CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

UNDERSTANDING YOUR QRUR

SEPTEMBER 2015

HOW TO UNDERSTAND YOUR 2014 ANNUAL QUALITY AND RESOURCE USE REPORT AND SUPPLEMENTARY EXHIBITS

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A. Background and Purpose of the Annual Quality and Resource Use Reports

The 2014 Annual Quality and Resource Use Reports (QRURs) are confidential feedback reports that are available for all groups and solo practitioners nationwide that billed for Medicare-covered services under a single Taxpayer Identification Number (TIN) over the performance period (January 1, 2014 through December 31, 2014), and that had at least one eligible case for one or more of the quality or cost measures included in the Annual QRURs. The 2014 Annual QRURs are also available for groups and solo practitioners that participated in the Medicare Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care Initiative in 2014. These reports show how groups and solo practitioners, as identified by their TIN, performed in 2014 on the quality and cost measures used to calculate the 2016 Value-Based Payment Modifier (Value Modifier). For TINs with 10 or more eligible professionals who are subject to the 2016 Value Modifier, the QRUR shows how the Value Modifier will apply to physician payments under the Medicare Physician Fee Schedule (PFS) for physicians who bill under the TIN in 2016. For all other TINs, the QRUR is for informational purposes only and will not affect the TIN's payments under the Medicare PFS in 2016.

These reports contain exhibits on Physician Quality Reporting System (PQRS) measures (if applicable), Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS survey measures (if applicable), claims-based quality outcome measures, and cost measures that reflect the quality and costs of the care that the physician or group provided to its attributed Fee-for-Service (FFS) Medicare beneficiaries.

The cost measures included in this report, and calculated using administrative claims, are Per Capita Costs for All Attributed Beneficiaries, Per Capita Costs for Beneficiaries with Specific Conditions (Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), and Heart Failure), and Medicare Spending per Beneficiary (MSPB). The claims-based quality outcome measures included in this report are the 30-day All Cause Hospital Readmission, Acute Ambulatory Care-Sensitive Condition (ACSC) Composite, and Chronic ACSC Composite measures. PQRS and CAHPS measures are also included, if your TIN reported these measures.

Performance information on the claims-based quality outcome measures and the cost measures may be different between a TIN's 2014 Mid-Year QRUR and the 2014 Annual QRUR due to the different performance periods on which each report is based. The 2014 Annual QRUR is based on a performance period from January 1, 2014 to December 31, 2014, while the Mid-Year QRUR was based on a period from July 1, 2013 to June 30, 2014. The 2016 Value Modifier is calculated based on the performance shown in the 2014 Annual QRUR.

Groups and solo practitioners should use the data presented in this report to identify opportunities to improve the quality and efficiency of the care they deliver. This document provides suggestions for how the 2014 Annual QRUR may be used to achieve these goals. Information on understanding the supplementary exhibits is also provided. Note that most of

these exhibits are for informational purposes only. Thus, those that support computation of your Value Modifier score are indicated with the phrase "for 2016 Value Modifier."

B. Exhibits Included in the Annual Quality and Resource Use Reports

Exhibit 1. Your TIN's Eligible Professionals

Exhibit 1 displays the count of physicians and non-physician eligible professionals[1] in your TIN over the performance period, allowing you to review the composition of your TIN. The exhibit indicates the number of eligible professionals billing claims under your TIN during the performance period, as well as the number of eligible professionals associated with your TIN in PECOS as of October 16, 2014. In order to determine the size of your TIN for the purposes of the Value Modifier, CMS uses the lower of the two eligible professional counts.

You may also wish to review this exhibit to understand the percentage of physicians and non-physician eligible professionals who were identified as part of your TIN in PECOS or in Medicare claims. For a list of the eligible professionals associated with your TIN and information on whether these eligible professionals billed under your TIN over the performance period and/or were associated with your TIN in PECOS as of October 16, 2014, refer to Supplementary Exhibit 1.

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

Exhibit 2 shows the number of FFS Medicare beneficiaries who are attributed to your TIN for the claims-based per capita cost and quality outcome measures included in the Annual QRUR. Medicare beneficiaries are attributed to a TIN using a two-step methodology:

- Step 1: Assign a beneficiary to a TIN if the beneficiary receives the plurality of primary care services, as measured by Medicare allowed charges, from primary care physicians (PCPs) within the TIN. Primary care services include evaluation and management visits in an office, other outpatient services, skilled nursing facility services, and those services rendered in home settings. Primary care physicians are defined by Family Practice, Internal Medicine, General Practice, and Geriatric Medicine specialty codes.

[1] Eligible professionals include physicians, practitioners, physical or occupational therapists or qualified speech-language pathologists, and qualified audiologists. A physician is one of the following: doctor of medicine, doctor of osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry, or doctor of chiropractic. A practitioner is any of the following: clinical nurse specialist, certified registered nurse anesthetist, anesthesiology assistant, certified nurse midwife, clinical social worker, clinical psychologist, nurse practitioner, physician assistant, or registered dietician or nutrition professional.

- Step 2 (for beneficiaries who did not receive a primary care service from a primary care physician during the performance period): Assign a beneficiary to a TIN if the beneficiary (a) received at least one primary care service from a physician of any specialty within the TIN, and (b) received a plurality of the primary care services from specialist physicians, nurse practitioners, physician assistants, and clinical nurse specialists within the TIN.

The second and third rows of the exhibit display the number of beneficiaries who were attributed to your TIN in the first and second steps of attribution, respectively, so that you may review the proportion of beneficiaries attributed to your TIN during each step. Refer to Supplementary Exhibit 2 for a list of all beneficiaries attributed to your TIN.

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

Exhibit 3 presents information on the average number of primary care services provided to beneficiaries attributed to your TIN. It includes average counts of primary care services provided by the eligible professionals in your TIN and by eligible professionals outside your TIN. If you observe that a large percentage of primary care services provided to your TIN's attributed beneficiaries is provided by eligible professionals outside your TIN, you may wish to coordinate with these eligible professionals to ensure that your TIN's attributed beneficiaries are receiving efficient, effective care. For more information on the services your TIN's attributed beneficiaries receive both inside and outside your TIN, refer to Supplementary Exhibit 2A.

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

Exhibit 4 provides information on the hospital episodes attributed to your TIN for the MSPB measure, as well as the number of unique beneficiaries associated with these attributed episodes. A hospital episode is attributed to a TIN if the TIN provided more Part B-covered services during the hospitalization, as measured by Medicare allowed charges, than any other TIN. A lower number of unique beneficiaries associated with attributed episodes (relative to the total number of MSPB episodes of hospital care attributed to your TIN) indicates that some beneficiaries experienced multiple MSPB episodes during the performance period. These beneficiaries may benefit from enhanced care management support. More information on the beneficiaries associated with each episode (as well as other information relevant to your TIN's performance on the MSPB measure) can be found in Supplementary Exhibit 4.

