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National Provider Call

Review of the 2015 Mid-Year Quality and Resource Use Reports

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Agenda and Learning Objectives

- Overview of the 2017 Value-Based Payment Modifier
- Overview of the 2015 Mid-Year QRUR
- Access the 2015 Mid-Year QRUR
- Information Contained in the 2015 Mid-Year QRUR
- Question and Answer Session

Acronyms

Overview of the 2017 Value-Based Payment Modifier (VM)

Policies for the 2017 VM

- 2015 is the performance year for application of the 2017 VM.
- Applies to all physicians in groups with 2+ eligible professionals (EPs) and physician solo practitioners, as identified by their Medicare Taxpayer Identification Number (TIN).
- Quality-tiering is mandatory.
  - Physicians in groups with 2 to 9 EPs and physician solo practitioners will be held harmless from downward adjustments.
  - Physicians in groups with 10+ EPs will be subject to upward, downward or neutral adjustments.
- An automatic downward adjustment will be applied for not meeting the criteria to avoid the 2017 PQRS payment adjustment as a group or as individuals.

Acronyms

2017 VM and 2017 PQRS

CY 2017 VM payment adjustment, for physicians in groups with 2+ EPs and physician solo practitioners

PQRS Reporters - 3 types – Category 1

1a. Group reporters: Report as a group via a PQRS GRPRO and meet the criteria to avoid the 2017 PQRS payment adjustment

OR

1b. Individual reporters in the group: at least 50% of EPs in the group report PQRS measures as individuals AND meet the criteria to avoid the 2017 PQRS payment adjustment

Solo practitioners: Report PQRS measures as individuals AND meet the criteria to avoid the 2017 PQRS payment adjustment

Mandatory Quality-Tiering Calculation

Physicians in groups of physicians with 2-9 EPs and physician solo practitioners

Upward or no VM adjustment based on quality–tiering (0.0% to +2.0x)

Physicians in groups of physicians with 10+ EPs

Upward, no, or downward VM adjustment based on quality–tiering (-4.0% to +4.0x)

Non-PQRS Reporters – Category 2

1. Groups: Do not avoid the 2017 PQRS payment adjustment as a group AND do not meet the 50% threshold option as individuals
2. Solo Practitioners: Do not avoid the 2017 PQRS payment adjustment as individuals

-2.0% (for physicians in groups of physicians with 2-9 EPS and physician solo practitioners)

-4.0% (for physicians in groups of physicians with 10+ EPs)
(Automatic VM downward adjustments)

Note: The VM payment adjustment is separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs.

Acronyms

Quality-Tiering Approach for 2017 VM: Physicians in Groups with 10+ EPs

- An automatic -4.0% VM downward adjustment will be applied for not meeting the criteria to avoid the 2017 PQRS payment adjustment.
- Under quality-tiering, the maximum upward adjustment is up to +4.0x ('x' represents the upward VM payment adjustment factor), and the maximum downward adjustment is -4.0%.

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+2.0x*	+4.0x*
Average Cost	-2.0%	+0.0%	+2.0x*
High Cost	-4.0%	-2.0%	+0.0%

** Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores*

Acronyms

Quality-Tiering Approach for 2017 VM: Physicians in Groups with 2-9 EPs & Physician Solo Practitioners

- An automatic -2.0% VM downward adjustment will be applied for not meeting the criteria to avoid the 2017 PQRS payment adjustment.
- Under quality-tiering, the maximum upward adjustment is up to +2.0x ('x' represents the upward VM payment adjustment factor) and held harmless from any downward adjustments for poor performance.

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0x*	+2.0x*
Average Cost	+0.0%	+0.0%	+1.0x*
High Cost	+0.0%	+0.0%	+0.0%

** Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores*

Acronyms

Quality Measures Used to Calculate the Quality Composite for the 2017 VM

- Groups with 2+ EPs: Measures reported through the PQRS Group Practice Reporting Option (GPRO) **OR** individual PQRS measures reported by at least 50% of the EPs in the group (50% threshold option)
  - ***Note:*** *Under the 50% threshold option, at least 50% of EPs in the group must report PQRS as individuals AND meet the criteria to avoid the 2017 PQRS payment adjustment.*
- Solo practitioners: Individual PQRS measures reported by the solo practitioner

Acronyms

Quality Measures Used to Calculate the Quality Composite for the 2017 VM (cont.)

- Three claims-based outcome measures: All-Cause Hospital Readmissions, Composite of Preventable Hospitalizations for Acute Conditions, and Composite of Preventable Hospitalizations for Chronic Conditions
  - ***Note:*** *All-cause Hospital Readmissions measure will not apply to groups with 2 to 9 EPs and solo practitioners.*
- CAHPS for PQRS survey measures (applicable only for groups that elect to use their 2015 CAHPS for PQRS survey results in the calculation of their 2017 VM)

Acronyms

Cost Measures Used to Calculate the Cost Composite for the 2017 VM

- Total per capita costs measure (Parts A & B)
- Total per capita costs for beneficiaries with 4 chronic conditions (Chronic Obstructive Pulmonary Disease, Heart Failure, Coronary Artery Disease, and Diabetes)
- Medicare Spending Per Beneficiary (MSPB) measure (3 days before and 30 days after an inpatient hospitalization)

Acronyms

2017 VM Policies for Participants of Certain Innovation Center Models

In 2017, the VM is waived for groups and solo practitioners, as identified by their TIN, if at least one EP who billed for PFS items and services under the TIN during 2015 participated in the:

- Pioneer ACO Model or
- Comprehensive Primary Care initiative in 2015.

Acronyms

2017 VM Policies for Shared Savings Program Participants

- TINs that participated in a Shared Savings Program ACO in 2015 will be subject to the 2017 VM based on the ACO's quality performance in 2015.
  - The VM will be applied at the participant TIN level based on the size and composition of the TIN (refer to slides 7 and 8).
  - ACO's quality performance is based on data submitted by the ACO via the GPRO Web Interface and the ACO's All-Cause Hospital Readmission measure for the 2015 performance period.
- If the ACO fails to successfully report on quality measures via the GPRO Web Interface in 2015, then the participant TINs under the ACO will be subject to an automatic downward adjustment under the 2017 VM.

Acronyms

2017 VM Policies for Shared Savings Program Participants (cont.)

- If the ACO successfully reports on quality measures via the GPRO Web Interface in 2015, then the 2017 VM for the participant TINs under the ACO will be calculated using the quality-tiering methodology.
- For TINs participating in a Shared Savings Program ACO in 2015, their VM in 2017 will be based on:
  - Cost composite = classified as “Average”
  - Quality composite = calculated based on quality data submitted by the ACO via the GPRO Web Interface and the ACO’s All-Cause Hospital Readmission measure for the 2015 performance period

Acronyms

Next Steps: What You Can Do

- Download your 2014 Annual Quality and Resource Use Report (QRUR) and 2015 Mid-Year QRUR at: https://portal.cms.gov
  - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html
- Watch for announcements about availability of the 2015 Annual QRUR (Fall 2016) to understand your TIN's 2015 quality and cost performance used to calculate the 2017 VM
- Download your TIN's 2015 Annual QRUR when it is available at https://portal.cms.gov
  - The same EIDM account can be used to access the Mid-Year QRUR and Annual QRUR.

Acronyms

Next Steps: What You Can Do (cont.)

- Decide whether and how to participate in the PQRS in 2016: Performance on these measures will be used to determine your TIN's 2018 VM
  - Group reporting - Register for the 2016 PQRS GPRO between **April 1, 2016 and June 30, 2016:** http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html
  - Individual reporting – No registration necessary
    - ***Note:*** *Under the 50% threshold option for the VM, at least 50% of EPs in the group must report PQRS as individuals AND meet the criteria to avoid the 2018 PQRS payment adjustment.*
- Choose a PQRS reporting mechanism and become familiar with the measures **AND** data submission timeframes: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html
- Review quality measure benchmarks under the VM; understand what is required for above average performance; and identify measures for distinguishing your performance: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

Acronyms

Overview of the 2015 Mid-Year Quality and Resource Use Report (QRUR)

What is the 2015 Mid-Year QRUR?

