HOW TO UNDERSTAND YOUR 2015 MID-YEAR QUALITY AND RESOURCE USE REPORT

CONTENTS

A. Background and Purpose of the Mid-Year Quality and Resource Use Reports

The 2015 Mid-Year Quality and Resource Use Reports (QRURs) are confidential feedback reports provided to solo practitioners and groups nationwide who billed for Medicare-covered services under a single Medicare-enrolled Taxpayer Identification Number (TIN) over the Mid-Year QRUR performance period (July 1, 2014 through June 30, 2015), and had at least one eligible case for one or more of the claims-based quality outcome or cost measures included in the Mid-Year QRURs. This performance period differs from the actual performance period used for the 2017 Value Modifier, which extends from January 1, 2015 through December 31, 2015. Mid-Year QRURs will not affect a TIN's Medicare Physician Fee Schedule payments. These reports and the detailed tables that accompany them contain information on the claims-based quality outcome measures and cost measures that reflect the quality and costs of the care that the solo practitioner or group provided to its attributed Medicare Fee-for-Service (FFS) beneficiaries.

The 2015 Mid-Year QRUR provides a preview of a TIN's performance on the six cost measures and three claims-based quality outcome measures that are a subset of the measures that will be used to calculate the 2017 Value Modifier. 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 Diabetes, Per Capita Costs for Beneficiaries with Chronic Obstructive Pulmonary Disease (COPD), Per Capita Costs for Beneficiaries with Coronary Artery Disease (CAD), Per Capita Costs for Beneficiaries with Heart Failure, and Medicare Spending per Beneficiary (MSPB). These cost measures are payment standardized to account for differences in Medicare-allowed charges that are unrelated to the care provided (such as indirect medical education add-on payments), risk adjusted to account for beneficiary-level risk factors that can affect medical costs, and specialty adjusted to account for TIN-level differences in specialty mix that can affect medical costs. The claims-based quality outcome measures included in this report are the 30-day All-Cause Hospital Readmissions, Acute Ambulatory Care-Sensitive Condition (ACSC) Composite, and Chronic ACSC Composite measures. These quality measures are risk adjusted to account for beneficiary-level risk factors that can affect quality outcomes.

Performance information on these measures may be different between a TIN's 2015 Mid-Year QRUR and the 2015 Annual QRUR. The 2015 Annual QRUR will be available in fall 2016 and will show the TIN's actual performance on all of the quality measures and cost measures that will be used to calculate the 2017 Value Modifier. This Mid-Year QRUR report is provided for informational purposes only. The information included will not affect a TIN's Medicare Physician Fee Schedule payments. Solo practitioners and groups 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 2015 Mid-Year QRUR may be used to achieve these goals. Information on understanding the tables that accompany the QRURs also follows.

B. Exhibits Included in the Mid-Year Quality and Resource Use Reports

Exhibit 1. Eligible Professionals in Your TIN

Exhibit 1 displays the counts of eligible professionals[1] (including both physicians and non-physician eligible professionals) in your TIN as indicated by a query of the Provider Enrollment, Chain, and Ownership System (PECOS) on July 10, 2015, and based on the number of eligible professionals submitting claims to Medicare under your TIN between July 1, 2014 and June 30, 2015.

To determine the size of your TIN for the purposes of the Value Modifier, CMS uses the lower of the number of eligible professionals identified in PECOS as having re-assigned their billing rights to your TIN and the number of eligible professionals submitting claims to Medicare under your TIN for the performance period for the Value Modifier. Because the 2017 Value Modifier uses a different performance period from the Mid-Year QRUR performance period, the number of eligible professionals billing for services under your TIN may change. (The number of eligible professionals on which your Value Modifier is based will be displayed in your 2015 Annual QRUR, available in fall 2016.)

You may 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 in PECOS or Medicare claims, refer to Table 1. Keeping your TIN's providers' billing and demographic information (including specialty) up to date in PECOS is important for ensuring the accuracy of QRUR-related calculations, including the number of eligible professionals and specialty mix of professionals in your TIN.

