QUESTIONS AND ANSWERS ABOUT THE 2016 QUALITY AND RESOURCE USE REPORTS AND THE 2018 VALUE-BASED PAYMENT MODIFIER

About the Frequently Asked Questions

These Frequently Asked Questions include information about the Quality and Resource Use Reports (QRURs) for 2016. The Annual QRUR, disseminated each fall, serves as the final summary report of performance on quality and cost measures during the performance year and on the Value-Based Payment Modifier (Value Modifier) payment adjustment for those groups and solo practitioners to which the Value Modifier applies. The Annual QRURs are intended to help groups and solo practitioners understand the quality and efficiency of care provided to Medicare beneficiaries and to inform them about their performance on some of the measures that will be included in the Value Modifier.

CONTENTS

TABLES

A. THE VALUE-BASED PAYMENT MODIFIER PROGRAM

A1. What is the Value-Based Payment Modifier Program?

The Value-Based Payment Modifier Program is part of a larger effort by the Centers for Medicare & Medicaid Services (CMS) to improve the quality and efficiency of medical care by developing meaningful and actionable ways to measure clinician performance. The program's main goal is to give providers information about the quality and cost of care furnished to their Medicare Fee-for-Service (FFS) beneficiaries. This program began under the Medicare Improvements for Patients and Providers Act of 2008 (formerly called the Physician Resource Use Measurement and Reporting Program) and was later extended and enhanced under the 2010 Patient Protection and Affordable Care Act (ACA). Confidential feedback reports, called Quality and Resource Use Reports (QRURs), are disseminated to groups and solo practitioners, as identified by their Medicare-enrolled Taxpayer Identification Numbers (TINs). See Section B, "Overview of the 2016 Quality and Resource Use Reports" for additional information.

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

A2. How is TIN size determined for purposes of computing the 2018 Value Modifier?

The magnitude of the Value Modifier payment adjustment depends, in part, on the number of eligible professionals (EPs)[1] in a TIN. To determine the size of a TIN for the purposes of applying the 2018 Value Modifier, CMS uses the lower of:

- the number of EPs identified in the Provider Enrollment, Chain and Ownership System (PECOS) on July 16, 2016 as having reassigned their billing rights to the TIN; and
- the number of EPs that submitted claims to Medicare under the TIN during 2016.

The size of a TIN is based on the number of physician and nonphysican EPs, including EPs who worked on a full-time or part-time basis or joined or withdrew from the TIN during 2016.

[1] EPs consist of physicians, practitioners, physical or occupational therapists, qualified speech-language pathologists, or qualified audiologists. For a list of providers designated as EPs by CMS based on their two-digit CMS specialty codes, see the document entitled "Detailed Methodology for the 2018 Value Modifier and 2016 Quality and Resource Use Report," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Detailed-Methodology-for-the-2018-Value-Modifier-and-2016-Quality-and-Resource-Use-Report-.pdf.

A3. How are the QRURs related to the Value Modifier?

For TINs to which the Value Modifier applies, the Annual QRURs, disseminated each fall, serve as the final summary report on performance on the quality and cost measures used to calculate the Value Modifier and the resulting payment adjustment. The Value Modifier can result in an upward, neutral, or downward payment adjustment to physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs) depending on their TIN's performance in 2016. The 2016 Annual QRUR shows calendar year 2016 performance, which is the performance period for the 2018 Value Modifier.

A4. Who has received a QRUR so far?

Since 2008, CMS has used a phased approach to create and disseminate physician feedback reports, in order to gain experience and obtain input from stakeholders. Throughout this process, CMS has used input from stakeholders, physician and medical specialty groups, QRUR recipients, and medical associations to guide changes to the QRURs.

In 2014, CMS began to make QRURs available to all physician groups and solo practitioners that had at least one physician who billed under the TIN during 2013. These were the first reports to include data used to determine Medicare PFS payment adjustments that would apply to some TINs, due to application of the Value Modifier starting in 2015.

In 2015, CMS made Mid-Year QRURs available, providing interim feedback about performance on claims-based quality outcome and cost measures (a subset of the measures used to calculate the Value Modifier) during the period July 1, 2014 through June 30, 2015, and continued to generate Annual QRURs for all groups and solo practitioners with at least one physician billing under the TIN. Both the Annual and Mid-Year QRURs provided feedback on a TIN's performance on cost and quality measures that were used to calculate the Value Modifier, regardless of whether the TIN was actually subject to the Value Modifier.

In 2016, CMS made Mid-Year QRURs available to all groups and solo practitioners that billed for Medicare-covered services under a single TIN, provided the TIN had at least one eligible case for at least one claims-based quality outcome or cost measure during the period July 1, 2014 through June 30, 2015. In September 2016, CMS made Annual QRURs available to all groups and solo practitioners that billed for Medicare-covered services under a single TIN, provided the TIN had at least one eligible professional in 2015. This included TINs that were not subject to the Value Modifier in 2017, namely, those with only nonphysician eligible professionals (EPs) in 2015 and TINs that participated in the Pioneer Accountable Care Organization (ACO) Model or the Comprehensive Primary Care initiative in 2015. For TINs that were subject to the 2017 Value Modifier (including, for the first time, all TINs that participated in the Shared Savings Program in 2015), the Annual QRURs included their Value Modifier information based on care provided during 2015.

In fall 2017, CMS will make the Annual QRURs available to all groups and solo practitioners that billed for Medicare-covered services under a single TIN, provided the TIN had

at least one eligible professional in 2016. This includes TINs that will not be subject to the Value Modifier in 2018, namely, those without any physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs) in 2016 and TINs that participated in the Pioneer ACO Model, the Comprehensive Primary Care initiative, the Next Generation ACO Model, the Oncology Care Model, or the Comprehensive End Stage Renal Disease (ESRD) Care Model in 2016.

A5. Will CMS continue to accept comments or suggestions about the QRURs?

Yes. Even though the 2016 QRURs are the final reports to be issued under the Value Modifier program, you can submit comments about the content and format of the QRUR by calling the Physician Value Help Desk at 1-888-734-6433 (select option 3) or emailing the Help Desk at pvhelpdesk@cms.hhs.gov. Normal business hours are Monday–Friday, 8 a.m. to 8 p.m. Eastern Time.

The Merit-based Incentive Payment System (MIPS) under the new Quality Payment Program is replacing the Value Modifier program. The first MIPS performance period is January 2017 through December 2017. CMS encourages everyone to learn more about the Quality Payment Program by visiting https://qpp.cms.gov/.

B. OVERVIEW OF THE 2016 QUALITY AND RESOURCE USE REPORTS

B1. What are the Quality and Resource Use Reports?

Under the Value Modifier Program, QRURs provide information about the resources used and the quality of care furnished to a group's or solo practitioner's Medicare FFS beneficiaries. The 2016 QRURs are generated for all groups and solo practitioners nationwide, as identified by their Medicare-enrolled TIN, regardless of whether the 2018 Value Modifier will apply to them. They can use their QRURs to see how their TIN compares with other TINs caring for Medicare beneficiaries.

The Annual QRURs provide information about performance on quality and cost measures during 2016. For physicians and nonphysician eligible professionals (EPs) in TINs that are subject to the Value Modifier in 2018, the Annual QRURs provide information on how the TIN's quality and cost performance will affect their Medicare PFS payments in 2018. The Value Modifier is used to adjust Medicare PFS payments to physicians and nonphysician EPs who are physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs), based on the quality and cost of care delivered to Medicare beneficiaries during 2016. For TINs that are not subject to the 2018 Value Modifier, the Annual QRURs are for informational purposes only.

The 2018 Value Modifier payment adjustments shown in the 2016 Annual QRURs are based on proposals that were included in the 2018 Medicare PFS Proposed Rule (82 FR 34124). The Proposed Rule can be found at https://federalregister.gov/d/2017-14639. Updated reports will be provided if these policies are not finalized as proposed. The 2018 Value Modifier proposals included:

- Reducing by half the automatic downward Value Modifier payment adjustment for practices that did not meet the minimum quality reporting requirements;
- Holding all practices that met the minimum quality reporting requirements harmless from downward Value Modifier payment adjustments based on performance; and
- Reducing the maximum upward Value Modifier payment adjustment for performance for large practices to align with the adjustment for small and solo practices.

B2. What information is in the 2016 Annual QRURs?

