2013 MEDICARE FEE-FOR-SERVICE QUALITY AND RESOURCE USE REPORT

Sample Medical Practice

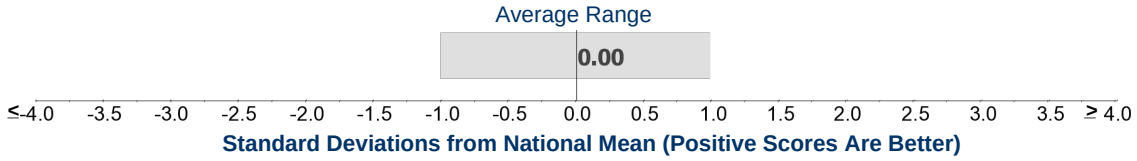
Last Four Digits of Your Taxpayer Identification Number (TIN): 1530

ABOUT THIS REPORT FROM MEDICARE	
WHAT	This Quality and Resource Use Report shows your physician group's value-based payment modifier for Medicare Physician Fee Schedule reimbursements in 2015. This report also includes performance information on new measures that will be used in the value-based payment modifier for 2016.
WHO	The Centers for Medicare & Medicaid Services (CMS) is phasing in a value-based payment modifier under the Medicare Physician Fee Schedule in 2015 and 2016. o In 2015, physician groups of 100 or more eligible professionals that submit claims to Medicare under a single Taxpayer Identification Number (TIN) will be subject to the payment modifier, based on their performance in calendar year 2013. o In both 2015 and 2016, the value-based payment modifier will not apply to those physician groups and solo practitioners participating in the Medicare Shared Savings Program (MSSP), the Pioneer ACO Model, or the Comprehensive Primary Care (CPC) initiative. o Medicare records indicate that the value-based payment modifier will apply to you in 2015 because at least 100 eligible professionals (at least one of whom is a physician) billed to your TIN in 2013, and your group did not participate in the Medicare Shared Savings Program (MSSP), the Pioneer ACO Model, or the Comprehensive Primary Care (CPC) initiative in 2013.
HOW	In 2015, the value-based payment modifier for physicians in groups of 100 or more eligible professionals will be based on participation in the Physician Quality Reporting System (PQRS) in 2013. o Medicare records indicate that your group participated in PQRS in 2013 and met the minimum reporting requirement. You also elected the quality tiering approach. Your 2015 value-based payment modifier is shown on the Performance Highlights page.

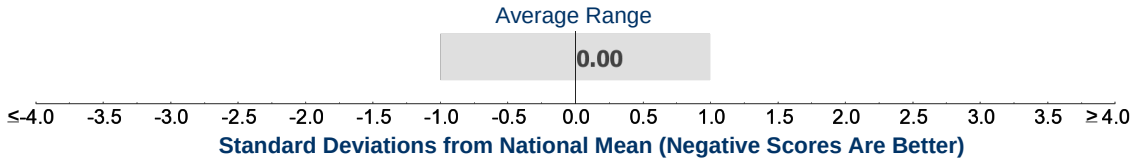
WHAT'S NEXT	In 2016, physicians in groups of 10 or more eligible professionals (at least one of whom is a physician) that submit claims to Medicare under a single TIN will be subject to the value-based payment modifier. Medicare will apply the payment modifier based on successful participation in the PQRS in 2014, as follows: o Groups of 10 or more eligible professionals that do not meet the criteria for satisfactory reporting will be subject to a -2.0% payment adjustment in 2016. o Groups of 10 to 99 eligible professionals that do meet the criteria for satisfactory reporting will have their 2016 value-based payment modifier calculated using the quality tiering approach, but they will not be subject to a downward payment adjustment. Quality tiering for these groups would result in an upward or no payment adjustment. o Groups of 100 or more eligible professionals that meet the criteria for satisfactory reporting will have their 2016 value-based payment modifier calculated using the quality tiering approach, which could result in an upward, downward, or no payment adjustment. For more information about the policies governing the 2015 and 2016 value-based payment modifiers, please see: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.
QUESTIONS	Contact the QRUR Help Desk at 1-888-734-6433 (select option 3) with questions or feedback about this report.

