Questions and Answers about the 2014 Mid-Year and Annual Quality and Resource Use Reports

About the Frequently Asked Questions

These Frequently Asked Questions include information about both the 2014 Annual and the Mid-Year Quality and Resource Use Reports (QRURs). The Annual QRUR, disseminated each fall, serves as the final summary report on performance on quality and cost measures and on the Physician Modifier for those groups to whom the Value Modifier applies. The Mid-Year QRUR, disseminated each spring, provides interim information about performance on only those quality outcome and cost measures that the Centers for Medicare & Medicaid Services (CMS) calculates directly from Medicare administrative claims, based on the most recent 12 months of data that are available. These reports are intended to provide timely and actionable information to help groups and solo practitioners understand and improve the quality and efficiency of care provided to Medicare beneficiaries and to inform them about their performance on measures that will be included in the Value Modifier. Because the Mid-Year QRURs do not include all quality and cost data included in the Value Modifier and use a performance period that precedes the Value Modifier's calendar year performance period, the Mid-Year QRURs do not estimate performance for the Value Modifier.

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FREQUENTLY ASKED QUESTIONS

APRIL 2015

A. THE VALUE-BASED PAYMENT MODIFIER PROGRAMS

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

The Value-Based Payment Modifier Program is part of a larger effort by the Centers for Medicare & Medicaid Services (CMS) to improve the quality and efficiency of medical care by developing meaningful and actionable ways to measure physician performance. The program's main goal is to give providers information about the quality and cost of care furnished to their Fee-for-Service Medicare beneficiaries. This program began under the Medicare Improvements for Patients and Providers Act of 2008 (formerly called the Physician Resource Use Measurement and Reporting Program) and was later extended and enhanced under the 2010 Patient Protection and Affordable Care Act (ACA). Confidential feedback reports, called Quality and Resource Use Reports (QRURs), are disseminated to solo practitioners and groups of practitioners, as identified by their Taxpayer Identification Numbers (TINs). See Section B, "Overview of the 2014 Quality and Resource Use Reports" for additional information.

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

2. How are feedback reports related to the Value Modifier?

For TINs to which the Value Modifier applies, the Annual QRURs, disseminated each fall, will serve as the final summary report on their quality and cost performance and will report their Value Modifier. The Value Modifier is determined using a quality-tiering approach that applies an upward payment adjustment to physicians if their performance is of higher quality and lower cost compared to their peers, and a downward adjustment if their performance is of lower quality and higher cost compared to their peers.

3. Who has received feedback reports so far?

CMS has been using a phased approach to create and disseminate physician feedback reports to gain experience and obtain feedback from stakeholders. The history of this phase-in is summarized below:

- In **2008–2009**, CMS tested resource use (cost) measures and prototype feedback reports with approximately 300 randomly selected physicians in 12 metropolitan areas.

- In **2009–2010**, CMS developed and tested feedback reports (which included both quality and cost measures) with approximately 1,600 physicians and 36 TINs with which they were affiliated.
- In **2010–2011**, CMS distributed group-level QRURs, based on 2010 data, to 35 TINs participating in the Group Practice Reporting Option (GPRO) I program of the Physician Quality Reporting System (PQRS) and individual physician-level QRURs to more than 20,000 primary care and specialist physicians practicing in Iowa, Kansas, Missouri, and Nebraska.
- In **December 2012**, QRURs based on care provided in 2011 were produced for 54 TINs participating in the CMS PQRS GPRO I with at least 200 eligible professionals. Additionally, CMS produced QRURs for nearly 95,000 individual primary care and specialist physicians practicing in TINs with 25 or more eligible professionals in California, Illinois, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, and Wisconsin. In May 2013, CMS also provided these 54 TINs with supplemental QRURs that reported episode costs for cardiac and pneumonia conditions.
- In **September 2013**, CMS made QRURs based on care provided in 2012 available to TINs that had at least 25 eligible professionals in 2012 and who had at least 20 Fee-for-Service Medicare beneficiaries attributed to the TIN. This nationwide dissemination effort included TINs participating in the Medicare Shared Savings Program (MSSP), the Pioneer Accountable Care Organization (ACO) Model, and the Comprehensive Primary Care (CPC) initiative. This report was also intended to provide a preview of Value Modifier performance, based on quality tiering. CMS did not produce QRURs for individual physicians in 2013.
- In **September 2014**, CMS made available QRURs, based on care provided in 2013, to TINs that had at least one physician who billed under the TIN in 2013. These were the first reports to include data determining actual Medicare Physician Fee Schedule payment adjustments in 2015, due to the Value Modifier, for selected TINs—namely, those with 100 or more eligible professionals. This nationwide dissemination effort excluded those TINs with at least one eligible professional that participated in the MSSP, the Pioneer ACO Model, and the CPC initiative in 2013, as well as those lacking at least one physician for whom quality or cost data could be computed.
- Most recently, in **April 2015**, CMS made available Mid-Year QRURs, for informational purposes only, to physician solo practitioners and groups of physicians nationwide who billed for Medicare-covered services under a single TIN over the Mid-Year QRUR performance period (July 1, 2013 through June 30, 2014). This nationwide dissemination effort excluded those lacking at least one physician or for whom no quality or cost data could be computed.
- In **Fall 2015**, CMS will disseminate Annual QRURs to solo practitioners and groups of practitioners (including physicians and non-physician eligible professionals), including those that participated in the MSSP, the Pioneer ACO Model, or the CPC initiative. The Annual