The 2016 Annual QRUR, available in fall 2017, provides complete information about how the 2018 Value Modifier applies to each TIN. This includes information about a TIN's performance during 2016 on all quality and cost measures used in calculating the 2018 Value Modifier, provided the TIN had at least one eligible professional. For TINs that meet the criteria to have their Value Modifier calculated using the quality-tiering approach, the Annual QRUR also indicates the quality and cost tier designation (high, average, or low cost and quality), based

on its 2016 performance. The Annual QRUR also includes benchmarks that allow each TIN to compare its performance on each measure to that of its peers. The 2016 Annual QRUR and 2018 Value Modifier is based on performance from January 1, 2016 through December 31, 2016. For more information on the criteria for TINs to have their Value Modifier calculated using the quality-tiering approach, and for other methodological information, please see the document entitled "Detailed Methodology for the 2018 Value Modifier and the 2016 Quality and Resource Use Report," located at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Detailed-Methodology-for-the-2018-Value-Modifier-and-2016-Quality-and-Resource-Use-Report-.pdf.

Supplementing each TIN's Annual QRUR are detailed tables with information about the eligible professionals (EPs) who billed to the TIN during 2016; the beneficiaries attributed to the TIN in 2016 for all claims-based quality outcome and total per capita cost measures; beneficiaries attributed to the TIN for the Medicare Spending per Beneficiary (MSPB) cost measure; beneficiaries' hospital admissions, primary diagnoses, and discharge disposition; TIN- and beneficiary-level total per capita cost breakdowns by category of service; and additional information on the quality measures that individual EPs in a TIN reported through the Physician Quality Reporting System (PQRS). Table A below outlines the metrics included in the 2016 Annual QRURs.

Table A. Metrics Displayed in the 2016 Annual QRURs (Performance Period: January 1, 2016-December 31, 2016)

QRUR Component	Relevant Exhibits
Value Modifier Calculation	Cover Page and Exhibit 1
Quality Tier Designation	Cover Page and Exhibit 1
Quality Composite Score	Exhibit 2, Exhibits 3-A and B
Quality Domain Scores	Exhibits 3-A and B, Exhibit 4
CMS-Calculated Quality Outcome Measures	Exhibit 4-CCC-B
PQRS Quality Measures	Exhibit 4, Table 7
CAHPS Survey Measures	Exhibit 4-PCE
Cost Composite Score	Exhibit 5, Exhibits 6-A and B
Cost Domain Scores	Exhibits 6-A and B, Exhibit 7
Per Capita Costs for All Attributed Beneficiaries	Exhibit 7-AAB
Per Capita Costs for Beneficiaries with Specific Conditions	Exhibit 7-BSC
Medicare Spending per Beneficiary	Exhibit 7-AAB
Eligible Professionals in Your TIN	Table 1
Medicare Beneficiaries Attributed to your TIN	Tables 2A and 5B
Beneficiary-Level Cost and Utilization Data	Tables 2C, 3B, 5D, 6A, and 6B
Hospitals Admitting Beneficiaries Attributed to your TIN	Tables 2B and 5A

B3. How can I download my 2016 Annual QRUR and Tables from the CMS Enterprise Portal?

The 2016 Annual QRUR and Tables can be downloaded directly from the CMS Enterprise Portal at https://portal.cms.gov using an Enterprise Identity Management (EIDM) account with the correct role. Please note that the Annual QRURs and Tables contain sensitive information, including protected health information (PHI) and personally identifiable information (PII). Therefore, users should follow the appropriate protocols for saving and printing this information securely.

For instructions on downloading the 2016 Annual QRUR and Tables, refer to Section VI and Section VIII of the document entitled Guide for Accessing the 2016 Annual QRURs and Tables available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-QRUR-Guide.pdf. Instructions for obtaining an EIDM account are also available on the CMS website https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html.

B4. Who received a 2016 QRUR?

The 2016 Annual QRURs are provided to groups and solo practitioners nationwide, as identified by their Medicare-enrolled TIN, with at least one eligible professional (defined in Section B, FAQ number 12 below) who billed Medicare Part B during 2016 regardless of whether they will be subject to the 2018 Value Modifier.

B5. How were beneficiaries attributed to TINs in the 2016 QRURs?

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

For five of the six cost measures (the Per Capita Costs for All Attributed Beneficiaries measure and the four Per Capita Costs for Beneficiaries with Specific Conditions measures) and for the three claims-based quality outcome measures that are calculated from Medicare administrative claims data, beneficiaries are attributed to a TIN using a two-step approach similar to the approach used to assign beneficiaries to ACOs under the Shared Savings Program. This two-step approach takes into account the level of primary care services received (as measured by Medicare allowed charges from final action claims during 2016) and the provider specialties that performed these services. Only beneficiaries who received a primary care service (as defined in Table B of Section B, FAQ number 6 below) during 2016 are considered in attribution. A beneficiary is attributed to a TIN in the first step if the beneficiary received more

primary care services from primary care physicians (PCPs),[2] nurse practitioners (NPs), physician assistants (PAs), or clinical nurse specialists (CNSs) within the TIN than from any other TIN. If a beneficiary did not receive a primary care service from any PCP, NP, PA, or CNS during 2016, 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. Beneficiaries are excluded from this attribution process if, for any month during 2016, any of the following situations applied to them: they were enrolled in Medicare Part A only or Medicare Part B only; they were enrolled in a private Medicare health plan (for example, a Medicare Advantage HMO/PPO, or a Medicare private FFS plan); or they resided outside the United States, its territories, and its possessions.

For specialty definitions and more details regarding attribution, please see 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-Attribution-Fact-Sheet.pdf.

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

B6. What are considered primary care services for the purposes of the QRURs?

For the purposes of the 2016 QRURs and the 2018 Value Modifier, primary care services are defined as Medicare Part B services billed under one of the Healthcare Common Procedure Coding System (HCPCS) codes listed in Exhibit G-1 of the 2016 QRUR. These codes are also available in Table B below. Only beneficiaries who received a primary care service as defined by these HCPCS codes during 2016 are considered in attribution.

[2] Primary care physicians are physicians with one of four specialty designations: internal medicine, general practice, family practice, or geriatric medicine.

Table B. Healthcare Common Procedure Coding System (HCPCS) Primary Care Service Codes

HCPCS codes	Brief description
99201–99205	New patient, office or other outpatient visit
99211–99215	Established patient, office or other outpatient visit
99304–99306	New patient, nursing facility care
99307–99310	Established patient, nursing facility care
99315–99316	Established patient, discharge day management service
99318	New or established patient, other nursing facility service
99324–99328	New patient, domiciliary or rest home visit
99334–99337	Established patient, domiciliary or rest home visit
99339–99340	Established patient, physician supervision of patient (patient not present) in home, domiciliary or rest home
99341–99345	New patient, home visit
99347–99350	Established patient, home visit
G0402	Initial Medicare visit
G0438	Annual wellness visit, initial
G0439	Annual wellness visit, subsequent
G0463	Hospital outpatient clinic visit (Electing Teaching Amendment hospitals only)

Note: Labels are approximate. For more details, see the American Medical Association's Current Procedural Terminology ® and the CMS website: http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html.

B7. Could beneficiaries who received most of their primary care services from a Federally Qualified Health Center or Rural Health Clinic be attributed to my TIN?

No. Beneficiaries who received more primary care services (as measured by Medicare-allowed charges) during 2016 from a Federally Qualified Health Center or Rural Health Clinic than any other TIN will be attributed to that entity and not to a group or solo practitioner billing under a TIN. Although Federally Qualified Health Centers and Rural Health Clinics will be attributed beneficiaries, they and other entities not paid under the Medicare PFS did not receive 2016 QRURs, and the 2018 Value Modifier will not apply to them.

B8. If a TIN consists solely of specialists, how could the TIN have attributed beneficiaries?

If a beneficiary did not receive a primary care service from any primary care physicians (PCPs), nurse practitioners (NPs), physician assistants (PAs), or clinical nurse specialists (CNSs), the beneficiary is attributed to a TIN in the second step of attribution if the beneficiary received more primary care services (as measured by Medicare-allowed charges) from specialist

physicians within the TIN than in any other TIN. (Please refer to Table B above for a list of primary care service codes used for attribution.)

Therefore, a TIN made up solely of specialists may be attributed beneficiaries in the second step of the attribution process if: (1) the beneficiary did not receive any primary care services from a PCP, NP, PA, or CNS, and (2) the TIN's specialists provided more primary care services than any other TIN's specialists. For more information about two-step attribution, please see 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-Attribution-Fact-Sheet.pdf. Additional information on attribution is also available in FAQ number 5 in Section B of this document.

B9. If patients receive primary care services from primary care physicians, nurse practitioners, physician assistants or clinical nurse specialists, can they be attributed in Step 2 of the attribution process?