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

Exhibit 2 shows the number of Medicare FFS beneficiaries who are attributed to your TIN based on primary care services provided. This attribution method is used for the Per Capita Costs for All Attributed Beneficiaries measure, the four Per Capita Costs for Beneficiaries with Specific Conditions measures, and the three claims-based quality outcome measures included in the Mid-Year QRUR. For these measures, Medicare beneficiaries are attributed to a TIN using a two-step methodology:

- Step 1: Assign a beneficiary to a TIN in the first step if the beneficiary received more primary care services (as measured by Medicare-allowed charges during the performance period for this report) from primary care physicians (PCPs), nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs) in that TIN than in any

[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.

other TIN.[2] Primary care services include evaluation and management services provided in an office and other non-inpatient and non–emergency room settings, as well as initial Medicare visits and annual wellness visits.

- Step 2 (for beneficiaries who did not receive a primary care service from a PCP, NP, PA, or CNS during the performance period): Assign a beneficiary to a TIN if the beneficiary received more primary care services from specialist physicians within the TIN than from specialist physicians in any other 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 Table 2A and Table 2B for a list of all beneficiaries attributed to your TIN for the three claims-based quality outcome measures and all cost measures except the MSPB measure.

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 physicians, NPs, PAs, and CNSs in your TIN and by physicians, NPs, PAs, and CNSs 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 Tables 2A and 2B.

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

Exhibit 4 provides information on the total hospitalization episodes attributed to your TIN for the MSPB measure, as well as the number of unique beneficiaries associated with these attributed episodes. An MSPB episode includes all Medicare Part A and Part B claims with a start date falling between 3 days prior to an Inpatient Prospective Payment System (IPPS) hospital admission (also known as the "index admission" for the episode) through 30 days following hospital discharge. A hospitalization episode is attributed to a TIN if, during the hospitalization, the TIN provided more Part B-covered services, 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 hospitalization episodes during the performance period. These beneficiaries may benefit from enhanced care management

[2] For a complete list of HCPCS codes associated with primary care services and the two-digit specialty codes that appear on Medicare carrier claims to define the specialties of the eligible professionals considered in the attribution process, please refer to the Supplementary Tables of the document entitled, "Two-Step Attribution for Claims-Based Quality Outcome Measures and Per Capita Cost Measures Included in the Value Modifier," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-03-25-Attribution-Fact-Sheet.pdf

support. More information on the beneficiaries associated with each hospitalization episode (as well as other information relevant to your TIN's performance on the MSPB measure) can be found in Table 4.

Exhibit 5. CMS-Calculated Quality Outcome Measure Performance

Exhibit 5 presents your TIN's performance rate and the number of eligible cases for the three CMS-calculated claims-based quality outcome measures: 30-day All-Cause Hospital Readmissions, Acute ACSC Composite, and Chronic ACSC Composite.[3] Review each measure within Exhibit 5 to identify those for which your TIN's performance rates compare least favorably to your TIN's peers. Lower rates on these measures indicate better performance. If your TIN's performance rate for a measure is higher than the benchmark rate, then your TIN demonstrated worse performance than your TIN's peers. Conversely, if your TIN's performance rate for a measure is lower than the benchmark rate, then your TIN demonstrated better performance than your TIN's peers. You may then use this information to develop a targeted quality improvement strategy. For the Acute ACSC Composite and the Chronic ACSC Composite measures, the peer group used to calculate the benchmark rates is all TINs that had at least 20 eligible cases for the given measure. For the 30-day All-Cause Hospital Readmissions measure, the peer group used to calculate the benchmark rate includes (1) all TINs not participating in the Shared Savings Program with ten or more eligible professionals and at least 200 eligible cases for the measure in calendar year 2014 and (2) all Medicare Shared Savings Program Accountable Care Organization (ACO) TINs with any cases for the measure in 2014.