QRURs will include Value Modifier information for those TINs subject to the 2016 Value Modifier and will be based on care provided during calendar year 2014.

Throughout this process, CMS has collaborated with stakeholders, reached out to physician and medical specialty groups, sought input from QRUR recipients and medical associations, and held public listening sessions to get feedback for future changes to the reports.

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

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

B. OVERVIEW OF THE 2014 QUALITY AND RESOURCE USE REPORTS

1. What are the Quality and Resource Use Reports?

Under the Value-Based Payment Modifier Program, Quality and Resource Use Reports (QRURs) provide information about the resources used and the quality of care furnished to a group's or solo practitioner's Medicare Fee-for Service beneficiaries. The 2014 QRURs will be generated for all solo practitioners and groups of practitioners nationwide, as identified by their Taxpayer Identification Number (TIN), that have at least one eligible case for at least one quality or cost measure, regardless of whether the 2016 Value Modifier will apply to them. TINs can use their QRURs to see how they compare with other TINs caring for Medicare beneficiaries.

Three types of QRURs will be generated for 2014: the Mid-Year QRUR, the Annual QRUR, and an annual Supplemental QRUR.

- **Mid-Year QRURs** will provide interim information about performance on only those cost and quality outcomes measures that CMS calculates directly from Medicare claims, based on care provided from July 1, 2013 through June 30, 2014. The Mid-Year QRURs are distributed for informational purposes only. Quality data reported as part of the Physician Quality Reporting System (PQRS) are not included in the Mid-Year QRUR. The information contained in the Mid-Year QRUR will not affect Medicare Physician Fee Schedule (MPFS) payments and is not intended to predict future value-based performance.
- **Annual QRURs** will provide information about performance on quality and cost measures during calendar year 2014. For physicians in TINs with 10 or more eligible professionals that are subject to the Value Modifier in 2016, the Annual QRURs will provide information on how the TIN's quality and cost performance will affect their Medicare payments in 2016. The Value Modifier will be used to adjust MPFS payments to physicians, based on the quality and cost of care delivered to Medicare beneficiaries during the performance period. Calendar year 2014 is the performance period for the Value Modifier in 2016.
- **Supplemental QRURs** are confidential feedback reports provided to solo practitioners and groups of practitioners with information on the management of their Medicare fee-for-service (FFS) beneficiaries based on episodes of care. An episode of care is defined as the set of services provided to treat a clinical condition or procedure. Section 3003 of the 2010 Patient Protection and Affordable Care Act (ACA) requires the Secretary of the Department of Health and Human Services to develop an episode grouper, and CMS is applying episode grouping algorithms specially designed for constructing episodes of care in the Medicare population. The Supplemental QRURs are currently generated for informational purposes only and complement the per capita cost and quality information provided in the Annual QRURs. The information included in the Supplemental QRURs is not incorporated in the 2016 Value Modifier.

2. What information is in the 2014 Annual QRUR?

The 2014 Annual QRUR provides information about a TIN's performance during calendar year 2014 on all quality and cost measures used in calculating the 2016 Value Modifier. From this information, CMS computes the Quality and Cost Composite Scores that determine the TIN's Value Modifier and displays its scores in the 2014 Annual QRURs. For TINs with 10 or more eligible professionals, the reports also display each TIN's quality and cost tier designations (high, low, or average) based on its 2014 performance. The Annual QRUR also includes benchmarks that allow each TIN to compare its performance on each measure to that of its peers.

