MID-YEAR QUALITY AND RESOURCE USE REPORT

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

PERFORMANCE PERIOD: 07/01/2013 - 06/30/2014

ABOUT THIS REPORT

- This Mid-Year Quality and Resource Use Report shows how your group or solo practice, as identified by your Medicare-enrolled Taxpayer Identification Number (TIN), performed during the performance period on selected quality outcomes and cost measures that Medicare calculates from fee-for-service claims data. 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 Medicare Physician Fee Schedule payments and is not intended to predict future value-based performance.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

- The Centers for Medicare & Medicaid Services (CMS) will continue to phase in the Value Modifier for Medicare Physician Fee Schedule payments.
- The Annual Quality and Resource Use Report, which will be disseminated in late summer 2015, will provide full information about your TIN's value-based performance in 2014, as applicable. Because the Annual Quality and Resource Use Report will be based on a different performance period, note that the metrics and performance rates computed for each exhibit in this report may change.
- In 2016, TINs with 10 or more eligible professionals that submit claims to Medicare and that have been identified through the Provider Enrollment, Chain and Ownership System, will be subject to the Value Modifier. The Value Modifier will be based on these TINs' participation in the Physician Quality Reporting System (PQRS) and on their quality and cost performance in 2014.
- The 2016 Value Modifier will not apply to those TINs in which at least one physician participated in the Medicare Shared Savings Program (MSSP), the Pioneer ACO Model, or the Comprehensive Primary Care (CPC) initiative in 2014.

QUESTIONS?

- Contact the QRUR Help Desk at 1-888-734-6433 (select option 3) with questions or feedback about this report.
- For more information about the policies governing the 2016 Value Modifier, please see http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/.

ABOUT THE DATA IN THIS REPORT

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

Section	Overview of the Data	For More Information
Eligible Professionals Billing to Your Taxpayer Identification Number (TIN)	A "TIN" (or "Taxpayer Identification Number") is defined as the single provider entity to which eligible professionals reassigned their Medicare billing rights in the performance period. In order to receive this Mid-Year QRUR, at least one eligible professional billing under your TIN must be a physician. The number of eligible professionals billing to your TIN is determined both by claims submitted to Medicare under that TIN during the performance period and by information reported by eligible professionals through the Provider Enrollment, Chain and Ownership System (PECOS) (Exhibit 1).	Links on the CMS Portal: ● Supplementary Exhibit 1 Physicians and Non-Physician Eligible Professionals Billing Under Your TIN, Selected Characteristics Glossary ● Eligible professional ● Provider Enrollment, Chain and Ownership System (PECOS) ● Taxpayer Identification Number (TIN) Appendix A (listing of eligible professional specialities)

Attribution of Medicare Beneficiaries and Episodes to Your TIN	Two methods of attribution are used in this report: 1. For the Per Capita Costs for All Attributed Beneficiaries measure, the four Per Capita Costs for Beneficiaries with Specific Conditions measures, and the three quality outcome measures, Medicare has attributed each beneficiary to the single TIN whose primary care physicians, non-primary care specialists, and certain non-physician practitioners provided the most primary care services (as measured by Medicare-allowed charges) for that beneficiary (Exhibits 2 and 3). 2. For the Medicare Spending per Beneficiary measure, an episode of care surrounding a hospital admission for a Medicare fee-for-service beneficiary is attributed to the TIN that provided the most Part B-covered services (as measured by Medicare-allowed charges) to that beneficiary during the hospitalization (Exhibit 4).	Links on the CMS Portal: ● Supplementary Exhibit 2A Beneficiaries Attributed to Your TIN and the Care that You and Others Provided ● Supplementary Exhibit 2B Beneficiaries Attributed to Your TIN: Costs of Services Provided by You and Others ● Supplementary Exhibit 4 Beneficiaries Attributed to Your TIN for the Medicare Spending per Beneficiary Measure Glossary ● Attribution ● Medicare Spending per Beneficiary ● Non-physician practitioner ● Per Capita Costs for All Attributed Beneficiaries ● Per Capita Costs for Beneficiaries with Specific Conditions ● Primary care services