PERFORMANCE HIGHLIGHTS

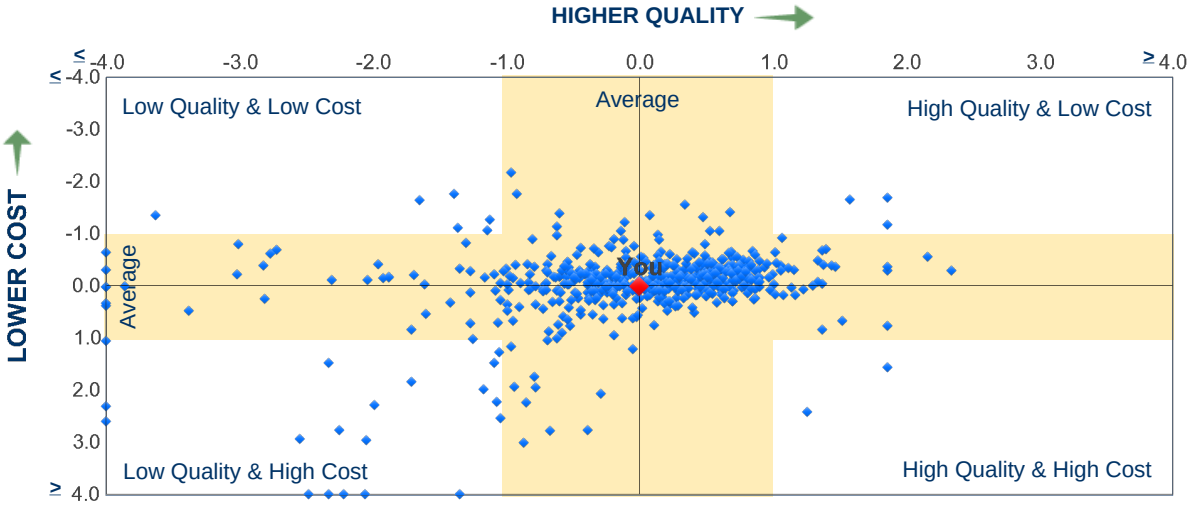
Your Quality Composite Score: Average



Your Cost Composite Score: Average



Your Performance: Average Quality, Average Cost



High-Risk Bonus Adjustment: Not Eligible

You are eligible for an additional upward adjustment for serving high-risk beneficiaries if you met (✓) all four criteria listed below in 2013:

- ✗ Your average beneficiary's risk (0th percentile of beneficiaries nationwide) is not at or above the 75th percentile.
- ✗ You had high overall performance
- ✓ You elected quality tiering for calendar year 2015.
- ✓ You satisfactorily reported PQRS quality measures via the Group Practice Reporting Option (GPRO) web interface or a qualified GPRO registry.

Your Value-Based Payment Modifier

The highlighted payment adjustment will be applied to your Medicare Physician Fee Schedule reimbursements in 2015.

	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0 x AF	+2.0 x AF
Average Cost	-0.5%	+0.0%	+1.0 x AF
High Cost	-1.0%	-0.5%	+0.0%

Note: The displayed payment adjustment includes the high-risk bonus adjustment, if applicable. The precise size of the reward for higher-performing groups will vary from year to year, based on an adjustment factor (AF) derived from actuarial estimates of projected billings. The AF for 2015 will be posted at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.

ABOUT THE DATA IN THIS REPORT

This report provides information on the 2013 quality and costs of care provided to the Medicare fee-for-service (FFS) beneficiaries attributed to you or your group, as identified by Taxpayer Identification Number (TIN), and on beneficiaries' utilization of hospital services, compared to the average for your peers.
Key terms and concepts are defined in the Glossary of Terms
(Link to Glossary of Terms). Some exhibits contain designated electronic links to more detailed information, including provider- and beneficiary-level data. All of the data in this report are available in an exportable comma-separated values (CSV) file (Link to CSV Report). A data dictionary to supplement the CSV file is available here
(http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2013-QRUR.html).

Attribution

For the purpose of assigning responsibility for most of the quality and cost measures reported here, Medicare has attributed each beneficiary to the single TIN whose primary care physicians or nonprimary care specialists provided the most primary care services for that beneficiary, based on Medicare-allowed charges. These attributed beneficiaries are enumerated in Supplementary Exhibit 2.

For the Spending per Hospital Patient with Medicare measure (also known as Medicare Spending per Beneficiary) shown in Exhibit 13, episodes are attributed to the TIN that provided the most Part B-covered services (as measured by Medicare-allowed charges) during specified inpatient hospital episodes.