No. Patients are attributed in Step 2 of the attribution process only if the patients did not receive any primary care services from primary care physicians (PCPs), nurse practitioners (NPs), physician assistants (PAs), or clinical nurse specialists (CNSs). A beneficiary would be attributed in Step 1 of the attribution process if he or she received a primary care service from a PCP, NP, PA, or CNS, even if the PCP, NP, PA, or CNS provided a smaller share of the total Medicare-allowed charges for primary care services than did specialist physicians.

For more information about the two-step process CMS uses to attribute beneficiaries to TINs, please see 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-Attribution-Fact-Sheet.pdf. Additional information on attribution is also available in FAQ number 5 in Section B of this document.

B10. Is the same population of Medicare beneficiaries included in all of the quality and cost measures?

No. Although the populations in the quality and cost measures used to calculate the Value Modifier are intended to be broadly representative of the Medicare FFS beneficiaries in each TIN, the methods for defining those populations differ as follows:

- **Per Capita Costs for All Attributed Beneficiaries measure**. This cost measure is based on the same population of Medicare FFS beneficiaries attributed to a TIN in the two-step process (described in further detail in FAQ number 5 above). This attribution method is based on primary care services received (as measured by Medicare-allowed charges) and the provider types that performed these services. Any beneficiary attributed to a TIN is eligible to be included in any or all total per capita cost measures.

- **Per Capita Costs for Beneficiaries with Specific Conditions** (four measures). For each of these cost measures calculated from Medicare claims, CMS uses a subset of the population of Medicare FFS beneficiaries attributed to a TIN for the Per Capita Costs for All Attributed Beneficiaries measure. Specifically, for each of the four condition-specific measures, the beneficiary population (also referred to as eligible cases) included in the measure is the subset of attributed beneficiaries that have the relevant condition (Coronary Artery Disease [CAD], Chronic Obstructive Pulmonary Disease [COPD], diabetes, or heart failure). For example, the beneficiaries included in the Per Capita Costs for Beneficiaries with Diabetes measure will include all beneficiaries in the Per Capita Costs for All Attributed Beneficiaries measure that were identified as having Diabetes.
- **Hospital Admissions for Acute and Chronic ACSC Composite measures** (Acute Conditions Composite and Chronic Conditions Composite). For each of these quality outcome measures calculated from Medicare claims, CMS uses the same population of Medicare FFS beneficiaries attributed to a TIN for the Per Capita Costs for All Attributed Beneficiaries measure, with the same exclusions. However, while the population included in the denominator for the Acute Conditions Composite includes all Medicare beneficiaries attributed to the TIN, the denominator for measures in the Chronic Conditions Composite is restricted to beneficiaries diagnosed with the given chronic condition (diabetes, chronic obstructive pulmonary disease/asthma, and heart failure). For more detailed specifications for these measures, please see the document entitled "2016 Measure Information about the Hospital Admissions for Acute and Chronic Ambulatory Care–Sensitive Condition (ACSC) Composite Measures, Calculated for the 2018 Value-Based Payment Modifier Program," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-ACSC-MIF.pdf.
- **30-day All-Cause Hospital Readmission.** For this quality outcome measure calculated from Medicare claims, CMS uses the same population of Medicare FFS beneficiaries attributed to a TIN for the Per Capita Costs for All Attributed Beneficiaries measure, with the same exclusions. For a more detailed description of exclusions specific to this measure, please see the document entitled "2016 Measure Information about the 30-Day All-Cause Hospital Readmission Measure, Calculated for the Value-Based Payment Modifier Program," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-ACR-MIF.pdf.
- **Medicare Spending per Beneficiary (MSPB).** The population of beneficiaries included in the MSPB measure is comprised of those Medicare FFS beneficiaries hospitalized during 2016 and for whom the TIN provided more Medicare Part B-covered services (as measured by Medicare-allowed charges) during the hospital stay than did any other TIN. This measure is based on episodes of care surrounding hospitalization for Medicare beneficiaries who were discharged from short-term acute hospitals during the period of performance. Medicare Part A and Part B claims are included in the MSPB episode if the beneficiary has been enrolled in Medicare Part A and Part B for the period 93 days prior to the start of an episode and for 30 days after discharge. Only claims for beneficiaries discharged from short-term acute hospitals paid under Medicare's inpatient prospective payment system during the period of performance are included. Populations excluded from the MSPB calculation are beneficiaries who, at any time 93 days before or during the episode and for 30 days after discharge, were

enrolled in a Medicare Advantage plan or for whom Medicare was the secondary payer. For more detailed information, please see the document entitled "Measure Information about the Medicare Spending Per Beneficiary, Calculated for the 2018 Value Modifier and 2016 Annual QRURs," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-MSPBM-MIF.pdf.

- **Quality measures reported through the Physician Quality Reporting System (PQRS).** The populations included in PQRS quality measures reflect the patients for whom a TIN submitted quality data. For more information on the eligible measure population for each reporting method, please refer to the document entitled "2016 Physician Quality Reporting System (PQRS): Implementation Guide," available at the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/downloads/2016_PQRS_ImplementationGuide.pdf?agree=yes&next=Accept?agree=yes&next=Accept. The measure population for TINs electing to submit data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS Survey in 2016 reflects the sample frame of beneficiaries in the TIN, as identified by CMS.

For additional information on the PQRS measures, please refer to the PQRS website at the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html.

B11. How are episodes of care attributed to a TIN for the Medicare Spending per Beneficiary (MSPB) measure?

For the MSPB measure, an episode of care includes all Medicare Part A and Part B claims with a start date falling between three days prior to an inpatient prospective payment system (IPPS) hospital admission ("index admission") through thirty days following hospital discharge. Each MSPB episode is attributed to the TIN responsible for the plurality (more than any other TIN) of Medicare Part B services, as measured by Medicare allowed amounts, performed by eligible professionals (EPs) during the episode's index hospitalization. Medicare Part B services are defined as all physician services that are billed on non-institutional claims. Medicare Part B services during the episode's index hospitalization include Medicare Part B services conducted in the period between the admission date and discharge date of the hospital stay. CMS considers any Medicare Part B services billed by EPs on the admission date and in a hospital setting, with place of service restricted to inpatient, outpatient, or emergency room hospital; or during the index hospital stay, regardless of place of service; or on the discharge date and in an inpatient hospital.

For more information on the MSPB measure, please see the document entitled "Measure Information about the Medicare Spending Per Beneficiary, Calculated for the 2018 Value Modifier and 2016 Annual QRURs," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-MSPBM-MIF.pdf.

B12. How are specialty designations that are reported in the TIN's QRUR assigned to a TIN's eligible professionals (EPs)?

For calculations in the QRURs, CMS needs to determine which healthcare providers (that is, physicians, nonphysician practitioners, and other suppliers) billing under a TIN are "eligible professionals" (EPs). This determination is, in general, based on each healthcare provider's self-reported "primary specialty" for the performance period, as reflected in the CMS PECOS enrollment and claims systems.[3] To account for any changes in the primary specialty that a physician might have made during a performance year, or to account for multiple PECOS enrollments for nonphysician healthcare providers, the specialty that appears in the QRUR is based on the primary specialty that is associated with the plurality of allowed charges for Medicare Part B services furnished by the healthcare provider under the TIN during the performance year.[4]

It is important that healthcare providers keep their specialty code(s) current in PECOS. CMS encourages healthcare providers to contact the Medicare Administrative Contractor that processes their claims to obtain additional details, if necessary, regarding their PECOS specialty codes. Healthcare providers may change their primary specialty, and/or any other applicable secondary specialty code(s), through PECOS. However, there is processing time for changes to be updated and reflected in future CMS enrollment and claims files. As a result, the methodology used to define EPs' specialties for the purposes of the QRUR can, at times, produce results that are different from what a TIN or eligible professional might have expected, such as when an eligible professional updates his/her PECOS information during or after the performance period.

For further details about the QRUR specialty designation methodology, please see the document entitled "Detailed Methodology for the 2018 Value Modifier and 2016 Quality and Resource Use Report," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Detailed-Methodology-for-the-2018-Value-Modifier-and-2016-Quality-and-Resource-Use-Report-.pdf. For more information on PECOS, please visit https://pecos.cms.hhs.gov/pecos/login.do#headingLv1.

[3] While physicians may select multiple secondary specialties in PECOS, they may select only one primary specialty. If nonphysician healthcare providers want to enroll in PECOS under more than one nonphysician specialty type, they must submit a separate CMS enrollment application for each specialty type.