Performance on Quality	Medicare calculated three outcome measures, based on FFS Medicare claims submitted for Medicare beneficiaries attributed to your TIN during the performance period (Exhibit 5). Performance on Physician Quality Report System (PQRS) measures you may have reported during the performance period will be available in your TIN's Annual Quality and Resource Use Report, disseminated in late summer 2015. **Risk Adjustment:** All claims-based quality outcome measures are risk-adjusted based on the mix of patients attributed to your TIN. Because patient populations and risk adjustment models vary, the effects of risk adjustment on a TIN's performance may not be the same for different measures. **Peer Group and Benchmarking:** Quality benchmarks are the case-weighted average performance rates within your peer group during performance year 2013. The peer group is defined as all TINs nationwide that had at least 20 eligible cases for the reported measure.	Glossary Attribution Benchmark Outcome measures Peer group Risk adjustment
Hospitals Admitting Your Patients	For beneficiaries attributed to your TIN based on the first attribution method described above (based on primary care services provided), Medicare identified the hospitals that provided at least five percent of inpatient stays (Exhibit 6).	Links on the CMS Portal: Supplementary Exhibit 3 Beneficiaries Included in the Per Capita Costs for All Attributed Beneficiaries Cost Measure: Hospital Admissions for Any Cause Glossary Attribution CMS Certification Number (CCN) Additional information on hospital performance is available on the Hospital Compare website (http://www.hospitalcompare.hhs.gov).

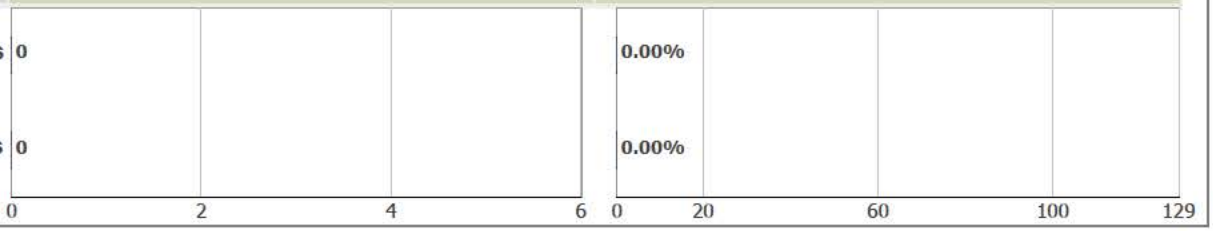
Performance on Costs	Cost information in this report is derived in two ways: 1. For the Per Capita Costs for All Attributed Beneficiaries measure and the four Per Capita Costs for Beneficiaries with Specific Conditions measures, costs reflect payments for all Medicare Parts A and B claims submitted by all providers who treated Medicare FFS patients attributed to your TIN for each measure in 2014, including providers that do not bill under your TIN (Exhibits 7 and 8). Part D prescription drug costs are not included. 2. Costs for the Medicare Spending per Beneficiary measure are based on Parts A and B expenditures surrounding specified inpatient hospital stays (3 days prior through 30 days post-discharge) (Exhibit 7 only). Part D prescription drug costs are not included. **Risk Adjustment:** All cost measures are risk-adjusted based on the mix of patients attributed to your TIN. Patient populations and risk adjustment models vary, and the effects of risk adjustment on a TIN's performance may not be the same across all measures. **Payment Standardization:** All comparative cost data are payment-standardized to account for differences in Medicare payments across geographic regions due to variations in local input prices. **Specialty Adjustment:** In addition to being payment-standardized and risk-adjusted, cost measures are also adjusted to reflect the mix of physician specialties within a TIN. **Peer Group and Benchmarking:** Comparative cost benchmarks are the case-weighted average performance rates within your peer group during the performance period. At the measure level, the peer group is defined as all TINs nationwide that had at least 20 eligible cases for the measure.	Links on the CMS Portal: ● Supplementary Exhibit 5 Per Capita Costs, by Categories of Service, for the Per Capita Costs for All Attributed Beneficiaries Measure Glossary ● Attribution ● Medicare Spending per Beneficiary ● Payment standardization ● Peer group ● Per Capita Costs for Beneficiaries with Specific Conditions ● Risk adjustment ● Specialty adjustment

ELIGIBLE PROFESSIONALS BILLING TO YOUR TAXPAYER IDENTIFICATION NUMBER (TIN)

The table below shows how many physician and non-physician eligible professionals billed to your TIN during the performance period.

Exhibit 1. Your Eligible Professionals

Eligible Professionals Billing to Your TIN	Number	Percentage
All eligible professionals	0	—
Physicians	0	0.00%
Non-physicians	0	0.00%



Note: This exhibit displays information on the eligible professionals billing to your TIN from July 1, 2013 through June 30, 2014. Because the Annual Quality and Resource Use Report, which will be disseminated in late summer 2015, will be based on a different performance period (January 1, 2014 through December 31, 2014), these numbers may change.