- Provides interim information to groups and solo practitioners (as identified by their Medicare TIN) about their performance on three quality outcome measures and six cost measures that CMS calculates directly from Medicare claims.
- Based on care provided from July 1, 2014 through June 30, 2015.
- Available for informational purposes only.
- Information will not affect your TIN's payments under the Medicare PFS.
- The following data are not included:
  - Information about the 2017 VM payment adjustment,
  - Quality and Cost Composite Scores for the 2017 VM, and
  - Quality data reported under the PQRS.
    - ***Note:*** All of this information will be included in the 2015 Annual QRUR (available Fall 2016)

Acronyms

Who Received a 2015 Mid-Year QRUR?

- All TINs (groups and solo practitioners) nationwide that had at least one eligible case during the performance period for at least one quality or cost measure included in the Mid-Year QRUR.
- TINs not meeting the above criterion received a one-page 2015 Mid-Year QRUR containing general information about the Mid-Year QRUR and the 2017 VM.

Acronyms

How to Access the 2015 Mid-Year QRUR

EIDM Introduction

- An Enterprise Identity Management (EIDM) account is required to access the PV-PQRS Registration System.

- If you want to know whether there is already someone who can access your TIN's QRUR → Contact the QualityNet Help Desk and provide the TIN and name of the TIN.

- You can sign up for a new EIDM account, modify an existing EIDM account to add the correct role, or reset an EIDM account password (every 60 days) by visiting the CMS portal at https://portal.cms.gov.

- Please note that if you already have an EIDM account, then you must **modify** your existing account to sign up for one of the group roles described above.

Acronyms

EIDM Roles for Groups

- Groups are identified in EIDM by their Medicare billing TIN and consist of two or more EPs (as identified by their National Provider Identifier (NPI) that bill under the TIN).

- One person from the group must first sign up for an EIDM account with the **Security Official** role.

  - If additional persons are needed to access the QRUR, they can request the **Security Official** role or the **Group Representative** role in EIDM.

- For example, a group wants to give access to its QRUR to a vendor, its ACO, or another third party. The third party may set up an EIDM account by submitting a request to the group's Security Official via the EIDM. The Security Official can approve the request and give the third party access to its report.

Acronyms

EIDM Roles for Groups (cont.)

- Security Official role allows the user to:
  1. Register a group to participate in the PQRS GPRO.
  2. Obtain the group's Mid-Year and Annual QRUR, Supplemental QRUR, and PQRS Feedback Report.
  3. Submit a VM informal review request on behalf of the group.
  4. Approve requests for the "Group Representative" role in EIDM.

Group Representative role allows the user to perform tasks 1, 2, and 3 listed above.

Acronyms

EIDM Roles for Solo Practitioners

- Solo practitioners are identified in EIDM by their Medicare billing TIN and consist of only 1 EP (as identified by a NPI) that bill under the TIN.

- One person must first sign up for an EIDM account with the **Individual Practitioner** role.

  - If additional persons are needed to access the QRUR, they can request the **Individual Practitioner** role or the **Individual Practitioner Representative** role in EIDM.

Acronyms

EIDM Roles for Solo Practitioners (cont.)

- Individual Practitioner role allows the user to:
  1. Obtain the group's Mid-Year and Annual QRUR, Supplemental QRUR, and PQRS Feedback Report.
  2. Submit a VM informal review request on behalf of the solo practitioner.
  3. Approve requests for the "Individual Practitioner Representative" role in EIDM.

Individual Practitioner Representative role allows the user to perform tasks 1 and 2 listed above.

Acronyms

Steps to Sign Up for an EIDM Account

Gather, Enter, & Verify

1. Gather all of the required information you need to create User ID and Password.
2. Request Role.
3. Complete Remote Identity Proofing Verification and Multi-Factor Authentication Process.
4. Associate to existing organization or Create new Organization.
5. Verify information and submit request.

Note: *When signing up for an EIDM account, use an email address that you monitor regularly. Email notifications will be sent with your User ID, temporary password, and information about password resets and recertification.*

Quick reference guides that provide step-by-step instructions for requesting each role in EIDM for a new or existing EIDM account are available on the How to Obtain a QRUR Website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html.

Acronyms

Required Information Needed for EIDM Account

User Information (all roles)

- *Your Information*: First Name, Last Name, E-mail Address, Social Security Number, Date of Birth, Home Address, City, State, Zip Code, and Primary Phone Number.
- *Business Contact Information*: Company Name, Address, City, State, Zip Code, Company Phone Number, and Office Phone Number.

Security Official

- *Organization Information*: Group's Medicare billing TIN, Legal Business Name, Rendering NPIs for **two different EPs** who bill under the TIN and their corresponding individual Provider Transaction Access Numbers (PTANS) (do not use the Group NPI or Group PTAN), Address and Phone Number.

Group Representative

- *Organization Information*: Group's Medicare billing TIN, or the Legal Business Name and the State, or the Legal Business Name and the Street Address.

Acronyms

Required Information Needed for EIDM Account (cont.)

Individual Practitioner

- *Professional Information*: Solo practitioner's First Name and Last Name, Medicare billing TIN, Legal Business Name, Rendering NPI and the corresponding individual PTAN, Address and Phone Number.

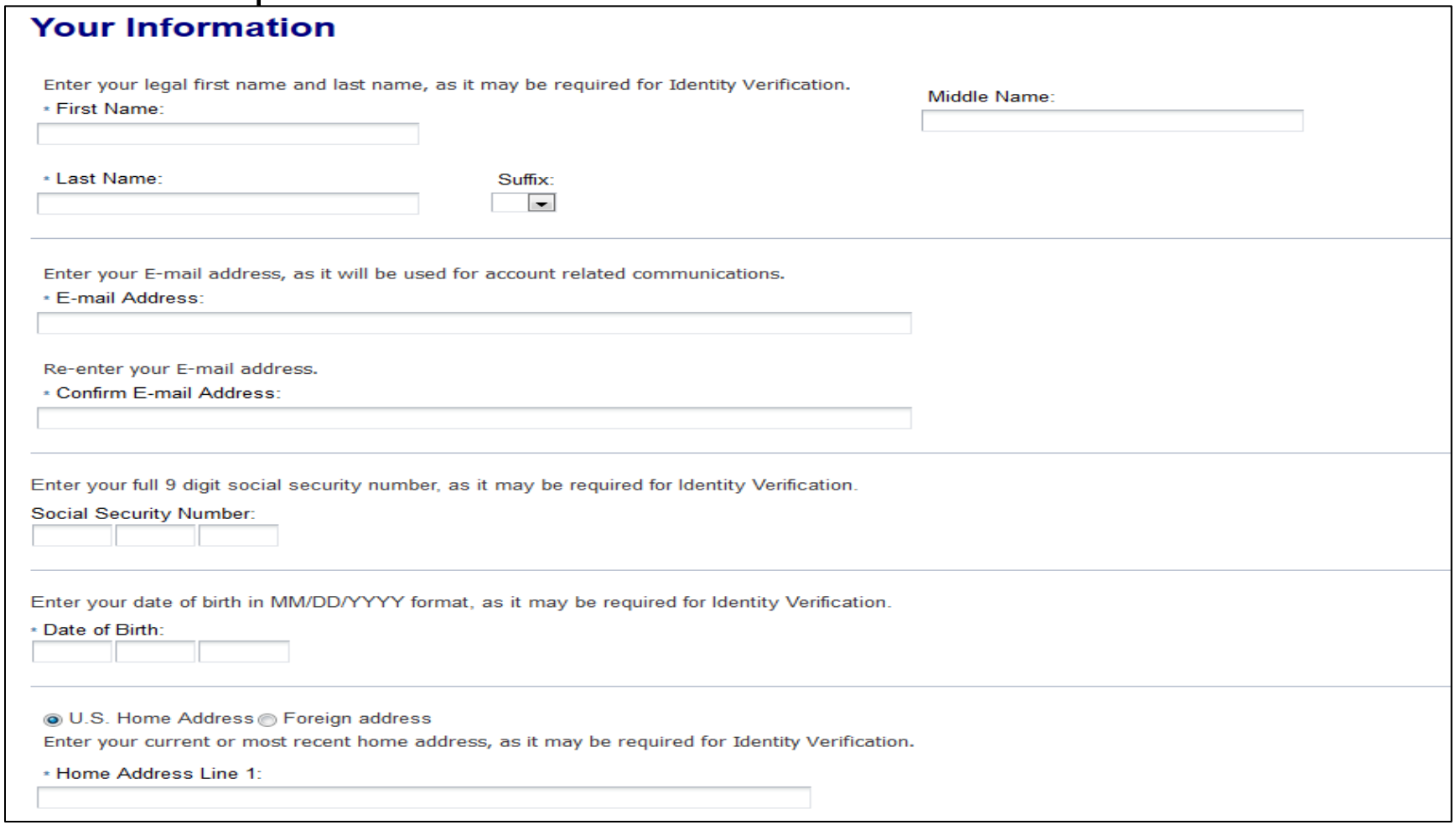
Individual Practitioner Representative

- *Professional Information*: Solo practitioner's Medicare billing TIN, or the Legal Business Name and the State, or the Legal Business Name and the Street Address.