Exhibit 5. Your TIN's Performance in 2014, by Quality Domain (for 2016 Value Modifier)

Exhibit 5 displays your TIN's domain score for each of the quality domains included in the Value Modifier, as well as the resulting Quality Composite Score and Quality Tier designation. Exhibit 5 is only populated for TINs that either (1) reported quality data via the PQRS Group Practice Reporting Option (GPRO) and met the criteria to avoid the 2016 PQRS payment

adjustment, (2) at least 50 percent of the eligible professionals in the TIN reported quality data under the PQRS as individuals and met the criteria to avoid the 2016 PQRS payment adjustment, or (3) for TINs that participated in the Medicare Shared Savings Program in 2014, met the PQRS reporting requirements under the Medicare Shared Savings Program.

The Quality Composite Score summarizes the TIN's performance on quality measures across up to six equally-weighted domains. Quality Domain Scores represent the equally-weighted average of standardized scores for all measures in the domain that have at least 20 eligible cases. (Standardized scores reflect how many standard deviations a TIN's performance differs from the national mean.) At the Quality Composite level, the peer group for TINs with 10 or more eligible professionals is all TINs with 10 or more eligible professionals subject to the Value Modifier. The peer group for TINs with between one and nine eligible professionals is all TINs with one or more eligible professionals and at least one physician, excluding TINs with physicians that participated in the Medicare Shared Savings Program, Pioneer ACO Model, or CPC initiative in 2014 and TINs with no physicians.

A higher Quality Composite Score (and higher Quality Domain Scores) indicates better quality performance. A low Quality Domain Score may alert you to opportunities for improvement; review Exhibit 6 to determine the quality domains of weakest performance and to identify the quality measures on which you may wish to focus your quality improvement efforts.

Exhibit 6. Performance on Quality Measures, by Domain

In a series of tables organized by quality domain, Exhibit 6 presents your TIN's performance rate and the number of eligible cases for each quality measure, as long as there was at least one measure with at least one eligible case. The "Standardized Score" column displays the standardized score for each measure, and the "Included in Domain Score?" column indicates whether each measure is included in your TIN's domain score. Only the measures for which your TIN had 20 or more eligible cases are included in your TIN's domain score.

The quality measures include the three CMS-calculated claims-based outcome measures (30-day All-Cause Hospital Readmission, Acute ACSC Composite, and Chronic ACSC Composite); PQRS measures (if applicable), either submitted through the PQRS GPRO or by individual eligible professionals who met the criteria as individuals to avoid the 2016 PQRS payment adjustment; and CAHPS measures (if applicable).

Please note that PQRS measures submitted in 2014 via qualified clinical data registry (QCDR) or electronic health record (EHR) reporting options (including GPRO EHR submissions) are not included in the 2014 Annual QRUR and will not be used to calculate the 2016 Value Modifier because we are unable to determine the accuracy of these data. (Please refer to the Detailed Methodology Document for the 2014 QRUR and 2016 Value Modifier for more information, available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html.) For eligible professionals reporting as individuals, information about performance on these measures is available in the PQRS feedback

report. In cases where the TIN reported PQRS measures only through QCDR or EHR reporting options, the TIN will not be subject to a low Quality Composite Score.

For TINs participating in the Medicare Shared Savings Program, Exhibit 6 will display only the 30-day All Cause Hospital Readmission measure and the Accountable Care Organization's (ACO) performance on any GPRO Web Interface measures submitted. For TINs participating in the Pioneer ACO Model or the CPC initiative, Exhibit 6 displays, for informational purposes only, PQRS data reported outside of the model or initiative, as well as performance on the three claims-based quality outcome measures and (if applicable) the CAHPS measures.

Review each measure within Exhibit 6 to identify those for which your TIN's performance rates compare least favorably to the benchmark presented in the third column, which is the case-weighted average performance rate for the peer group based on 2013 data. The peer group is defined as all TINs nationwide for which the measure is reported with at least 20 eligible cases. For measures for which higher performance rates indicate better performance, identify the measure(s) for which your TIN's performance rate is lower than the benchmark; for measures for which lower performance rates indicate better performance (indicated by an asterisk in Exhibit 6), identify the measure(s) for which your TIN's performance rate exceeds the benchmark. You may then use this information to develop a targeted quality improvement strategy.

Exhibit 7. Hospitals Admitting Medicare Beneficiaries Attributed to Your TIN Based on Primary Care Services Provided

Exhibit 7 identifies the hospitals that provided at least 5 percent of your TIN's attributed beneficiaries' inpatient stays over the performance period. This exhibit includes only the beneficiaries attributed to your TIN for the three claims-based outcome measures and the five per capita cost measures. It provides the hospital name, CMS Certification Number (CCN), and location of the hospital. Information about the efficiency and quality of care at these hospitals can be found on Hospital Compare (http://www.hospitalcompare.hhs.gov). Use the data presented in the last column to better understand which hospitals most frequently admitted your TIN's attributed beneficiaries. This information can help you target care coordination efforts more appropriately. Review Supplementary Exhibit 3 for information on each beneficiary's hospital admissions.

Exhibit 8. Hospitals Accounting for Episodes of Care Attributed to Your TIN for the Medicare Spending per Beneficiary Measure

Exhibit 8 identifies the hospitals that were associated with at least 5 percent of the episodes of care attributed to you for the MSPB measure over the performance period. Like Exhibit 7, this exhibit provides the hospital name, CMS Certification Number (CCN), and location of the hospital. Information about the efficiency and quality of care at these hospitals can be found on Hospital Compare (http://www.hospitalcompare.hhs.gov). The data presented in the last column enables you to identify the hospitals that were most frequently associated with your attributed MSPB episodes of care. This information may help you in prioritizing care coordination efforts.

Exhibit 9. Your TIN's Performance in 2014, by Cost Domain (for 2016 Value Modifier)

Exhibit 9 displays your domain score for each of the cost domains included in the Value Modifier, as well as the resulting Cost Composite Score and Cost Tier designation. The Cost Composite Score summarizes the TIN's performance on up to six cost measures across two equally-weighted cost domains. Cost Domain Scores represent the equally-weighted average of standardized scores for all measures in the domain that have at least 20 eligible cases. (Standardized scores show by how many standard deviations a TIN's performance differs from the national mean.) At the Cost Composite level, the peer group for TINs with 10 or more eligible professionals is all TINs with 10 or more eligible professionals subject to the Value Modifier. The peer group for TINs with between one and nine eligible professionals is all TINs with one or more eligible professionals and at least one physician, excluding TINs with physicians that participated in the Medicare Shared Savings Program, Pioneer ACO Model, or CPC initiative in 2014 and TINs with no physicians.

A lower Cost Composite Score (and lower Cost Domain Scores) indicates better cost performance compared with peers. A high cost domain score may alert you to opportunities for improvement; review Exhibit 10 to identify the cost measures on which you may wish to focus your efforts to improve the efficiency of your care.

