a TIN did not register to report as a GPRO but only submitted GPRO data, then CMS will use any GPRO data the TIN satisfactorily reported in Value Modifier computations.

#### **2. What services and costs are included in the Quality and Resource Use Report's cost measures?**

Medicare Part A and Part B payments (allowed amounts) are included in the cost measures.

The Per Capita Costs for All Attributed Beneficiaries measure includes all Medicare Part A and Part B payments for items and services provided to beneficiaries attributed to a TIN during the performance period, whether or not the items and services were provided by the TIN receiving the QRUR.

The QRURs also include Per Capita Costs for Beneficiaries with Specific Conditions: diabetes, coronary artery disease, chronic obstructive pulmonary disease, or heart failure. The four conditions are not mutually exclusive; beneficiaries with more than one of these conditions are counted in each relevant condition category. These measures include all costs of care, not just those associated with treating the condition.

Per episode costs for the MSPB measure include payments for all Medicare Part A and Part B claims with a start date falling between 3 days prior to an inpatient admission to a short-term acute care hospital (index admission) through 30 days post-hospital discharge.

### **3. Which quality data and cost data are included in the QRURs for TINs participating in the Shared Savings Program, Pioneer ACO Model, or CPC initiative?**

For TINs that participated in a Shared Savings Program ACO in 2015, the Annual QRURs contain ACO-level performance on the 30-day All-Cause Hospital Readmission measure and measures submitted by the ACO through the GPRO Web Interface. Hospital admissions for Acute and Chronic ACSC Composite measures and CAHPS for PQRS survey measures are not included in the Annual QRURs for TINs that participated in a Shared Savings Program ACO in 2015. For TINs that participated in more than one Shared Savings Program ACO in 2015, the TIN's Annual QRUR contains quality data for the ACO that had the highest numerical Quality Composite Score. For Shared Savings Program ACO TINs, the Mid-Year QRURs contain only TIN-level performance on the 30-day All-Cause Hospital Readmission measure.

For TINs with at least one eligible professional that participated in the Pioneer ACO Model or the CPC initiative in 2015, the 2015 Annual QRURs contain information on any quality measures reported in 2015 for eligible professionals in the TIN who reported through PQRS outside the Pioneer ACO Model or the CPC initiative and who met the criteria to avoid the 2017 PQRS payment adjustment and available CAHPS for PQRS survey measures. The 30-day All-Cause Hospital Readmission measure and hospital admissions for Acute and Chronic ACSC Composite measures are included in the 2015 Mid-Year and Annual QRURs for TINs that participated in the Pioneer ACO Model or the CPC initiative in 2015.

The 2015 Mid-Year and Annual QRURs report the same TIN-level cost measures for TINs that participated in a Shared Savings Program ACO, the Pioneer ACO Model, or the CPC initiative in 2015 that are displayed for other TINs.

#### **4. How are eligible cases determined for the cost and quality measures found in the QRURs?**

For the claims-based measures included in the 2015 Annual QRUR, the number of eligible cases will differ depending on the measure. For five of the six cost measures (excluding MSPB), the number of eligible cases is a subset of a TIN's attributed beneficiaries. Specifically, the number of eligible cases for the Per Capita Costs for All Attributed Beneficiaries measure is the number of attributed beneficiaries who are included in the measure (beneficiaries are excluded when they meet certain exclusion criteria, such as part-year enrollment that isn't related to new enrollment or death). The number of eligible cases for the Per Capita Costs for Beneficiaries with Specific Conditions measures is equal to the number of attributed beneficiaries who have each specific condition and who do not meet the measure exclusion criteria. By contrast, the number of eligible cases for the MSPB measure is the number of MSPB episodes of care that were attributed to a TIN. For more information on how episodes of care are attributed to a TIN for the MSPB measure, please refer to FAQ number 13 in Section B of this document.

For the three claims-based quality outcome measures, the number of eligible cases for the Acute Conditions Composite and the Chronic Conditions Composite measures are based on a TIN's attributed beneficiaries. The Acute Conditions Composite includes all beneficiaries that did not meet the measure exclusion criteria. The Chronic Conditions Composite includes all attributed beneficiaries with one or more of the chronic conditions (diabetes, COPD or asthma, or heart failure) who do not meet the measure exclusion criteria. By contrast, the number of eligible cases for the 30-day All-Cause Hospital Readmission measure is the number of qualifying hospitalizations ("index hospitalizations") among a TIN's attributed beneficiaries. For more information on measure-specific exclusion criteria, refer to the Measure Information Form for each measure available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html>.