In addition, each TIN's Annual QRUR is accompanied by detailed supplementary information about the eligible professionals that billed to the TIN in calendar year 2014; the beneficiaries attributed to the TIN in 2014 for all claims-based quality outcome and cost measures; beneficiaries attributed to the TIN for the Medicare Spending per Beneficiary cost measure; beneficiaries' hospital admissions, primary diagnoses, and discharge disposition; per capita cost breakdowns for the TIN by category of service; and additional information on the quality measures that individual eligible professionals in a TIN reported through PQRS.

3. How do the 2013 and 2014 Annual QRURs differ?

In response to stakeholder feedback and experience with the reports, and as part of a continuing effort to make QRURs more informative and actionable, CMS incorporated the following changes in the 2014 Annual QRURs:

1. **Expanded the number of TINs receiving reports.** CMS provided the 2013 QRURs to physician solo practitioners and groups of physicians nationwide who billed under the Taxpayer Identification Number (TIN) in 2013. CMS expanded the number of TINs eligible to receive a QRUR to include all solo practitioners and groups of practitioners (including TINs that consist only of non-physician eligible professionals). In addition, TINs with eligible professionals that participated in the MSSP, the Pioneer ACO Model, and the CPC initiative in 2014 will receive a 2014 QRUR.
2. **Included information on the new cost measure that will be included in the 2016 Value Modifier.** The Medicare Spending per Beneficiary measure is a new cost measure, finalized in the 2014 Medicare Physician Fee Schedule Final Rule that will be included in the Cost Composite for the 2016 Value Modifier. The 2013 QRURs provided a preview of the performance on this measure, based on calendar year 2013 performance data. To provide actionable information to help TINs understand and improve on this measure, CMS added information about the number of episodes attributed to the TIN, the names of the admitting hospitals at which these hospitalizations occurred, and the TIN's breakdown of their costs.

3. **Provided additional detailed information each TIN's associated eligible professionals, and attributed beneficiaries and cost of service breakdowns.** Supplementary exhibits accompanying the 2014 QRURs provide information on each beneficiary attributed to the TIN and each eligible professional billing under the TIN. Information added into the 2014 supplementary exhibits is summarized below:

- For the 2016 Value Modifier, the size of the TIN is determined both by information reported by the eligible professionals in the Provider Enrollment, Chain and Ownership System (PECOS) and by the number of eligible professionals who submitted claims to Medicare under the TIN during the 2014 calendar year. Supplementary exhibits in the 2014 QRURs will include additional information on eligible professionals that were identified as part of the TIN via PECOS.
- For each of the cost measures included in the Cost Composite Score, a detailed breakdown of costs by category of service has been provided for beneficiaries attributed to the TIN for that measure. CMS has enhanced the supplementary exhibits to provide more detailed information regarding the TIN's costs by including this information for beneficiaries with specific chronic conditions and by adding more detailed beneficiary-level breakdowns of costs.

4. What information is in the 2014 Mid-Year QRURs?

The 2014 Mid-Year QRUR was distributed in the spring of 2015 *for informational purposes only*. The Mid-Year QRUR contains performance data on CMS-calculated claims-based measures only. This includes three quality outcome measures based on Fee-for-Service Medicare claims: two composite measures of hospital admissions for ambulatory care-sensitive conditions (one for acute conditions and one for chronic conditions) and one measure of 30-day all-cause hospital readmissions.

To assess cost, the Mid-Year QRURs include performance information on two per capita cost measures: the Per Capita Costs for All Attributed Beneficiaries measure and the Medicare Spending per Beneficiary measure. The Mid-Year QRURs also include the four Per Capita Costs for Beneficiaries with Specific Conditions measures: per capita costs for beneficiaries with diabetes, coronary artery disease, chronic obstructive pulmonary disease, and heart failure. For all cost measures, beneficiary costs, as identified by allowed charges on Medicare Part A and Part B claims, are payment standardized to remove geographic Medicare payment differences, risk adjusted to account for differences in beneficiaries' medical histories, and specialty adjusted to account for differences in TINs' specialty mix (described in Section C). Additionally, the Mid-Year QRUR includes benchmarks that indicate how well the TIN performed on these measures relative to its peers. For both cost and quality measures, the peer group is defined as all TINs nationwide that had at least 20 eligible cases for the measure.