The aggregate PQRS performance information displayed in Exhibits 14 reflects care provided to Medicare beneficiaries, as reported by individual eligible professionals that were PQRS incentive-eligible as individuals under the TIN in 2013.

Quality Measures

The quality data shown in Exhibits 4 and 5 of this report reflect the quality measurement and reporting option that applied to you in 2013:

• If your TIN satisfactorily reported data to the Physician Quality Reporting System (PQRS) via the Group Practice Reporting Option (GPRO), the measures used in this report are the quality indicators you reported for your patients. (Supplementary Exhibit 6 (Link to Supplementary Exhibit 6) provides information about your GPRO incentive payment, if applicable.)

• If you requested to have the Centers for Medicare & Medicaid Services (CMS) compute your quality performance to meet the PQRS requirements for 2013, the quality measures in this report are based on 14 administrative claims-based quality indicators derived from FFS Medicare claims submitted by your TIN for Medicare beneficiaries attributed to you. This option will not be available in 2014.

• Medicare calculates, in addition, three outcome-of-care measures (or simply, outcome measures) in the Care Coordination domain, based on FFS Medicare claims submitted for Medicare beneficiaries attributed to you in 2013.

In 2014, for physician groups that do not participate in the PQRS via the GPRO, CMS will aggregate individually-reported PQRS data to calculate the group-level Quality Composite Score for the 2016 value-based payment modifier. These data are shown in Exhibits 14.

Cost Measures

The cost information in this report is derived from payments for all Medicare Parts A and B claims submitted by all providers who treated Medicare FFS patients attributed to you in 2013, including providers that do not bill under your TIN. Outpatient prescription drug (Part D) costs are not included. The Cost Composite Score for the 2016 value-based payment modifier will include a new cost measure, Spending per Hospital Patient with Medicare (also known as Medicare Spending per Beneficiary), based on Parts A and B expenditures for patients you treated surrounding specified inpatient hospital stays (3 days prior through 30 days post-discharge).

Construction of Quality and Cost Composite Scores

The Quality Composite Score summarizes performance on quality indicators across up to six equally weighted quality domains: Clinical Process/Effectiveness, Patient and Family Engagement, Population/Public Health, Patient Safety, Care Coordination, and Efficient Use of Healthcare Resources.

The Cost Composite Score summarizes performance on costs across two equally weighted cost domains: Per Capita Costs for All Attributed Beneficiaries and Per Capita Costs for Beneficiaries with Specific Conditions (diabetes, coronary artery disease, chronic obstructive pulmonary disease, and heart failure).

Performance within a domain represents the equally weighted average of standardized scores for all measures within the domain that have at least 20 eligible cases. Standardized scores indicate how much your performance differs from the national mean performance.

A standardized Quality Composite Score that is (1) +1.00 or higher, representing composite performance across all domains that is at least one standard deviation better than the peer group mean, and (2) statistically significantly different from the mean standardized Quality Composite Score would place you in the high performance category, whereas a score of -1.00 or lower that is statistically significantly different from the mean would place you in the low performance category. Similarly, a standardized Cost Composite Score of -1.00 or lower that is statistically significantly different from the mean standardized Cost Composite Score would place you in the high performance category (indicating lower costs), whereas a score of +1.00 or higher that is statistically significantly different from the mean would place you in the low performance category (indicating higher costs).

Risk Adjustment and Payment Standardization

All comparative quality outcome measures and cost data have been risk adjusted to account for differences in patient characteristics that might affect costs or quality outcomes. Exhibits 11 and 12 show how risk adjustment affects all of the outcome measures and cost measures, respectively, calculated for you.

In addition, all comparative cost data are payment standardized to account for differences in Medicare payments across geographic regions due to differences in factors such as wages or rents.

Benchmarks and Peer Groups

Benchmarks used to calculate the quality and cost measures in this report are the case-weighted average performance rate within your peer group. Cost benchmarks are computed based on peer group performance in 2013; quality benchmarks are based on the previous year's peer group performance.

For quality measure calculations in this report, the peer group is defined as all groups and solo practitioners nationwide that had at least 20 eligible cases for the measure.

The peer group for cost measure calculations varies with physician group size. For physician groups with 100 or more eligible professionals, the peer group for each cost measure includes all groups nationwide with 100 or more eligible professionals that have at least 20 attributed beneficiaries for the measure. For physician groups with fewer than 100 eligible professionals, including solo practitioners, the peer group includes all groups nationwide with at least 20 attributed beneficiaries for the measure, regardless of the group's size.