Acronyms

Security Official: New Registration

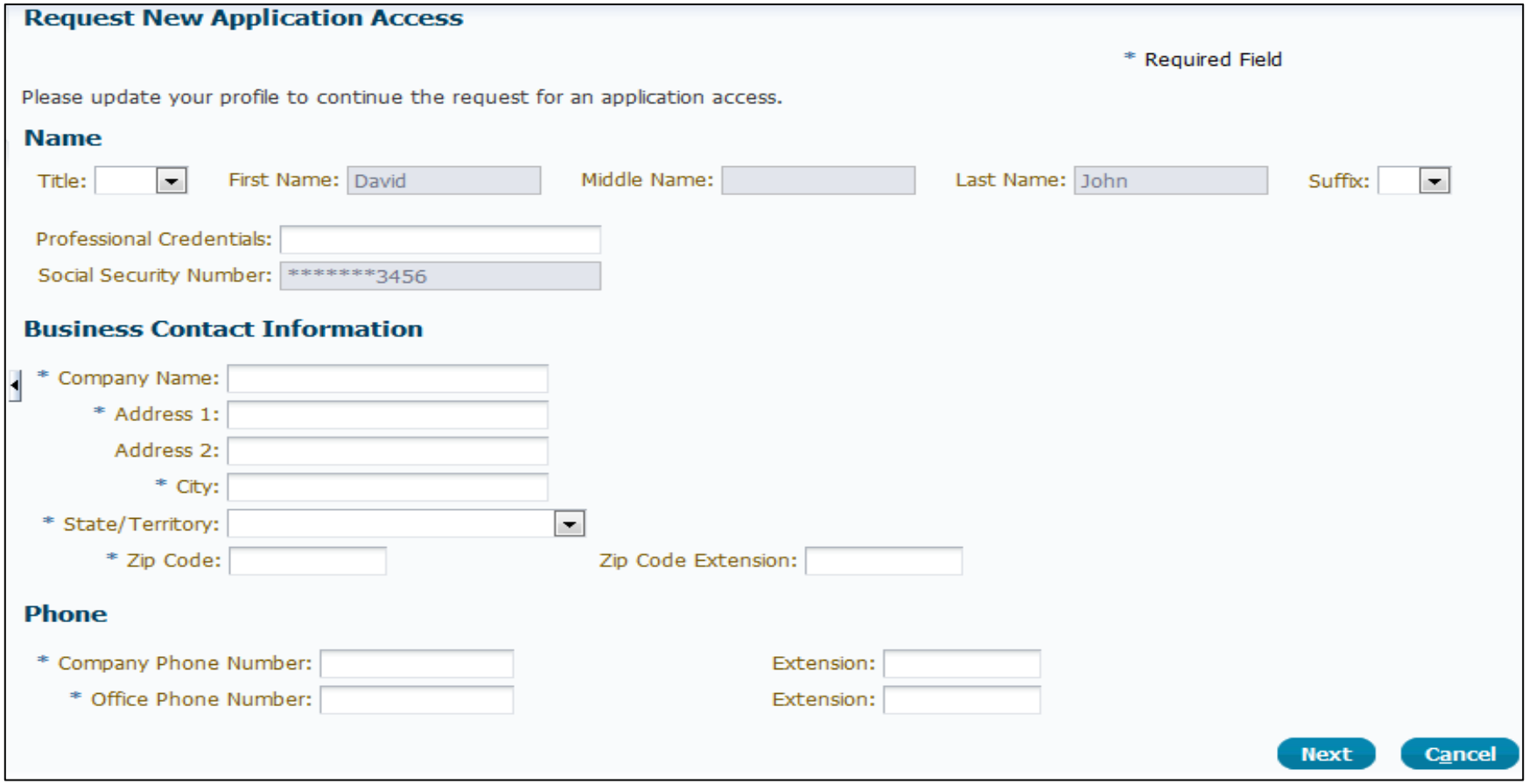
Enter the required information in the **Your Information** section.



Acronyms

Security Official: New Registration (cont.)

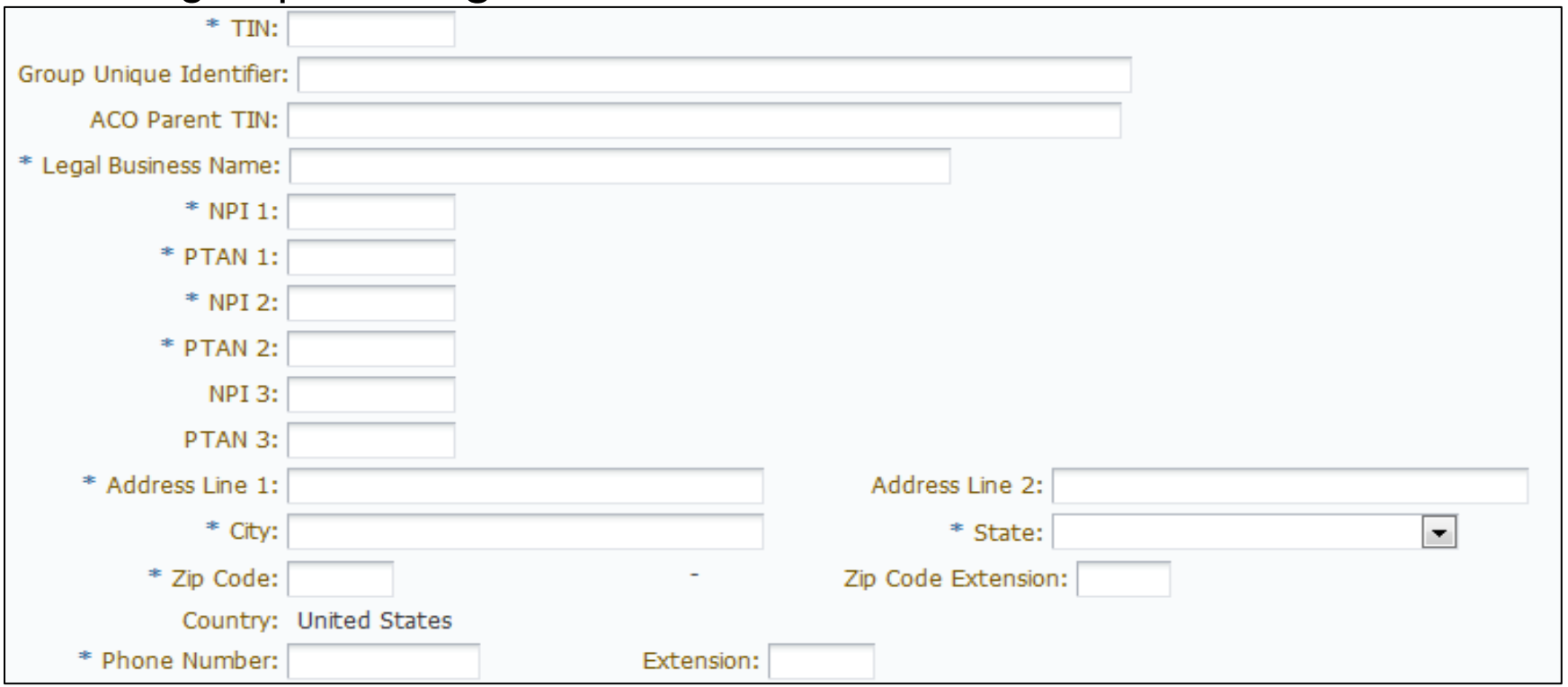
Enter the required information in the **Business Contact Information** section.