The Mid-Year QRUR also includes information on the hospitals treating beneficiaries and lists the primary diagnosis and discharge status for most of their hospital stays. Each recipient's report also contains detailed information on the eligible professionals that billed under the TIN during the performance period for the Mid-Year QRUR (July 1, 2013 through June 30, 2014). They also include detailed information on the beneficiaries attributed to the TIN for claims-based cost and quality outcomes measures and on the costs associated with delivering their care.

5. What is the difference between the 2014 Mid-Year and Annual QRURs?

The 2014 Mid-Year QRUR was distributed in the spring of 2015 for informational purposes only. It is intended to provide TINs with up-to-date interim information on their performance on both the claims-based quality outcome and cost measures. The 2014 Annual QRUR will provide a final report of performance for the 2014 calendar year, which is the performance period for the 2016 Value Modifier.

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

1. **Performance period.** The Mid-Year QRUR will be based on care provided from July 1, 2013 through June 30, 2014. The 2016 Value Modifier will be based on performance during the 2014 calendar year, from January 1, 2014 through December 31, 2014.
2. **Quality measures provided in the reports.** The Mid-Year QRUR contains performance data on CMS-calculated claims-based measures only. These include three quality outcome measures based on Fee-for-Service Medicare claims submitted for Medicare beneficiaries attributed to the TIN during the Mid-Year QRUR performance period. The three measures are: two composite measures of hospital admissions for ambulatory care-sensitive conditions (one for acute conditions and one for chronic conditions) and one measure of 30-day all-cause hospital readmissions. The Mid-Year QRUR does not contain performance information on quality measures submitted through the Physician Quality Reporting System (PQRS), because these data are only calculated on an annual basis. The Annual QRUR, by contrast, will include all quality measures used to calculate a TIN's Quality Composite Score, including PQRS data. The same benchmarks will be used for the quality measures in the Mid-Year and Annual QRURs, and is based on performance on these measures between January 1, 2013 and December 31, 2013.
3. **Information related to the Value Modifier.** The Mid-Year QRUR does not include a Value Modifier calculation, and information reported will not affect the TIN's payments under the Medicare Physician Fee Schedule. The Mid-Year QRUR is intended to provide timely, actionable information to help TINs understand and improve the quality and efficiency of care provided to Medicare beneficiaries and their performance on the claims-based measures quality outcome and cost measures that are a subset of the measures that will be used to calculate the 2016 Value Modifier. Because the performance period and quality

measures differ from those used to calculate the 2016 Value Modifier, the Mid-Year QRUR may not be indicative of a TIN's future Value Modifier performance.

Exhibit 1 below outlines the metrics included in the 2014 Annual QRURs and 2014 Mid-Year QRURs.

Exhibit 1. Comparison of metrics displayed in the 2014 Mid-Year QRURs and 2014 Annual QRURs

QRUR Component	2014 Mid-Year QRUR (Performance Period: July 1, 2013–June 30, 2014)		2014 Annual QRUR (Performance Period: January 1, 2014–December 31, 2014)	
	Included?	Relevant Exhibits	Included?	Relevant Exhibits
Value Modifier Calculation	**No**	**-**	**Yes**	**Performance Highlights**
Quality Tier Designation	**No**	**-**	**Yes**	**Performance Highlights**
Quality Measures				
Quality Composite Score	No	-	Yes	Exhibit 5
Quality Domain Scores	No	-	Yes	Exhibit 5
CMS-Calculated Quality Outcome Measures	Yes	Exhibit 5	Yes	Exhibits 5 and 6-CCC-B
PQRS Quality Measures	No	-	Yes	Exhibits 5 and 6; Supplementary Exhibits 11 and 12
CAHPS Survey Measures	No	-	Yes	Exhibits 5 and 6-PCE
Cost Measures				
Cost Composite Score	No	-	Yes	Exhibit 9
Cost Domain Scores	No	-	Yes	Exhibit 9
Per Capita Costs for All Attributed Beneficiaries	Yes	Exhibits 7 and 8	Yes	Exhibits 9, 10, and 11
Per Capita Costs for Beneficiaries with Specific Conditions	Yes	Exhibits 7 and 8	Yes	Exhibits 9, 10, and 11
Medicare Spending per Beneficiary	Yes	Exhibit 7	Yes	Exhibits 10 and 12;
Additional Information				
Eligible Professionals Billing Under Your TIN	Yes	Exhibit 1; Supplementary Exhibit 1	Yes	Exhibit 1; Supplementary Exhibit 1
Medicare Beneficiaries Attributed to your TIN	Yes	Exhibit 2; Supplementary Exhibits 2A, 2B, and 4	Yes	Exhibit 2; Supplementary Exhibits 2A, 2B, 4, and 13
Beneficiary-Level Cost and Utilization Data	Yes	Exhibits 3, 4, 6, and 8; Supplementary Exhibits 3, 4, and 5	Yes	Exhibits 3, 4, 7, 8, and 11; Supplementary Exhibits 3, 5, 6, 7,8, 9, and 10

