

2016 ANNUAL QUALITY AND RESOURCE USE REPORT AND THE 2018 VALUE-BASED PAYMENT MODIFIER

Sample Medical Practice B

LAST FOUR DIGITS OF YOUR MEDICARE-ENROLLED TAXPAYER IDENTIFICATION NUMBER
(TIN): 0000

PERFORMANCE PERIOD: 01/01/2016 – 12/31/2016

ABOUT THIS REPORT FROM MEDICARE

The 2016 Annual Quality and Resource Use Report (QRUR) shows how your group or solo practice, as identified by its Medicare-enrolled Taxpayer Identification Number (TIN), performed in calendar year 2016 on the quality and cost measures used to calculate the Value-Based Payment Modifier (Value Modifier) for 2018.

In 2018, the Value Modifier will apply to all physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists (clinicians subject to the Value Modifier) who bill under the Medicare Physician Fee Schedule.

As a participant in a Medicare Shared Savings Program Accountable Care Organization (ACO) in 2016, your TIN's 2018 Value Modifier is based on the ACO's quality performance in 2016.

The information contained in this report is believed to be accurate at the time of production. The information may be subject to change at the discretion of the Centers for Medicare & Medicaid Services (CMS), including, but not limited to, circumstances in which an error is discovered.

Please note that payment adjustments under the 2018 Value Modifier are based on a proposal that was included in the 2018 Medicare Physician Fee Schedule Proposed Rule (82 FR 34124) and is subject to change. Information on the Proposed Rule can be found at <https://federalregister.gov/d/2017-14639>.

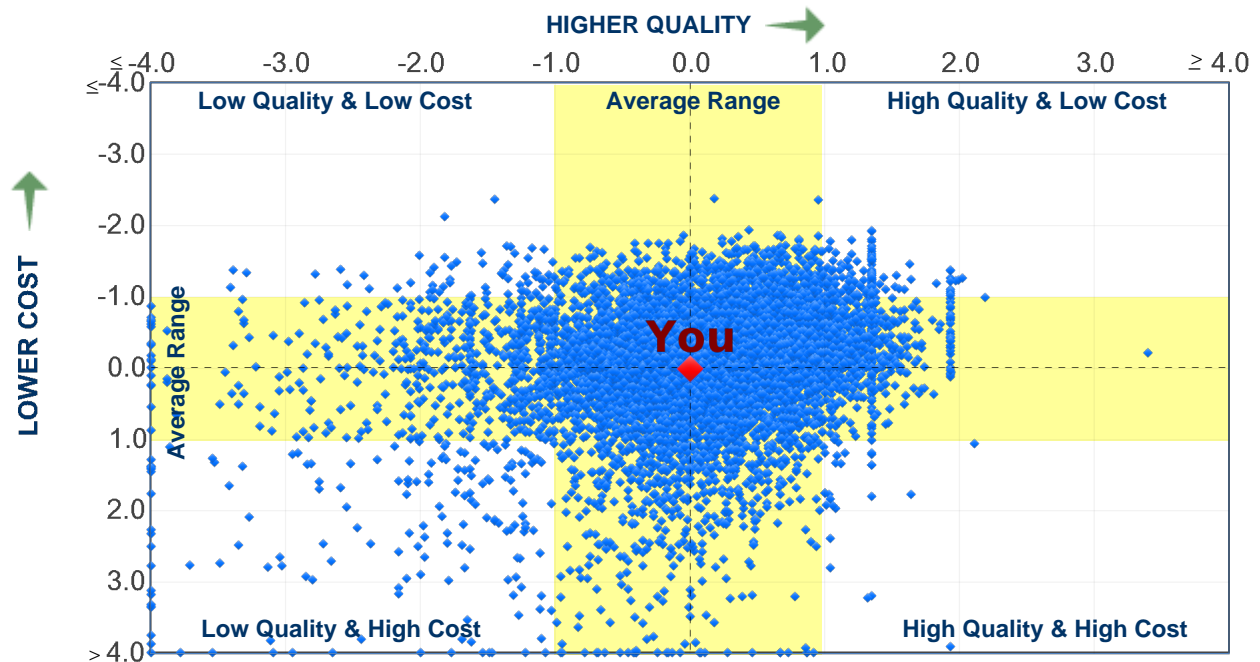
YOUR TIN'S 2018 VALUE MODIFIER

High Quality, Average Cost = Upward Adjustment (+1.0 x adjustment factor)

Your ACO's performance was determined to be high on quality measures. As a participant in a Shared Savings Program ACO in 2016, your TIN's cost composite is classified as Average Cost.