[4] As a technical note, if a healthcare provider's specialty is not included in the CMS Medicare Part B claims files, then for purposes of the QRUR, CMS uses the healthcare provider's PECOS specialty listed as of the date when PECOS data are downloaded to produce the QRURs.

B13. If the eligible professionals (EPs) in a TIN are participating in the Physician Quality Reporting System (PQRS) as individuals, rather than as a group, how does CMS determine whether 50 percent of the eligible professionals in the TIN avoided the 2018 PQRS payment adjustment as individuals?

The percent of eligible professionals (EPs) in a TIN that avoided the 2018 Physician Quality Reporting System (PQRS) payment adjustment as individuals is calculated by taking the total number of EPs in the TIN who avoided the 2018 PQRS payment adjustment as individuals, divided by the total number of EPs in the TIN, and then multiplying the result by 100. Both full-time and part-time EPs, as well as those who billed under the TIN for only part of 2016, are included in the calculations. Specifically:

- The numerator is the number of EPs in the TIN who avoided the 2018 PQRS payment adjustment and either: (a) billed under the TIN for services furnished during 2016 or (b) were associated with the TIN in PECOS as of July 16, 2016 and reported PQRS data in 2016.
- The denominator is based on the lower of the number of EPs indicated by a query of PECOS on July 16, 2016 as having reassigned their billing rights to the TIN, and the number of EPs who submitted at least one claim to Medicare under the TIN during 2016.

B14. Does the 2018 Value Modifier apply to a TIN that participates in a Shared Savings Program Accountable Care Organization (ACO)?

Yes. In 2018, the Value Modifier will apply to payments under the Medicare Physician Fee Schedule (Medicare PFS) for physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs) billing under TINs that participated in a Shared Savings Program Accountable Care Organization (ACO) in 2016.

If the ACO reported on quality measures via the Group Practice Reporting Option (GPRO) Web Interface in 2016 and avoided the 2018 PQRS payment adjustment, then the 2018 Value Modifier for the participant TINs under the ACO will be calculated based on the ACO's quality performance, using the quality-tiering methodology. For these participant TINs, the TIN will be classified as Average Cost, and the Quality Composite Score will be calculated based on the quality data submitted by the ACO via the GPRO Web Interface and the ACO's performance on the claims-based 30-day All-Cause Hospital Readmission measure calculated by Medicare for 2016. If a TIN participated in more than one Shared Savings Program ACO in 2016, then the TIN's Quality Composite Score will be based on the performance of the ACO with the highest numerical Quality Composite Score, among the ACOs that avoided the 2018 PQRS payment adjustment.

If the ACO did not avoid the 2018 PQRS payment adjustment and a participant TIN reported quality data to the PQRS outside of the ACO through a GPRO and avoided the 2018 PQRS payment adjustment or at least 50 percent of the eligible professionals (EPs) in the TIN

reported quality data to the PQRS and avoided the 2018 PQRS payment adjustment as individuals (or if the TIN is a solo practitioner and avoided the 2018 PQRS payment adjustment as an individual), then the TIN will avoid the automatic downward payment adjustment under the Value Modifier and be classified as Average Quality and Average Cost.

If the ACO did not avoid the 2018 PQRS payment adjustment and a participant TIN did not report quality data to the PQRS outside of the ACO through a GPRO and avoid the 2018 PQRS payment adjustment and did not have at least 50 percent of the EPs in the TIN report quality data to the PQRS and avoid the 2018 PQRS payment adjustment as individuals (or if the TIN was a solo practitioner and did not avoid the 2018 PQRS payment adjustment as an individual), then the TIN will be subject to the automatic downward payment adjustment under the Value Modifier. The magnitude of the automatic downward payment adjustments are the same for ACO participant and non-participant TINs.

For more information, please see the document entitled "Medicare Shared Savings Program Interaction with the 2018 Value Modifier Frequently Asked Questions," available at the following URL, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2018-VM-MSSP-FAQs.pdf.

For more information on Value Modifier payment adjustments for both ACO and non-ACO participant TINs, please see the document entitled, "Computation of the 2018 Value Modifier," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2018-VM-factsheet.pdf.

B15. Will the 2018 Value Modifier apply to a TIN that participates in the Pioneer Accountable Care Organization (ACO) Model, the Comprehensive Primary Care initiative, the Next Generation ACO Model, the Oncology Care Model, or the Comprehensive End Stage Renal Disease (ESRD) Care Model?

The 2018 Value Modifier will be waived for groups and solo practitioners, as identified by their Medicare-enrolled TIN, if at least one eligible professional who billed for Medicare Physician Fee Schedule (Medicare PFS) items and services under the TIN during 2016 participated in the Pioneer Accountable Care Organization (ACO) Model, the Comprehensive Primary Care initiative, the Next Generation ACO Model, the Oncology Care Model, or the Comprehensive End Stage Renal Disease (ESRD) Care Model and none of the TIN's eligible professionals (EPs) participated in a Shared Savings Program ACO in 2016.

B16. If a TIN is new in calendar year 2017, how will the TIN's 2018 and 2019 Value Modifier be affected?

If a TIN is newly enrolled in the Medicare program in calendar year 2017 and did not exist during calendar year 2016 (the performance period for the 2016 Annual QRURs and 2018 Value Modifier), the TIN will not be affected by the 2018 Value Modifier since there would be no data for this TIN during 2016.

The Value Modifier payment adjustment based on 2016 Quality and Cost performance ends in 2018. The Merit-based Incentive Payment System (MIPS) under the new Quality Payment Program is replacing the Value Modifier. The first MIPS performance period is January 2017 through December 2017. CMS encourages everyone to learn more about the Quality Payment Program by visiting https://qpp.cms.gov/.

B17. Does the Value Modifier apply to eligible professionals who furnish services at a Rural Health Clinic, Federally Qualified Health Center or Critical Access Hospital?

The Value Modifier payment adjustment applies to payments for services furnished by physicians, Nurse Practitioners (NPs), Physician Assistants (PAs), Clinical Nurse Specialists (CNSs), or Certified Registered Nurse Anesthetists (CRNAs) under the Medicare Physician Fee Schedule (Medicare PFS). The Value Modifier does not apply to payments that are not made under the Medicare PFS. Therefore, the Value Modifier does not apply to payments for Rural Health Clinic services and Federally Qualified Health Center services.

The Value Modifier applies to payments for services furnished in Critical Access Hospitals (CAHs), in limited circumstances. Payments for an eligible professional's (EP's) services are separately billed and paid under the Medicare PFS when the EP's services are furnished in a CAH that bills under the standard payment methodology (Method I). Therefore, the Value Modifier payment adjustment applies to the Medicare PFS payments for services furnished in a Method I CAH.

However, the Value Modifier payment adjustment does not apply to payments for EP services furnished in CAHs when these services are billed and paid under the CAH Method II payment methodology. That is, CAH Method II payments for professional services are not paid under the Medicare PFS, so the Value Modifier payment adjustment does not apply. However, please note that even if a TIN's physicians, NPs, PAs, CNSs or CRNAs typically furnish services in a CAH that bills for services under the CAH Method II payment methodology, the payments for services that these physicians, NPs, PAs, CNSs or CRNAs furnish in other settings may still be subject to the Value Modifier if the services are billed and paid under the Medicare PFS (such as in an office or in a CAH that bills for its services under the standard payment methodology or Method I).

B18. Does the Value Modifier apply to physicians providing services in an Independent Diagnostic Testing Facility or an Independent Lab?

Yes, the Value Modifier payment adjustment applies to payments under the Medicare Physician Fee Schedule (Medicare PFS) for services furnished in an Independent Diagnostic Testing Facility (IDTF) or Independent Lab (IL) by physicians, Nurse Practitioners (NPs), Physician Assistants (PAs), Clinical Nurse Specialists (CNSs), or Certified Registered Nurse Anesthetists (CRNAs), if the eligible professional bills using an individual NPI. However, the Value Modifier payment adjustment does not apply to Medicare PFS services furnished and billed *by* IDTFs or ILs. IDTFs and ILs are not included in the definition of an eligible

professional and are therefore not subject to the Value Modifier. For more information about IDTF and IL billings, please contact your Medicare Administrative Contractor (MAC).

B19. Could a TIN with a hardship exemption under the Electronic Health Record (EHR) Incentive Program receive a downward 2018 Value Modifier payment adjustment?

Yes. While hardship exemptions apply under the Electronic Health Record (EHR) Incentive Program there is no hardship exemption under the Value Modifier program. A TIN does not avoid the Physician Quality Reporting System (PQRS) payment adjustment or the automatic downward Value Modifier payment adjustment solely by receiving a hardship exemption under the EHR Incentive Program.