6. Who received a 2014 Mid-Year QRUR?

The 2014 Mid-Year QRURs are confidential feedback reports provided to TINs based on performance during July 1, 2013 through June 30, 2014. Reports are provided to solo physicians and groups of physicians that had at least one eligible case for one or more of the quality or cost measures. In future years, CMS intends to expand the dissemination of the Mid-Year QRURs to solo practitioners and groups of practitioners consisting only of non-physician eligible professionals.

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

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

For the five per capita cost measures (the Per Capita Costs for All Attributed Beneficiaries measure and the four Per Capita Costs for Beneficiaries with Specific Conditions measures) and for the three claims-based quality outcome measures that are calculated from Medicare administrative claims data, beneficiaries are attributed using a two-step approach to attribution similar to the approach used to assign beneficiaries to Accountable Care Organizations under the Medicare Shared Savings Program. Under this rule, a beneficiary receiving primary care services (as defined in Exhibit 2) from one or more primary care physicians is attributed to the TIN whose primary care physicians provided the plurality of allowed Medicare charges for the beneficiary's primary care services. In the second step, beneficiaries who did not receive any primary care services from a primary care physician during the performance period, the beneficiary is attributed to a TIN whose other (non-primary care) physicians, clinical nurse specialists, nurse practitioners, and physician assistants provided the plurality of allowed Medicare charges for the beneficiary's primary care services, as long as at least one physician in the TIN, regardless of specialty, provided primary care services to that beneficiary. For specialty definitions and more details regarding attribution, see the Detailed Methodology Document for the 2014 QRURs and 2016 Value Modifier available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html

Exhibit 2. Healthcare Common Procedure Coding System (HCPCS) Primary Care Service Codes

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

Note: Labels are approximate. For detailed definitions, see the American Medical Association's Current Procedural Terminology available at: http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html

Because the Medicare Spending per Beneficiary (MSPB) cost measure is based on care surrounding an episode of inpatient hospitalization, beneficiaries are attributed to TINs in a different manner. For this measure, an MSPB episode is attributed to the TIN that furnished more Part B-covered services (as measured by Medicare allowed charges) during the index hospitalization than did any other TIN.

The Value-Based Payment Modifier Program does not impose any single attribution methodology on quality measures reported through the Physician Quality Reporting System (PQRS). The method of attributing beneficiaries for PQRS quality measures varies by measure type and reporting mechanism:

- For individual PQRS measures reported via claims, qualified registries, or electronic health records (EHR), the TINs reporting the measures identify the Medicare Part B Fee-for-Service (FFS) beneficiaries seen during the reporting period to which each measure applies.
- For PQRS measures reported through the Group Practice Reporting Option (GPRO) Web Interface, CMS assigns a ranked pool of eligible Medicare FFS beneficiaries for which the TINs must submit data.

- For individual eligible professionals reporting PQRS measures group via qualified registries, a majority (but not all) of the eligible beneficiaries included in the measures group must be Medicare Part B FFS beneficiaries.
- For individual eligible professionals satisfying PQRS reporting requirements through participation in a qualified clinical data registry in 2014, the registry identifies the applicable beneficiaries seen during the reporting period to which its measures applies. The registry may report measures for both Medicare and non-Medicare beneficiaries.
- For TINs electing to submit data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for PQRS in 2014, CMS provides the identified CAHPS Survey Vendor with an appropriate sample frame of beneficiaries from the TIN.

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

No. Beneficiaries who received the plurality of their primary care services from a Federally Qualified Health Center or Rural Health Clinic will be attributed to that entity and not to a group or solo practitioner billing under a Taxpayer Identification Number (TIN). Although Federally Qualified Health Centers and Rural Health Clinics will be attributed beneficiaries, they and other entities not reimbursed under the Medicare Physician Fee Schedule do not receive 2014 QRURs, and the 2016 Value Modifier will not apply to them.