This means that the Value Modifier applied to payments for items and services under the Medicare Physician Fee Schedule for clinicians subject to the Value Modifier billing under your TIN in 2018 will result in an upward adjustment equal to one (+1.0) times the adjustment factor.

The scatter plot below shows how your TIN ("You" diamond) compares to a representative sample of other TINs on the Quality Composite scores used to calculate the 2018 Value Modifier.



Note: The scatter plot shows performance among a representative sample of all TINs with Quality and Cost Composite Scores reflecting standard deviations from the mean for each Composite Score.

QUESTIONS?

- Contact the Physician Value Help Desk at 1-888-734-6433 (select option 3) or at pvhelpdesk@cms.hhs.gov with questions or feedback about this report.
- If your TIN is subject to the Value Modifier in 2018 and you disagree with the Value Modifier calculation indicated above in the “Your TIN’s 2018 Value Modifier” section and in Exhibit 1 of this report, then an authorized representative of your TIN can submit a request for an Informal Review through the CMS Enterprise Portal. The informal review period lasts for 60 days.
- For more information about the 2018 Value Modifier and 2016 Annual QRUR, how to submit an informal review request, and the deadline for submitting an informal review request, please visit: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2016-QRUR.html>.

YOUR TIN'S 2018 VALUE MODIFIER

How does the Value Modifier apply to your TIN in 2018?

The Value Modifier will apply to your TIN because all of the following conditions were met: (1) at least one physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified registered nurse anesthetist in your TIN was identified in Medicare claims for 2016, and (2) at least one physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified registered nurse anesthetist in your TIN was identified in the Provider Enrollment, Chain and Ownership System (PECOS). In 2016, your TIN had 0 eligible professional(s). For more information on how we identify the number of professionals in a TIN for Value Modifier Program purposes, please see the Detailed Methodology: <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>.

Your TIN participated in Sample ACO, a Shared Savings Program ACO, in 2016. This ACO successfully reported quality data to the Physician Quality Reporting System (PQRS) through the Group Practice Reporting Option (GPRO) Web Interface to avoid the 2018 PQRS payment adjustment. CMS used its quality-tiering methodology to calculate your TIN's 2018 Value Modifier based on your ACO's performance on quality measures during 2016. As a participant in a Shared Savings Program ACO in 2016, your TIN's cost performance is classified as Average Cost.

Please note that if your TIN participated in more than one Shared Savings Program ACO in 2016, the ACO designated above is the one with the highest numerical Quality Composite Score. Your TIN's Quality Composite Score is based on the performance of this ACO.

The Value Modifier calculated for your TIN is shown in the highlighted cell in Exhibit 1. The Value Modifier applied to payments for items and services under the Medicare Physician Fee Schedule for clinicians subject to the Value Modifier billing under your TIN in 2018 will result in an upward adjustment equal to one (+1.0) times the adjustment factor.

Please note that payment adjustments under the 2018 Value Modifier are based on a proposal that was included in the 2018 Medicare Physician Fee Schedule Proposed Rule (82 FR 34124) and is subject to change. Information on the Proposed Rule can be found at <https://federalregister.gov/d/2017-14639>.

**Exhibit 1. 2018 Value Modifier Payment Adjustments under Quality-Tiering
(Shared Savings Program Participant TINs)**

	Low Quality	Average Quality	High Quality
Low Cost	<i>Does not apply</i>	<i>Does not apply</i>	<i>Does not apply</i>
Average Cost	0.0%	0.0%	+0.0 x AF
High Cost	<i>Does not apply</i>	<i>Does not apply</i>	<i>Does not apply</i>

Note: An adjustment factor (AF) derived from actuarial estimates of projected billings will determine the precise size of the reward for higher performing TINs in a given year. The AF for the 2018 Value Modifier will be posted at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2016-QRUR.html>. If an asterisk (*) appears in the highlighted cell, it indicates that an additional upward adjustment of 1.0 x AF was applied to your TIN for serving a disproportionate share of high-risk beneficiaries.

For more information about the eligible professionals in your TIN -- including how CMS identified them, how they performed on individually-reported PQRS measures, and how many avoided the PQRS payment adjustment (if applicable) -- please refer to the following tables on the CMS Enterprise Portal:

- Table 1. Physicians and Nonphysician Eligible Professionals in Your Medicare-Enrolled Taxpayer Identification Number (TIN), Selected Characteristics
- Table 7. Individual Eligible Professional Performance on the 2016 PQRS Measures

For more information about how the Shared Savings Program interacts with the 2018 Value Modifier, please refer to the "Medicare Shared Savings Program Interaction with the 2018 Value Modifier Frequently Asked Questions," posted at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2018-VM-MSSP-FAQs.pdf>.