Finally, the number of eligible cases for each PQRS measure is based on the total number of cases the TIN submits to the PQRS that did not meet the exclusion criteria for the measure.

For more information on PQRS measure-specific exclusion criteria, refer to the measure specifications manual available at the following URL, which contains information on claims, registry, Web Interface, and measures group reporting: [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/2015\\_Physician\\_Quality\\_Reporting\\_System.html](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/2015_Physician_Quality_Reporting_System.html).

For information on EHR reporting, please visit the following URL: [https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2014\\_eCOM\\_EligibleProfessional\\_July2014.zip](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2014_eCOM_EligibleProfessional_July2014.zip).



### 5. If a TIN and individual eligible professionals in a TIN reported PQRS data under multiple mechanisms, how does CMS calculate a TIN's PQRS measure performance rates?

The data CMS uses to calculate PQRS performance rates depends on whether the TIN registered for GPRO, satisfactorily reported under elected or other GPRO mechanism, and reported individual eligible professional (IEP) data. Table D below indicates which data CMS uses in Value Modifier calculations under various scenarios.

**Table D. Hierarchy of PQRS Data Used in the 2017 Value Modifier**

Did TIN register for GPRO?	Did TIN satisfactorily report under elected GPRO mechanism?	Did TIN satisfactorily report via another GPRO mechanism?	Did TIN report IEP PQRS data?	Data used in the Value Modifier
Yes	Yes	N/A	Yes	GPRO data of the elected mechanism
Yes	Yes	N/A	No	GPRO data of the elected mechanism
Yes	No	Yes	Yes	GPRO data that is reported satisfactorily ( <u>not</u> GPRO mechanism elected by TIN)
Yes	No	Yes	No	GPRO data that is reported satisfactorily ( <u>not</u> GPRO mechanism elected by TIN)
Yes	No	No	Yes	IEP data (if Category 1)
Yes	No	No	No	N/A
No	N/A	Yes	Yes	IEP data (if Category 1)
No	N/A	No	Yes	IEP data (if Category 1)
No	N/A	Yes	No	GPRO data that is reported satisfactorily
No	N/A	No	No	N/A

Note: TINs are classified as Category 1 if the TIN avoided the PQRS payment adjustment as a group or at least 50 percent of the TIN's eligible professionals avoided the PQRS payment adjustment as individuals.

If a TIN did not register as a GPRO and did not satisfactorily report under a GPRO mechanism, CMS will calculate the TIN's PQRS measure performance rates based on individual eligible professional (IEP) reporting (assuming at least 50 percent of the eligible professionals in

that TIN avoided the PQRS payment adjustment as individuals). If a TIN registered as a GPRO and satisfactorily reported under a GPRO mechanism, CMS will calculate the TIN's PQRS measure performance rates based on GPRO reporting, whether or not eligible professionals in the TIN reported PQRS data as individuals. Please refer to FAQ number 6 in Section C below for information on which PQRS measures are used in Quality Composite Score calculations.

### **6. Does CMS use all PQRS measures reported by a TIN in Quality Composite Score calculations or only the best measures?**

The Value Modifier program does not make a determination as to which measures are “best” for the purpose of determining whether to include them in the quality composite. Please refer to FAQ number 5 in Section C above for an explanation of which PQRS data is used for each TIN.

For a complete list of PQRS measures, listed by quality domain, used to calculate the 2017 Value Modifier, please see the document entitled, “Detailed Methodology for the 2017 Value Modifier and the 2015 Quality and Resource Use Report,” available at the following URL: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Detailed-Methodology-for-the-2017-Value-Modifier-and-2015-Quality-and-Resource-Use-Report-.pdf>.