ATTRIBUTION OF MEDICARE BENEFICIARIES AND EPISODES TO YOUR TIN

Exhibits 2 and 3 provide information on beneficiaries attributed to your TIN based on primary care services provided. For more information about this attribution method, which is used for the Per Capita Costs for All Attributed Beneficiaries measure, and the four Per Capita Costs for Beneficiaries with Specific Conditions measures, as well as the three quality outcome measures, please see the "About the Data in this Report" section.

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

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

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

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

Note: Because the beneficiaries attributed to your TIN may receive different numbers of services, the average percentage of services will not necessarily equal the average number of services divided by the average total number of services.

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

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

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

PERFORMANCE ON QUALITY

The table below displays your TIN's performance on the three CMS-calculated outcome measures during the performance period for this report (July 1, 2013 through June 30, 2014). The Annual Quality and Resource Use Report, which will be disseminated in late summer 2015, will have a different performance period (January 1, 2014 through December 31, 2014); therefore, your performance on the measures reported here, and the measure benchmarks, may change. Additionally, performance on Physician Quality Reporting System (PQRS) measures you may have reported for the 2014 calendar year performance period will be available in your TIN's Annual Quality and Resource Use Report, but are not included in this report.

Exhibit 5. CMS-Calculated Outcome Measure Performance

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

Note: Lower performance rates indicate better performance. CMS-1, CMS-2, and CMS-3 are calculated by CMS using administrative claims data.

HOSPITALS ADMITTING YOUR PATIENTS

The hospitals in the table below each account for at least five percent of inpatient hospitalizations during the performance period for beneficiaries attributed to your TIN. This includes hospital stays associated with beneficiaries attributed to your TIN for the CMS-calculated outcome measures and the Per Capita Costs for All Attributed Beneficiaries measure.

Exhibit 6. Hospitals Admitting Your Medicare Beneficiaries

Hospital Name	Hospital CMS Certification Number	Hospital Location	Number of Stays	Percentage of All Stays
Total			0	**100%**
Hospital Name 1	111111	City 1, State 1	0	0.00%
Hospital Name 2	222222	City 2, State 2	0	0.00%
Hospital Name 3	333333	City 3, State 3	0	0.00%

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

PERFORMANCE ON COSTS

The table below displays your TIN's payment-standardized, risk-adjusted, and specialty-adjusted per capita costs for each cost measure during the performance period for this report (July 1, 2013 through June 30, 2014). The Annual Quality and Resource Use Report, which will be disseminated in late summer 2015, will have a different performance period (January 1, 2014 through December 31, 2014); therefore, your performance on the measures reported here, and the measure benchmarks, may change.