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

No. Although the populations used to calculate the quality and cost measures in the QRURs are intended to be broadly representative of the Fee-for-Service (FFS) Medicare beneficiaries in each group, the methods for defining those populations differ as follows:

- **Per Capita Costs for All Attributed Beneficiaries measure and Per Capita Costs for Beneficiaries with Specific Conditions (four measures).** These cost measures include all FFS Medicare beneficiaries attributed to a TIN in a two-step process based on the TIN having furnished the plurality of primary care services, as captured in Part B Medicare claims. Beneficiaries are not included if, for any month during the performance period, any of the following situations applied to them: they were enrolled in Part A only or Part B only; were not enrolled in both Medicare Part A and Part B for every month during the performance period; they were enrolled in Medicare managed care (for example, a Medicare Advantage plan); they resided outside of the United States, its territories, and its possessions; or they did not have any Medicare allowed charges during the performance period. See the Per Capita Costs for All Attributed Beneficiaries Measure Information Form

and Per Capita Costs for Beneficiaries with Specific Conditions Measure Information Form for additional details about each measure: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.

- **Hospital admissions for Ambulatory Care-Sensitive Conditions (ACSC) measures (Acute Conditions Composite and Chronic Conditions Composite).** For each of these quality outcome measures calculated from Medicare claims, CMS uses the same population of Medicare FFS beneficiaries attributed to a TIN for the Per Capita Costs for All Attributed Beneficiaries measure and Per Capita Costs for Beneficiaries with Specific Conditions measures, with the same exclusions. However, while the population included in the denominator for the Acute Conditions Composite includes all Medicare beneficiaries attributed to the TIN, the denominator for measures in the Chronic Conditions Composite is restricted to beneficiaries diagnosed with the given chronic condition (diabetes, chronic obstructive pulmonary disease/asthma, and heart failure). For more detailed specifications for these measures, see the Measure Information Form for the Acute and Chronic Ambulatory Care-Sensitive Condition Composite measures available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

- **30-day All-Cause Hospital Readmissions.** For this quality outcome measure calculated from Medicare claims, CMS also uses the same population of Medicare FFS beneficiaries attributed to a TIN for the Per Capita Costs for All Attributed Beneficiaries measure and Per Capita Costs for Beneficiaries with Specific Conditions measures, with the same exclusions. For a more detailed description of exclusions specific to this measure, see http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.

- **Medicare Spending per Beneficiary (MSPB).** Populations eligible for inclusion in the MSPB calculation are Medicare beneficiaries enrolled in Medicare Parts A and B who were discharged from short-term acute hospitals during the period of performance. Medicare Part and Part B claims are included in the MSPB episode if the beneficiary has been enrolled in Medicare Part A and Part B for the period 90 days prior to the start of an episode until the 30 days after discharge. Only claims for beneficiaries admitted to short-term acute hospitals reimbursed through Medicare's inpatient prospective payment system during the period of performance are included. Populations excluded from the MSPB calculation are made up of any episodes where, at any time 90 days before or during the episode, the beneficiary was enrolled in a Medicare Advantage plan, covered by the Railroad Retirement Board, or where Medicare was the secondary payer.

- **Quality measures reported through the Physician Quality Reporting System (PQRS).** *Note that no PQRS measures are reported in the 2014 Mid-Year QRUR. These data will be included only in the 2014 Annual QRUR, disseminated in fall 2015.*

  The populations included in PQRS quality measures vary by measure type and reporting mechanism.

- For individual PQRS measures reported via claims, qualified registries, or Electronic Health Record (EHR), the measure population must include 50 percent or more of the Medicare Part B FFS beneficiaries seen during the reporting period to which the measure applies.
- For PQRS measures reported through the GPRO Web Interface, the measure population is a sample of Medicare FFS beneficiaries, defined as follows:
  - For TINs with 25–99 eligible professionals: the first 218 consecutively ranked and CMS-assigned Medicare FFS beneficiaries, or 100 percent of assigned beneficiaries if the pool is smaller than 218.
  - For TINs with 100 or more eligible professionals: the first 411 consecutively ranked and CMS-assigned Medicare FFS beneficiaries, or 100 percent of assigned beneficiaries if the pool is smaller than 411.
- For individual eligible professionals reporting PQRS measures TINs via qualified registries, the measure population consists of 20 or more beneficiaries for each measures TIN, a majority (but not all) of who must be Medicare Part B FFS beneficiaries.
- For PQRS data submitted through participation in a qualified clinical data registry in 2014, the measure population must include 50 percent or more of the eligible professional's applicable beneficiaries seen during the reporting period to which the measure applies, but the population may include both Medicare and non-Medicare beneficiaries.
- For data submitted from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS, the measure population is the sample frame of beneficiaries from the TIN that CMS provides to the identified CAHPS Survey Vendor.