### **7. How is a TIN's Cost Composite Score calculated?**

The six cost measures are organized into two cost domains: (1) Per Capita Costs for All Beneficiaries and (2) Per Capita Costs for Beneficiaries with Specific Conditions. A score for each domain is calculated as the equally-weighted average of measures in the domain that had the required minimum number of eligible cases. Performance is then summarized across those domains for which scores could be calculated. This summary score is standardized relative to the mean of summary scores within the peer group, to create a TIN's final Cost Composite Score. Therefore, a TIN's Cost Composite Score may be higher or lower than the average of the TIN's cost domain scores, depending on the distribution of scores within the peer group.

CMS uses the following steps to calculate a Cost Composite Score for each TIN:

- 1. Standardize performance scores for each of the six individual cost measures** by subtracting the benchmark for the measure from the TIN's per capita or per episode costs and dividing by the case-weighted peer group standard deviation of the measure.
- 2. Calculate the two cost domain scores** as the simple, unweighted average of standardized scores for every measure within each domain for which the TIN has the minimum number of eligible cases (at least 125 eligible episodes for the MSPB measure and at least 20 eligible cases for other cost measures).

- 3. Calculate a simple average of cost domain scores.**
- 4. Calculate the Cost Composite Score** by standardizing the average of cost domain scores. To standardize the average of the cost domains scores, subtract the peer group mean from each TIN's average domain score and divide the difference by the peer group standard deviation. For TINs subject to the Value Modifier, the peer group for the Cost Composite includes all TINs subject to the 2017 Value Modifier for which a Cost Composite Score could be calculated, with the exception of TINs that participated in the Shared Savings Program in 2015. For all other TINs, the peer group for the Cost Composite includes all TINs for which a Cost Composite Score could be calculated, with the exception of TINs that participated in the Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care initiative in 2015.

For additional information, please see the document entitled, "Computation of the 2017 Value Modifier," available at the following URL: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2017-VM-factsheet.pdf>.

### 8. How is a TIN's Quality Composite Score calculated?

All quality measures are classified into six quality domains, aligned with the six priorities outlined in the National Quality Strategy: (1) Effective Clinical Care, (2) Person and Caregiver-Centered Experience and Outcomes, (3) Community/Population Health, (4) Patient Safety, (5) Communication and Care Coordination, and (6) Efficiency and Cost Reduction. A score for each quality domain is calculated as the equally-weighted average of scores within the domain, for all measures that have the required minimum number of eligible cases. Performance is then summarized across those domains for which scores could be calculated. This summary score is standardized relative to the mean of summary scores within the peer group to create a TIN's final Quality Composite Score. Therefore, a TIN's Quality Composite Score may be higher or lower than the average of the TIN's quality domain scores, depending on the distribution of scores within the peer group.

Specifically, CMS uses the following steps to calculate a Quality Composite Score for each TIN:

- 1. Standardize performance scores for each individual quality measure** by subtracting the benchmark for the measure from the TIN's performance rate and dividing by the case-weighted peer group standard deviation of the measure.
- 2. Calculate the quality domain scores** as the simple average of standardized scores for every measure within each domain for which the TIN has the minimum number of eligible cases. (For all quality measures except the 30-day All-Cause Hospital Readmission measure, the minimum number of eligible cases is 20. For the 30-day All-Cause Hospital Readmission measure, the minimum number of eligible cases is 200 for non-Shared Savings Program

ACO TINs with 10 or more eligible professionals and 1 for Shared Savings Program ACO TINs. The 30-day All-Cause Hospital Readmission measure is not included in the domain scores for non-Shared Savings Program ACO TINs with fewer than 10 eligible professionals.

- 3. Calculate a simple average of quality domain scores.**
- 4. Calculate the Quality Composite Score** by standardizing the average of quality domain scores. To standardize the average of the quality domain scores, subtract the peer group mean from each TIN's average domain score and divide the difference by the peer group standard deviation. For TINs subject to the Value Modifier, the peer group for the Quality Composite includes all TINs subject to the 2017 Value Modifier for which a Quality Composite Score could be calculated. For all other TINs, the peer group for the Quality Composite includes all TINs for which a Quality Composite Score could be calculated, with the exception of TINs that participated in the Pioneer ACO Model, or the Comprehensive Primary Care initiative in 2015.

For additional information, please see the document entitled, "Computation of the 2017 Value Modifier," available at the following URL: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2017-VM-factsheet.pdf>.