Exhibit 10. Per Capita or Per Episode Costs for Your TIN's Attributed Medicare Beneficiaries

Exhibit 10 shows the five per capita cost measures (Per Capita Costs for All Attributed Beneficiaries, Per Capita Costs for Beneficiaries with Specific Conditions [Diabetes, COPD, CAD, Heart Failure]) and the MSPB measure that are included in the Value Modifier, displaying for each measure the payment-standardized, risk-adjusted, and specialty-adjusted per capita or per episode cost performance and the number of eligible cases or episodes. The last column indicates whether each measure is included in your TIN's domain score; only the measures for which your TIN had 20 or more eligible cases or episodes are included in your TIN's domain score.

Cost data for the Per Capita Costs for All Attributed Beneficiaries measure and the four Per Capita Costs for Beneficiaries with Specific Conditions measures are based on allowed charges for Medicare Parts A and B claims submitted by all providers for Medicare beneficiaries attributed to your TIN for these measures. For the MSPB measure, per episode costs are based on Medicare Parts A and B allowed amounts surrounding specified inpatient hospital stays (3 days prior to admission through 30 days post-discharge) for beneficiaries attributed to your TIN for this measure. Part D-covered prescription drug costs are not included in the per capita cost or MSPB measures.

Compare your TIN's costs for each measure with the benchmark that is in the third column to better understand how your TIN fared relative to the benchmark, which is the case-weighted average cost for the peer group based on the 2014 data. The peer group is defined as all TINs

nationwide that had at least 20 eligible cases for the measure. For example, if your TIN's Per Capita Costs for All Attributed Beneficiaries are higher than your peers, then use the detailed cost information presented in Supplementary Exhibits 2B and 5 (discussed in more detail below) to identify the types of costs incurred over the performance period for the beneficiaries attributed to your TIN. Similarly, if the MSPB costs for your TIN's attributed beneficiaries are higher than your peers, then you can use the detailed cost information presented in Supplementary Exhibits 4 and 6 to identify opportunities to improve the care for these beneficiaries, as discussed in more detail below.

The information on Per Capita Costs for Beneficiaries with Specific Conditions allows you to determine specific groups of beneficiaries for which your TIN's costs are higher than your peers. For example, if your TIN's Per Capita Costs for Beneficiaries with Diabetes are higher than your peers, then you could consider developing a strategy to improve the efficiency of the care of these beneficiaries, perhaps by adopting care management practices or by educating beneficiaries on self-management techniques. Supplementary Exhibits 7-10 provide a detailed cost of service breakdown for each condition-specific measure, which may aid in these efforts.

Exhibit 11. Differences between Your TIN's Per Capita Costs and Mean Per Capita Costs among TINs with these Measures, by Category of Service: Per Capita Costs for All Attributed Beneficiaries and Beneficiaries with Specific Conditions

Exhibit 11 displays the dollar difference between your TIN's attributed beneficiaries' payment-standardized, risk-adjusted, and specialty-adjusted per capita cost performance, by selected category, and the corresponding costs for your TIN's peer group. Your TIN's peer group is defined for each cost category as all TINs that had at least 20 eligible cases for the given measure. Use this exhibit to identify potential areas for cost reduction, based upon how your TIN's costs compare to your peers in each category. Per capita costs for inpatient care or emergency services that are higher than your peers, for instance, could suggest that additional care coordination or chronic illness management efforts may prove valuable in improving your TIN's cost performance. Refer to Supplementary Exhibit 5 and Supplementary Exhibits 7-10 for a more comprehensive cost of services breakdown for each per capita cost measure.

Exhibit 12. Differences between Your TIN's Per Episode Costs and Mean Per Episode Costs among TINs with this Measure, by Category of Service: Medicare Spending per Beneficiary Measure

For the MSPB measure, Exhibit 12 displays the dollar difference between your TIN's payment-standardized, risk-adjusted, and specialty-adjusted per episode cost performance, by selected category, and the corresponding costs for your peer group, defined as all TINs that had at least 20 eligible cases for the measure. Similar to Exhibit 11, use this exhibit to identify potential areas to improve the efficiency of the care that you provide, based upon how your TIN's costs compare to your peers in each category. Refer to Supplementary Exhibit 6 for a more comprehensive cost of services breakdown for the MSPB measure and Supplementary Exhibit 4 for a distribution of costs at the episode level.

C. Background and Purpose of the Supplementary Exhibits

The 2014 Annual QRUR supplementary exhibits supplement the information provided in the Annual QRURs, so that you have a better sense of your TIN's beneficiary population, their use of health care services, and an awareness of the other eligible professionals involved in your TIN's beneficiaries' care. This report's primary sources of information are the Medicare Part A and Part B claims from the performance period, submitted by all eligible professionals who treated beneficiaries attributed to your TIN, even if the eligible professionals were not affiliated with your TIN.

Specifically, these supplementary exhibits build on the information in the Annual QRUR and present:

1. Information about the physician and non-physician eligible professionals billing under your TIN
2. Information about the Medicare beneficiaries attributed to your TIN for the five per capita cost measures and three quality outcome measures
3. Data on the hospital admissions for your TIN's attributed beneficiaries
4. Data on the Medicare beneficiaries attributed to your TIN for the MSPB measure
5. Information on your TIN's per capita or per episode costs, by category of service, for the Per Capita Costs for All Attributed Beneficiaries measure, the four Per Capita Costs for Beneficiaries with Specific Conditions measures, and the MSPB measure
6. Information on individual eligible professional performance on 2014 PQRS measures (if eligible professionals submitted any PQRS measures under your TIN)
7. A summary of your 2014 GPRO earned incentive (if your TIN was eligible to receive one)

To aid in your interpretation of these exhibits, you may wish to download the "Notes and Hover Over Terms" document, which defines key terms used in the Supplementary Exhibits. This document is available from the Physician Value Landing Portlet or the CMS Enterprise Portal. After navigating to your 2014 Annual QRUR through either of these methods (please see the "Quick Reference Guide for Accessing the 2014 QRURs"), click the "Download educational materials related to the Annual QRURs" link to access this resource.

The information below suggests ways you can use data from the supplementary exhibits to improve quality of care, streamline resource use, and identify care coordination opportunities for your TIN's beneficiaries. Supplementary Exhibit 1 gives data to support your TIN's practice management systems. Supplementary Exhibits 2A, 2B, and 3 provide data that you can use to improve care coordination for beneficiaries attributed to your TIN. You can use Supplementary Exhibits 4-10 to better understand your TIN's performance on the MSPB measure, the Per

Capita Costs for All Attributed Beneficiaries measure, and the four Per Capita Costs for Beneficiaries with Specific Conditions measures. Finally, Supplementary Exhibit 11 displays the PQRS performance of any measures that your eligible professionals submitted as individuals, and Supplementary Exhibit 12 provides information on your GPRO incentive (if your TIN earned one).