Glossary Terms

Adjustment factor (AF)

Beneficiary

Clinicians subject to the Value Modifier

Comprehensive End-Stage Renal Disease (ESRD) Care Model

Comprehensive Primary Care initiative

Eligible professional

Group practice reporting mechanisms

Group Practice Reporting Option (GPRO)

Innovation Models

Next Generation Accountable Care Organization (ACO) Model

Oncology Care Model

Physician

Physician Quality Reporting System (PQRS)

The Physician Quality Reporting System (PQRS) payment adjustment

Pioneer Accountable Care Organization (ACO) Model

Provider Enrollment, Chain and Ownership System (PECOS)

Quality Composite Score

Quality-tiering

Shared Savings Program

Taxpayer Identification Number (TIN)

Value Modifier (Value-Based Payment Modifier)

How does the high-risk bonus adjustment apply to your TIN?

TINs that qualify for an upward adjustment under quality-tiering will receive an additional upward adjustment to their 2018 Value Modifier equal to one (1.0) times the adjustment factor, if they served a disproportionate share of high-risk beneficiaries in 2016. The average risk for all beneficiaries assigned to your ACO is at the ##th percentile of beneficiaries nationwide.

Medicare determined your TIN's eligibility for the high-risk bonus adjustment based on whether your ACO met (✓) or did not meet (✗) both of the following criteria in 2016:

- ✓ Had strong quality and cost performance
- ✗ Average beneficiary's risk is at or above the 75th percentile of beneficiaries nationwide

Your TIN will not receive the high-risk bonus adjustment to the 2018 Value Modifier because your ACO did not meet these criteria.

For more information about the characteristics of the Medicare beneficiaries attributed to your TIN, please refer to the following tables on the CMS Enterprise Portal:

- Table 2A. Beneficiaries Attributed to Your TIN for the Cost Measures (except Medicare Spending per Beneficiary) and Claims-Based Quality Outcome Measures, and the Care that Your TIN and Other TINs Provided
- Table 5B. Beneficiaries and Episodes Attributed to Your TIN for the Medicare Spending per Beneficiary (MSPB) Measure

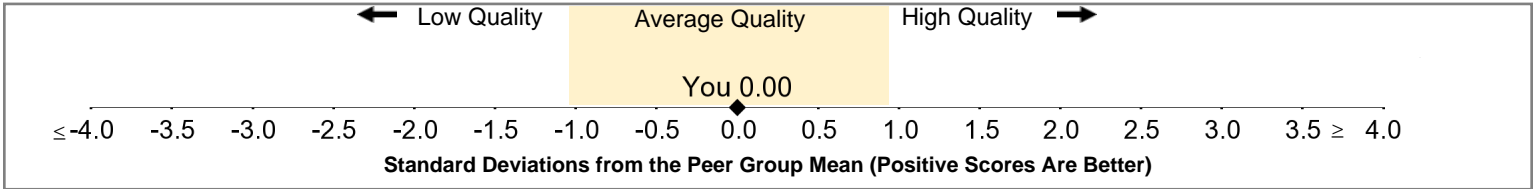
<i>Glossary Terms</i>
<i>Adjustment Factor</i>
<i>Attribution</i>
<i>Beneficiary</i>
<i>High-risk bonus adjustment</i>
<i>Quality-tiering</i>
<i>Risk score</i>
<i>Taxpayer Identification Number (TIN)</i>
<i>Value Modifier (Value-Based Payment Modifier)</i>

PERFORMANCE ON QUALITY MEASURES

Your TIN's Quality Tier: High

As a participant in a Shared Savings Program ACO, your TIN's Quality Composite Score is based on the quality performance of the ACO in 2016.

Exhibit 2. Your TIN's Quality Composite Score



Your TIN's Quality Composite Score (Exhibit 2) indicates that your ACO's overall performance on quality measures is 0.00 standard deviations below the mean for your TIN's peer group and is statistically significantly different from the mean. Therefore, your TIN's quality performance is classified as High Quality under quality-tiering.

The Quality Composite Score and Cost Composite Score are the two summary scores used to calculate the Value Modifier under quality-tiering. The Quality Composite Score standardizes a TIN's quality performance relative to the mean for the TIN's peer group, such that 0 represents the peer group mean and the TIN's Quality Composite Score indicates how many standard deviations a TIN's performance is from the mean. Your TIN's peer group includes all TINs for which a Quality Composite Score was calculated and used to determine the 2018 Value Modifier.