### **9. How will the transition to ICD-10 affect the calculation of quality and cost measures in the 2015 Annual QRURs and the 2017 Value Modifier?**

Effective October 1, 2015, the United States healthcare system transitioned from the International Classification of Diseases, ninth revision (ICD-9) codes to the tenth revision (ICD-10) codes. Therefore providers submitting Medicare FFS claims were required to use ICD-10 codes starting October 1, 2015 for all services. Because this transition occurred during the period of performance for several measures reported in the 2015 Annual QRURs and is used in the 2017 Value Modifier, CMS will use both ICD-9 and ICD-10 codes to calculate nine quality and cost measures that are calculated based on CMS administrative claims for the 2015 QRURs and the 2017 Value Modifier.<sup>5</sup>

- Per Capita Costs for All Attributed Beneficiaries
- Four (4) Per Capita Costs For Beneficiaries with Specific Conditions
- Medicare Spending Per Beneficiary (MSPB)
- Acute and Chronic Ambulatory Care-Sensitive Conditions (ACSCs)

<sup>5</sup> PQRS measures that use claims data could also be affected by the ICD-10 transition.

- 30-day All-Cause Hospital Readmission

CMS will use ICD-9 codes to calculate measures based on claims from January 1 through September 30, 2015, and will use ICD-10 codes to calculate measures based on claims from October 1 through December 31, 2015. Specific ICD-10 codes used in each measure can be found in the Measure Information Forms available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html>.

### **10. Why are hospital-based costs included in cost measures for TINs?**

CMS seeks to align incentives and encourage care coordination across settings, as requested by our stakeholders. This is based on the assumption that the TIN providing the plurality of services to beneficiaries over the course of the performance period or during a hospital episode of care is well positioned to influence the overall care of the beneficiaries attributed to the TIN. For this reason, costs for all Medicare Part A and Part B services during the performance period for each beneficiary attributed to the TIN are included in the calculation of the cost measures.

### **11. If a TIN is affiliated with a hospital, but some beneficiaries attributed to the TIN were admitted to an unaffiliated hospital, are those unaffiliated hospital costs included in the calculation of the TIN's costs?**

Yes. All Medicare Part A and Part B claims paid for Medicare beneficiaries attributed to a TIN are included in that TIN's costs. For example, the TIN that a beneficiary is attributed to is responsible for all of the beneficiary's hospital costs regardless of whether the hospital is affiliated with the TIN. Additionally, if an eligible professional, outside of the TIN, treats a beneficiary and admits that beneficiary to a hospital affiliated with the TIN, then those cost are also assigned to the TIN to which the beneficiary is attributed.

### **12. Could "split billing" affect how costs are distributed among various types of services?**

Yes. "Split billing" or "provider-based billing" could affect reported categories of service in the QRUR, as well as reported cost measures. There are several reasons why two separate bills (that is, split billing) might be generated for a single service. One common instance is when two bills are generated separately for the professional and technical components of a service provided by a physician in a hospital facility. The professional component of the service might include physician consultation or physician interpretation of an X-ray, CT scan, MRI, or laboratory test done in the hospital. Professional component payments are made to the physician or group of physicians. The technical component of the service might include laboratory tests, X-rays, or any other non-professional aspect of the service. Technical component payments are made to the



hospital. The site-of-service coding on Medicare claims determines how costs with split bills were categorized. Medicare payment accounts for higher overhead costs at hospitals than at freestanding sites, so the site-of-service coding also determines how those costs were standardized.

### **13. How did CMS account for differences in Medicare payment rates for medical services in calculating cost measures (payment standardization)?**

Before calculating any cost measures for the Mid-Year and Annual QRURs, CMS standardized the unit costs (payments) for the Medicare claims incurred during the performance period. This process equalizes the Medicare payments associated with a specific service, so that a given service is priced at the same level across all TINs in the same type of health care setting, regardless of geographic location or differences in Medicare payment rates (such as from payments to hospitals for graduate medical education, for indirect medical education, and for serving a disproportionate number of poor and uninsured beneficiaries).