These data can be downloaded in Microsoft Excel so that you can analyze the data. For Excel analyses using the beneficiary level data, you may remove personally identifiable information by deleting the first three columns of the exhibit. You may instead rely on the non-personally identifiable "Index" column to link beneficiaries between exhibits.

Supplementary Exhibit 1: Physicians and Non-Physician Eligible Professionals Billing under Your TIN, Selected Characteristics

Supplementary Exhibit 1 provides a list of the eligible professionals that were in your TIN during the performance period, based on October 16, 2014 PECOS data and Medicare claims submitted under TIN during the performance period. For each eligible professional, this table lists the National Provider Identifier (NPI) number and name, whether the eligible professional is a physician or non-physician eligible professional, specialty designation, whether the provider was identified as part of the TIN through the Provider Enrollment, Chain, and Ownership System (PECOS) and/or Medicare billing over the performance period, and the date of the last claim billed under the TIN. Use these data to verify information about eligible professionals in your TIN and to understand how CMS determined that these eligible professionals are associated with your TIN. In an effort to be transparent, we disclose this information for your review and understanding.

1. What should we do if some of the specialties for the eligible professionals in our TIN are listed incorrectly in the table?

Eligible professionals whose specialty is listed incorrectly should update their record in PECOS at https://pecos.cms.hhs.gov/pecos/login.do.

2. What should we do if eligible professionals identified through PECOS no longer belong to our TIN?

You should alert any eligible professionals who are still associated with your TIN in PECOS, but who no longer belong to your TIN, to update their PECOS record at https://pecos.cms.hhs.gov/pecos/login.do.

3. What should we do if an eligible professional identified through billings no longer belongs to our TIN?

If this information appears inaccurate, review your practice management system's setup, make sure the eligible professional in question has been inactivated, and let the medical group charge entry staff know the proper charge entry procedures. Moreover, you should contact your

TIN's Medicare Administrative Contractor (MAC) to find out whether you can correct the claims, if you believe an eligible professional was paid erroneously.

4. There is a difference between the number of eligible professionals in my TIN identified through PECOS and those identified through billings. How did this difference arise?

Eligible professionals may be identified through PECOS but not billings if they were registered to your TIN in PECOS as of October 16, 2014, but did not bill under your TIN during the performance period. Alternatively, eligible professionals may be identified through billings, but not PECOS if they billed under your TIN during the performance period, but their record in PECOS as of October 16, 2014 did not indicate that they were associated with your TIN. To determine your TIN's group size for the purposes of the Value Modifier, CMS will use the lower of the two eligible professional counts.

Supplementary Exhibit 2A: Beneficiaries Attributed to Your TIN for the Cost Measures (excluding MSPB) and Claims-Based Quality Outcome Measures, and the Care that You and Others Provided

Supplementary Exhibit 2A provides information about the Medicare beneficiaries attributed to your TIN for the five per capita cost and three claims-based quality outcome measures. You can use these data as a starting point for examining systematic ways to improve and maintain delivery of high-quality and efficient care to beneficiaries. The table is divided into sections that describe beneficiary characteristics, specific Medicare claims data, the eligible professionals that billed the most services for the beneficiary, the date of the last hospital admission, and whether the beneficiary had one or more of four chronic conditions requiring more integrative care.

1. How can I use the listing of beneficiaries attributed to me?

You can use the data to confirm that you furnished services to these beneficiaries and identify the beneficiaries who are receiving the plurality of their primary care services from a physician or non-physician eligible professional under your TIN. Check the information in the column titled "Date of Last Claim Filed by TIN" to make sure that CMS captured this information correctly. The Health Insurance Claim (HIC) number will allow you to match the listed beneficiary with your TIN's practice management system's records. You may wish to use this information to better understand your TIN's performance on the Acute and Chronic ACSC Composites, 30-day All-Cause Hospital Readmission, Per Capita Costs for All Attributed Beneficiaries, and Per Capita Costs for Beneficiaries with Specific Conditions measures, or to focus your care management efforts.

2. How should we interpret and use the CMS-HCC percentile ranking?

Use this column to help identify the high- and low-risk beneficiaries to whom your TIN provides care. The CMS-HCC risk score is derived from prior year Medicare claims data for

each beneficiary and gives an estimate of the relative burden of illness for that beneficiary as reflected by those claims. The CMS-HCC risk score percentile is based on FFS Medicare beneficiaries nationwide, with 1 being low and 100 being high (83, for example, means that 83 percent of beneficiaries nationwide had relatively lower burden of illness). Higher scores tend to be associated with more severe illness (most often, multiple chronic conditions). As a result, these beneficiaries are at risk for having conditions that may benefit from more intensive efforts from your TIN at managing their chronic illness, including closer monitoring of the beneficiary's condition, actively coordinating care, and supporting beneficiaries' self-management. Such efforts may reduce unnecessary costs and improve the quality and outcomes of care.[2] You may also seek opportunities for more coordinated care for beneficiaries with low risk scores who, in the performance period, had a high percentage of total costs in unexpected categories of services (such as emergency services).

You can sort data by CMS-HCC risk score percentile, in descending order, to see the high- and low-risk beneficiaries to whom your TIN provide care. Once you identify a risk population, you can link these beneficiaries to the data in Supplementary Exhibit 2B by "Index" to examine their cost category percentages and identify opportunities for more coordinated care.

3. How should I interpret the "Basis for Attribution" column?

For the five per capita cost measures and for the three claims-based quality outcome measures, beneficiaries are attributed to your TIN using a two-step attribution process. The first step assigns a beneficiary to a TIN if the beneficiary receives the plurality (as measured by allowed charges) of his or her primary care services from PCPs within the TIN. The second step applies only to beneficiaries who did not receive a primary care service from any PCP during the performance period. Under this second step, a beneficiary is assigned to a TIN if the beneficiary (a) received at least one primary care service from a physician within the TIN and (b) received a plurality of his or her primary care services from specialist physicians and certain non-physician practitioners (nurse practitioners, clinical nurse specialists, and physician assistants) within the TIN. This column indicates the step of attribution in which each beneficiary was attributed to your TIN.

4. How can we use data in the "Number of Primary Care Services Provided by TIN" and "Percent of Primary Care Services Billed by TIN" columns?

Sort the data in the "Percent of Primary Care Services Billed by TIN" column in ascending order to identify the beneficiaries attributed to your TIN who received most of their services outside your TIN. This process will allow you to see which services were received outside your

[2] Bodenheimer, T., E. Wagner, K. Grumbach. "Improving Primary Care for Patients with Chronic Illness: The Chronic Care Model, Part 2." *Journal of the American Medical Association*, vol. 288, no. 15, 2002, pp. 1909-1914.

Coleman, K., B. Austin, C. Brach, E. Wagner. "Evidence on the Chronic Care Model in the New Millennium." *Health Affairs*, vol. 28, no. 1, 2009, pp. 75-85.