For additional information on the PQRS measures, see the Detailed Methodology Document for the 2014 QRURs and 2016 Value Modifier available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html.

10. Why are there unpopulated cells in some exhibits of my report?

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

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

Yes. Supplementary Exhibits 2, 3, and 4 include information on the beneficiaries attributed to the group, including sex, date of birth, risk status, Fee-for-Service Medicare claims filed and services provided, chronic conditions, and hospital admissions.

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

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

In both the Mid-Year and the Annual QRURs for 2014, CMS displays three quality outcome measures calculated from administrative claims: two composite measures of hospital admissions for acute and chronic Ambulatory Care-Sensitive Conditions and one measure of 30-day all-cause hospital readmissions.

In the 2014 Annual QRUR only, performance based on quality measures submitted through the Physician Quality Reporting System (PQRS) is also reported. The particular measures reported will depend on the TIN's participation in PQRS, as follows:

- For TINs that satisfactorily reported data to the PQRS via the Group Practice Reporting Option (GPRO), the measures shown in the QRUR are the quality measures reported for the TIN's beneficiaries via the mechanism the TIN chose in 2014 (qualified registry, electronic health record, or GPRO Web Interface).
- For TINs whose eligible professionals participated in PQRS as individuals and solo practitioners, CMS aggregated PQRS and/or qualified clinical data registry data, as applicable, reported by individual eligible professionals in the TIN, to calculate TIN-level quality performance.
- TINs supplementing PQRS data with the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey can elect to have these measures included in the calculation of their 2016 Value Modifier.

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

The Per Capita Costs for All Attributed Beneficiaries measure includes all Fee-for-Service Medicare Part A (hospital insurance) and Part B (medical insurance) payments to all eligible professionals who treated beneficiaries attributed to a TIN during the performance period, whether or not the treating eligible professionals were associated with TIN receiving the QRUR.

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

Per episode costs for the Medicare Spending per Beneficiary measure include all Medicare Part A and Part B claims with a start date falling between 3 days prior to an inpatient admission to a short-term acute care hospital (index admission) through 30 days post-hospital discharge. Part D outpatient prescription drug costs are not included.

Medicare costs for all cost measures include those associated with inpatient, outpatient, skilled nursing facility, home health, hospice, durable medical equipment, and non-institutional provider/supplier services. Part D outpatient prescription drug costs are not included. To the extent that Medicare claims include such information, the cost measures also include provider payments from Medicare, beneficiaries (copayments and deductibles), and third-party private payers.

3. Why are hospital-based costs included in cost measures for TINs?

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

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

Yes. All Medicare Part A and Part B claims paid for Medicare beneficiaries attributed to a TIN are included in that TIN's costs.

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

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

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

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

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

Medicare payments for the same services can vary depending on local input prices (such as wage index and geographic practice costs) and on payment rates for different classes of TINs in a given category. Without payment standardization, a TIN with higher Medicare payments could appear to have higher costs than other TINs in the peer group when, in fact, differences in geographic location or facility-specific payments (rather than resource use) might be responsible. More information on payment standardization is available at http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772057350. [1]

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

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

[1] This document refers to this process as "price standardization" rather than "payment standardization," but the two terms are equivalent.