Medicare payments for the same services can vary depending on local input prices (such as wage index and geographic practice costs) and on payment rates for different classes of TINs in a given category. Without payment standardization, a TIN with higher Medicare payments could appear to have higher costs than other TINs in the peer group when, in fact, differences in geographic location or facility-specific payments (rather than resource use) might be responsible. More information on payment standardization is available at:

<http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772057350>.<sup>6</sup>

### **14. How did CMS account for differences in beneficiaries' medical histories (risk adjustment) when calculating quality or cost measures?**

Risk adjustment accounts for differences in quality or cost measures caused by physiologic differences among beneficiaries (such as age or complex disease histories) that could be expected to make their outcomes better or worse than average or their costs higher or lower than average, regardless of the quality and efficiency of their care. For the peer group comparisons reported in the QRURs, a TIN's performance on all cost and quality outcome measures calculated using administrative claims have been risk-adjusted based on the mix of attributed beneficiaries to whom each measure applies. However, risk adjustment does not apply to all measures used to calculate the Value Modifier. Because beneficiary populations and risk-adjustment models vary with different types of cost and outcome measures, moreover, the effects

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<sup>6</sup> This document refers to this process as "price standardization" rather than "payment standardization," but the two terms are equivalent.

of risk adjustment on a TIN's performance may not be consistent across different measure categories.

- For the **Per Capita Costs for All Attributed Beneficiaries** measure reported in the 2015 QRURs, and for the four cost measures included in Per Capita Costs for Beneficiaries with Specific Conditions, CMS used the CMS-HCC risk-adjustment model, which predicts beneficiaries' costs for the coming year, based on diagnoses from Medicare claims for the beneficiary from the previous year. The CMS-HCC model assigns codes from the International Statistical Classification of Diseases and Related Health Problems–9th Revision to 79 clinical conditions. For each beneficiary enrolled in Medicare FFS the previous year, the CMS-HCC model generates a risk score based on the presence of these 79 conditions and on the beneficiary's age, sex, original reason for Medicare entitlement (age or disability), and Medicaid entitlement. Risk adjustment of 2015 costs also takes into account the presence of end-stage renal disease in the prior year. For more details, please see the document entitled, "2015 Measure Information about the Per Capita Costs for All Attributed Beneficiaries Measure, Calculated for the 2017 Value-Based Payment Modifier Program," available at the following URL: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-TPCC-MIF.pdf>.
- For the **Medicare Spending per Beneficiary (MSPB)** measure, the condition codes used in the CMS-HCC model are also used, but they are gathered from claims submitted in the 90 days preceding the start date of a MSPB episode. This method captures those conditions most relevant to the shorter episodes surrounding inpatient hospitalizations that are used in this measure. The risk-adjustment methodology for the MSPB measure also includes beneficiary age and institutional status, but it does not control for sex or Medicaid entitlement.
- The **Hospital Admissions for Acute and Chronic Ambulatory Care-Sensitive Condition (ACSC) Composite** measures that Medicare calculated for the 2015 QRURs also are risk adjusted to account for differences in the age and sex of beneficiaries attributed to different TINs. For measures in the Acute Conditions Composite (bacterial pneumonia, urinary tract infection, and dehydration), the denominator includes all Medicare beneficiaries attributed to the TIN. However, the denominator for measures in the Chronic Conditions Composite (diabetes, chronic obstructive pulmonary disease, and heart failure) is restricted to beneficiaries diagnosed with the specific condition. For more details, please see the document entitled, "2015 Measure Information about the Hospital Admissions for Acute and Chronic Ambulatory Care–Sensitive Condition (ACSC) Composite Measures, Calculated For the 2017 Value-Based Payment Modifier Program," available at the following URL: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-ACSC-MIF.pdf>.
- The **30-day All-Cause Hospital Readmission** measure that CMS calculates from Medicare claims is risk adjusted to account for differences in beneficiary case mix based on beneficiary age and clinical characteristics. Moreover, service mix is accounted for by assigning the index admission to one of five mutually exclusive specialty cohort groups consisting of

related conditions or procedures—groupings that presume that admissions treated by similar teams of clinicians are likely to have similar risks of readmission. The specialty cohort-specific readmissions are then combined in constructing the 30-day All-Cause Hospital Readmission measure. For more information, please see the document entitled, “2015 Measure Information about the 30-Day All-Cause Hospital Readmission Measure, Calculated for the Value-Based Payment Modifier Program,” available at the following URL:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-ACR-MIF.pdf>.