TIN's care and why, in some cases, a high percentage of evaluation and management services were provided outside your TIN. For these beneficiaries, review the data in the "Eligible Professionals Outside of TIN Billing Most Primary Care Services" column to identify which eligible professionals outside your TIN provided this care.

5. How can we learn about the services that our TIN and health care professionals outside of our TIN provided to the beneficiaries attributed to us?

Supplementary Exhibit 2A displays the eligible professionals both inside and outside your TIN who billed the most primary care services and non-primary care services for each beneficiary. Use the information on the eligible professionals within your TIN who billed the most primary care and non-primary care services to each beneficiary, in order to help you identify the types of services your TIN provided to your attributed beneficiaries. You may also check the information in the column titled "Date of Last Claim Filed by TIN" to make sure that CMS captured this information correctly.

Use the information on the eligible professionals outside of your TIN who billed the most primary care and non-primary care services to each beneficiary to make you aware of other key eligible professionals who provide care to your TIN's beneficiaries. This information may offer an opportunity to talk with your beneficiaries to better understand their full range of health care needs and the additional services they receive.

6. How can we use the data in the "Date of Last Hospital Admission" column?

Compare values in the "Date of Last Hospital Admission" column with values in the "Date of Last Claim Filed by TIN" column to identify beneficiaries who did not have a visit with any eligible professional in your TIN following inpatient care. This process allows you to examine why the beneficiaries attributed to your TIN did not receive follow-up care.

7. How can we use the information on the four chronic condition subgroups to improve how we care for our beneficiaries?

These four subgroups reflect widespread chronic conditions among Medicare beneficiaries—conditions for which improved management may improve beneficiary outcomes as well as efficiency of care.[3] The Annual QRUR gives general information regarding the utilization patterns for beneficiaries with these chronic conditions who are attributed to your TIN. The supplementary exhibits show which beneficiaries were in each of these groups. Therefore, you can use this information to identify individual beneficiaries with these conditions

[3] Bodenheimer, T., E. Wagner, K. Grumbach. "Improving Primary Care for Patients with Chronic Illness: The Chronic Care Model, Part 2." *Journal of the American Medical Association*, vol. 288, no. 15, 2002, pp. 1909-1914.

Coleman, K., B. Austin, C. Brach, E. Wagner. "Evidence on the Chronic Care Model in the New Millennium." *Health Affairs*, vol. 28, no. 1, 2009, pp. 75-85.

who may benefit from improved chronic-illness management. For example, a higher hospital admission rate for a beneficiary with congestive heart failure represents an opportunity to re-examine how you manage such beneficiaries. You may decide to update or change beneficiaries' preventive care, self-management support, monitoring, or medical treatment plans. These beneficiaries may also benefit from greater efforts at care coordination across providers.

In general, it may be helpful to sort the data in the column labeled "Chronic Condition Subgroup," and the associated subcolumns (Diabetes, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, and Heart Failure), to identify beneficiaries with one or more of the four conditions. For each condition, consider linking beneficiary data by "Index" to Supplementary Exhibit 2B to use the data in the "Percent of Total Costs, by Category of Services Provided, All Providers" to assess whether a specific beneficiary's pattern of utilization suggests an opportunity for improved care.

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

Supplementary Exhibit 2B provides information about the costs of the care provided to the Medicare beneficiaries attributed to your TIN for the five per capita cost and three claims-based quality outcome measures (as shown in Supplementary Exhibit 2A). It provides both the beneficiary's total payment-standardized FFS Medicare costs and the distribution of these costs across categories of service. You can use this information (as well as the information in Supplementary Exhibit 3 about the hospitals admitting your TIN's attributed beneficiaries) to learn general information about the types of services used by specific beneficiaries, including specialty services and hospital-based services. By reviewing your TIN's own records and the records of hospitalizations, you can determine, for specific beneficiaries, the services provided by eligible professionals who billed under your TIN and the services billed by eligible professionals outside your TIN. If you discover unexpected patterns of service use for beneficiaries attributed to your TIN, you may want to ask other eligible professionals for additional medical records to aid efforts in coordinating care.

1. How should we use the "Included in the Per Capita Costs for All Attributed Beneficiaries Measure" column?

To better understand your performance on the Per Capita Costs for All Attributed Beneficiaries measure, sort by this column to identify those beneficiaries who represented an eligible case for the measure. Beneficiaries who were not included in this measure either did not meet the criteria to be considered an eligible case or were excluded in the process of risk adjustment. (More information is included in the Detailed Methodology for the 2016 Value Modifier and 2014 QRUR available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html.)

2. How can we interpret and use the data in the "Total Payment-Standardized FFS Medicare Costs" column?

This column displays the total FFS Medicare costs associated with the care of each beneficiary over the performance period. Since risk adjustment is applied across all TINs in order to compare costs across TINs, these beneficiary level costs are payment standardized, but not risk adjusted. Risk adjustment accounts for differences among beneficiaries (such as age or burden of illness) that could be expected to make their costs higher or lower than average, regardless of the quality and efficiency of their care. Payment standardization removes differences in payments due to geographic location, incentive payments, and other add-on payments that support specific Medicare program goals. It allows for a more equitable comparison of Medicare payments across the nation. Payment-standardized costs are risk adjusted when used in the per capita cost measures included in the 2016 Value Modifier.

Sort the column in descending order to determine the beneficiaries who are responsible for the highest costs. The data in the "Percent of Total Costs by Category of Services" columns can help you better understand the sources of these costs and determine whether any of the high-cost beneficiaries are strong candidates for enhanced care coordination or follow-up. Beneficiaries with high payment-standardized FFS Medicare costs and for whom emergency services represent a large share of these costs may benefit most from care coordination services.

3. How can we use the data in the "Percent of Total Costs, by Category of Services" columns to improve care for the beneficiaries we manage?

This section gives a breakdown of non-risk adjusted costs for your TIN's Medicare beneficiaries for the performance period. Use these columns to identify trends in service use among beneficiaries attributed to your TIN. Some patterns of use may present opportunities for you to improve care coordination. For example, if you provided a low percentage of all primary care services for a beneficiary with substantial costs devoted to procedures, ancillary services, or hospital services, there may be opportunities for you to further engage this beneficiary in care management and coordination. Similarly, beneficiaries who have a high proportion of total costs for emergency services may benefit from outreach to improve their use of primary care for urgent concerns, as well as additional efforts at care coordination. Beneficiaries who had substantial costs in post-acute care may benefit from closer monitoring. You can sort data in descending order in each column to identify high percentages for specific service categories utilized by your TIN's beneficiaries. (For more information on these cost categories, refer to Exhibit D.1 of the Detailed Methodology for the 2016 Value Modifier and the 2014 QRUR, available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html.)