A TIN's Quality Composite Score is classified into one of three quality tiers (high, average, or low), based on how the score compares to the mean for the TIN's peer group. To be considered either High Quality or Low Quality, a TIN's score must be at least one standard deviation from the peer group mean and statistically significantly different from the mean at the five percent level of significance. That is, a TIN with a statistically significant positive Quality Composite Score of one (+1.0) or higher would be classified as High Quality, and a TIN with a statistically significant negative score of one (-1.0) or lower would be classified as Low Quality. A TIN with any other Quality Composite Score would be classified as Average Quality. That is, a TIN with a Quality Composite Score in the range between (but not including) negative one (-1.0) and positive one (+1.0) would be classified as Average Quality, because its score is less than one standard deviation from the mean. A TIN with a score of negative one (-1.0) or lower or positive one (+1.0) or higher that is NOT statistically significantly different from the mean would also be classified as Average Quality.

Glossary Terms

Comprehensive End-Stage Renal Disease (ESRD) Care Model
Comprehensive Primary Care initiative
Cost Composite Score
Eligible professional
Next Generation Accountable Care Organization (ACO) Model
Oncology Care Model
Peer group
Physician Quality Reporting System (PQRS)
The Physician Quality Reporting System (PQRS) payment adjustment
Pioneer Accountable Care Organization (ACO) Model
Quality Composite Score
Quality-tiering
Shared Savings Program
Standard deviation
Statistical significance
Taxpayer Identification Number (TIN)
Value Modifier (Value-Based Payment Modifier)

What quality measures are used to calculate the Quality Composite Score?

The following measures were used to calculate your TIN's Quality Composite Score based on performance in 2016:

- Quality measures that your ACO successfully reported through the GPRO Web Interface in order to avoid the 2018 PQRS payment adjustment, and
- Your ACO's All-Cause Hospital Readmission measure that Medicare calculates from Medicare fee-for-service claims submitted for services provided in 2016 to beneficiaries assigned to your ACO, and
- Patient experience data for the ACO's patients, as reported by a Medicare-certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Vendor

Please note that if your TIN participated in more than one Shared Savings Program ACO in 2016, your TIN's Quality Composite Score is based on the performance of the ACO that had the highest numerical Quality Composite Score.

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 measure scores within the domain, for all measures that have 2015 benchmarks and the required minimum number of eligible cases. Performance is then summarized across all quality domains for which scores could be calculated. This summary score is standardized relative to the mean of summary scores within the TIN's peer group to create a TIN's Quality Composite Score. The information used in the calculation of your TIN's Quality Composite Score is shown in Exhibit 3, below.

Exhibits 3-A and B. Information Used in the Calculation of Your TIN's Quality Composite Score

A. Summary Quality Performance

Your ACO			All TINs and ACOs in Peer Group	
Number of Domains Included	Summary Score (Mean Domain Score)	Quality Composite Score (Standardized Summary Score)	Benchmark (Peer Group Mean Summary Score)	Standard Deviation
0	0.00	0.00	0.00	0.00

B. Quality Domain Scores

Domain	Number of Measures Included in Domain Score	Domain Score
Effective Clinical Care	0	0.00
Person and Caregiver-Centered Experience and Outcomes	0	0.00
Community/Population Health	0	0.00
Patient Safety	0	0.00
Communication and Care Coordination	0	0.00
Efficiency and Cost Reduction	0	0.00

The exhibits below show your TIN's quality domain scores and the quality measures reported by your ACO in each quality domain, if your ACO had at least one measure with at least one eligible case. Additionally, Exhibit 4-CCC-B shows how your ACO performed on the All-Cause Hospital Readmission measure calculated by CMS, if your ACO had at least one eligible case for this measure. The exhibits also show which measures are included in the domain scores, and therefore, your TIN's Quality Composite Score. A measure is included in the domain score and the Quality Composite Score only if your ACO had the required minimum number of eligible cases for the measure and a 2015 benchmark (national mean) is available for the measure.