- For most of the quality measures reported through **PQRS**, risk adjustment does not apply. Beneficiaries identified by the TIN or eligible professional as individuals for whom the recommended treatment would not be appropriate are excluded from the denominator (according to measure specifications). These quality measures are therefore not risk adjusted.

### **15. How can I estimate my TIN’s costs prior to CMS accounting for differences in beneficiaries’ medical histories (risk adjustment)?**

A TIN can use the information found in the accompanying tables of the 2015 Annual QRUR to determine each beneficiary’s pre-risk-adjusted spending. For example, refer to Column N in Table 3B of the 2015 Annual QRUR. The values in this column show the payment-standardized costs billed to a TIN for each of the TIN’s attributed beneficiaries. Payment-standardized amounts account for variation in prices in different geographic locations across the country, but are neither risk nor specialty adjusted. The indicator in column N will specify whether a beneficiary’s costs were included in the per capita costs measures. To determine a TIN’s non-risk-adjusted (and non-specialty-adjusted) per capita costs, take the average of these costs among beneficiaries included in the measure. TINs can follow this same process for beneficiaries with specific conditions, using Columns H, I, J, and K in Table 3B of the 2015 Annual QRUR to identify which beneficiaries are in each chronic conditions subgroup.

For more information on risk adjustment, please see the document entitled “Risk Adjustment,” available at the following URL: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-RiskAdj-FactSheet.pdf>.

### **16. What is the CMS Hierarchical Condition Category (CMS-HCC) score?**

A CMS Hierarchical Condition Categories (CMS-HCC) model generates a risk score for each beneficiary. CMS uses these CMS-HCC risk scores in the risk-adjustment methodology for Medicare Advantage. This score summarizes each beneficiary’s expected cost of care relative to other beneficiaries. Separate CMS-HCC models exist for new enrollees and continuing enrollees. The new enrollee CMS-HCC model accounts for each beneficiary’s age, sex, and disability status and is used when a beneficiary has less than twelve months of medical history. The

continuing enrollee CMS-HCC model accounts for each beneficiary's age, sex, original reason for Medicare enrollment (age or disability), Medicaid enrollment, and clinical conditions as measured by CMS-HCCs.

### 17. Does CMS account for differences in specialty mix when making peer group comparisons for cost measures?

Yes. All cost measures presented in the Mid-Year and Annual QRURs, and contributing to the 2017 Value Modifier (based on performance in 2015), are adjusted to reflect the mix of physician and non-physician specialties within a TIN. The specialty-adjustment methodology, applied separately for each cost measure, is as follows:

1. **Compute “national, specialty-specific expected costs” for each specialty.** This component of the measure is computed as the weighted average of all TINs' observed payment-standardized and risk-adjusted costs, where the weight for each TIN is the number of attributed beneficiaries multiplied by the relevant specialty's share of the TIN's eligible professionals, multiplied by the number of eligible professionals of that specialty in the TIN.
2. **Compute the “specialty-adjusted expected cost” for each TIN.** This component of the measure is computed as the weighted average of the national, specialty-specific expected cost for each specialty across all TINs, where the weights are each TIN's proportion of the specialty-specific Part B payments.
3. **Compute the “specialty-adjusted cost” for each TIN.** The TIN's payment-standardized and risk-adjusted cost is divided by the TIN's specialty-adjusted expected cost, and this ratio is multiplied by the national average cost.

For more information about specialty adjustment, please see the document entitled, “Specialty Adjustment,” available at the following URL: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-SpecAdj-FactSheet.pdf>.

### 18. How did CMS define benchmarks for the quality and cost measures?

Each TIN's performance on quality and cost measures is compared with a case-weighted national mean (benchmark) performance among all TINs in the measure's peer group. Quality benchmarks for the 2015 Mid-Year and Annual QRURs are based on performance in the prior year (2014), and cost benchmarks are based on performance during July 1, 2014 through June 30, 2015 for the Mid-Year QRURs and 2015 for the Annual QRURs. For some PQRS quality measures introduced in 2015, there are no comparable prior-year benchmarks. In these cases, CMS did not calculate the benchmark for these measures and does not display the measures in the 2015 Annual QRURs. In addition, if there is no benchmark, the measure is not eligible for inclusion in the Quality Composite Score for the Value Modifier. The prior-year benchmarks for quality measures included in the 2017 Value Modifier are found in the document entitled



“Benchmarks For Measures Included in the Performance Year 2015 Quality and Resource Use Reports,” available at the following URL: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/PY2015-Prior-Year-Benchmarks.pdf>.