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

Supplementary Exhibit 3 provides details about hospitalizations over the performance period (if applicable) for beneficiaries attributed to your TIN for the five per capita cost and three claims-based quality outcome measures. The beneficiaries in Supplementary Exhibit 3 will be a subset of all beneficiaries attributed to your TIN (as shown in Supplementary Exhibit 2A). Data are broken down by beneficiary and the admitting hospital, along with the principal diagnosis associated with the admission, the date of discharge, and the subsequent care environment. For TINs not participating in an Medicare Shared Savings ACO, the exhibit also shows whether the hospital admission was the result of an emergency department evaluation, an ACSC admission, or a readmission within 30 days of prior admission. (For TINs participating in a Medicare Shared Savings ACO, data on 30-day readmissions are available in Supplementary Exhibit 13.)

Note: This table does **not** include hospitalizations with a primary diagnosis of alcohol and substance abuse.

You can use these data as a starting point, along with your medical records, to examine systematic ways to improve or maintain the delivery of high-quality and efficient care to beneficiaries attributed to your TIN. You can also link the data in Supplementary Exhibit 3 with data in Supplementary Exhibit 2B using the "Index" column to understand the overall scope of services that a beneficiary admitted to the hospital has been receiving. Furthermore, you can study this combination to see how to better align and coordinate these services, how information may have been shared across the continuum of care, and how beneficiaries may become better engaged in their care—all of which might have worked to prevent the hospitalization.

1. How can the data in the "Admitting Hospital" column help us care for beneficiaries attributed to us?

These data allow you to determine which hospitals are providing inpatient services to your TIN's Medicare beneficiaries, as well as the principal diagnoses for these admitted beneficiaries. By assessing both the frequency of hospitalization to different facilities and the types of conditions accounting for these admissions, you can identify the hospitals on which you might focus specific efforts at management of care transitions, or the types of hospitalizations for chronic illnesses that you might aim to avoid through targeted care management efforts. You may also use this information to verify the data presented in Exhibit 7 of the Annual QRUR.

2. How can we use data in the "Principal Diagnosis" column?

Sorting data in the "Principal Diagnosis" column allows you to more closely examine the conditions that are drivers of your TIN's beneficiaries' hospitalizations. This exercise may be particularly beneficial for PCPs and groups of physicians that treat a broad range of diseases. If

certain diagnoses seem to appear frequently, you may find it useful to pay additional attention to how you manage that set of beneficiaries.

3. How can we identify preventable hospital admissions using the data provided in this table?

For TINs not participating in the Medicare Shared Savings Program, Supplementary Exhibit 3 has three key categories: ACSC admissions, admissions via the emergency department, and 30-day readmissions. Thirty-day readmissions are provided at the ACO level for Medicare Shared Savings Program TINs in Supplementary Exhibit 13. Each category represents an opportunity for you to identify and take another look at beneficiaries with potentially preventable admissions.

- *ACSC admissions*: Effective coordinated care has been shown to prevent hospitalizations and unnecessary resource use for beneficiaries with conditions in this category, including asthma, COPD, heart failure, diabetes mellitus, and hypertension. Therefore, this is an important group of beneficiaries on whom to focus. Use the column “ACSC Admission” to identify beneficiaries attributed to your TIN and who were admitted for one of the diagnoses in this category. For this group of beneficiaries, improved access to care, care coordination, appropriate preventive services, beneficiary self-management support, and proactive monitoring of beneficiary conditions may lead to fewer instances of worsening illness, less emergency care, and fewer hospital admissions.
- *Admissions via the emergency department*: Sort the column “Admissions via the ED” to identify beneficiaries who received emergency hospital services. You can also view the percentage of the overall costs that came from emergency department use from the “Percent of Total Costs, by Category of Services Provided” column in Supplementary Exhibit 2B. Beneficiaries who disproportionately use the emergency department in their medical care are a subset that may benefit from more intensive primary care, including improved access for urgent concerns and better care coordination.
- *Readmissions*: Filter the data in the column titled “Followed by All-Cause Readmission within 30 Days of Discharge” to focus on beneficiaries readmitted, for unplanned causes, to the hospital within 30 days of discharge. You can use these data to study how your TIN’s care pathways and collaboration with the hospital might be improved to identify and follow up with beneficiaries discharged from the hospital, to reduce readmissions.

4. How can we use the information on hospital discharge status to improve the care that we provide?

Discharge information highlights which beneficiaries were discharged to post-acute care in the performance period. Better collaboration and care coordination efforts with post-acute care providers associated with adverse outcomes, such as a 30-day readmission following discharge, may prevent future complications for your TIN’s beneficiaries. Sort or filter data in the “Discharge Status” column to find beneficiaries discharged to home, home care, skilled nursing facilities, and other post-acute care facilities.

Supplementary Exhibit 4: Beneficiaries Attributed to Your TIN for the Medicare Spending per Beneficiary Measure

Supplementary Exhibit 4 displays information on the beneficiaries attributed to your TIN for the MSPB measure. Data are presented at the beneficiary-episode level; if a beneficiary has more than one episode that was eligible for the MSPB measure, he or she will appear in the exhibit for each episode. The table is organized into four sections: beneficiary characteristics, the apparent lead eligible professional, features of the episode hospitalization, and the episode cost by category of service. For each episode, the total payment-standardized episode cost is also displayed. Use this exhibit to better understand the hospitalization episodes included in the MSPB measure, including where your attributed beneficiaries were hospitalized, the diagnoses that were the basis for their hospitalizations, their discharge dispositions, and the costs of these episodes.

Note: This table does **not** include hospitalizations with a primary diagnosis of alcohol and substance abuse.

1. How should we interpret the data in the "Apparent Lead Eligible Professional" sub-columns?

For each hospitalization episode included in the MSPB measure, the eligible professional associated with the plurality of the episode's Part B costs (meaning he or she was responsible for more Part B costs than any other eligible professional) is designated the apparent lead eligible professional.

2. How should we interpret and use the data in the "Total Payment-Standardized Episode Cost" column?

The data presented in the "Total Payment-Standardized Episode Cost" column displays the total of payment-standardized Part A and Part B allowed amounts over the period starting three days before the episode's index admission through 30 days after discharge from the index admission. By sorting the data in this column in descending order, you will be able to identify the most costly hospitalization episodes. You may use this sorted data to identify high-cost beneficiaries that might be candidates for enhanced care coordination. Secondly, reviewing the principal diagnoses associated with these high-cost episodes may help you to identify the types of beneficiaries for whom efforts to reduce unnecessary hospitalizations may result in the greatest cost savings. Additionally, patterns you observe among the hospitals associated with the highest total payment-standardized episode costs may suggest opportunities to improve efficiency in the care of your TIN's beneficiaries. Approaches might include examining your TIN's care of beneficiaries with these conditions, as well as reviewing the relative costs of hospitals and post-acute care options in your region, and the quality of transitional care services offered by the hospitals to which your TIN's beneficiaries are regularly admitted.