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

Exhibit 6 identifies the hospitals that provided at least 5 percent of your TIN's attributed beneficiaries' inpatient stays over the performance period for this report. This exhibit includes only the beneficiaries attributed to your TIN for the three claims-based quality outcome measures and for five of the six cost measures. (Exhibit 7 addresses hospitalization episodes included in the MSPB measure.) 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 the Hospital Compare website (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 most appropriately. Review Table 3 for information on each beneficiary's hospital admissions.

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

Exhibit 7 identifies the hospitals that were associated with at least 5 percent of the episodes of care attributed to your TIN for the MSPB measure over the performance period for this report. Like Exhibit 6, this exhibit provides the hospital name, CCN, and location of the hospital. Information about the efficiency and quality of care at these hospitals can be found on Hospital

[3] If your TIN participated in a Shared Savings Program ACO in 2015, then your TIN's 2017 Value Modifier will be based on ACO-level quality measures, which includes an ACO-level 30-day All-Cause Hospital Readmissions measure, rather than the TIN-level measures shown in this report. The 2015 Annual QRUR, which will be available in fall 2016, will provide full information about your TIN's 2017 Value Modifier.

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

Exhibit 8 shows the five per capita cost measures (Per Capita Costs for All Attributed Beneficiaries, Per Capita Costs for Beneficiaries with Diabetes, Per Capita Costs for Beneficiaries with COPD, Per Capita Costs for Beneficiaries with CAD, Per Capita Costs for Beneficiaries with 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 costs and the number of eligible cases or episodes.

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 Medicare-allowed charges for Medicare Parts A and B claims during the period of performance that were 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. These measures do not reflect the actual costs billed through claims but instead standardizes those costs to facilitate more accurate comparisons to peers. Specifically, CMS standardizes cost data from claims to account for differences in allowed charges that are unrelated to the care provided and then risk adjusts and specialty adjusts the data to account for beneficiary-level risk factors and TIN-level differences in specialty mix that can affect medical costs.

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 your TIN's peers, which are all TINs that had at least 20 eligible cases for the total per capita cost measures, or at least 125 eligible cases for the MSPB 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 Tables 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 TIN's peers, then you can use the detailed cost information presented in Table 4 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 TIN's peers. For example, if your TIN's Per Capita Costs for Beneficiaries with Diabetes are higher than your TIN's peers, then you could refer to Table 7 for more detailed data and 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.

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

Exhibit 9 displays the dollar difference between your TIN's payment-standardized, risk-adjusted, and specialty-adjusted per capita costs for your attributed beneficiaries, 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 measure. Use this exhibit to identify potential areas for cost reduction. Per capita costs for inpatient care or emergency services that are higher for your TIN than for 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 Table 5 and Tables 7-10 for a more comprehensive breakdown of costs by categories of service.

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

Exhibit 10 displays the dollar difference between your TIN's payment-standardized, risk-adjusted, and specialty-adjusted per episode cost performance for the MSPB measure, by selected category, and the corresponding costs for your peer group, defined as all TINs that had at least 125 eligible cases for the measure. Similar to Exhibit 9, 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 Table 6 for a more comprehensive breakdown of costs by categories of service and Table 4 for a distribution of costs at the episode level.

C. Background and Purpose of the Tables

The 2015 Mid-Year QRUR Tables supplement the information provided in the Mid-Year 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 tables build on the information in the Mid-Year 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 claims-based quality outcome measures
3. Data on hospital admissions for your TIN's attributed beneficiaries and MSPB episodes
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

The information below suggest ways you can use data from the tables to improve quality of care, streamline resource use, and identify care coordination opportunities for your TIN's beneficiaries. For example, Tables 2A, 2B, and 3 provide data that you can use to improve care coordination for beneficiaries attributed to your TIN. Table 1 displays data to support your TIN's practice management systems. You can use Tables 4 and 5 to better understand your TIN's performance on the MSPB measure and the Per Capita Costs for All Attributed Beneficiaries measure.

You can download these tables in Microsoft Excel and 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 and relying instead on the non-personally identifiable "Index" column to link beneficiaries between exhibits.