Please note that this report excludes PQRS data that could not be used for Value Modifier calculations. For more information about measures that are excluded from the Value Modifier, please see the Detailed Methodology, Section II.C:

<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 about your ACO's quality measures and the data underlying their computation, including both measures reported by your ACO and any claims-based quality outcome measures calculated by CMS, please refer to the following tables on the CMS Enterprise Portal:

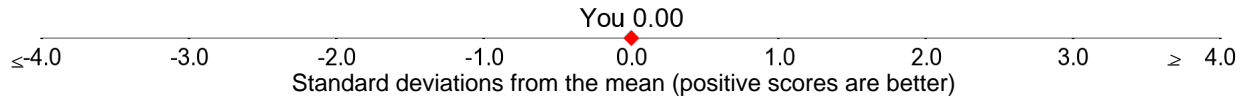
- Table 2A. Beneficiaries Attributed to Your TIN for the Cost Measures (except Medicare Spending per Beneficiary) and Claims-Based Quality Outcome Measures, and the Care that Your TIN and Other TINs Provided
- Table 2B. Admitting Hospitals: Beneficiaries Attributed to Your TIN for the Cost Measures (except Medicare Spending per Beneficiary) and Claims-Based Quality Outcome Measures
- Table 2C. Hospital Admissions for Any Cause: Beneficiaries Attributed to Your TIN for the Cost Measures (except Medicare Spending per Beneficiary) and Claims-Based Quality Outcome Measures
- Table 6B. Hospital Admissions for Any Cause: Beneficiaries Assigned to Your ACO for the All-Cause Hospital Readmission Measure and Attributed to Your TIN for the Cost Measures – Shared Savings Program ACO TINs Only
- Table 7. Individual Eligible Professional Performance on the 2016 PQRS Measures

Glossary Terms

<i>All-Cause Hospital Readmission</i>
<i>Ambulatory Care-Sensitive Conditions (ACSCs)</i>
<i>Attribution</i>
<i>Benchmark</i>
<i>Beneficiary</i>
<i>Chronic Conditions</i>
<i>Consumer Assessment of Healthcare Providers and Systems (CAHPS)</i>
<i>Eligible professional</i>
<i>Group practice reporting mechanisms</i>
<i>Group Practice Reporting Option (GPRO)</i>
<i>Innovation Models</i>
<i>Measure populations</i>
<i>National Quality Strategy</i>
<i>Peer group</i>
<i>Physician Quality Reporting System (PQRS)</i>
<i>The Physician Quality Reporting System (PQRS) payment adjustment</i>
<i>Quality Composite Score</i>
<i>Quality domains</i>
<i>Quality outcome measures</i>
<i>Quality-tiering</i>
<i>Shared Savings Program</i>
<i>Standard deviation</i>
<i>Standardized performance score</i>
<i>Taxpayer Identification Number (TIN)</i>
<i>Value Modifier (Value-Based Payment Modifier)</i>

Exhibit 4-ECC. Effective Clinical Care Domain Quality Indicator Performance

Domain Score

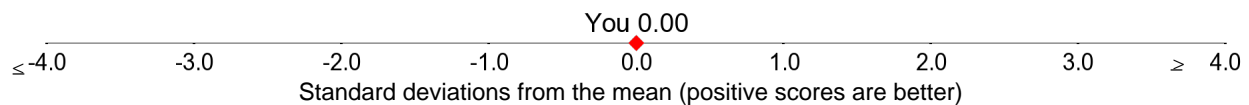


Measure Identification Number(s)	Measure Name	Your ACO				All TINs and ACOs in Peer Group	
		Number of Eligible Cases	Performance Rate	Standardized Performance Score	Included in Domain Score?	Benchmark (National Mean)	Standard Deviation
-	Diabetes Mellitus (DM): Composite (All or Nothing Scoring) (includes GPRO DM-2 and GPRO DM-7)	0	0.00	0.00	No	0.00	0.00
1* (GPRO DM-2)	Diabetes: Hemoglobin A1c Poor Control	0	0.00	0.00	No	0.00	0.00
117 (GPRO DM-7)	Diabetes: Eye Exam	0	0.00	0.00	No	0.00	0.00
8 (GPRO HF-6)	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	0	0.00	0.00	No	0.00	0.00
113 (GPRO PREV-6)	Colorectal Cancer Screening	0	0.00	0.00	No	0.00	0.00
118 (GPRO CAD-7)	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	0	0.00	0.00	No	0.00	0.00
204 (GPRO IVD-2)	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	0	0.00	0.00	No	0.00	0.00
236 (GPRO HTN-2)	Controlling High Blood Pressure	0	0.00	0.00	No	0.00	0.00
438 (GPRO PREV-13)	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	0	0.00	0.00	No	0.00	0.00

Note: If an asterisk (*) appears after the measure identification number, it indicates that the measure is an inverse (negative) measure, and a lower performance rate for this measure reflects better performance. This is taken into account when calculating the quality domain score, such that a positive (+) domain score indicates better performance and negative (-) domain score indicates worse performance. Only those measures for which benchmarks are available and for which your ACO had at least 20 eligible cases are included in the domain score. The benchmark for a quality measure is the case-weighted national mean performance rate among all TINs in the measure's peer group during calendar year 2015. The peer group is defined as all TINs nationwide that reported the measure and had at least 20 eligible cases during calendar year 2015. If a dash (-) appears in the Benchmark column, this indicates that no benchmark is available for this measure. For TINs or ACOs that reported quality data to the PQRS via the GPRO Web Interface, GPRO DM-2 (measure #1) and GPRO DM-7 (measure #117) are components of the "Diabetes Mellitus: Composite (All or Nothing Scoring)" measure and are not included in the calculation of the domain score as individual measures.