3. How should we use the "Medicare Spending per Beneficiary, by Category of Service Furnished by All Providers" columns?

The data presented in these columns help you to understand the distribution of costs associated with your TIN's beneficiaries' hospitalizations. High costs in some of the cost categories presented in Supplementary Exhibit 4 may suggest ways to improve care management for your TIN's attributed beneficiaries and consequently, your TIN's performance on the MSPB measure. For instance, high spending for costs associated with emergency department visits or hospital readmissions may perhaps be minimized through care coordination strategies to reduce unnecessary emergency department visits or prevent avoidable readmissions post-discharge. Additionally, if you observe that your TIN's imaging costs tend to be high, consider reviewing clinical criteria for using imaging to improve the efficiency of your care. (For more information on these cost categories, refer to Exhibit D.2 of the Detailed Methodology for the 2016 Value Modifier and the 2014 QRUR, available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html.)

Supplementary Exhibit 5: Per Capita Costs, by Categories of Service, for the Per Capita Costs for All Attributed Beneficiaries Measure

Similarly to Supplementary Exhibit 2B, Supplementary Exhibit 5 displays your TIN's attributed beneficiaries' costs for various types of services performed by providers both within and outside your TIN. The exhibit shows the percentage of your TIN's attributed beneficiaries using a service in a given category; your TIN's payment-standardized, risk-adjusted, and specialty-adjusted per capita cost performance; and the difference between your TIN's beneficiary per capita costs and the per capita costs of your TIN's peers, defined as all TINs with at least 20 eligible cases for the measure. Review this exhibit to identify those services and procedures that are contributing most to the cost per beneficiary.

1. How should we use the "Number of Attributed Beneficiaries Using any Service in this Category" and the "Percentage of Your Attributed Beneficiaries Using any Service in this Category" columns?

The data presented in these columns (which are the same categories shown at the beneficiary level in Supplementary Exhibit 2B) may be used to identify patterns of utilization among your TIN's attributed beneficiaries, in order to better understand the care that your TIN's beneficiaries receive. If a large share of your TIN's beneficiaries received evaluation and management services from other TINs, for example, you may find increased care coordination helpful. Alternatively, if a large percentage of your TIN's attributed beneficiaries received major procedures or ambulatory/minor procedures over the performance period, consider reviewing clinical guidelines for when particular procedures are indicated.

2. How should we interpret and use the data in the "Per Capita Costs for Your Attributed Beneficiaries" column?

Use the data presented in this column to better understand the data presented in Exhibit 11, to identify the types of services that contribute most to the total costs of your TIN's attributed beneficiaries, and to determine opportunities to improve the efficiency of the care your TIN provides. For example, if per capita costs for emergency services are high, consider investing in care management resources, such as enhanced access for urgent concerns or care coordination. Or, if your TIN's per capita skilled nursing facility expenses are high, perhaps consider options for arranging needed support at home or other venues (for example, assisted living). Per capita costs reflect care furnished by all providers, so you may also wish to use this column to better understand how care provided outside of your TIN contributes to your beneficiaries' total per capita costs. Supplementary Exhibit 2B may be useful in identifying the particular beneficiaries who used a service in each given category.

3. How should we use the benchmark cost columns ("Benchmark Per Capita Costs" and "Amount by Which Your Costs Were Higher or (Lower) Compared to the Benchmark") to improve care for the beneficiaries we manage?

The benchmark cost columns display the payment-standardized, risk-adjusted, and specialty-adjusted per capita cost performance of your TIN's peers, defined as all TINs with at least 20 eligible cases for the measure. Use the data in the "Amount by Which Your Costs Were Higher or (Lower) Compared to the Benchmark" to discern the categories for which your TIN's per capita costs exceed those of your peers. These categories may be ideal starting points for efforts at improving care efficiency.

Supplementary Exhibit 6: Per Episode Costs, by Categories of Service, for the Medicare Spending per Beneficiary Measure

Similar to Supplementary Exhibit 4, Supplementary Exhibit 6 displays the per episode costs for various types of services for the episodes of care attributed to your TIN for the MSPB measure. The exhibit shows the percentage of attributed episodes with costs in a given category; your TIN's payment-standardized, risk-adjusted, and specialty-adjusted per episode cost performance; and the difference between your per episode costs and the per episode costs of your peers. Your peers are defined for each category as all TINs with at least 20 eligible cases for the measure. Review this exhibit to identify those services and procedures that are contributing most to the cost per episode.

1. How should we use the "Number of Your Episodes with Costs in this Category" and the "Percentage of Your Episodes with Costs in this Category" columns?

The data presented in these columns may be used to improve the quality and efficiency of your care. If a large number of your attributed episodes are associated with inpatient readmissions, for example, enhancing your care coordination supports may improve your

performance on this measure. Similarly, if a large percentage of your attributed episodes include costs for emergency room services, you may wish to encourage increased use of primary care services or to enhance care coordination for patients post-hospitalization to improve future performance.

2. How should we interpret and use the data in the "Your Per Episode Costs" column?

Use the data presented in this column to better understand the data presented in Exhibit 12, identify the types of services that contribute most to the total costs of your TIN's attributed episodes, and to determine opportunities to improve the efficiency of the care your TIN provides. Episode costs reflect care furnished by all providers, so you may also wish to use this column to better understand how care provided outside of your TIN, such as in skilled nursing facilities or by home health agencies, contributes to your beneficiaries' total episode costs. If per episode costs are high in a particular category, refer to Supplementary Exhibit 4 to identify the particular episodes associated with this type of service. Review these identified cases to determine if opportunities exist for efficiency improvement.

3. How should we use the benchmark cost columns ("Benchmark Per Episode Costs" and "Amount by Which Your Costs Were Higher or (Lower) Compared to the Benchmark") to improve care for the patients we manage?

The benchmark cost columns display the payment-standardized, risk-adjusted, and specialty-adjusted per episode cost performance of your peers, or all TINs with at least 20 eligible cases for the measure. Use the data in the "Amount by Which Your Costs Were Higher or (Lower) Compared to the Benchmark" to discern the categories for which your per capita costs exceed those of your peers. These categories may be ideal starting points for efforts at improving care efficiency. For example, if your per capita costs for Imaging Services or Laboratory, Pathology, and Other Tests exceed those of your peers, you may wish to review available records to identify possible patterns of duplicative scans or tests associated with your MSPB episodes.