YOUR MEDICARE BENEFICIARIES AND THE ELIGIBLE PROFESSIONALS TREATING THEM

Exhibit 1 shows how many eligible professionals, including physicians, billed to your TIN in 2013. (More information about the eligible professionals billing to your TIN is available here (Link to Supplementary Exhibit 1).)

Exhibit 1. Eligible Professionals Billing to Your TIN in 2013

	Your TIN's Eligible Professionals	
	Number	Percentage
All eligible professionals (links to data table)	0	100.00%
Physicians	0	0.00%
Non-physicians	0	0.00%

Exhibit 2 shows the number of beneficiaries attributed to you for cost and quality measures in 2013, and the basis of their attribution. (More information about your attributed beneficiaries is available here (Link to Supplementary Exhibit 2).)

Exhibit 2. Your Attributed Medicare Beneficiaries in 2013

Basis for Attribution	Your Attributed Beneficiaries	
	Number	Percentage
All attributed beneficiaries (links to data table)	0	0.00%
Attributed beneficiaries for whom primary care physicians provided the most primary care services	0	0.00%
Attributed beneficiaries for whom specialist physicians (or non-physician practitioners) provided the most primary care services	0	0.00%

Exhibit 3 shows the average number of eligible professionals treating beneficiaries attributed to you in 2013 and the number of primary care services provided to your beneficiaries. (More information about your attributed beneficiaries and claims for services provided inside and outside of your TIN is available here (Link to Supplementary Exhibit 2).)

Exhibit 3. Services to Your Attributed Medicare Beneficiaries in 2013

Services to Attributed Beneficiaries	Total	In Your TIN		Outside of Your TIN	
		Average Number	Average Percentage	Average Number	Average Percentage
Average number of eligible professionals who provided any service to each attributed beneficiary	0	0	0.00%	0	0.00%
Average number of primary care services provided to each attributed beneficiary	0	0	0.00%	0	0.00%

Note: Because the beneficiaries attributed to your TIN may receive different numbers of services, the average percentage of services, computed across all of your TIN's attributed beneficiaries, is not necessarily the same as the average number of services divided by the total number of services.

PERFORMANCE ON QUALITY

Exhibit 4 summarizes your 2013 quality performance.

Exhibit 4. Your Performance in 2013, by Quality Domain

Quality Domain	Number of Quality Measures Included in Composite Score	Standardized Score
Standardized Quality Composite Score	**0**	**--**
Average Quality Composite Score	0	--
Clinical Process/Effectiveness	0	--
Patient and Family Engagement	0	--
Population/Public Health	0	--
Patient Safety	0	--
Care Coordination	0	--
Efficient Use of Health Care Resources	0	--

Note: The standardized quality composite score is a standardized average of equally-weighted domain scores indicating within how many standard deviations of the national mean a group practice's performance rate falls; positive scores reflect performance better than the mean, and negative scores reflect performance worse than the mean. Each domain-level performance score is an equally-weighted average of the standardized scores for all measures in the domain with at least 20 cases; the standardized score is the difference between the raw score and the peer group benchmark, divided by the peer group standard deviation. "Insufficient Data to Determine" for the standardized quality composite score indicates that, although the score was at least one standard deviation from the mean standardized quality composite score, it was not statistically significantly different from that mean at the 5 percent level. Domain scores are not computed for domains with no measure with at least 20 cases. See the glossary (Link to Glossary of Terms) for more detail on how this score is computed.

* Significantly different from the mean standardized quality composite score at the 5 percent level.

Exhibits 5 display your performance on the measures for each quality domain. Exhibits are displayed only for domains with at least one measure with at least one eligible case. Only those measures for which benchmarks are available and for which you had 20 or more eligible cases may be included in the domain and quality composite scores. Domain scores are not calculated for TINs that neither satisfactorily reported quality data under the Group Practice Reporting Option nor elected the Administrative Claims option.