B20. What is the most frequent reason for a TIN to receive a downward payment adjustment under the Value Modifier in 2018?

A TIN will receive an automatic downward payment adjustment under the 2018 Value Modifier if:

- a group fails to avoid the 2018 Physician Quality Reporting System (PQRS) payment adjustment by reporting quality data to the PQRS through the Group Practice Reporting Option (GPRO) and less than 50 percent of the eligible professionals (EPs) in the group avoid the 2018 PQRS payment adjustment as individuals; or
- a solo practitioner fails to avoid the 2018 PQRS payment adjustment as an individual.

For more information on how to report through PQRS, please see the document titled "2016 Physician Quality Reporting System (PQRS): Implementation Guide," available at the following URL: https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/downloads/2016_pqrs_implementationguide.pdf.

B21. Why are there unpopulated cells in some exhibits in my QRUR?

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

B22. Does CMS provide beneficiary-level data (with beneficiary identifiers) to TINs, so that the TINs can see which beneficiaries have been attributed to them and what services the beneficiaries used?

Yes. Tables 2A, 2C, 3B, 5B and 5D (as well as 6A and 6B for Shared Savings Program ACO TINs) in the 2016 Annual QRURs include information on the beneficiaries attributed to the TIN, including sex, date of birth, risk status, Medicare FFS claims filed and services provided, chronic conditions, and hospital admissions. Tables 2A and 3B in the 2016 Annual QRUR list the beneficiaries attributed to the TIN for the cost measures (except MSPB) and claims-based

quality outcome measures, and detail the care that the TIN and others provided. Table 5B in the 2016 Annual QRURs lists beneficiaries attributed to the TIN for the MSPB measure.

B23. Do the total per capita costs of patients attributed to a given TIN reflect costs from Medicare providers and suppliers outside of the TIN?

Yes. The Per Capita Costs for All Attributed Beneficiaries and Per Capita Costs for Beneficiaries with Specific Conditions measures include *all* Medicare FFS Part A and Part B allowed charges for a TIN's attributed beneficiaries during the performance period, regardless of whether the claims were billed by eligible professionals (EPs) in the given TIN, or by other providers and suppliers. Similarly, MSPB episode costs attributed to a TIN include all Part A and Part B payments during the period from three days prior to hospital admission through thirty days after discharge.

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

C1. What quality measures does CMS display in the Quality and Resource Use Reports?

In the Annual QRURs for 2016, CMS displays three quality outcome measures calculated from claims: hospital admissions for Acute and Chronic ACSC Composite measures and the 30-day All-Cause Hospital Readmission measure. The 2016 Annual QRURs also report performance based on quality measures submitted through the Physician Quality Reporting System (PQRS). The particular measures reported will depend on the TIN's participation in PQRS, as follows:

- For TINs that reported data to the PQRS via the Group Practice Reporting Option (GPRO) and avoided the 2018 PQRS payment adjustment, the measures shown in the QRUR are the quality measures reported by the TIN via the mechanism through which the TIN reported in 2016 (qualified registry, electronic health record, qualified clinical data registry, or GPRO Web Interface).
- For TINs who did not report data to the PQRS via the GPRO and whose eligible professionals (EPs) participated in PQRS as individuals and solo practitioners, CMS aggregated PQRS data reported by the individual EPs in the TIN that avoided the PQRS payment adjustment to calculate TIN-level quality performance.
- For TINs that elected to supplement PQRS data with the 2016 CAHPS for PQRS survey, patient experience data provided by the Medicare-certified CAHPS Survey Vendor are displayed in the 2016 QRURs.
- For TINs that participated in a Medicare Shared Savings Program ACO in 2016, the measures shown in the QRUR are the quality measures reported by the ACO, if the ACO reported through the GPRO Web Interface and avoided the 2018 PQRS payment adjustment. The ACO-level All-Cause Readmission measure would also be displayed in these TINs' QRURs, but no other claims-based measures would be shown.
- For TINs that participated in a Medicare Shared Savings Program ACO that did not avoid the 2018 PQRS payment adjustment, but the TIN reported to PQRS outside of the ACO and avoided the 2018 PQRS payment adjustment as a group or as individuals, the measures shown in the QRUR are the measures the TIN reported via GPRO or the aggregated PQRS data reported by individual EPs in the TIN. These measures would be shown for informational purposes only because these TINs are classified as having Average Quality and Average Cost.
- For TINs that did not participate in a Medicare Shared Savings Program ACO in 2016 that reported via the GPRO Web Interface, CAHPS for PQRS survey measures are only included in the Quality Composite Score if the TIN was eligible to report them through the PQRS and elected to include these survey results in the calculation of the TIN's 2018 Value Modifier.

For purposes of calculating the 2018 Value Modifier, CMS will consider quality data reported by a TIN through PQRS reporting mechanisms other than the one initially selected. If a TIN registered as a GPRO but failed as a group to avoid the 2018 PQRS payment adjustment, CMS will use quality data reported by the individual EPs in the TIN for purposes of applying the 2018 Value Modifier. Similarly, for TINs that registered for GPRO but reported and avoided the PQRS payment adjustment through a GPRO mechanism other than the one for which the TIN registered, CMS will use GPRO data reported through the GPRO mechanism through which the TIN avoided the PQRS payment adjustment for the purpose of applying the 2018 Value Modifier.

C2. What services and costs are included in the Quality and Resource Use Report's cost measures?

Medicare Part A and Part B payments (allowed amounts) are included in the cost measures.

The Per Capita Costs for All Attributed Beneficiaries measure includes all Medicare Part A and Part B payments for items and services provided to beneficiaries attributed to a TIN during the performance period, whether or not the items and services were provided by the TIN receiving the QRUR.

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

Per episode costs for the MSPB measure include payments for all Medicare Part A and Part B claims with a start date falling between 3 days prior to an inpatient admission to a short-term acute care hospital (index admission) through 30 days post-hospital discharge.

C3. Which quality data and cost data are included in the QRURs for TINs participating in the Pioneer Accountable Care Organization (ACO) Model, the Comprehensive Primary Care initiative, the Next Generation ACO Model, the Oncology Care Model, or the Comprehensive End Stage Renal Disease (ESRD) Care Model?

For TINs that did not participate in a Shared Savings Program ACO and that had at least one eligible professional that participated in the Pioneer Accountable Care Organization model, the Comprehensive Primary Care initiative, the Next Generation ACO Model, the Oncology Care Model, or the Comprehensive End-Stage Renal Disease (ESRD) Care Model in 2016, the 2016 Annual QRURs contain information on any quality measures reported in 2016 outside of these programs. These data can include measures reported to the PQRS as a group through the GPRO or measures reported to the PQRS individually by the eligible professionals (EPs) in the TIN who avoided the 2018 PQRS payment adjustment, as well as any available CAHPS for PQRS survey measures. Additionally, the 30-day All-Cause Hospital Readmission measure and hospital

admissions for Acute and Chronic ACSC Composite measures are included in the Annual QRURs.

The 2016 Annual QRURs report the same TIN-level cost measures for TINs that participated in a Shared Savings Program ACO, the Pioneer ACO Model, Comprehensive Primary Care initiative, the Next Generation ACO Model, the Oncology Care Model, or the Comprehensive ESRD Care Model in 2016 that are displayed for other TINs.

C4. How is the 2018 Value Modifier accounting for the new ICD-10 codes introduced on October 1, 2016?

New ICD-10 diagnosis and procedure codes came into effect on October 1, 2016. The new codes relevant to the Value Modifier program primarily include new diabetes diagnosis codes and cardiac procedure codes. Diabetes diagnosis codes are used when flagging chronic conditions for both the Per Capita Costs for Beneficiaries with Diabetes measure and for the denominator of the diabetes component measure included in the Hospital Admissions for Ambulatory Care Sensitive Conditions (ACSCs) Chronic Conditions Composite. Cardiac procedure codes are an exclusion for the numerator of the heart failure component measure included in the Hospital Admissions for ACSCs Chronic Conditions Composite. For the 30-day All-Cause Readmission (ACR) measure, diabetes diagnosis codes are used for identifying condition categories and cardiac procedure codes are used in identifying planned procedures. Finally, eighteen new pancreatitis codes are relevant when flagging planned readmissions in the ACR measure.

CMS will not include the new ICD-10 codes in algorithms used to compute the quality and cost measures for the 2018 Value Modifier or the 2016 Quality and Resource Use Reports (QRURs). Instead, CMS will use the same algorithms as previously, which accommodate all ICD-10 codes available prior to October 1, 2016 and are the same ones used to calculate the prior year benchmarks. This policy matches the approach taken by the Shared Savings Program.