Acronyms

Security Official: New Registration (cont.)

Enter your group's Medicare billing **TIN**; enter **rendering NPIs** for **two different** EPs who bill under the TIN and their corresponding **individual PTANs** (*do not use the group NPI or group PTAN*); and enter the remaining required **Organization Information**.



Acronyms

How Can I Access My QRUR?

- Go to https://portal.cms.gov and select “Login to CMS Secure Portal”
- Accept the Terms and Conditions and enter your EIDM User ID and Password
- For step-by-step instructions, refer to the “Guide for Accessing the 2015 Mid-Year QRURs” on the “How to Obtain a QRUR” website

Acronyms

Information Contained in the 2015 Mid-Year QRUR

What Information is Contained in the 2015 Mid-Year QRUR?

Mid-Year QRUR Report Section	Exhibit	Use the Information in the Report to:
Cover Page	-	Understand why you received a 2015 Mid-Year QRUR
About the Data in this Report	-	Read a summary of the report methodology and retrieve links to supplementary tables and glossary items (if viewing the report dashboard)
Eligible Professionals Billing to Your Taxpayer Identification Number (TIN)	1	Understand how many eligible professionals billed under your TIN during the performance period and how they were identified
Attribution of Medicare Beneficiaries and Episodes to Your TIN	2-4	Understand how Medicare FFS beneficiaries and episodes of hospital care were attributed to your TIN
Performance on Quality	5	Review your performance on the three, CMS-calculated outcome measures
Hospitals Admitting Your Patients	6	Identify the hospitals that accounted for at least five percent of your attributed beneficiaries' inpatient stays during the performance period
	7	Identify hospitals that accounted for at least five percent of the inpatient episodes of care surrounding a hospital admission for the Medicare Spending per Beneficiary (MSPB) measure
Performance on Costs	8-10	Review your performance on costs across two performance categories, and understand the dollar difference between your attributed beneficiaries' payment-standardized and risk-adjusted per capita costs, by category, and the corresponding costs for your peer group for the Per Capita Costs for All Attributed Beneficiaries measure and the MSPB measure

Acronyms

What Additional Information Is Available in the Supporting Tables?

Supporting Table Name	Supporting Table Number	Use the Information in the Table to:
Physicians and Non-Physician Eligible Professionals in Your TIN, Selected Characteristics	1	Understand how many eligible professionals billed under your TIN during the performance period
Beneficiaries Attributed to Your TIN and the Care that You and Others Provided and Costs of Services Provided by You and Others	2A, 2B	Understand which attributed beneficiaries are driving your TIN's cost measures and identify those beneficiaries that are in need of greater care coordination
Beneficiaries Included in the Per Capita Costs for All Attributed Beneficiaries Cost Measure: Hospital Admissions for Any Cause	3	Understand which beneficiaries are driving your TIN's performance on the three hospital-related, claims-based quality outcome measures
Beneficiaries Attributed to Your TIN for the Medicare Spending per Beneficiary Measure	4	Understand which attributed beneficiaries were attributed to your TIN for the Medicare Spending per Beneficiary (MSPB) measure
Per Capita Costs, by Categories of Service, for each of the six cost measures	5-10	Review a categories of service breakdown for each of the cost measures

Note: All references to "episodes" in this presentation indicate episodes of hospital care for the Medicare Spending per Beneficiary measure.

Acronyms

Cover Page

MID-YEAR QUALITY AND RESOURCE USE REPORT

QFRNJWJ XRNYM
Last Four Digits of Your Medicare Taxpayer Identification Number (TIN): 8212

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

ABOUT THIS REPORT

- This Mid-Year Quality and Resource Use Report shows how your group or solo practice, as identified by its Medicare-enrolled Taxpayer Identification Number (TIN), performed during the performance period for this report (July 1, 2014 to June 30, 2015) on up to three quality outcome measures and six cost measures that the Centers for Medicare & Medicaid Services (CMS) calculates from Medicare fee-for-service claims data. These measures are a subset of the quality and cost measures CMS uses to calculate the 2017 Value Modifier. Quality data reported as part of the Physician Quality Reporting System (PQRS) are not included in this report.
- This report is provided for informational purposes only. It will not affect your TIN's Medicare Physician Fee Schedule payments. The data in this report reflect a performance period that is different than the one used to calculate the 2017 Value Modifier (January 1, 2015 to December 31, 2015) and may not represent actual performance during the later period. The information contained in this report is believed to be accurate at the time of production. The information may be subject to change at CMS' discretion, including but not limited to, circumstances in which an error is discovered.

WHAT'S NEXT

- CMS will continue to phase in the Value Modifier for Medicare Physician Fee Schedule payments.
- In 2017, the Value Modifier will apply to physician payments under the Medicare Physician Fee Schedule for physicians billing under TINs with one or more eligible professionals. The 2017 Value Modifier will be based on a TIN's participation in the Physician Quality Reporting System (PQRS) and on quality and cost performance in calendar year 2015. It will not apply to eligible professionals who are not physicians.
- The 2017 Value Modifier will be waived for physicians in TINs, if at least one eligible professional billing under the TIN in 2015 participated in the Pioneer ACO Model or the Comprehensive Primary Care initiative in 2015.
- The 2015 Annual Quality and Resource Use Report, which will be available in fall 2016, will provide full information about your TIN's 2017 Value Modifier, as applicable. Because the Annual Quality and Resource Use Report will be based on a different performance period (January 1, 2015 to December 31, 2015), note that the measures and performance rates computed for each exhibit in this report may change.

QUESTIONS?

- Contact the QRUR Help Desk by email at pvhelpdesk@cms.hhs.gov or by phone at 1-888-734-6433 (select option 3) with questions or feedback about this report.
- For more information about the 2017 Value Modifier, please visit https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html.

Acronyms

Exhibit 1. Eligible Professionals in Your TIN

- Exhibit 1 shows counts of physicians and non-physician EPs in your TIN based on a query of the Provider Enrollment, Chain, and Ownership System (PECOS) on July 10, 2015, and based on the number of EPs that submitted claims to Medicare under your TIN between July 1, 2014 and June 30, 2015.

Exhibit 1. Your TIN's Eligible Professionals

	Number Identified in PECOS	Percentage Identified in PECOS	Number Identified in Claims	Percentage Identified in Claims
All eligible professionals	1,356	100.00%	1,123	100.00%
Physicians	852	62.83%	707	62.96%
Non-physicians	504	37.17%	416	37.04%

Review the EP composition of your TIN

Acronyms

Exhibits 2 and 3. Attribution of Medicare Beneficiaries to Your TIN

- For five of the per capita cost measures and the three quality outcome measures, Medicare beneficiaries are attributed to a TIN using a two-step methodology:
  - Step 1: Assign a beneficiary to a TIN in the first step if the beneficiary received more primary care services (as measured by Medicare-allowed charges) during the performance period from primary care physicians (PCP), nurse practitioners (NP), clinical nurse specialists (CNS), and physician assistants (PA) in that TIN than in any other TIN.
  - Step 2 (for beneficiaries who did not receive a primary care service from any PCP, NP, CNS, or PA during the performance period): Assign a beneficiary to a TIN in the second step if the beneficiary received more primary care services from specialist physicians within the TIN than in any other TIN.
  - Primary care physicians include Family Practice, Internal Medicine, General Practice, and Geriatric Medicine specialty codes.
  - Primary care services include evaluation and management services provided in office and other non-inpatient and non–emergency-room settings, as well as initial Medicare visits and annual wellness visits.

Acronyms

Exhibits 2 and 3. Attribution of Medicare Beneficiaries to Your TIN based on Primary Care Services Provided

- Exhibit 2 shows the number of Medicare FFS beneficiaries attributed to your TIN based on primary care services provided and the basis for their attribution.
- Exhibit 3 shows the average number of primary care services provided to beneficiaries attributed to your TIN.