Exhibit 4-PCE. Person and Caregiver-Centered Experience and Outcomes Domain Quality Indicator Performance

Domain Score



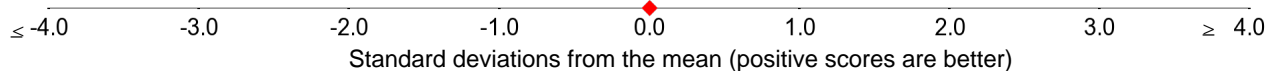
Measure Identification Number(s)	Measure Name	Your ACO				All TINs and ACOs in Peer Group	
		Number of Eligible Cases	Performance Rate	Standardized Performance Score	Included in Domain Score?	Benchmark (National Mean)	Standard Deviation
CAHPS	Getting Timely Care	0	0.00	0.00	No	0.00	0.00
CAHPS	Provider Communication	0	0.00	0.00	No	0.00	0.00
CAHPS	Rating of Provider	0	0.00	0.00	No	0.00	0.00
CAHPS	Access to Specialists	0	0.00	0.00	No	0.00	0.00
CAHPS	Health Promotion and Education	0	0.00	0.00	No	0.00	0.00
CAHPS	Shared Decision-Making	0	0.00	0.00	No	0.00	0.00
CAHPS	Health Status/Functional Status	0	0.00	0.00	No	0.00	0.00
CAHPS	Courteous/Helpful Office Staff	0	0.00	0.00	No	0.00	0.00
CAHPS	Care Coordination	0	0.00	0.00	No	0.00	0.00
CAHPS	Between Visit Communication	0	0.00	0.00	No	0.00	0.00
CAHPS	Education About Medication Adherence	0	0.00	0.00	No	0.00	0.00
CAHPS	Stewardship of Patient Resources	0	0.00	0.00	No	0.00	0.00

Note: If an asterisk (*) appears after the measure identification number, it indicates that the measure is an inverse (negative) measure, and a lower performance rate for this measure reflects better performance. This is taken into account when calculating the quality domain score, such that a positive (+) domain score indicates better performance and negative (-) domain score indicates worse performance. Only those measures for which benchmarks are available and for which your ACO had at least 20 eligible cases are included in the domain score. The benchmark for a quality measure is the case-weighted national mean performance rate among all TINs in the measure's peer group during calendar year 2015. The peer group is defined as all TINs nationwide that reported the measure and had at least 20 eligible cases during calendar year 2015. If a dash (-) appears in the Benchmark column, this indicates that no benchmark is available for this measure.

Exhibit 4-CPH. Community/Population Health Domain Quality Indicator Performance

Domain Score

You 0.00

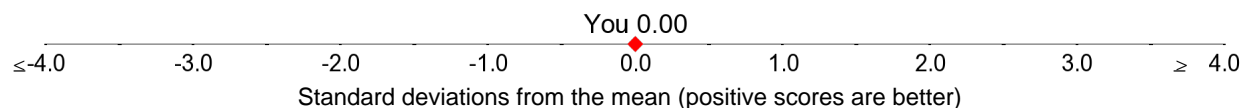


Measure Identification Number(s)	Measure Name	Your ACO				All TINs and ACOs in Peer Group	
		Number of Eligible Cases	Performance Rate	Standardized Performance Score	Included in Domain Score?	Benchmark (National Mean)	Standard Deviation
110 (GPRO PREV-7)	Preventive Care and Screening: Influenza Immunization	0	0.00	0.00	No	0.00	0.00
111 (GPRO PREV-8)	Pneumonia Vaccination Status for Older Adults	0	0.00	0.00	No	0.00	0.00
128 (GPRO PREV-9)	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up Plan	0	0.00	0.00	No	0.00	0.00
134 (GPRO PREV-12)	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	0	0.00	0.00	No	0.00	0.00
226 (GPRO PREV-10)	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	0	0.00	0.00	No	0.00	0.00
317 (GRPO PREV-11)	Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented	0	0.00	0.00	No	0.00	0.00

Note: If an asterisk (*) appears after the measure identification number, it indicates that the measure is an inverse (negative) measure, and a lower performance rate for this measure reflects better performance. This is taken into account when calculating the quality domain score, such that a positive (+) domain score indicates better performance and negative (-) domain score indicates worse performance. Only those measures for which benchmarks are available and for which your ACO had at least 20 eligible cases are included in the domain score. The benchmark for a quality measure is the case-weighted national mean performance rate among all TINs in the measure's peer group during calendar year 2015. The peer group is defined as all TINs nationwide that reported the measure and had at least 20 eligible cases during calendar year 2015. If a dash (-) appears in the Benchmark column, this indicates that no benchmark is available for this measure.