For the MSPB cost measure, the peer group is defined as all TINs nationwide that had at least 125 eligible episodes. For the 30-day All-Cause Hospital Readmission measure, the peer group is defined as all Shared Savings Program ACOs with at least one eligible case for the measure and all non-Shared Savings Program ACO TINs nationwide with 10 or more eligible professionals who have at least 200 eligible cases for the measure. For other cost and quality measures, the peer group is defined as all TINs nationwide that had at least 20 eligible cases for the measure. For PQRS quality measures, only those TINs and individual eligible professionals who met the criteria to avoid the 2017 PQRS payment adjustment are included in peer groups.

For TINs subject to the Value Modifier, the peer group for the Quality Composite includes all TINs subject to the 2017 Value Modifier for which a Quality Composite Score could be calculated. For all other TINs, the peer group for the Quality Composite includes all TINs for which a Quality Composite Score could be calculated, with the exception of TINs that participated in the Pioneer ACO Model, or the Comprehensive Primary Care initiative in 2015.

For TINs subject to the Value Modifier, the peer group for the Cost Composite includes all TINs subject to the 2017 Value Modifier for which a Cost Composite Score could be calculated, with the exception of TINs that participated in the Shared Savings Program in 2015. For all other TINs, the peer group for the Cost Composite includes all TINs for which a Cost Composite Score could be calculated, with the exception of TINs that participated in the Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care initiative in 2015.

### **19. The list of hospitals admitting my TIN’s attributed beneficiaries does not appear to be complete. How did CMS identify the hospitals that account for my Medicare beneficiaries’ inpatient stays?**

To help TINs identify the hospitals most associated with their attributed beneficiaries’ inpatient hospital costs, both Exhibit 6 of the Mid-Year QRURs and Table 2B of the Annual QRURs list the hospitals that accounted for at least 5 percent of all beneficiaries’ stays during the performance period. CMS used a hierarchical methodology to identify the name and location of the hospital associated with each provider number on Medicare Part A claims. First, CMS used the Provider of Services file (<http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/NonIdentifiableDataFiles/ProviderofServicesFile.html>), which is updated quarterly using data collected through CMS regional offices. If the provider number, name, and location were found in the Provider of Services file, CMS displayed this name and location in the QRUR. If the name or location was not in the file, CMS consulted PECOS and displayed the name and location identified there. If the full name or location of the hospital was not found in either



source, the QRUR exhibit displays “NAME NOT FOUND” in the hospital name column and “CITY NOT FOUND” and “STATE NOT FOUND” in the location columns.

### **20. How can a TIN improve its performance based on the information provided in the 2015 QRURs?**

To discern how to improve performance, a TIN must carefully examine the unique characteristics of the expenditures and utilization of its attributed patient population. This includes looking for opportunities to improve care coordination between the acute and post-acute setting, reducing unnecessary and/or low-value care, and ensuring the highest level of quality care throughout the care continuum.

The information in the QRURs can help TINs identify areas where costs are high relative to their peers. For example, Exhibit 5 in the 2015 Annual QRURs (Exhibit 8 in the 2015 Mid-Year QRURs) displays a TIN’s performance on the cost measures (“Per Capita or Per Episode Costs”), and the average costs of all TINs in the peer group (“Benchmark”). For the Per Capita Costs for All Attributed Beneficiaries and Per Capita Costs for Beneficiaries with Specific Conditions measures, Tables 3A and 4A-4D in the 2015 Annual QRURs (Exhibit 9 in the 2015 Mid-Year QRURs) can be used to identify potential areas for performance improvement based on the costs of services a TIN’s attributed beneficiaries received within the TIN and outside of the TIN relative to that of its peers by category of service. For example, total per capita costs for inpatient care or emergency services that are higher than a TIN’s peers, could suggest that additional care coordination or chronic illness management efforts may prove valuable in improving a TIN’s performance.