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

Table 1 provides information about the eligible professionals in your TIN during the performance period, based on July 10, 2015 PECOS data and Medicare claims submitted under your 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 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. If you believe this information is not up to date for your TIN, you may update it in PECOS by contacting your Medicare Administrative Contractor.

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

The methodology used to define eligible professionals' specialties for the purposes of the QRUR can, at times, produce results that are different from what a TIN or eligible professional might expect. For the QRURs and Value Modifier, CMS in most instances assigns an eligible professional's specialty based on the specialty included on the eligible professional's Part B claims. This specialty might not always match the eligible professional's self-designated PECOS specialty, as could occur if the PECOS specialty is not current or was changed during the performance period. Eligible professionals may check their self-designated specialties in PECOS and make updates as needed 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 has reassigned their billing rights to 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 the eligible professional's record in PECOS at https://pecos.cms.hhs.gov/pecos/login.do to ensure the individual's billing rights are no longer assigned to your TIN.

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 July 10, 2015, 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 July 10, 2015 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 smaller of the two eligible professional counts.

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

Table 2A provides information about the Medicare beneficiaries attributed to your TIN 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. You can also identify the eligible professionals within your TIN and outside of your TIN who provided the largest shares of primary care services and non–primary care services to your beneficiaries. Check the information in the column titled "Date of Service on Last Claim" 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 Readmissions, 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 risk score percentile ranking?

Use this column to help identify the high- and low-risk beneficiaries to whom your TIN provides care. CMS computes for each beneficiary a CMS-HCC risk score from Medicare claims data from prior to the period of performance. This risk score provides 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 Medicare FFS 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, beneficiaries with higher CMS-HCC risk scores are at higher 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.[4] 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 high-risk population, you can link these beneficiaries to the data in Table 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. A beneficiary is attributed to a TIN in the first step if the beneficiary received more primary care services from PCPs, NPs, PAs, and CNSs in that TIN than from any other TIN. If a beneficiary did not receive a primary care service from any PCP, NP, PA, or CNS during the performance period, then the beneficiary is attributed to a TIN in the second step if the beneficiary received more primary care services from specialist physicians within the TIN than from any other 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 "Percent of Total Primary Care Charges" column?

Sort the data in the "Percent of Total Primary Care Charges" column in ascending order to identify the beneficiaries attributed to your TIN who received most of their services outside your TIN. This will allow you to see which services were received outside your TIN's care and to identify cases where a high percentage of evaluation and management services were provided outside your TIN. For these beneficiaries, review the data in the "EP Outside of TIN Billing Most Primary Care Services" column to identify which eligible professionals outside your TIN provided this care.

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[4] 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.

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?

Table 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 services and non-primary care services to each beneficiary to help you identify the eligible professionals in your TIN who could be best positioned to understand and improve the care of your attributed beneficiaries. You may also check the information in the column titled "Date of Service on Last Claim" 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 point to opportunities to speak 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 Service on Last Claim" 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?

Table 2A displays whether a beneficiary had one or more of the following chronic conditions: Diabetes, CAD, COPD, and Heart Failure. These four subgroups reflect chronic conditions that are widespread among Medicare beneficiaries and for which improved management may improve beneficiary outcomes as well as efficiency of care.[5] Table 2A shows which beneficiaries were in each of these groups. You can use this information to identify individual beneficiaries with these conditions who may benefit from improved chronic illness management. For example, a beneficiary with congestive heart failure and a high percentage of costs attributable to inpatient stays (indicated in Table 2B) 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 sub columns (Diabetes, CAD, Chronic COPD, and Heart Failure), to identify beneficiaries with one or more of the four conditions. For each condition, consider linking beneficiary data by "Index" to Table 2B to use the data in the "Percent of Total Costs, by

[5] 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.

Category of Services Provided, All Providers" to assess whether a specific beneficiary's pattern of utilization suggests an opportunity for improved care.

8. How can I identify beneficiaries included in the Per Capita Costs for Beneficiaries with Specific Conditions measures?