Exhibit 4-PS. Patient Safety Domain Quality Indicator Performance

Domain Score

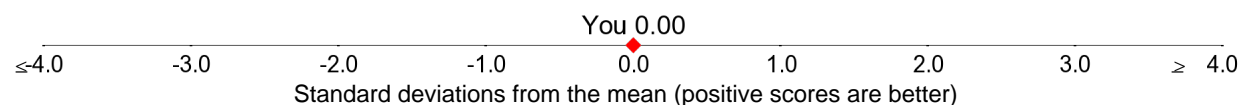


Measure Identification Number(s)	Measure Name	Your ACO				All TINs and ACOs in Peer Group	
		Number of Eligible Cases	Performance Rate	Standardized Performance Score	Included in Domain Score?	Benchmark (National Mean)	Standard Deviation
130 (GPRO CARE-3)	Documentation of Current Medications in the Medical Record	0	0.00	0.00	No	0.00	0.00
318 (GRPO CARE-2)	Falls: Screening for Fall Risk	0	0.00	0.00	No	0.00	0.00

Note: If an asterisk (*) appears after the measure identification number, it indicates that the measure is an inverse (negative) measure, and a lower performance rate for this measure reflects better performance. This is taken into account when calculating the quality domain score, such that a positive (+) domain score indicates better performance and negative (-) domain score indicates worse performance. If two asterisks (**) appear after the measure identification number, it indicates the measure is one of two measures incorrectly identified in the 2016 PQRS feedback report as either inverse or non-inverse. MIRAMED 6 is an inverse measure; MIRAMED 9 is not an inverse measure. Because they do not have prior year benchmarks, neither measure was used in the calculation of the Quality Composite Score. Only those measures for which benchmarks are available and for which your ACO had at least 20 eligible cases are included in the domain score. The benchmark for a quality measure is the case-weighted national mean performance rate among all TINs in the measure's peer group during calendar year 2015. The peer group is defined as all TINs nationwide that reported the measure and had at least 20 eligible cases during calendar year 2015. If a dash (-) appears in the Benchmark column, this indicates that no benchmark is available for this measure.

Exhibits 4-CCC-A and B. Communication and Care Coordination Domain

Domain Score



A. Communication and Care Coordination Domain Quality Indicator Performance

Exhibit 4-CCC-A is not displayed because your ACO did not have at least one eligible case for at least one measure in this domain.

B. Communication and Care Coordination Domain CMS-Calculated Quality Outcome Measures

Exhibit 4-CCC-B provides information on the quality outcome measure calculated from Medicare Part A and Part B claims data.

Performance Category	Measure Identification Number	Measure Name	Your ACO				All TINs and ACOs in Peer Group	
			Number of Eligible Cases	Performance Rate	Standardized Performance Score	Included in Domain Score?	Benchmark (National Mean)	Standard Deviation
Hospital Readmission	CMS-3	All-Cause Hospital Readmission	0	0.00%	0.00	No	0.00%	0.00

Note: CMS-3 is calculated by the Centers for Medicare & Medicaid Services using Medicare Part A and Part B claims data. Lower performance rates for this measure indicates better performance. This is taken into account when calculating the quality domain score, such that a positive (+) domain score indicates better performance and a negative (-) domain score indicates worse performance. The benchmark for this measure is the case-weighted national mean performance rate among all TINs and ACOs in the measure's peer group during calendar year 2015. The peer group for CMS-3 is defined as all TINs nationwide with 10 or more eligible professionals that had at least 200 eligible cases and all ACOs in the Shared Savings Program with at least 1 eligible case.

Exhibit 4-ECR. Efficiency and Cost Reduction Domain Quality Indicator Performance

Domain Score

No domain score was calculated because your ACO did not have at least one measure that had the minimum number of eligible cases to be included in the domain score.