C5. How are eligible cases determined for the cost and quality measures found in the QRURs?

For the claims-based measures included in the 2016 Annual QRUR, the number of eligible cases will differ depending on the measure. For five of the six cost measures (excluding MSPB), the number of eligible cases is a subset of a TIN's attributed beneficiaries. Specifically, the number of eligible cases for the Per Capita Costs for All Attributed Beneficiaries measure is the number of attributed beneficiaries who are included in the measure (beneficiaries are excluded when they meet certain exclusion criteria, such as part-year enrollment that isn't related to new enrollment or death). The number of eligible cases for the Per Capita Costs for Beneficiaries with Specific Conditions measures is equal to the number of attributed beneficiaries who have each specific condition and who do not meet the measure exclusion criteria. By contrast, the number of eligible cases for the MSPB measure is the number of MSPB episodes of care that were attributed to a TIN. For more information on how episodes of care are attributed to a TIN for the MSPB measure, please refer to FAQ number 13 in Section B of this document.

For the three claims-based quality outcome measures, the number of eligible cases for the Acute Conditions Composite and the Chronic Conditions Composite measures are based on a TIN's attributed beneficiaries. The Acute Conditions Composite includes all beneficiaries that did not meet the measure exclusion criteria. The Chronic Conditions Composite includes all attributed beneficiaries with one or more of the chronic conditions (diabetes, Chronic Obstructive Pulmonary Disease [COPD] or asthma, or heart failure) who do not meet the measure exclusion criteria. By contrast, the number of eligible cases for the 30-day All-Cause Hospital Readmission measure is the number of qualifying hospitalizations ("index hospitalizations") among a TIN's attributed beneficiaries. For more information on measure-specific exclusion criteria, refer to the Measure Information Form for each measure available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2016-QRUR.html.

Finally, the number of eligible cases for each Physician Quality Reporting System (PQRS) measure is based on the total number of cases the TIN submits to the PQRS that did not meet the exclusion criteria for the measure.

For more information on PQRS measure-specific exclusion criteria, refer to the measure specifications manual available at the following URL, which contains information on claims, registry, Web Interface, and measures group reporting: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/2016_Physician_Quality_Reporting_System.html.

For information on EHR reporting, please visit the following URL: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2014_eCQM_EligibleProfessional_July2014.zip.

C6. If a TIN and individual eligible professionals (EPs) in a TIN reported Physician Quality Reporting System (PQRS) data under multiple mechanisms, how does CMS calculate a TIN's PQRS measure performance rates?

The data CMS uses to calculate Physician Quality Reporting System (PQRS) performance rates depends on whether the TIN registered for GPRO, reported under elected or other GPRO mechanism, reported individual eligible professional (IEP) data, and avoided the 2018 PQRS payment adjustment. Table C below indicates which data CMS uses in Value Modifier calculations under various scenarios.

Table C. Hierarchy of PQRS Data Used in the 2018 Value Modifier

Did TIN register for the GPRO?	Did TIN report under elected GPRO mechanism and avoid the PQRS payment adjustment?	Did TIN report through another GPRO mechanism and avoid the PQRS payment adjustment?	Did TIN report Individual Eligible Professional (IEP) PQRS data?	Data used in the Value Modifier
Yes	Yes	No	No	GPRO data of the elected mechanism
Yes	Yes	Yes	No	GPRO data of the elected mechanism
Yes	Yes	No	Yes	GPRO data of the elected mechanism
Yes	Yes	Yes	Yes	GPRO data of the elected mechanism
Yes	No	Yes	No	GPRO data through which the TIN avoided the PQRS payment adjustment (not GPRO mechanism elected by TIN)
Yes	No	No	Yes	IEP data (if Category 1)
Yes	No	No	No	N/A
Yes	No	Yes	Yes	GPRO data through which the TIN avoided the PQRS payment adjustment (not GPRO mechanism elected by TIN)
No	N/A	Yes	Yes	GPRO data through which the TIN avoided the PQRS payment adjustment
No	N/A	Yes	No	GPRO data through which the TIN avoided the PQRS payment adjustment
No	N/A	No	Yes	IEP data (if Category 1)
No	N/A	No	No	N/A

Note: TINs are classified as Category 1 if the TIN avoided the PQRS payment adjustment as a group or at least 50 percent of the TIN's EPs avoided the PQRS payment adjustment as individuals.

If a TIN did not register as a GPRO and did not report under a GPRO mechanism, CMS will calculate the TIN's PQRS measure performance rates based on individual eligible professional (IEP) reporting (assuming at least 50 percent of the EPs in that TIN avoided the PQRS payment adjustment as individuals). If a TIN registered as a GPRO reported under a GPRO mechanism

and avoided the 2018 PQRS payment adjustment, CMS will calculate the TIN's PQRS measure performance rates based on GPRO reporting, whether or not EPs in the TIN reported PQRS data as individuals. Please refer to FAQ number 7 in Section C below for information on which PQRS measures are used in Quality Composite Score calculations.

C7. Does CMS use all Physician Quality Reporting System (PQRS) measures reported by a TIN in Quality Composite Score calculations or only the best measures?

CMS uses all data reported to the Physician Quality Reporting System (PQRS) through the mechanism by which the TIN avoided the PQRS payment adjustment, as described in FAQ number 6 in Section C above. All measures with a benchmark and that have at least the minimum number of required eligible cases are included in the Quality Composite Score, unless excluded for technical reasons. The Value Modifier program does not make a determination as to which measures are "best" for the purpose of determining whether to include them in the Quality Composite. Please refer to FAQ number 6 in Section C above for an explanation of which Physician Quality Reporting System (PQRS) data is used for each TIN.

For a complete list of PQRS measures, listed by quality domain, used to calculate the 2018 Value Modifier, please see the document entitled, "Detailed Methodology for the 2018 Value Modifier and the 2016 Quality and Resource Use Report," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Detailed-Methodology-for-the-2018-Value-Modifier-and-2016-Quality-and-Resource-Use-Report-.pdf.

C8. How is a TIN's Cost Composite Score calculated?

The six cost measures are organized into two cost domains: (1) Per Capita Costs for All Beneficiaries and (2) Per Capita Costs for Beneficiaries with Specific Conditions. A score for each domain is calculated as the equally-weighted average of measures in the domain that had the required minimum number of eligible cases. Performance is then summarized across those domains for which scores could be calculated. This summary score is standardized relative to the mean of summary scores within the peer group, to create a TIN's final Cost Composite Score. Therefore, a TIN's Cost Composite Score may be higher or lower than the average of the TIN's cost domain scores, depending on the distribution of scores within the peer group.

CMS uses the following steps to calculate a Cost Composite Score for each TIN:

1. **Standardize performance scores for each of the six individual cost measures** by subtracting the benchmark for the measure from the TIN's per capita or per episode costs and dividing by the case-weighted peer group standard deviation of the measure.
2. **Calculate the two cost domain scores** as the simple, unweighted average of standardized scores for every measure within each domain for which the TIN has the

minimum number of eligible cases (at least 125 eligible episodes for the MSPB measure and at least 20 eligible cases for other cost measures).

3. **Calculate a simple average of cost domain scores.**
4. **Calculate the Cost Composite Score** by standardizing the average of cost domain scores. To standardize the average of the cost domains scores, subtract the peer group mean from each TIN's average domain score and divide the difference by the peer group standard deviation. For TINs subject to the Value Modifier, the peer group for the Cost Composite includes all TINs subject to the 2018 Value Modifier for which a Cost Composite Score could be calculated, with the exception of TINs that participated in the Shared Savings Program in 2016. For all other TINs, the peer group for the Cost Composite includes all TINs for which a Cost Composite Score could be calculated, with the exception of TINs that participated in the Shared Savings Program, the Pioneer Accountable Care Organization (ACO) Model, the Comprehensive Primary Care initiative, the Next Generation ACO Model, the Oncology Care Model, or the Comprehensive End-Stage Renal Disease (ESRD) Care Model in 2016.

For additional information, please see the document entitled, "Computation of the 2018 Value Modifier," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2018-VM-factsheet.pdf.

C9. How is a TIN's Quality Composite Score calculated?

All quality measures are classified into six quality domains, aligned with the six priorities outlined in the National Quality Strategy: (1) Effective Clinical Care, (2) Person and Caregiver-Centered Experience and Outcomes, (3) Community/Population Health, (4) Patient Safety, (5) Communication and Care Coordination, and (6) Efficiency and Cost Reduction. A score for each quality domain is calculated as the equally-weighted average of scores within the domain, for all measures that have the required minimum number of eligible cases. Performance is then summarized across those domains for which scores could be calculated. This summary score is standardized relative to the mean of summary scores within the peer group to create a TIN's final Quality Composite Score. Therefore, a TIN's Quality Composite Score may be higher or lower than the average of the TIN's quality domain scores, depending on the distribution of scores within the peer group.