Supplementary Exhibits 7-10: Per Capita Costs, by Categories of Service, for the Per Capita Costs for the Beneficiaries with Specific Conditions Measures

Supplementary Exhibits 7-10 mirror Supplementary Exhibit 5, providing information on the various types of services performed by providers both within and outside your TIN for the beneficiaries included in the Condition-Specific Total Per Capita Cost measures. For these subgroups of attributed beneficiaries, each exhibit shows the percentage of attributed beneficiaries using a service in a given category; the payment-standardized, risk-adjusted, and specialty-adjusted per capita cost performance; and the difference between your TIN's per capita costs and the per capita costs of your peers. Your peers are defined for each cost category as all TINs with at least 20 eligible cases for the given measure. Use these exhibits in the same manner as described above for Supplementary Exhibit 5 to better understand the data presented in Exhibit 11 and to identify opportunities to improve the quality and reduce the costs of the care provided to beneficiaries with diabetes (Supplementary Exhibit 7), COPD (Supplementary

Exhibit 8), CAD (Supplementary Exhibit 9), and Heart Failure (Supplementary Exhibit 10). In particular, consider using these exhibits to learn more about the care that is provided outside of your TIN and to determine the cost categories that contributed most to your TIN's performance on each measure.

Supplementary Exhibit 11: Individual Eligible Professional Performance on the 2014 PQRS Measures

Supplementary Exhibit 11 displays performance on PQRS measures for each eligible professional who participated in PQRS as an individual under your TIN in 2014, including the PQRS measures reported, each measure's Value Modifier quality domain, the reporting mechanism(s) used by each eligible professional, and the number of eligible cases for each measure. It also displays whether each eligible professional met the criteria to avoid the 2016 PQRS payment adjustment, according to PQRS program rules.

Please note that PQRS measures submitted in 2014 via QCDR or EHR reporting options are not included in the 2014 Annual QRUR and will not be used to calculate the 2016 Value Modifier because we are unable to determine the accuracy of these data. Information about performance on these measures is available in the PQRS feedback report.

1. How should we use information regarding which of our TIN's eligible professionals met the criteria to avoid the 2016 PQRS payment adjustment?

If your TIN did not register for GPRO, but eligible professionals under your TIN participated in PQRS as individuals and met the criteria to avoid the PQRS payment adjustment, the aggregate group-level performance on individual eligible professional PQRS measures is shown in Exhibit 6. Since only the data submitted by eligible professionals who met the criteria to avoid the PQRS payment adjustment is used to compute the TIN level performance displayed in Exhibit 6, use the information on which eligible professionals avoided the PQRS payment adjustment to understand which eligible professionals' PQRS submissions factored into your TIN level PQRS performance results.

2. How should we use the "Performance Rate" and "Benchmark Rate" columns?

You may use these columns to identify areas for improvement for care settings and medical teams that support individual eligible professionals billing under your TIN. For example, for each eligible professional receiving a Supplementary Exhibit 11, compare the "Performance Rate" column to the "Benchmark Rate" column to identify measures for which the given eligible professional least frequently performs the recommended quality action, relative to other TINs reporting the measure with at least 20 eligible cases. Measures with low performance rates could suggest areas for your TIN to target quality improvement efforts. An eligible professional's performance rate that is much lower than the associated benchmark may be an important indicator of an opportunity for improvement in the care for the beneficiaries captured in the measure. (Note that for a small number of measures, designated by one asterisk in

Supplementary Exhibit 11, a lower performance rate indicates better quality; for these measures, select areas for improvement by identifying the measures with the highest performance rate or for which the performance rate is much higher than the benchmark.)

Supplementary Exhibit 12: Summary of 2014 GPRO Earned Incentive

Supplementary Exhibit 12 provides details about any incentive you may have earned by participating in the Group Practice Reporting Option (GPRO) in 2014. This table reports your total incentive amount and your incentive as a percentage of your total Part B Physician Fee Schedule allowed charges.

Beginning in 2015, TINs may no longer earn incentives for participating in GPRO. For information on the 2015 GPRO reporting requirements, please refer to the GPRO 2015 Criteria document at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_PQRS_GPRO_Criteria.pdf.

Supplementary Exhibit 13: Beneficiaries Attributed to Your ACO and Attributed to Your TIN for the All-Cause Hospital Readmissions Measure: Hospital Admissions for Any Cause

For TINs participating in an MSSP ACO, Supplementary Exhibit 13 provides details about hospitalizations over the performance period (if applicable) for beneficiaries who are both attributed to your ACO and who are either attributed to your TIN based on the two-step attribution rule or are associated with MSPB episodes attributed to your TIN. Like Supplementary Exhibit 3, data are broken down by beneficiary and the admitting hospital, along with the principal diagnosis associated with the admission, the date of discharge, and the subsequent care environment. The exhibit also shows whether the hospital admission was a readmission within 30 days of prior admission.

Note: This table does **not** include hospitalizations with a primary diagnosis of alcohol and substance abuse.

You can use these data to better understand the hospitalizations experienced by beneficiaries attributed to your ACO and treated by your TIN, as well as to help you to identify patterns in principal diagnoses or discharge dispositions that are associated with frequent readmissions.

1. How do the hospitalizations in Supplementary Exhibit 13 differ from the hospitalizations in Supplementary Exhibit 3?

Supplementary Exhibit 13 displays the hospitalizations over the performance period for the beneficiaries both attributed to the ACO in which your TIN participates and either attributed to your TIN based on the two-step attribution rule or associated with MSPB episodes attributed to your TIN. Supplementary Exhibit 3 provides details about your TIN's attributed beneficiaries' hospitalizations during the performance period for the beneficiaries attributed to your TIN for the per capita cost and claims-based quality outcome measures included in the Annual QRUR.

2. How can we use data in the "Principal Diagnosis" column?

Sorting data in the "Principal Diagnosis" column allows you to more closely examine the conditions that are drivers of the hospitalizations experienced by beneficiaries attributed to your ACO. If certain diagnoses seem to appear frequently, your ACO may find it useful to introduce quality improvement efforts focused on managing the care of patients with those conditions.

3. How can we identify hospital readmissions using the data provided in this table?

Filter the data in the column titled "Followed by All-Cause Readmission within 30 Days of Discharge" to focus on patients readmitted, for unplanned causes, to the hospital within 30 days of discharge. You can use these data to study how your ACO's care pathways might be improved to identify and follow up with patients discharged from the hospital and support your efforts to reduce readmissions.

4. How can we use the information on hospital discharge status to improve the care that we provide?

Use the hospital discharge information in Supplementary Exhibit 13 similarly to the corresponding data in Supplementary Exhibit 3. Sort data in the "Discharge Status" column to identify beneficiaries discharged to home, home care, or post-acute care, in order to gain a better understanding of the environments into which your ACO's attributed beneficiaries are frequently discharged. With this information, you may be better able to target resources to improve outcomes for future beneficiaries discharged to these settings.

D. Feedback for CMS

1. What additional information would you like to know about your beneficiaries and the care they receive from other Medicare providers?

You can contact CMS at the QRUR Help Desk at 1-888-734-6433 (select option 3) to share your thoughts about the content and format of these reports. We value your input and feedback to help make these reports meaningful.

2. Would you like to share other ways you have used these data?

We are interested in learning how you and your colleagues have used the report data in ways not mentioned in this document. Share your tips by contacting the QRUR Help Desk.