Exhibit 7. Per Capita Costs for Your Attributed Medicare Beneficiaries

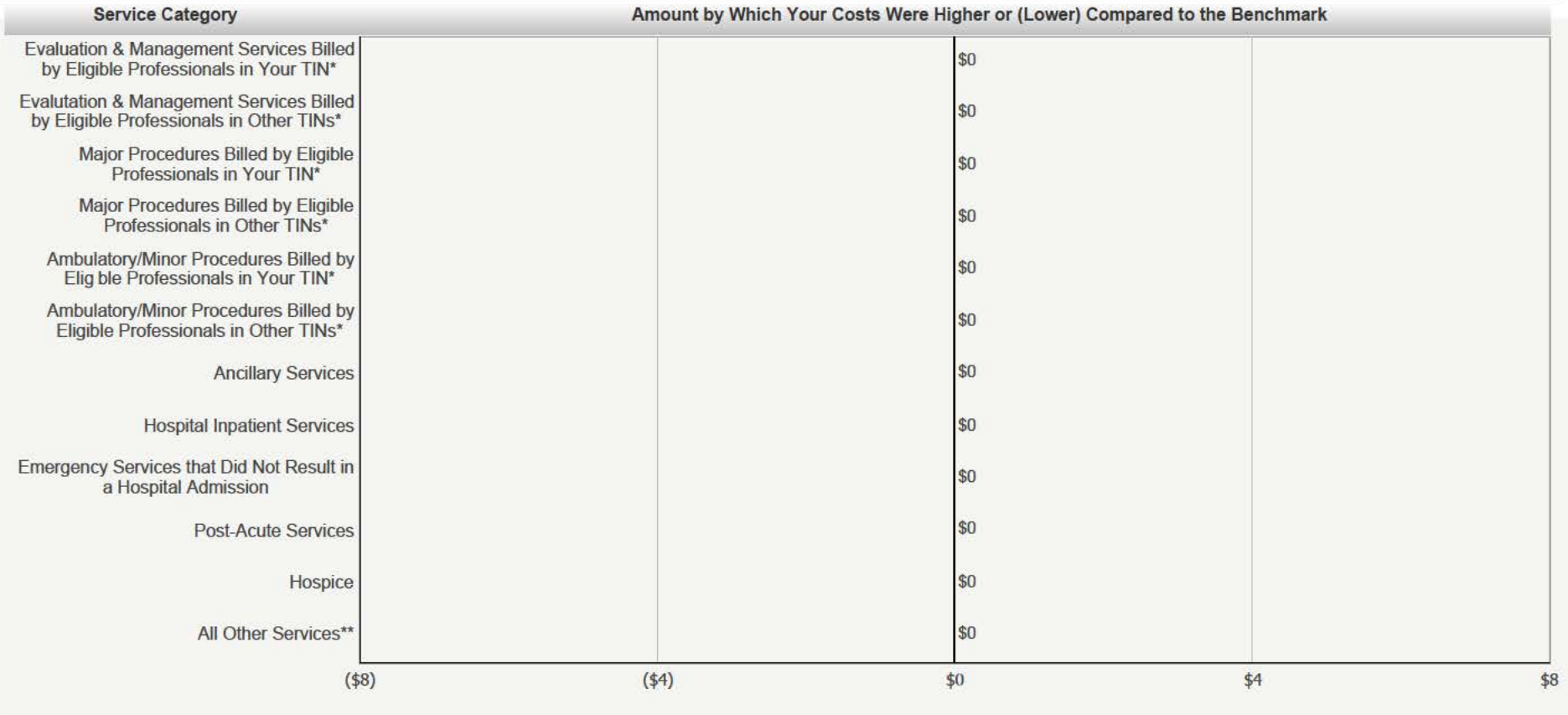
Performance Category	Cost Measure	Your Eligible Cases or Episodes	Your Per Capita or Per Episode Costs	Benchmark	Benchmark – 1 Standard Deviation	Benchmark + 1 Standard Deviation
Per Capita Costs for All Attributed Beneficiaries	All Beneficiaries	0	$0	$0	$0	$0
	Medicare Spending per Beneficiary	0	$0	$0	$0	$0
Per Capita Costs for Beneficiaries with Specific Conditions	Diabetes	0	$0	$0	$0	$0
	Chronic Obstructive Pulmonary Disease (COPD)	0	$0	$0	$0	$0
	Coronary Artery Disease (CAD)	0	$0	$0	$0	$0
	Heart Failure	0	$0	$0	$0	$0

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

Per Capita Costs of Care for Specific Services

For Medicare beneficiaries attributed to your TIN for the Per Capita Costs for All Attributed Beneficiaries measure, the table below provides more detailed information about per capita costs for specific types of services provided, compared with the mean among TINs with at least 20 cases for the measure (benchmark). A detailed cost of services breakdown for this measure is available in a downloadable supplementary exhibit (see the "About the Data in this Report" section).

Exhibit 8. Differences between Your Per Capita Costs for All Attributed Beneficiaries and Mean Per Capita Costs among TINs with this Measure



Note: Per capita costs are based on allowed amounts for Medicare Parts A and B claims submitted by all providers (including medical professionals, hospitals, and post-acute care facilities) for Medicare beneficiaries attributed to your TIN. Part D prescription drug costs are not included. In calculating service-specific per capita costs, the numerator is the total costs for a category of service used by attributed patients; the denominator is the total number of Medicare patients attributed to a TIN, not only those who used the service. Per capita costs shown here have been payment-standardized and risk-adjusted, but not specialty-adjusted.

* Refers to services in non-emergency settings.

** "All Other Services" represents a subtotal composed of he particular miscellaneous expenses detailed in Supplementary Exhibit 5 (available via the CMS Portal; see the "About the Data in this Report" section). This exhibit shows only select cost categories; not all costs are captured in the categories shown in this exhibit. For a more comprehensive cost of services breakdown, please refer to he aforementioned supplementary exhibit.