Specifically, CMS uses the following steps to calculate a Quality Composite Score for each TIN:

1. **Standardize performance scores for each individual quality measure** by subtracting the benchmark for the measure from the TIN's performance rate and dividing by the case-weighted peer group standard deviation of the measure.
2. **Calculate the quality domain scores** as the simple average of standardized scores for every measure within each domain for which the TIN has the minimum number of eligible cases. For all quality measures except the 30-day All-Cause Hospital Readmission measure, the minimum number of eligible cases is 20. For the 30-day All-Cause Hospital Readmission

measure, the minimum number of eligible cases is 200 for non-Shared Savings Program Accountable Care Organization (ACO) TINs with 10 or more eligible professionals (EPs) and 1 for Shared Savings Program ACO TINs. The 30-day All-Cause Hospital Readmission measure is not included in the domain scores for non-Shared Savings Program ACO TINs with fewer than 10 EPs.

3. **Calculate a simple average of quality domain scores.**
4. **Calculate the Quality Composite Score** by standardizing the average of quality domain scores. To standardize the average of the quality domain scores, subtract the peer group mean from each TIN's average domain score and divide the difference by the peer group standard deviation. For TINs subject to the Value Modifier, the peer group for the Quality Composite includes all TINs subject to the 2018 Value Modifier for which a Quality Composite Score was calculated and used to determine the Value Modifier. For all other TINs, the peer group for the Quality Composite includes all TINs for which a Quality Composite Score could be calculated, with the exception of TINs that participated in the Pioneer ACO Model, the Comprehensive Primary Care initiative, the Next Generation ACO Model, the Oncology Care Model (OCM), or the Comprehensive End-Stage Renal Disease (ESRD) Care Model in 2016.

For additional information, please see the document entitled, "Computation of the 2018 Value Modifier," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2018-VM-factsheet.pdf.

C10. Why are hospital-based costs included in cost measures for TINs?

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

C11. If a TIN is affiliated with a hospital, but some beneficiaries attributed to the TIN were admitted to an unaffiliated hospital, are those unaffiliated hospital costs included in the calculation of the TIN's costs?

Yes. All Medicare Part A and Part B claims paid for Medicare beneficiaries attributed to a TIN are included in that TIN's costs. The TIN that a beneficiary is attributed to is responsible for all of the beneficiary's hospital costs regardless of whether the hospital is affiliated with the TIN. Additionally, if an eligible professional, outside of the TIN, treats a beneficiary and admits that beneficiary to a hospital affiliated with the TIN, then those cost are also assigned to the TIN to which the beneficiary is attributed.

C12. Could "split billing" affect how costs are distributed among various types of services?

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

C13. How did CMS account for differences in Medicare payment rates for medical services in calculating cost measures (payment standardization)?

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

Medicare payments for the same services can vary depending on local input prices (such as wage index and geographic practice costs) and on payment rates for different classes of TINs in a given category. Without payment standardization, a TIN with higher Medicare payments could appear to have higher costs than other TINs in the peer group when, in fact, differences in geographic location or facility-specific payments (rather than resource use) might be responsible. More information on payment standardization is available at: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772057350.[5]

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

C14. How did CMS account for differences in beneficiaries' medical histories (risk adjustment) when calculating quality or cost measures?

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

- For the **Per Capita Costs for All Attributed Beneficiaries** measure reported in the 2016 QRURs, and for the four **Per Capita Costs for Beneficiaries with Specific Conditions** measures, CMS used the CMS-HCC risk-adjustment model, which predicts beneficiaries' costs for the coming year, based on diagnoses from Medicare claims for the beneficiary from the previous year. The CMS-HCC model assigns diagnosis codes to 79 clinical conditions. For each beneficiary enrolled in Medicare FFS the previous year, the CMS-HCC model generates a risk score based on the presence of these 79 conditions and on the beneficiary's age, sex, original reason for Medicare entitlement (age or disability), and Medicaid entitlement. Risk adjustment of 2016 costs also takes into account the presence of end-stage renal disease in the prior year. For more details, please see the document entitled, "2016 Measure Information about the Per Capita Costs for All Attributed Beneficiaries Measure, Calculated for the 2018 Value-Based Payment Modifier Program," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-CSTPCC-MIF.pdf.
- For the **Medicare Spending per Beneficiary (MSPB)** measure, the condition codes used in the CMS-HCC model are also used, but they are gathered from claims submitted in the 90 days preceding the start date of a MSPB episode. This method captures those conditions most relevant to the shorter episodes surrounding inpatient hospitalizations that are used in this measure. The risk-adjustment methodology for the MSPB measure also includes beneficiary age and institutional status, but it does not control for sex or Medicaid entitlement.
- The **Hospital Admissions for Acute and Chronic Ambulatory Care-Sensitive Condition (ACSC) Composite** measures that Medicare calculated for the 2016 QRURs also are risk adjusted to account for differences in the age and sex of beneficiaries attributed to different TINs. For more details, please see the document entitled, "2016 Measure Information about the Hospital Admissions for Acute and Chronic Ambulatory Care–Sensitive Condition (ACSC) Composite Measures, Calculated For the 2018 Value-Based Payment Modifier Program," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-ACSC-MIF.pdf.

- The **30-day All-Cause Hospital Readmission** measure that CMS calculates from Medicare claims is risk adjusted to account for differences in beneficiary case mix based on beneficiary age and clinical characteristics. Moreover, service mix is accounted for by assigning the index admission to one of five mutually exclusive specialty cohort groups consisting of related conditions or procedures—groupings that presume that admissions treated by similar teams of clinicians are likely to have similar risks of readmission. The specialty cohort-specific readmissions are then combined in constructing the 30-day All-Cause Hospital Readmission measure. For more information, please see the document entitled, "2016 Measure Information about the 30-Day All-Cause Hospital Readmission Measure, Calculated for the Value-Based Payment Modifier Program," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-ACR-MIF.pdf.
- Measures reported via **Physician Quality Reporting System (PQRS)** may be risk adjusted under the PQRS policies. However, these measures are presented in the 2016 QRURs as reported by the PQRS program, and are used in the Value Modifier calculation without additional risk adjustment. For comprehensive information on the risk adjustment policies of PQRS, please see the PQRS website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRI/.

C15. How can I estimate my TIN's costs prior to CMS accounting for differences in beneficiaries' medical histories (risk adjustment)?

A TIN can use the information found in the accompanying tables of the 2016 Annual QRUR to determine each beneficiary's pre-risk-adjusted spending. For example, refer to Column L in Table 3B of the 2016 Annual QRUR. The values in this column show the payment-standardized costs billed to a TIN for each of the TIN's attributed beneficiaries. Payment-standardized amounts account for variation in prices in different geographic locations across the country, but are neither risk nor specialty adjusted. The indicator in column K will specify whether a beneficiary's costs were included in the per capita costs measures. To determine a TIN's non-risk-adjusted (and non-specialty-adjusted) per capita costs, take the average of these costs among beneficiaries included in the measure. TINs can follow this same process for beneficiaries with specific conditions, using Columns G, H, I and J in Table 3B of the 2016 Annual QRUR to identify which beneficiaries are in each chronic conditions subgroup.

For more information on risk adjustment, please see the document entitled "Risk Adjustment," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-RiskAdj-FactSheet.pdf.

C16. What is the CMS Hierarchical Condition Category (CMS-HCC) score?

A CMS Hierarchical Condition Categories (CMS-HCC) model generates a risk score for each beneficiary. CMS uses these CMS-HCC risk scores in the risk-adjustment methodology for Medicare Advantage. This score summarizes each beneficiary's expected cost of care relative to other beneficiaries. Separate CMS-HCC models exist for new enrollees and continuing enrollees.

The new enrollee CMS-HCC model accounts for each beneficiary's age, sex, and disability status and is used when a beneficiary has less than twelve months of medical history. The continuing enrollee CMS-HCC model accounts for each beneficiary's age, sex, original reason for Medicare enrollment (age or disability), Medicaid enrollment, and clinical conditions as measured by CMS-HCCs.

C17. Does CMS account for differences in specialty mix when making peer group comparisons for cost measures?