Exhibits 5. 2013 Performance on Quality Measures, By Domain

Exhibit 5-CPE. Clinical Process/Effectiveness Domain Quality Indicator Performance in 2013

PQRS Measure Number and Name		Your Performance		Peer Group Performance			Contribution to Your Domain Score	
					Average Range			
		Eligible Cases	Performance Rate	Benchmark Rate	Benchmark –1 Standard Deviation	Benchmark +1 Standard Deviation	Standardized Score	Included In Domain Score
3	Diabetes Mellitus (DM): High Blood Pressure Control	0	0.00%	0.00%	0.00%	0.00%	0.00	Yes
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVSD) (LVEF < 40%)	0	0.00%	0.00%	0.00%	0.00%	0.00	Yes
8	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	0	0.00%	0.00%	0.00%	0.00%	0.00	Yes
201	Ischemic Vascular Disease (IVD): Blood Pressure Management	0	0.00%	0.00%	0.00%	0.00%	0.00	Yes

** Lower performance rates on this measure indicate better performance. However, the domain score for this domain has been calculated such that positive (+) scores indicate better performance and negative (-) scores indicate worse performance.

Exhibit 5-PPH. Population/Public Health Domain Quality Indicator Performance in 2013

PQRS Measure Number and Name		Your Performance		Peer Group Performance			Contribution to Your Domain Score	
		Eligible Cases	Performance Rate	Benchmark Rate	Average Range: Benchmark –1 Standard Deviation	Average Range: Benchmark +1 Standard Deviation	Standardized Score	Included In Domain Score
173	Preventive Care and Screening: Unhealthy Alcohol Use - Screening	0	0.00%	0.00%	0.00%	0.00%	0.00	Yes
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	0	0.00%	0.00%	0.00%	0.00%	0.00	Yes

Exhibit 5-CC. Care Coordination Domain Quality Indicator Performance in 2013

PQRS Measure Number and Name		Your Performance		Peer Group Performance			Contribution to Your Domain Score	
		Eligible Cases	Performance Rate	Benchmark Rate	Average Range: Benchmark –1 Standard Deviation	Average Range: Benchmark +1 Standard Deviation	Standardized Score	Included In Domain Score
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care-Sensitive Conditions								
CMS-1**	Acute Conditions Composite (links to data table)	0	0.00	0.00	0.00	0.00	0.00	Yes
-	PQI-11 Bacterial Pneumonia**	0	0.00	0.00	0.00	0.00	-	-
-	PQI-12 Urinary Tract Infection**	0	0.00	0.00	0.00	0.00	-	-
-	PQI-10 Dehydration**	0	0.00	0.00	0.00	0.00	-	-
CMS-2**	Chronic Conditions Composite (links to data table)	0	0.00	0.00	0.00	0.00	0.00	Yes
-	Diabetes (composite of 4 indicators)**	0	0.00	0.00	0.00	0.00	-	-
-	PQI-5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma**	0	0.00	0.00	0.00	0.00	-	-
-	PQI-8 Heart Failure**	0	0.00	0.00	0.00	0.00	-	-
Hospital Readmissions								
CMS-3**	All-Cause Hospital Readmissions (links to data table)	0	0.00%	0.00%	0.00%	0.00%	0.00	Yes
Additional Care Coordination Quality Indicators								

No data returned for this view. This might be because the applied filter excludes all data.

Note: CMS-1, CMS-2, and CMS-3 are calculated by CMS using administrative claims data.
**Lower performance rates on this measure indicate better performance. However, the domain score for this domain has been calculated such that positive (+) scores indicate better performance and negative (-) scores indicate worse performance.

HOSPITALS ADMITTING YOUR PATIENTS

Based on Medicare Part A claims, at least 5 percent of your attributed Medicare beneficiaries' inpatient stays in 2013 were at the hospitals shown in Exhibit 6. Information on hospital performance is available on the Hospital Compare website (http://www.hospitalcompare.hhs.gov). (More information about your attributed beneficiaries' inpatient stays is available here (Link to Supplementary Exhibit 3).)

Exhibit 6. Hospitals Admitting Your Attributed Medicare Beneficiaries in 2013

Hospital			Medicare Beneficiaries Attributed to Your TIN	
Name	CMS Certification Number	Location	Number of Inpatient Stays (links to data table)	Percentage of All Inpatient Stays
Total			**0**	**100.00%**
QNPJQNQQJ RJQNHFQ HJSYJW	000000	QNPJQNQQJ, PD	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 why the names of the hospitals displayed might be unexpected, review the Performance Year 2013 Frequently Asked Questions (FAQs) available here (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2013-QRUR.html).

PERFORMANCE ON COSTS

Exhibit 7 summarizes your 2013 cost performance.