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

Basis for Attribution	Number	Percentage
All attributed beneficiaries	16,838	100.00%
Beneficiaries attributed because your TIN's primary care physicians, nurse practitioners, physician assistants, or clinical nurse specialists provided the most primary care services	15,800	93.84%
Beneficiaries attributed because your TIN's specialist physicians provided the most primary care services	1,038	6.16%

"Step 1"

"Step 2"

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

Primary Care Services for Attributed Beneficiaries	Average Number	Average Percentage
Primary care services provided to each attributed beneficiary	8	100.00%
Provided by any physicians, nurse practitioners, physician assistants, or clinical nurse specialists in your TIN	6	83.00%
Provided by any physicians, nurse practitioners, physician assistants, or clinical nurse specialists outside of your TIN	2	17.00%

Review the proportion of beneficiaries attributed during each step

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

Acronyms

Exhibit 4. Hospital Episodes and Beneficiaries Attributed to your TIN for the MSPB Measure

- Exhibit 4 provides information on the total hospitalization episodes attributed to your TIN, and the number of unique beneficiaries associated with the attributed episodes.
- 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.

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

Hospital Episodes and Beneficiaries	Number
Total episodes of hospital care attributed to your TIN	2,600
Unique Medicare beneficiaries associated with attributed episodes of hospital care	2,135

Review your TIN's attributed MSPB episodes

Acronyms

Exhibit 5. Performance on Quality Outcome Measures

- Exhibit 5 presents your TIN's performance rate and the number of eligible cases for the three CMS-calculated claims-based quality outcome measures.
- Lower performance rates on these measures indicate better performance.
- The benchmark is the case-weighted average performance rate within the peer group during 2014. The peer groups for CMS-1 and CMS-2 measures are all TINs nationwide that had at least 20 eligible cases for each measure. The peer group for the CMS-3 measure is all TINs nationwide with 10 or more EPs that had at least 200 eligible cases and all SSP ACO participant TINs.

Exhibit 5. CMS-Calculated Quality Outcome Measure Performance

Performance Category	Measure Number	Measure Name	Your TIN's Eligible Cases	Your TIN's Performance Rate	Benchmark Rate	Reference Range
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care Sensitive Conditions	CMS-1	**Acute Conditions Composite**	16,838	5.41	6.90	1.46 - 12.35
	-	Bacterial Pneumonia	16,838	7.85	9.96	1.23 - 18.68
	-	Urinary Tract Infection	16,838	4.78	7.02	0.00 - 14.77
	-	Dehydration	16,838	3.61	3.69	0.00 - 7.87
	CMS-2	**Chronic Conditions Composite**	5,867	53.78	54.56	28.73 - 80.39
	-	Diabetes (composite of 4 indicators)	3,741	15.71	17.98	0.00 - 38.09
	-	Chronic Obstructive Pulmonary Disease (COPD) or Asthma	1,796	46.99	76.29	28.54 - 124.04
	-	Heart Failure	1,825	137.80	112.54	57.74 - 167.34
Hospital Readmissions	CMS-3	**All-Cause Hospital Readmissions**	3,037	14.42%	15.[illegible]%	13.88 - 16.75

Compare your TIN's performance rates against the benchmark rates

Acronyms

Exhibit 6. Hospitals Admitting Medicare Beneficiaries Attributed to Your TIN Based on Primary Care Services Provided

- Exhibit 6 identifies the hospitals that provided at least 5 percent of your TIN's attributed beneficiaries' inpatient stays during the performance period.
- This exhibit includes only the beneficiaries attributed to your TIN for the three claims-based quality outcome measures and five per capita cost measures.
- Information about the quality of care at these hospitals can be found at http://www.hospitalcompare.hhs.gov.

Exhibit 6. Hospitals Admitting Medicare Beneficiaries Attributed to Your TIN Based on Primary Care Services Provided

Hospital Name	Hospital CMS Certification Number	Hospital Location	Number of Stays	Percentage of All Stays
Total			**5,933**	**100.00%**
RJRTWNFQ RJQNHFQ HJSYJW	494993	RTQJXYT, HF	1,999	33.69%
XY QTXJQMX RJQNHFQ HJSYJW TK XYTHPYTS	494418	XYTHPYTS, HF	1,108	18.68%
QTQN RJRTWNFQ MTXQNYFQ	494550	QTQN, HF	790	13.32%
QFRJWTS MTXQNYFQ	494677	XYTHPYTS, HF	360	6.07%
JRFSZJQ RJQNHFQ HJSYJW	494632	YZWQTHP, HF	316	5.33%

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

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

Acronyms

Exhibit 7. Hospitals Accounting for Episodes of Care Attributed to Your TIN for the MSPB Measure

- Exhibit 7 identifies the hospitals that accounted for at least 5 percent of episodes of care attributed to your TIN for the MSPB measure during the performance period.
- Information about the quality of care at these hospitals can be found at http://www.hospitalcompare.hhs.gov.

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

Hospital Name	Hospital CMS Certification Number	Hospital Location	Number of MSPB Episodes	Percentage of All MSPB Episodes
Total			**2,600**	**100.00%**
QFWP SNHTQQJY RJYMTQNXY MTXQNYFQ	784495	XFNSY QTZNX QFWP, RS	2,547	97.96%

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

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

Acronyms

Performance on Cost Measures

- For the Per Capita Costs for All Attributed Beneficiaries measure and the four Per Capita Costs for Beneficiaries with Specific Conditions measures, costs reflect payments for all Medicare Parts A and B claims submitted by all providers who treated Medicare FFS beneficiaries attributed to your TIN for each measure during the performance period for this report, including providers who do not bill under your TIN (Exhibits 8 and 9).
- Costs for the Medicare Spending per Beneficiary measure are based on payments for all Medicare Parts A and B claims submitted by all providers for care surrounding specified inpatient hospital stays (3 days prior through 30 days post-discharge) attributed to your TIN during the performance period for this report (Exhibits 8 and 10).
- All cost measures have been payment-standardized, risk-adjusted, and adjusted for the TIN's mix of medical specialties (specialty-adjusted).
- Cost benchmarks are the case-weighted average costs within the peer group during the performance period for this report.

Acronyms

Exhibit 8. Performance on Cost Measures

- Exhibit 8 shows six cost measures that are included in the VM, displaying for each measure the payment-standardized, risk-adjusted, and specialty-adjusted per capita or per episode costs and the number of eligible cases or episodes.
- For all cost measures except MSPB measure, the peer group is all TINs nationwide that had at least 20 eligible cases for the measure. For the MSPB measure, the peer group is all TINs nationwide with at least 125 eligible episodes.

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

Performance Category	Cost Measure	Your TIN's Eligible Cases or Episodes	Your TIN's Per Capita or Per Episode Costs	Benchmark	Reference Range
Per Capita Costs for All Attributed Beneficiaries	Per Capita Costs for All Attributed Beneficiaries	16,735	$10,992	$12,214	$8,120 - $16,308
	Medicare Spending per Beneficiary	2,600	$18,622	$20,298	$19,056 - $21,541
Per Capita Costs for Beneficiaries with Specific Conditions	Diabetes	3,728	$15,527	$18,084	$11,747 - $24,420
	Chronic Obstructive Pulmonary Disease (COPD)	1,083	$27,150	$29,382	$18,845 - $39,920
	Coronary Artery Disease (CAD)	2,881	$20,132	$21,592	$14,007 - $29,178
	Heart Failure	1,824	$30,855	$33,411	$21,749 - $45,074

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

Acronyms

Exhibit 9. Performance on Costs, by Category of Service

- Exhibit 9 shows the dollar difference between your TIN's per capita costs for attributed beneficiaries, by service category, and the corresponding costs for your TIN's peer group.