Yes. All cost measures presented in the QRURs, and contributing to the 2018 Value Modifier (based on performance in 2016), are adjusted to reflect the mix of physician and nonphysician specialties within a TIN. The specialty-adjustment methodology, applied separately for each cost measure, is as follows:

1. **Compute "national, specialty-specific expected costs" for each specialty.** This component of the measure is computed as the weighted average of all TINs' observed payment-standardized and risk-adjusted costs, where the weight for each TIN is the number of attributed beneficiaries multiplied by the relevant specialty's share of the TIN's eligible professionals (EPs), multiplied by the number of EPs of that specialty in the TIN.
2. **Compute the "specialty-adjusted expected cost" for each TIN.** This component of the measure is computed as the weighted average of the national, specialty-specific expected cost for each specialty across all TINs, where the weights are each TIN's proportion of the specialty-specific Part B payments.
3. **Compute the "specialty-adjusted cost" for each TIN.** The TIN's payment-standardized and risk-adjusted cost is divided by the TIN's specialty-adjusted expected cost, and this ratio is multiplied by the national average cost.

For more information about specialty adjustment, please see the document entitled, "Specialty Adjustment," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-SpecAdj-FactSheet.pdf.

C18. How did CMS define benchmarks for the quality and cost measures?

Each TIN's performance on quality and cost measures is compared with a case-weighted national mean (benchmark) performance among all TINs in the measure's peer group. Quality benchmarks for the 2016 Annual QRURs are based on performance in the prior year (2015), and cost benchmarks are based on performance during 2016 for the Annual QRURs. For some Physician Quality Reporting System (PQRS) quality measures introduced in 2016, there are no comparable prior-year benchmarks. In these cases, CMS did not calculate the benchmark for these measures and does not display the measures in the 2016 Annual QRURs. In addition, if there is no benchmark, the measure is not eligible for inclusion in the Quality Composite Score for the Value Modifier.

The prior-year benchmarks for quality measures included in the 2018 Value Modifier are found in the document entitled "Benchmarks For Measures Included in the Performance Year 2016 Quality and Resource Use Reports," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/PY2016-Prior-Year-Benchmarks.pdf.

For the MSPB cost measure, the peer group is defined as all TINs nationwide that had at least 125 eligible episodes. For the 30-day All-Cause Hospital Readmission measure, the peer group is defined as all Shared Savings Program ACOs with at least one eligible case for the measure and all non-Shared Savings Program ACO TINs nationwide with 10 or more eligible professionals (EPs) who have at least 200 eligible cases for the measure. For other cost and quality measures, the peer group is defined as all TINs nationwide that had at least 20 eligible cases for the measure. For PQRS quality measures, only those TINs and individual EPs who avoided the 2018 PQRS payment adjustment are included in peer groups.

For TINs subject to the Value Modifier, the peer group for the Quality Composite includes all TINs subject to the 2018 Value Modifier for which a Quality Composite Score was calculated and used to determine the Value Modifier. For all other TINs, the peer group for the Quality Composite includes all TINs for which a Quality Composite Score could be calculated, with the exception of TINs that participated in the Pioneer ACO model, the Comprehensive Primary Care initiative, the Next Generation ACO Model, the Oncology Care Model, or the Comprehensive End-Stage Renal Disease (ESRD) Care Model in 2016.

For TINs subject to the Value Modifier, the peer group for the Cost Composite includes all TINs subject to the 2018 Value Modifier for which a Cost Composite Score could be calculated, with the exception of TINs that participated in the Shared Savings Program in 2016. For all other TINs, the peer group for the Cost Composite includes all TINs for which a Cost Composite Score could be calculated, with the exception of TINs that participated in the Shared Savings Program, the Pioneer ACO Model, the Comprehensive Primary Care initiative, the Next Generation ACO Model, the Oncology Care Model, or the Comprehensive ESRD Care Model in 2016.

C19. The list of hospitals admitting my TIN's attributed beneficiaries does not appear to be complete. How did CMS identify the hospitals that account for my Medicare beneficiaries' inpatient stays?

To help TINs identify the hospitals most associated with their attributed beneficiaries' inpatient hospital costs, Tables 2B and 5A of the Annual QRUR list the hospitals that accounted for at least 5 percent of all beneficiaries' stays and episodes of care, respectively, during the performance period. CMS used a hierarchical methodology to identify the name and location of the hospital associated with each provider number on Medicare Part A claims. First, CMS used the Provider of Services file (http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/NonIdentifiableDataFiles/ProviderofServicesFile.html), which is updated quarterly using data collected through CMS regional offices. If the provider number, name, and location were found in the Provider of Services file, CMS displayed this name and location in the QRUR.

If the name or location was not in the file, CMS consulted PECOS and displayed the name and location identified there. If the full name or location of the hospital was not found in either source, the QRUR exhibit displays "NAME NOT FOUND" in the hospital name column and "CITY NOT FOUND" and "STATE NOT FOUND" in the location columns.

C20. How can a TIN improve its performance based on the information provided in the 2016 QRURs?

To discern how to improve performance, a TIN must carefully examine the unique characteristics of the expenditures and utilization of its attributed patient population. This includes looking for opportunities to improve care coordination between the acute and post-acute setting, reducing unnecessary and/or low-value care, and ensuring the highest level of quality care throughout the care continuum.

The information in the QRURs can help TINs identify areas where costs are high relative to their peers. For example, Exhibit 7 in the 2016 Annual QRURs displays a TIN's performance on the cost measures ("Per Capita or Per Episode Costs"), and the average costs of all TINs in the peer group ("Benchmark"). For the Per Capita Costs for All Attributed Beneficiaries and Per Capita Costs for Beneficiaries with Specific Conditions measures, Tables 3A and 4A-4D in the 2016 Annual QRURs can be used to identify potential areas for performance improvement based on the costs of services a TIN's attributed beneficiaries received within the TIN and outside of the TIN relative to that of its peers by category of service. For example, total per capita costs for inpatient care or emergency services that are higher than a TIN's peers could suggest that additional care coordination or chronic illness management efforts may prove valuable in improving a TIN's performance.

Likewise, the information displayed in Table 5C of the 2016 Annual QRURs may help a TIN identify ways to improve performance for the MSPB measure, as this exhibit can help identify potential areas to improve the efficiency of the care that a TIN provides based on how a TIN's costs compare to that of its peers in each category of service.

For data at the beneficiary level, Table 3B in the 2016 Annual QRURs provides total, payment-standardized Medicare FFS costs during the period January 1, 2016 through December 31, 2016 for each of a TIN's beneficiaries and the breakdown of beneficiaries' costs by service category. These costs are not risk adjusted, so it will not sum by service category to the costs displayed in Tables 3A and 4A-4D of the 2016 Annual QRURs. However, TINs can use the CMS-HCC percentile-ranking in Table 2A of the Annual QRURs to identify beneficiaries who are more clinically complex and match them with the service category costs in Table 3B. Higher scores mean higher levels of clinical complexity; after risk-adjustment, these beneficiaries' costs are more likely to be adjusted downward. TINs can use this information for improving care coordination or treatment practices for these beneficiaries to improve performance and outcomes. For more information, please see the document entitled, "How To Understand Your 2016 Annual Quality and Resource Use Report," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-UnderstandingYourAQRUR.pdf.

C21. How can the information in the 2016 QRURs help groups and solo practitioners deliver higher quality care and lower costs?

The information in the QRURs can be used by groups and solo practitioners to improve quality of care, streamline resource use, and identify care coordination opportunities for a TIN's beneficiaries.

Table 2A in the 2016 Annual QRURs shows the number of Medicare FFS beneficiaries who are attributed to a TIN based on primary care services provided, as well as additional details about the Medicare beneficiaries attributed to a TIN for the five per capita cost and any claims-based quality outcome measures. The table is divided into sections that describe beneficiary characteristics, specific Medicare claims data, the eligible professionals (EPs) who 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. Groups and solo practitioners 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. Table 5B in the Annual QRURs provides analogous information for the MSPB measure.

Table 2B in the 2016 Annual QRUR identifies the hospitals that provided at least 5 percent of a TIN's attributed beneficiaries' inpatient stays during 2016. It provides the hospital name, CMS Certification Number, and location of the hospital. Groups and solo practitioners can use the data presented to learn which hospitals most frequently admitted a TIN's attributed beneficiaries and this information can help groups and solo practitioners target care coordination efforts most appropriately. Table 5A of the Annual QRURs provides analogous information for the MSPB measure.

For more information on how solo practitioners and groups can use the Annual QRURs and accompanying detailed tables to understand their performance and to improve quality of care, please see the document entitled, "How To Understand Your 2016 Annual Quality and Resource Use Report," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-UnderstandingYourAQRUR.pdf.