The chronic conditions subgroups displayed in Table 2A (Diabetes, CAD, COPD, and Heart Failure), are equivalent to the four conditions included in the Per Capita Costs for Beneficiaries with Specific Conditions measures. Beneficiaries identified in Table 2A as having one or more of the corresponding chronic conditions are included in the corresponding condition-specific total per capita cost measure.

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

Table 2B provides information about the costs of the care provided to the Medicare beneficiaries attributed to your TIN (as shown in Table 2A). It provides both the beneficiary's total payment-standardized Medicare FFS costs and the distribution of these standardized costs across categories of service. You can use this information (as well as the information in Table 3 about the hospitals admitting your TIN's attributed beneficiaries) to learn general information about the types of services used by specific beneficiaries. 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 categories of 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 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 excluded from this measure did not meet the criteria to be considered an eligible case. More information is included in the document entitled, "2015 Measure Information about the Per Capita Costs for All Attributed Beneficiaries Measure, Calculated for the 2017 Value-Based Payment Modifier Program," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-TPCC-MIF.pdf.

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

This column displays the total standardized Medicare FFS costs associated with the care of each beneficiary over the performance period. Unlike the costs included in the total per capita cost measures in the QRURs and the 2017 Value Modifier, the beneficiary-level costs in this column are neither risk adjusted nor specialty adjusted because risk and specialty adjustment are applied at the TIN level. 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.

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 Furnished by All Providers" 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 Medicare FFS 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 Furnished by All Providers" columns to improve care for the beneficiaries we manage?

This section displays the distribution of total payment standardized Medicare FFS costs for your TIN's Medicare beneficiaries for the performance period. Use these columns to identify patterns 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 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.

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

Table 3 provides details about hospitalizations over the performance period (if applicable) for beneficiaries attributed to your TIN for the five total per capita cost and three claims-based quality outcome measures. The beneficiaries in Table 3 will be a subset of all beneficiaries attributed to your TIN (as shown in Table 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. Table 3 also shows whether the hospital admission was the result of an emergency department evaluation, an ambulatory care-sensitive condition, or a readmission within 30 days of prior admission.

Note: This table does **not** display hospitalizations for attributed beneficiaries with a primary diagnosis of alcohol and substance abuse. The costs associated with such hospitalizations are still included in your TIN's per capita cost measure calculations, however.

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 Table 3 with data in Table 2B using the "Index" column to understand better 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" and "Principal Diagnosis" columns 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 6.

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 eligible professionals 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.

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

Table 3 has three key categories related to admissions: ACSC admissions, admissions via the emergency department, and 30-day readmissions. 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 other 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 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 "Admission 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 Furnished by All Providers" column in Table 2B. Beneficiaries who disproportionately use the emergency department in their medical care 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 Unplanned 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.

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

Table 4 displays information on the beneficiaries attributed to your TIN for the MSPB measure. Data are presented at the beneficiary-episode level; if a beneficiary has more than one episode that was eligible for the MSPB measure, he or she will appear in the exhibit for each episode. 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. Unlike the costs included in the MSPB measure in the QRURs and the 2017 Value Modifier, the beneficiary-episode-level costs in this column are neither risk adjusted nor specialty adjusted because risk and specialty adjustment are applied at the TIN level.

Note: This table does **not** display hospitalizations for attributed episodes with a primary diagnosis of alcohol and substance abuse. However, the costs associated with such hospitalizations are still included in your TIN's MSPB measure calculations.

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 largest share of the episode's Part B costs 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 Part A and Part B billings from all TINs 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. 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 Table 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 might be minimized through care coordination strategies to reduce unnecessary emergency department visits or prevent avoidable readmissions post-discharge.

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

Table 5 displays your TIN's attributed beneficiaries' costs for various categories of services performed by providers both within and outside your TIN. The categories of service are the same as in Table 2B but include additional subcategories. The table shows for each category (1) the percentage of your TIN's attributed beneficiaries using services in that category; (2) the part of your TIN's payment-standardized, risk-adjusted and specialty-adjusted total per capita costs attributable to the category; and (3) the difference between your TIN's per capita costs and the per capita costs of your TIN's peers for that category. (Your TIN's peers are all TINs with at least 20 eligible cases for the Per Capita Costs for All Attributed Beneficiaries 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 Your TIN's Attributed Beneficiaries Using any Service in this Category" and the "Percentage of Your TIN's Attributed Beneficiaries Using any Service in this Category" columns?