Likewise, the information displayed in Table 5C of the 2015 Annual QRURs (Exhibit 10 in the 2015 Mid-Year QRURs) may help a TIN identify ways to improve performance for the MSPB measure, as this exhibit can help identify potential areas to improve the efficiency of the care that a TIN provides based on how a TIN’s costs compare to that of its peers in each category of service.

For data at the beneficiary level, Table 3B in the 2015 Annual QRURs (Table 2B in the 2015 Mid-Year QRURs) provides total, payment standardized Medicare FFS costs during the period July 1, 2014 through June 30, 2015 for each of a TIN’s beneficiaries and the breakdown of beneficiaries costs by service category. These costs are not risk adjusted, so it will not sum by service category to the costs displayed in Tables 3A and 4A-4D of the 2015 Annual QRURs (Exhibit 9 in the 2015 Mid-Year QRURs). However, TINs can use the CMS-HCC percentile-ranking in Table 2A for both the Mid-Year and Annual QRURs to identify beneficiaries who are more clinically complex and match them with the service category costs in Table 3B in the Annual QRURs (Table 2B in the Mid-Year QRURs). Higher scores mean higher levels of clinical complexity; after risk-adjustment, these beneficiaries’ costs are more likely to be adjusted downwards. TINs can use this information to identify for improving care coordination

or treatment practices for these beneficiaries to improve performance and outcomes. For more information, please see the document entitled, “How To Understand Your 2015 Annual Quality and Resource Use Report,” available at the following URL:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-UnderstandingYourAQRUR.pdf>.

### **21. How can the information in the 2015 Annual QRURs help groups and solo practitioners deliver higher quality care and lower costs?**

The information in the QRURs can be used by groups and solo practitioners to improve quality of care, streamline resource use, and identify care coordination opportunities for a TIN’s beneficiaries.

Table 2A in the 2015 Annual QRURs shows the number of Medicare FFS beneficiaries who are attributed to a TIN based on primary care services provided, as well as additional details about the Medicare beneficiaries attributed to a TIN for the five per capita cost and three claims-based quality outcome measures. The table is divided into sections that describe beneficiary characteristics, specific Medicare claims data, the eligible professionals who 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. Groups and solo practitioners 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. Table 5B in the Annual QRURs provides analogous information for the MSPB measure.

Table 2B in the 2015 Annual QRUR identifies the hospitals that provided at least 5 percent of a TIN’s attributed beneficiaries’ inpatient stays during 2015. It provides the hospital name, CMS Certification Number, and location of the hospital. Groups and solo practitioners can use the data presented to learn which hospitals most frequently admitted a TIN’s attributed beneficiaries and this information can help groups and solo practitioners target care coordination efforts most appropriately. Table 5A of the Annual QRURs provides analogous information for the MSPB measure.

For more information on how solo practitioners and groups can use the Annual QRURs and accompanying detailed tables to understand their performance and to improve quality of care, please see the document entitled, “How To Understand Your 2015 Annual Quality and Resource Use Report,” available at the following URL: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-UnderstandingYourAQRUR.pdf>.

### 22. How can my TIN improve its Cost and Quality Composite Scores?

CMS provides resources along with a TIN's QRUR to help the TIN determine how to decrease costs without decreasing beneficiaries' quality of care. Specifically, the tables included with a TIN's QRUR provide disaggregated data on beneficiaries attributed to the TIN and the care they received during the year. TINs can use these data to determine where greater efficiencies and quality improvements might be possible. For example, 2015 Annual QRUR Table 3 shows each attributed beneficiary's cost for the year, broken out by category of service. If a TIN notices that its beneficiaries have unexpectedly high post-acute care costs, then the TIN might consider reviewing its care transition practices or reaching out to other members of these beneficiaries' care team to see if there are opportunities for better coordination. In addition, 2015 Annual QRUR Table 2A shows the care that the given TIN and other TINs provided to beneficiaries attributed to the given TIN. To improve care coordination, TINs can use Table 2A to identify which attributed beneficiaries received a high percentage of services outside of the TIN and which eligible professionals outside of the TIN provided these services.

For more information on how TINs can use the data in the Annual QRUR and Tables to provide higher quality, more efficient care, please see the document entitled, "How To Understand Your 2015 Annual Quality and Resource Use Report," available at the following URL: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-UnderstandingYourAQRUR.pdf>.