Exhibit 9. Differences between Your TIN's Per Capita Costs and Mean Per Capita Costs among TINs with these Measures, by Service Category: Per Capita Costs for All Attributed Beneficiaries and Beneficiaries with Specific Conditions

Service Category	Amount by Which Your TIN's Costs Were Higher/(Lower) than Benchmark: Per Capita Costs for All Attributed Beneficiaries	Amount by Which Your TIN's Costs Were Higher/(Lower) than Benchmark: Per Capita Costs for Beneficiaries with Diabetes	Amount by Which Your TIN's Costs Were Higher/(Lower) than Benchmark: Per Capita Costs for Beneficiaries with Chronic Obstructive Pulmonary Disease	Amount by Which Your TIN's Costs Were Higher/(Lower) than Benchmark: Per Capita Costs for Beneficiaries with Coronary Artery Disease	Amount by Which Your TIN's Costs Were Higher/(Lower) than Benchmark: Per Capita Costs for Beneficiaries with Heart Failure
TOTAL PER CAPITA COSTS	**($1,157)**	**($2,309)**	**($3,305)**	**($1,759)**	**($2,923)**
Evaluation & Management Services Billed by Eligible Professionals in Your TIN*	$202	$267	$270	$259	$182
Evaluation & Management Services Billed by Eligible Professionals in Other TINs*	($251)	($352)	($346)	($325)	($326)
Major Procedures Billed by Eligible Professionals in Your TIN*	$16	$21	$40	$25	$27
Major Procedures Billed by Eligible Professionals in Other TINs*	$42	$20	$106	$43	$94
Ambulatory/Minor Procedures Billed by Eligible Professionals in Your TIN*	$84	$107	$122	$107	$94
Ambulatory/Minor Procedures Billed by Eligible Professionals in Other TINs*	($122)	($162)	($121)	($151)	($120)
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	($40)	($49)	($23)	($59)	($73)
Ancillary Services	($176)	($221)	($205)	($228)	($134)
Hospital Inpatient Services	($65)	($328)	($344)	$1	$292
Emergency Services Not Included in a Hospital Admission	$10	$25	$59	$58	$66
Post-Acute Services	($521)	($1,336)	($2,162)	($1,229)	($2,784)
Hospice	($127)	($160)	($345)	($210)	($445)
All Other Services**	($209)	($141)	($357)	($50)	$201

Acronyms

Exhibit 10. Performance on Costs, by Category of Service

- For the MSPB measure, Exhibit 10 shows the dollar difference between your TIN's per episode costs, by service category, and the corresponding costs for your TIN's peer group.

Exhibit 10. Differences between Your TIN's Per Episode Costs and Mean Per Episode Costs among TINs with this Measure, by Service Category:
Medicare Spending per Beneficiary Measure

Service Category	Amount by Which Your TIN's Costs Were Higher/(Lower) than the Benchmark: Medicare Spending per Beneficiary Measure
TOTAL PER EPISODE COSTS	**($721)**
Evaluation & Management Services*	($155)
Major Procedures and Anesthesia*	($11)
Ambulatory/Minor Procedures*	($43)
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	($18)
Ancillary Services	($30)
Hospital Inpatient Services	($351)
Emergency Services Not Included in a Hospital Admission	$31
Post-Acute Services	($329)
Hospice	($1)
All Other Services**	$188

Acronyms

Additional Information Contained in the Mid-Year QRUR

(The following tables can be downloaded as Excel spreadsheets)

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

- Table 1 provides a listing of the EPs (NPI, Name, and Specialty) in your TIN based on PECOS data as of July 10, 2015 and Medicare claims submitted under your TIN during the performance period.
- These data can be used to verify the EP counts in Mid-Year QRUR Exhibit 1, which affects how the VM will apply to your TIN. Please review the list of EPs and contact your Medicare Administrative Contractor (MAC) to make any changes to the information.

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

NPI	Name	Physician †	Non-Physician Eligible Professional †	Specialty Designation †
6002009850	FQNSF MFV	X	-	Internal Medicine
6002042573	RFSNSQJWQNY XNSLM	X	-	Family Practice

Verify the EPs billing under your TIN and the data in Mid-Year QRUR Exhibit 1

Verify your EPs' specialty designation

Identified via PECOS †	Identified via Billings †	Date of Last Claim Billed Under TIN
X	X	06/29/15
X	X	06/30/15

Understand how CMS determined EP affiliation with your TIN

Confirm the date of the last claim billed by a given EP

Acronyms

Table 2A. Beneficiaries Attributed to Your TIN for the Cost Measures (except MSPB) and Claims-Based Quality Outcome Measures, and the Care that Your TIN and Others Provided

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

Beneficiaries Attributed to Your TIN							Your TIN's Medicare FFS Claims		
HIC	Gender	DOB	Index †	HCC Percentile Ranking †	Died in Performance Period	Basis for Attribution †	Date of Service on Last Claim	Number of Primary Care Services †	Percent of Total Primary Care Charges †
981216832A	M	02/03/1952	100005687	14	-	Step 1	05/04/2015	1	100.00%
638846325A	M	08/01/1948	100005799	98	-	Step 1	06/24/2015	22	89.48%

Verify the beneficiaries attributed to your TIN

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

Acronyms

Table 2A. Beneficiaries Attributed to Your TIN for the Cost Measures (except MSPB) and Claims-Based Quality Outcome Measures, and the Care that Your TIN and Others Provided (cont.)

- You can use the data in this exhibit to identify the services your TIN furnished to these beneficiaries and identify the EPs in your TIN who provided most primary care and non-primary care services under your TIN.

EP in TIN Billing Most Primary Care Services †				EP in TIN Billing Most Non-Primary Care Services †			
NPI	Name	Specialty	Date of Service on Last Claim	NPI	Name	Specialty	Date of Service on Last Claim
6485884189	PMZS QFB MYJY FZSL	Internal Medicine	05/04/2015	-	STSJ	-	-
6520325363	DTZMFSF QFHTGX	Internal Medicine	05/29/2015	6455689144	WTSFP XMFM	Nephrology	06/01/2015

Review information about the EPs in your TIN providing the most primary and non-primary care services to your TIN's attributed beneficiaries

Verify claims information

Acronyms

Table 2A. Beneficiaries Attributed to Your TIN for the Cost Measures (except MSPB) and Claims-Based Quality Outcome Measures, and the Care that Your TIN and Others Provided (cont.)

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

EP Outside of TIN Billing Most Primary Care Services †				EP Outside of TIN Billing Most Non-Primary Care Services †				Hospital Admission	Chronic Condition Subgroup †			
NPI	Name	Specialty	Date of Service on Last Claim	NPI	Name	Specialty	Date of Service on Last Claim	Date of Last Hospital Admission	Diabetes	Coronary Artery Disease	Chronic Obstructive Pulmonary Disease	Heart Failure
-	STSJ	-	-	-	STSJ	-	-	-	-	-	-	-
6435987030	QJKKJWJD WFQQM	Neurology	06/26/2015	6540112104	XYJQMJS QNZ	Diagnostic Radiology	04/07/2015	-	X	X	-	-

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

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

Acronyms

Table 2B. Beneficiaries Attributed to Your TIN for the Cost Measures (except MSPB) and Claims-Based Quality Outcome Measures: Costs of Services Provided by Your TIN and Others

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

Table 2B. Beneficiaries Attributed to Your TIN for the Cost Measures (except MSPB) and Claims-Based Qu

Beneficiaries Attributed to Your TIN				Included in Per Capita Costs for All Attributed Beneficiaries Measure †	Total Payment-Standardized † Medicare FFS Costs
HIC	Gender	DOB	Index †		
{4450521280	F	5/28/1928	177298	X	$1,153
{6278296564	M	9/22/1927	820051	X	$930
014775287A	M	12/9/1937	106041744	X	$36,059

Identify your TIN's cost drivers

Acronyms

Table 2B. Beneficiaries Attributed to Your TIN for the Cost Measures (except MSPB) and Claims-Based Quality Outcome Measures: Costs of Services Provided by You TIN and Others (cont.)

- You can use this information to learn about the types of services used by specific patients.
- Use this information, along with the information in Table 3 (hospitals admitting your TIN's attributed beneficiaries), to identify specialty services and hospital-based services provided to each attributed beneficiary.