The data presented in these columns may be used to identify patterns of utilization among your TIN's attributed beneficiaries to help you 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 your TIN performed major procedures or ambulatory/minor procedures for a large percentage of your TIN's attributed beneficiaries 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 TIN's Attributed Beneficiaries" column?

Use the data presented in this column 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 per capita skilled nursing facility expenses for your TIN's attributed beneficiaries are high, perhaps consider options for arranging needed support at home or other venues (for example, assisted living). Table 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 TIN's Costs Were Higher or (Lower) Compared to the Benchmark") to improve care for the beneficiaries we manage?

The benchmark cost columns display for each category of service the average amount contributed by that category to your peers' payment-standardized, risk-adjusted and specialty-adjusted total per capita costs. (Your peers are all TINs with at least 20 eligible cases for the Per Capita Costs for All Attributed Beneficiaries measure.) Use the data in the "Amount by Which Your TIN's Costs Were Higher or (Lower) Compared to the Benchmark" to discern the

categories for which your TIN's category-specific per capita costs exceed those of your TIN's peers. These categories may be ideal starting points for efforts at improving care efficiency.

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

Table 6 displays the per episode costs for various categories of services for the episodes of care attributed to your TIN for the MSPB measure. The categories of service are the same as in Table 4 but include additional subcategories. The table shows for each category (1) the percentage of your TIN's attributed episodes using services in that category; (2) the part of your TIN's payment-standardized, risk-adjusted, and specialty-adjusted total per episode costs attributable to the category; and (3) the difference between your TIN's per episode costs and the per episode costs of your peers for that category. (Your TIN's peers are all TINs with at least 125 eligible cases for the MSPB measure.) Review this table to identify those services and procedures that are contributing most to the cost per episode.

1. How should we use the "Number of Your TIN's Episodes with Costs in this Category" and the "Percentage of Your TIN's 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 TIN's 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 TIN's Per Episode Costs" column?

Use the data presented in this column to better understand the data presented in Exhibit 10, 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 Table 4 to identify the specific episodes associated with this type of service. Review these identified cases to determine if opportunities exist for improving efficiency.

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

The benchmark cost columns display for each category of service the average amount contributed by that category to your peers' payment-standardized, risk-adjusted and specialty-adjusted total per episode costs for the MSPB measure. (Your peers are all TINs with at least 125 eligible cases for the MSPB measure.) Use the data in the "Amount by Which Your TIN's Costs Were Higher or (Lower) Compared to the Benchmark" to discern the categories for which your TIN's category-specific per episode costs exceed those of your peers. These categories may be

ideal starting points for efforts at improving care efficiency. For example, if your total 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.

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

Tables 7-10 mirror Table 5, providing information on the various types of services performed by providers both within and outside your TIN for the beneficiaries included in the Per Capita Costs for Beneficiaries with Specific Conditions measures. For these subgroups of attributed beneficiaries, each table shows for each category of service (1) the percentage of attributed beneficiaries using services in that category; (2) part of your TIN's payment-standardized, risk-adjusted, and specialty-adjusted total per capita costs attributable to the category; and (3) the difference between your TIN's per capita costs and the per capita costs of your peers for that category. (Your peers are defined for each cost category as all TINs with at least 20 eligible cases for the given measure.) Use these tables in the same manner as described above for Table 5 to better understand the data presented in Exhibit 9 and to identify opportunities to improve the quality and reduce the costs of the care provided to beneficiaries with diabetes (Table 7), COPD (Table 8), CAD (Table 9), and Heart Failure (Table 10). In particular, consider using these tables to learn more about the care that is provided outside of your TIN and to determine the categories of services that contributed most to your TIN's per capita costs for each measure.

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) or by email at pvhelpdesk@cms.hhs.gov 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.