Exhibit 7. Your Performance in 2013, by Cost Domain

Cost Domain	Number of Cost Measures Included in Composite Score	Standardized Score
Standardized Cost Composite Score	**0**	**0.00 (Average)**
Average Cost Composite Score	0	-
Per Capita Costs for *All* Attributed Beneficiaries	0	-
Per Capita Costs for Beneficiaries *with Specific Conditions*	0	-

Note: The standardized cost composite score is a standardized average of equally-weighted domain scores indicating within how many standard deviations of the national mean a group practice's performance rate falls; positive scores reflect costs higher than the mean, and negative scores reflect costs lower than the mean. Each domain-level performance score is an equally-weighted average of the standardized scores for all measures in the domain with at least 20 cases; the standardized score is the difference between the raw score and the peer group benchmark, divided by the peer group standard deviation. "Insufficient Data to Determine" for the standardized cost composite score indicates that, although the score was at least one standard deviation from the mean standardized cost composite score, it was not statistically significantly different from that mean. Domain scores are not computed for domains with no measure with at least 20 cases. See the glossary(Link to Glossary of Terms) for more detail on how this score is computed.

* Significantly different from the mean standardized cost composite score at the 5 percent level.

Exhibit 8 displays your risk-adjusted and payment-standardized per capita costs for each cost domain. Only those measures for which you had 20 or more eligible cases are included in the domain and cost composite scores. (Please note that the risk-adjusted costs and benchmarks contributing to the 2015 value-based payment modifier, as shown in Exhibit 8, are not adjusted for specialty mix. However, those that will apply to the 2016 value-based payment modifier will be specialty adjusted, as shown in Exhibit 13.)

Exhibit 8. Per Capita Costs for Your Attributed Medicare Beneficiaries in 2013

Cost Categories	Your Performance		Peer Group Performance			Contribution to Your Domain Score	
				Average Range			
	Eligible Cases	Per Capita Costs	Benchmark Per Capita Costs	Benchmark –1 Standard Deviation	Benchmark +1 Standard Deviation	Standardized Score	Included in Domain Score
Per Capita Costs for All Attributed Beneficiaries							
All Beneficiaries	0	$0	$0	$0	$0	0.00	Yes
Per Capita Costs for Beneficiaries with Specific Conditions							
Diabetes	0	$0	$0	$0	$0	0.00	Yes
Chronic Obstructive Pulmonary Disease (COPD)	0	$0	$0	$0	$0	0.00	Yes
Coronary Artery Disease	0	$0	$0	$0	$0	0.00	Yes
Heart Failure	0	$0	$0	$0	$0	0.00	Yes

Note: 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 physician group. Outpatient prescription drug costs are not included.

Per Capita Costs for All Attributed Beneficiaries

Exhibits 9 and 10 provide more detailed information about the per capita costs of care for specific types of services provided to all attributed Medicare beneficiaries, compared with the mean among your peer group.

Exhibit 9. Difference Between Per Capita Costs for Specific Services for Your Attributed Beneficiaries and Mean Per Capita Costs Among Your Peer Group in 2013

Note: 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 your group. Outpatient prescription drug (Part D) costs are not included. All per capita costs are payment standardized and risk adjusted. 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 medical group, not only those who used the service.

Exhibit 10. Medicare Beneficiaries' Per Capita Costs for Specific Services in 2013