Percent of Total Costs, by Category of Services Furnished by All Providers														
Evaluation & Management* Services Billed by Eligible Professionals in Your TIN	Evaluation & Management* Services Billed by Eligible Professionals in Other TINs	Major Procedures* Billed by Eligible Professionals in Your TIN	Major Procedures* Billed by Eligible Professionals in Other TINs	Ambulatory/Minor Procedures* Billed by Eligible Professionals in Your TIN	Ambulatory/Minor Procedures* Billed by Eligible Professionals in Other TINs	Outpatient Physical, Occupational, or Speech and Language Pathology Therapy*	Ancillary Services*	Inpatient Hospital Facility Services	Eligible Professional Services During Hospitalization Billed by Your TIN	Eligible Professional Services During Hospitalization Billed by Other TINs	Emergency Services Not Included in a Hospital Admission	Post-Acute Services	Hospice	All Other Services
54.00%	18.58%	0.00%	0.00%	0.00%	0.00%	0.00%	21.59%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.82%
34.68%	0.00%	0.00%	0.00%	9.02%	9.81%	0.00%	42.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.99%
5.97%	1.55%	0.00%	0.00%	0.14%	0.00%	1.63%	3.72%	35.56%	6.48%	0.10%	1.67%	40.45%	0.00%	2.73%

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

Acronyms

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

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

Attributed Beneficiaries Admitted to the Hospital			
HIC	Gender	DOB	Index †
014775287A	M	12/09/1937	106041744
040580406A	M	08/24/1958	115503616
040917209A	M	07/01/1946	108033476

Verify the beneficiaries attributed to your TIN

Acronyms

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

- Table 3 also shows whether the hospital admission was the result of an emergency department evaluation, an ambulatory care sensitive condition, or a readmission within 30 days of prior admission. This exhibit also indicates the date of discharge and the subsequent care environment.
- You can link the data in Table 3 with data in Table 2B, using the "Index" column, to understand the overall scope of services that a patient admitted to the hospital has been receiving.

Identify potentially preventable hospital admissions

Understand where beneficiaries were discharged

Characteristics of Hospital Admission										Discharge Disposition		
Date of Admission	Admitting Hospital (Name, CCN, City, State)				Principal Diagnosis † (Code, Description)		Admission Via the ED	ACSC Admission †	Followed by Unplanned All-Cause Readmission within 30 Days of Discharge †	Date of Discharge	Discharge Status † (Code, Description)	
10/06/14	RJRTWNFQ RJQNHFQ	494993	MODESTO	CA	82009	Fx femur intrcaps NEC-cl	X	-	-	10/09/14	03	Disch to Medicare SNF
02/27/15	HFQNKTWSNF QFHNKNH	494483	SAN FRANCISCO	CA	5733	Hepatitis NOS	-	-	-	03/07/15	01	Disch Home

Verify the data in Mid-Year QRUR Exhibit 6

Identify which diagnoses were the basis for hospitalization

Identify hospital readmissions

Acronyms

Table 4. Beneficiaries Attributed to Your TIN for the MSPB Measure

- Table 4 displays information on the beneficiaries attributed to your TIN for the MSPB measure.
- Data are presented at the beneficiary-episode level; if a beneficiary has more than one episode that was eligible for the MSPB measure, he or she will appear in the exhibit for each episode.

Understand where beneficiaries were hospitalized

Beneficiaries Attributed to Your TIN for the Medicare Spending per Beneficiary Measure					Apparent Lead Eligible Professional†				Characteristics of Hospital Admission					
HIC	Gender	DOB	Index †	HCC Percentile Ranking†	NPI	Name	Specialty	Total Payment-Standardized Episode Cost †	Date of Admission	Admitting Hospital (Name, CCN, City, State)				Principal Diagnosis † (Code, Description)
473585499T	M	06/30/1946	124840305	-	6297593193	HFYMJWNSJ SLZDJS	Qjqnfywnh Rjqnhnsj	$25,894	03/21/15	QFWP SNHTQQJY RJYMTQNXY MTXQNYFQ	784495	SAINT LOUIS PARK	MN	42823 Ac on chr syst hrt fail
473706410A	F	01/13/1933	5460848	78	6455637937	BMNYSJD JQFQTQQ	Nsyjwsfq Rjqnhnsj	$21,288	02/28/15	QFWP SNHTQQJY RJYMTQNXY MTXQNYFQ	784495	SAINT LOUIS PARK	MN	8054 Fx lumbar vertebra-close
471718011A	M	01/19/1937	96411598	19	6267221802	HMWNJXYNFS	Kfrnqd Qwfhynhj					SAINT LOUIS		

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

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

Identify which diagnoses were the basis for hospitalization

Acronyms

Table 4. Beneficiaries Attributed to Your TIN for the MSPB Measure (cont.)

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

Discharge Disposition		Medicare Spending per Beneficiary, by Category of Service Furnished by All Providers																				
Date of Discharge	Discharge Status † (Code, Description)	Outpatient Non-ER Evaluation and Management Services*	Outpatient Major Procedures and Anesthesia*	Ambulatory/ Minor Procedures*	Outpatient Physical, Occupational, or Speech and Language Pathology Therapy*	Ancillary Laboratory, Pathology, and Other Tests	Ancillary Imaging Services	Durable Medical Equipment and Supplies	Inpatient Hospital: Trigger	Inpatient Hospital: Readmission	Physician Services During Hospitalization	ER Evaluation & Management Services	ER Procedures	ER Laboratory, Pathology, and Other Tests	ER Imaging Services	Home Health	Skilled Nursing Facility	Inpatient Rehabilitation or Long-Term Care Hospital	Hospice	Ambulance Services	Chemotherapy and Other Part B-Covered Drugs	Dialysis	All Other Services Not Otherwise Classified
03/25/15	01 Disch Home	$1,515	$0	$124	$131	$52	$9	$213	$5,679	$3,056	$1,702	$0	$0	$0	$0	$0	$12,879	$0	$0	$534	$0	$0	$0
03/05/15	03 Disch to Medicare SNF	$693	$0	$0	$0	$59	$0	$0	$8,978	$0	$1,104	$0	$0	$0	$0	$2,271	$7,463	$0	$0	$534	$0	$0	$185

Understand where beneficiaries were discharged

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

Acronyms

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

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

Acronyms

Table 5. Per Capita Costs, by Categories of Service, for the Per Capita Costs for All Attributed Beneficiaries Measure (cont.)

Note: Table 5 is truncated for this presentation. The actual table in the Mid-Year QRUR contains more service categories.

Service Category	Number of Your TIN's Attributed Beneficiaries Using any Service in this Category	Percentage of Your TIN's Attributed Beneficiaries Using any Service in this Category	Per Capita Costs for Your TIN's Attributed Beneficiaries	Benchmark Percentage of Beneficiaries Using Any Service in This Category	Benchmark Per Capita Costs	Amount by Which You TIN's Costs Were Higher (Lower) Compared to t Benchmark
All SERVICES	16,735	100.00%	$10,992	100.00%	$12,214	($1,222)
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	16,735	100.00%	$1,661	99.99%	$1,903	($242)
Evaluation & Management Services Billed by Eligible Professionals	16,735	100.00%	$1,030	99.99%	$1,143	($113)
Billed by Your TIN	16,735	100.00%	$724	99.98%	$493	$231
Primary Care Physicians	14,272	85.28%	$311	62.68%	$345	($33)
Medical Specialists	8,389	50.13%	$153	18.09%	$52	$101
Surgeons	5,168	30.88%	$60	8.00%	$21	$39
Other Eligible Professionals	9,943	59.41%	$199	19.54%	$76	$124
Billed by Other TINs	9,397	56.15%	$306	81.05%	$649	($343)
Primary Care Physicians	1,943	11.61%	$27	23.77%	$55	($29)
Medical Specialists, Surgeons, and Other Eligible Professionals	9,068	54.19%	$279	79.08%	$594	($315)
Major Procedures Billed by Eligible Professionals	1,592	9.51%	$119	9.57%	$180	($61)
Billed by Your TIN	1,144	6.84%	$57	1.53%	$21	$36
Primary Care Physicians	17	0.10%	$0	0.24%	$1	($1)
Medical Specialists	682	4.08%	$28	0.72%	$8	$20
Surgeons	335	2.00%	$16	0.41%	$6	$10
Other Eligible Professionals	353	2.11%	$13	0.28%	$6	$6
Billed by Other TINs	597	3.57%	$62	8.29%	$159	($97)
Primary Care Physicians	7	0.04%	$1	0.20%	$2	($1)
Medical Specialists, Surgeons, and Other Eligible Professionals	590	3.53%	$61	8.17%	$157	($96)
Ambulatory/Minor Procedures Billed by Eligible Professionals	10,219	61.06%	$353	62.92%	$421	($67)
Billed by Your TIN	7,801	46.61%	$217	22.34%	$63	$155
Primary Care Physicians	1,537	9.18%	$10	10.21%	$16	($6)
Medical Specialists	4,275	25.55%	$107	5.01%	$20	$87

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

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

Understand the detailed services that influence the data in Mid-Year QRUR Exhibit 9.