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

- For the **Per Capita Costs for All Attributed Beneficiaries** measure reported in the 2014 QRURs, and for the four cost measures included in Per Capita Costs for Beneficiaries with Specific Conditions, CMS used the CMS Hierarchical Condition Categories (CMS-HCC) risk-adjustment model, which predicts beneficiaries' costs for the coming year, based on diagnoses from Medicare claims for the beneficiary from the previous year. The CMS-HCC model assigns codes from the International Statistical Classification of Diseases and Related Health Problems–9th Revision to 70 clinical conditions. For each beneficiary enrolled in Medicare Fee-for-Service the previous year, the CMS-HCC model generates a risk score based on the presence of these 70 conditions and on the beneficiary's age, sex, original reason for Medicare entitlement (age or disability), and Medicaid entitlement. Risk adjustment of 2014 costs also takes into account the presence of end-stage renal disease in the prior year. For more details, see the Per Capita Costs for All Attributed Beneficiaries Measure Information Form available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.
- For the **Medicare Spending per Beneficiary (MSPB)** measure, the condition codes used in the CMS-HCC model are also used, but they are gathered from claims submitted in the 90 days preceding the start date of a MSPB episode. This method captures those conditions most relevant to the shorter episodes surrounding inpatient hospitalizations that are used in this measure. The risk-adjustment methodology for the MSPB measure also includes beneficiary age and institutional status, but does not control for sex or Medicaid entitlement.
- The **two composite measures of hospital admissions for Ambulatory Care-Sensitive Conditions (ACSCs)** that Medicare calculated for the 2014 QRURs also are risk adjusted to account for differences in the age and sex of beneficiaries attributed to different TINs. For measures in the acute conditions composite (bacterial pneumonia, urinary tract infection, and dehydration), the denominator includes all Medicare beneficiaries attributed to the TIN. However, the denominator for measures in the chronic conditions composite (diabetes, chronic obstructive pulmonary disease, and heart failure) is restricted to beneficiaries diagnosed with the specific condition. For more details, see the Ambulatory Care-Sensitive Condition Measure Information Form available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.
- The **30-day All-Cause Hospital Readmissions** measure that CMS calculates from Medicare claims is risk adjusted to account for differences in beneficiary case mix based on beneficiary age and clinical characteristics. Moreover, service mix is accounted for by assigning the index admission to one of five mutually exclusive specialty cohort groups consisting of related conditions or procedures—groupings that presume that admissions treated by similar teams of clinicians are likely to have similar risks of readmission. The specialty cohort-specific readmissions are then combined in constructing the All-Cause Hospital Readmissions measure. For more information, see the 30-day All-Cause Hospital

Readmissions Measure Information Form available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.

- For the quality measures reported through the **Physician Quality Reporting System (PQRS)** reflect the proportion of beneficiaries seen by an eligible professional or group who received recommended services or treatments (rather than beneficiary outcomes), risk adjustment does not apply. Beneficiaries for whom the recommended treatment would not be appropriate are excluded from the denominator. PQRS quality measures are therefore not risk-adjusted.

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

Yes. All cost measures presented in the Mid-Year and Annual QRURs, and contributing to the 2016 Value Modifier (based on performance in 2014) are now adjusted to reflect the mix of physician specialties within a practitioner group. The specialty-adjustment methodology, applied separately for each cost measure, is as follows:

a. **Compute "national, specialty-specific expected costs" for each specialty.** This component of the measure will be computed as the weighted average of all TINs' payment-standardized and risk-adjusted costs, where the weight for each TIN is the number of eligible cases multiplied by that specialty's share of the TIN's eligible professionals, multiplied by the number of eligible professionals of that specialty in the TIN.

b. **Compute the "specialty-adjusted expected cost" for each TIN.** This component of the measure will be computed as the weighted average of the national, specialty-specific expected cost of all the specialties in the TIN, where the weights are each specialty's proportion of the TIN's Part B payments.

c. **Compute the "specialty-adjusted cost" for each TIN.** Divide the TIN's payment-standardized and risk-adjusted cost by the TIN's specialty-adjusted expected cost, and multiply this ratio by the national average cost.

For more information about specialty adjustment, see the Specialty Adjustment Fact Sheet available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.

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

Each TIN's performance on quality and cost measures is compared with a weighted mean (benchmark) performance of its peers. Quality benchmarks for the 2014 QRURs are based on performance in the prior year (calendar year 2013), and cost benchmarks are based on

performance in the performance period (July 1, 2013 to June 30, 2014 for the Mid-Year QRURs and calendar year 2014 for the Annual QRURs). For some quality Physician Quality Reporting System (PQRS) measures introduced in 2014, there are no comparable prior-year benchmarks. In these cases, CMS did not calculate the benchmark for that measure and does not display the measure in the 2014 QRURs. In addition, if there is no benchmark, the measure is not eligible for inclusion in the Quality Composite Score for the Value Modifier.

For the 2014 QRUR quality and cost measures, CMS defined the peer group for benchmarking purposes as all eligible TINs nationwide with at least 20 cases for the measure. For PQRS quality measures, only those TINs and individuals meeting the criteria to avoid the 2016 PQRS payment adjustment are included as peer groups.

10. The list of hospitals admitting my beneficiaries does not appear to be complete. How did CMS identify the hospitals that account for my Medicare beneficiaries' inpatient stays?

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