Service Category	Your Attributed Beneficiaries			Peer Group Mean		Amount by Which Your Costs Were Higher or (Lower) than Peer Group Mean
	Your Beneficiaries Using Any Service in This Category		Per Capita Costs	Beneficiaries Using Any Service in This Category	Per Capita Costs	
	Number	Percentage				
All Services	**0**	**100.00%**	**$0**	**100.00%**	**$0**	**$0**
Evaluation and Management (E&M) Services in All Non-Emergency Settings						
All E&M Services Provided by Your TIN	**0**	**0.00%**	**$0**	**0.00%**	**$0**	**$0**
Primary Care Physicians	0	0.00%	$0	0.00%	$0	$0
Medical Specialists	0	0.00%	$0	0.00%	$0	$0
Surgeons	0	0.00%	$0	0.00%	$0	$0
Other Eligible Professionals	0	0.00%	$0	0.00%	$0	$0
All E&M Services Provided by Other TINs	**0**	**0.00%**	**$0**	**0.00%**	**$0**	**$0**
Primary Care Physicians	0	0.00%	$0	0.00%	$0	$0
Medical Specialists, Surgeons, and Other Eligible Professionals	0	0.00%	$0	0.00%	$0	$0
Procedures in All Non-Emergency Settings						
All Procedures Performed by Your TIN	**0**	**0.00%**	**$0**	**0.00%**	**$0**	**$0**
Primary Care Physicians	0	0.00%	$0	0.00%	$0	$0
Medical Specialists	0	0.00%	$0	0.00%	$0	$0
Surgeons	0	0.00%	$0	0.00%	$0	$0
Other Eligible Professionals	0	0.00%	$0	0.00%	$0	$0
All Procedures Performed by Other TINs	**0**	**0.00%**	**$0**	**0.00%**	**$0**	**$0**
Primary Care Physicians	0	0.00%	$0	0.00%	$0	$0
Medical Specialists, Surgeons, and Other Eligible Professionals	0	0.00%	$0	0.00%	$0	$0
Hospital Services (Excluding Emergency Outpatient)						
Inpatient Hospital Facility Services	**0**	**0.00%**	**$0**	**0.00%**	**$0**	**$0**
Outpatient Hospital Facility Services	**0**	**0.00%**	**$0**	**0.00%**	**$0**	**$0**
Emergency Services That Did Not Result in a Hospital Admission						
All Emergency Services	**0**	**0.00%**	**$0**	**0.00%**	**$0**	**$0**
Emergency Visits	0	0.00%	$0	0.00%	$0	$0
Procedures	0	0.00%	$0	0.00%	$0	$0
Laboratory and Other Tests	0	0.00%	$0	0.00%	$0	$0
Imaging Services	0	0.00%	$0	0.00%	$0	$0
Services in Non-Emergency Ambulatory Settings						
All Ancillary Services	**0**	**0.00%**	**$0**	**0.00%**	**$0**	**$0**
Laboratory and Other Tests	0	0.00%	$0	0.00%	$0	$0
Imaging Services	0	0.00%	$0	0.00%	$0	$0
Durable Medical Equipment	0	0.00%	$0	0.00%	$0	$0
Post-Acute Care						
Hospice Care	**0**	**0.00%**	**$0**	**0.00%**	**$0**	**$0**
All Other Post-Acute Services	**0**	**0.00%**	**$0**	**0.00%**	**$0**	**$0**
Skilled Nursing Facility	0	0.00%	$0	0.00%	$0	$0
Home Health	0	0.00%	$0	0.00%	$0	$0
Psychiatric, Rehabilitation, or Other Post-Acute Care	0	0.00%	$0	0.00%	$0	$0
Other Services Billed by Non-Institutional Providers						
All Other Services	**0**	**0.00%**	**$0**	**0.00%**	**$0**	**$0**
Ambulance Services	0	0.00%	$0	0.00%	$0	$0
Chemotherapy and Other Part B-Covered Drugs	0	0.00%	$0	0.00%	$0	$0
All Other Services Not Otherwise Classified	0	0.00%	$0	0.00%	$0	$0

Note: 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 and whose costs were risk adjusted, not only those who used the service. See Appendix A for a list of physician specialties assigned to each specialty category.

EFFECT OF RISK ADJUSTMENT ON QUALITY AND COST MEASURES

All comparative claims-based quality outcome measures and cost data have been risk adjusted to account for differences in patient characteristics that may affect outcomes and costs. Exhibits 11 and 12 show the effects of risk adjustment on your measures.

Exhibit 11. 2013 Performance on Risk-Adjusted Claims-Based Quality Measures, Before and After Risk Adjustment

PQRS Measure Number and Name	Performance Rate Before Risk Adjustment	Performance Rate After Risk Adjustment
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care-Sensitive Conditions		
CMS-1 Acute Conditions Composite	0.00	0.00
- PQI-11 Bacterial Pneumonia	0.00	0.00
- PQI-12 Urinary Tract Infection	0.00	0.00
- PQI-10 Dehydration	0.00	0.00
CMS-2 Chronic Conditions Composite	0.00	0.00
- Diabetes (composite of 4 indicators)	0.00	0.00
- PQI-5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma	0.00	0.00
- PQI-8 Heart Failure	0.00	0.00
Hospital Readmissions		
CMS-3 All-Cause Hospital Readmissions	0.00%	0.00%

Note: Lower performance rates indicate better performance.