Acronyms

Table 6. Per Episode Costs, by Categories of Service, for the MSPB Measure

- Table 6 displays the per episode costs for various categories of services for the episodes of care attributed to your TIN for the MSPB measure.
- The categories of service are same as in Table 4, but include additional subcategories.

Service Category	Number of Your TIN's Episodes with Costs in This Category	Percentage of Your TIN's Episodes with Costs in This Category	Your TIN's Per Episode Costs	Benchmark Percentage of Episodes with Costs in This	Benchmark Per Episode Costs	Amount by Which Your TIN's Episode Costs Were Higher or (Lower) Compared to the Benchmark
ALL SERVICES	2,600	100.00%	$18,622	100.00%	$20,298	($1,677)
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	2,467	94.88%	$835	91.58%	$874	($40)
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	285	10.96%	$40	8.35%	$33	$7
Ancillary Services	2,196	84.46%	$285	85.42%	$347	($62)
Laboratory, Pathology, and Other Tests	1,811	69.65%	$82	62.62%	$94	($12)
Imaging Services	1,390	53.46%	$130	58.32%	$139	($9)
Durable Medical Equipment and Supplies	610	23.46%	$73	29.79%	$114	($41)
Hospital Inpatient Services	2,600	100.00%	$11,941	100.00%	$12,659	($718)
Inpatient Hospital: Trigger	2,600	100.00%	$8,805	100.00%	$9,122	($317)
Inpatient Hospital: Readmission	370	14.23%	$1,445	15.20%	$1,649	($204)
Physician Services During Hospitalization	2,600	100.00%	$1,691	100.00%	$1,888	($197)
Emergency Services Not Included in a Hospital Admission	376	14.46%	$116	16.98%	$157	($41)
Emergency Evaluation & Management Services	375	14.42%	$102	16.96%	$135	($33)
Procedures	175	6.73%	$11	7.20%	$17	($6)
Laboratory, Pathology, and Other Tests	132	5.08%	$0	4.43%	$1	$0
Imaging Services	156	6.00%	$3	8.96%	$5	($2)
Post-Acute Services	1,183	45.50%	$4,560	49.50%	$5,292	($732)
Home Health	544	20.92%	$564	28.21%	$817	($252)
Skilled Nursing Facility	858	33.00%	$3,620	25.90%	$3,426	$195
Inpatient Rehabilitation or Long-Term Care Hospital	22	0.85%	$375	5.46%	$1,050	($674)
Hospice	80	3.08%	$158	2.06%	$132	$26
All Other Services	1,770	68.08%	$724	66.49%	$831	($107)
Ambulance Services	1,190	45.77%	$313	47.54%	$456	($143)
Chemotherapy and Other Part B-Covered Drugs	405	15.58%	$193	13.36%	$171	$22
Dialysis	116	4.46%	$195	4.87%	$177	$18
All Other Services Not Otherwise Classified	694	26.69%	$23	25.28%	$27	($4)

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

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

Understand the detailed services that influence the data in Mid-Year QRUR Exhibit 10.

Acronyms

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

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

Acronyms

Tables 7 - 10. Per Capita Costs, by Categories of Service, for Beneficiaries with Specific Conditions (cont.)

Note: This table is truncated for this presentation. The actual table in the Mid-Year QRUR contains more service categories.

Service Category	Number of Your TIN's Attributed Beneficiaries Using any Service in this Category	Percentage of Your TIN's Attributed Beneficiaries Using any Service in this Category	Per Capita Costs for Your TIN's Attributed Beneficiaries	Benchmark Percentage of Beneficiaries Using Any Service in This Category	Benchmark Per Capita Costs	Amount by Which Your TIN's Costs Were Higher or (Lower) Compared to the Benchmark
All SERVICES	5,879	100.00%	$15,775	100.00%	$18,084	($2,309)
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	5,879	100.00%	$2,163	100.00%	$2,310	($147)
Evaluation & Management Services Billed by Eligible Professionals	5,879	100.00%	$1,340	100.00%	$1,424	($84)
Billed by Your TIN	5,879	100.00%	$883	99.99%	$615	$267
Primary Care Physicians	5,580	94.91%	$475	82.90%	$451	$24
Medical Specialists	2,853	48.53%	$214	9.09%	$57	$157
Surgeons	2,219	37.74%	$74	2.65%	$18	$56
Other Eligible Professionals	2,569	43.70%	$120	16.44%	$90	$31
Billed by Other TINs	4,250	72.29%	$457	89.86%	$809	($352)
Primary Care Physicians	893	15.19%	$40	30.40%	$78	($38)
Medical Specialists, Surgeons, and Other Eligible Professionals	4,134	70.32%	$417	88.12%	$730	($313)
Major Procedures Billed by Eligible Professionals	698	11.87%	$279	12.46%	$238	$41
Billed by Your TIN	313	5.32%	$42	1.05%	$21	$21
Primary Care Physicians	3	0.05%	$0	0.27%	$1	($1)
Medical Specialists	157	2.67%	$17	0.50%	$8	$9
Surgeons	105	1.79%	$14	0.21%	$6	$8
Other Eligible Professionals	90	1.53%	$11	0.18%	$5	$6
Billed by Other TINs	416	7.08%	$237	11.61%	$218	$20
Primary Care Physicians	6	0.10%	$3	0.31%	$4	($1)
Medical Specialists, Surgeons, and Other Eligible Professionals	412	7.01%	$234	11.43%	$214	$21
Ambulatory/Minor Procedures Billed by Eligible Professionals	3,879	65.98%	$425	69.28%	$480	($55)
Billed by Your TIN	2,587	44.00%	$164	19.38%	$57	$107
Primary Care Physicians	634	10.78%	$11	14.01%	$20	($8)
Medical Specialists	916	15.58%	$53	1.77%	$13	$40
Surgeons	951	16.18%	$63	1.21%	$15	$48
Other Eligible Professionals	1,105	18.80%	$36	3.55%	$9	$27
Billed by Other TINs	2,284	38.85%	$261	62.42%	$423	($162)
Primary Care Physicians	169	2.87%	$11	4.50%	$10	$1
Medical Specialists, Surgeons, and Other Eligible Professionals	2,229	37.91%	$251	61.30%	$414	($163)

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

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

Understand the detailed services that influence the data in Mid-Year QRUR Exhibit 9.

Acronyms

Technical Assistance Information

- For QRUR and VM questions or to provide feedback on the content and format of the QRUR, contact the Physician Value Help Desk:
  - Phone: 1-888-734-6433 (select option 3)
  - Monday – Friday: 8:00 am – 8:00 pm EST
  - Email: pvhelpdesk@cms.hhs.gov
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  - Phone: 1-866-288-8912 (TTY 1-877-715-6222)
  - Monday – Friday: 8:00 am – 8:00 pm EST
  - Email: qnetsupport@hcqis.org
- 2015 QRUR Educational Documents: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html
- How to Obtain a QRUR: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html
- VM Program: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html
- PQRS Program: http://www.cms.gov/PQRS

Acronyms

Acronyms in this Presentation

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

Question & Answer Session

Evaluate Your Experience

- Please help us continue to improve the MLN Connects® National Provider Call Program by providing your feedback about today's call.

- To complete the evaluation, visit http://npc.blhtech.com and select the title for today's call.

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

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/CEInfo-MLNConnects-TC-L05192016.pdf

Thank You

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