Exhibit 12. 2013 Payment-Standardized per Capita Costs for Attributed Beneficiaries, Before and After Risk Adjustment

Cost Categories	Per Capita Costs Before Risk Adjustment	Per Capita Costs After Risk Adjustment
Per Capita Costs for All Attributed Beneficiaries		
All Beneficiaries	$0	$0
Per Capita Costs for Beneficiaries with Specific Conditions		
Diabetes	$0	$0
Chronic Obstructive Pulmonary Disease (COPD)	$0	$0
Coronary Artery Disease	$0	$0
Heart Failure	$0	$0

ADDITIONAL COST AND QUALITY PERFORMANCE DATA FOR 2016

This section provides additional information on your 2013 performance, reflecting revisions that will apply to the calculation of value-based performance in 2016 (for which the period of performance will be calendar year 2014). Note that this information will not affect Medicare Physician Fee Schedule reimbursements in 2015.

Cost Measures

Spending per Hospital Patient with Medicare (also known as Medicare Spending per Beneficiary) is a new cost measure that will be used to calculate the Cost Composite Score for the 2016 value-based payment modifier, based on 2014 performance. This measure reflects all Parts A and B expenditures for services surrounding specified inpatient hospital episodes in the time frame from 3 days before admission to 30 days after discharge, for patients treated by physicians who billed under your TIN during the inpatient stay. Exhibit 13 shows your performance on this measure in 2013. Detailed information on the episodes attributed to you for this measure in 2013 can be found here (Link to Supplementary Exhibit 4).

Unlike the per capita cost measures used to calculate the Cost Composite Score in 2015, the cost measures used for 2016 will be adjusted to reflect the mix of physician specialties within a TIN. Exhibit 13 also shows your specialty-adjusted cost performance for the per capita costs for all attributed beneficiaries and beneficiaries with specific conditions measures (as in Exhibit 8, above), based on 2013 data.

Exhibit 13. 2013 Performance on Cost Measures for the 2016 Value-Based Payment Modifier
FOR INFORMATIONAL PURPOSES ONLY

Cost Categories	Your Performance		Peer Group Performance		
				Average Range	
	Eligible Cases or Episodes	Cost	Benchmark for Cost	Benchmark -1 Standard Deviation	Benchmark +1 Standard Deviation
Per Capita Costs or per Episode Costs, as Appropriate					
All Beneficiaries	0	$0	$0	$0	$0
Spending per Hospital Patient with Medicare (links to data table)	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	0	$0	$0	$0	$0
Heart Failure	0	$0	$0	$0	$0

Quality Measures

For calculation of the Quality Composite Score that will be used for the 2016 value-based payment modifier, based on 2014 performance, groups of 10 or more eligible professionals will have their aggregate group-level performance on individual eligible professional PQRS measures used for quality-tiering if the group (i) does not report quality measures as a group and (ii) at least 50 percent of their eligible professionals participate in PQRS and meet the criteria to avoid the PQRS negative payment adjustment in 2016. Exhibits 14 show the aggregate group-level 2013 PQRS performance for eligible professionals in your TIN, by quality domain and measure.

In your TIN,50.00% of the eligible professionals were PQRS incentive-eligible. Only eligible professionals who were incentive-eligible and reported performing the recommended clinical quality action for at least one measure are included in the results presented in Exhibits 14. PQRS data for all eligible professionals in your TIN are displayed here
(Link to Supplementary Exhibit 5).

Exhibits 14. 2013 Aggregate Group-Level Performance on PQRS Quality Measures for the 2016 Value-Based Payment Modifier, by Quality Domain and Measure
FOR INFORMATIONAL PURPOSES ONLY

Exhibit 14-CPE. Clinical Process/Effectiveness Domain PQRS Quality Indicator Performance in 2013

PQRS Measure Number and Name		Your Performance			Peer Group Performance
		Eligible Cases	Number of Eligible Professionals Reporting	Performance Rate*	Benchmark Rate
14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination	0	0	0%	0%
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	0	0	0%	0%
117	Diabetes Mellitus (DM): Dilated Eye Exam	0	0	0%	0%

*Only the individual eligible professional data submitted through the reporting mechanism with the highest performance are incorporated into the group performance reported here.

**Indicates an inverse measure, for which lower performance rates indicate better performance.