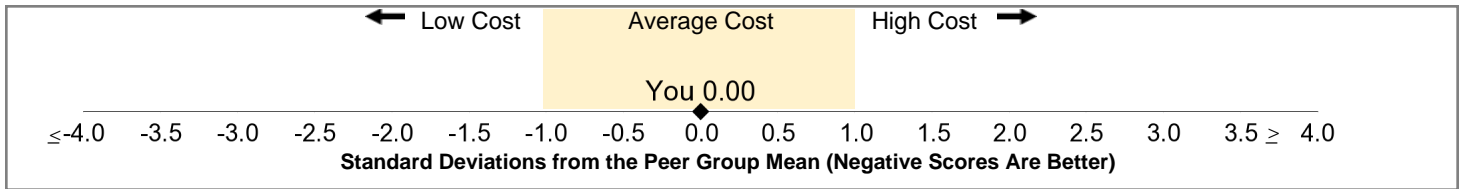
Exhibit 4-ECR is not displayed because your ACO did not have at least one eligible case for at least one measure in this domain.

PERFORMANCE ON COST MEASURES

Your TIN's Cost Tier: Average

The Cost Composite Score for participants of a Shared Savings Program ACO is provided in this report for informational purposes only and is based on the TIN's cost performance, not the ACO's cost performance.

Exhibit 5. Your TIN's Cost Composite Score



Your TIN's Cost Composite Score (Exhibit 5) indicates that your TIN's overall performance on cost measures is 0.00 standard deviations from the mean for your TIN's peer group. As a participant in a Shared Savings Program ACO in 2016, your TIN's cost performance is classified as Average Cost under quality-tiering. The Cost Composite Score is provided for informational purposes only.

The Cost Composite Score and Quality Composite Score are the two summary scores used to calculate the Value Modifier under quality-tiering. The Cost Composite Score standardizes a TIN's cost performance relative to the mean for the TIN's peer group, such that 0 represents the peer group mean and the TIN's Cost Composite Score indicates how many standard deviations a TIN's performance is from the mean. Your TIN's peer group 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.

A TIN's Cost Composite Score is classified into one of three cost tiers (high, average, or low), based on how the score compares to the mean for the TIN's peer group. To be considered either High Cost or Low Cost, a TIN's score must be at least one standard deviation from the peer group mean and statistically significantly different from the mean at the five percent level of significance. That is, a TIN with a statistically significant positive Cost Composite Score of one (+1.0) or higher would be classified as High Cost, and a TIN with a statistically significant negative score of one (-1.0) or lower would be classified as Low Cost. A TIN with any other Cost Composite Score would be classified as Average Cost. That is, a TIN with a Cost Composite Score in the range between (but not including) negative one (-1.0) and positive one (+1.0) would be classified as Average Cost, because its score is less than one standard deviation from the mean. A TIN with a score of negative one (-1.0) or lower or positive one (+1.0) or higher that is NOT statistically significantly different from the mean would also be classified as Average Cost.

Glossary Terms

Comprehensive End-Stage Renal Disease (ESRD) Care Model

Comprehensive Primary Care initiative

Cost Composite Score

Next Generation Accountable Care Organization (ACO) Model

Oncology Care Model

Peer group

Pioneer Accountable Care Organization (ACO) Model

Quality Composite Score

Quality-tiering

Shared Savings Program

Standard deviation

Statistical significance

Taxpayer Identification Number (TIN)

Value Modifier (Value-Based Payment Modifier)

What cost measures are used to calculate the Cost Composite Score?

Six cost measures are used to calculate your TIN's Cost Composite Score based on performance in 2016:

1. Per Capita Costs for All Attributed Beneficiaries
2. Per Capita Costs for Beneficiaries with Diabetes
3. Per Capita Costs for Beneficiaries with Chronic Obstructive Pulmonary Disease (COPD)
4. Per Capita Costs for Beneficiaries with Coronary Artery Disease (CAD)
5. Per Capita Costs for Beneficiaries with Heart Failure
6. Medicare Spending per Beneficiary

For the Per Capita Costs for All Attributed Beneficiaries measure and the four Per Capita Costs for Beneficiaries with Specific Conditions measures, costs reflect payments for all Medicare Part A and Part B claims submitted by all providers who treated the beneficiaries attributed to your TIN for each measure during 2016, including providers who did not bill under your TIN.

For the Medicare Spending per Beneficiary measure, costs are based on payments for all Medicare Part A and Part B claims submitted by all providers for care surrounding specified inpatient hospital stays (3 days prior to a hospital admission through 30 days post-discharge). This includes payments to providers who do not bill under your TIN.

The six cost measures are classified into two cost domains: (1) Costs for All Attributed Beneficiaries and (2) Costs for Beneficiaries with Specific Conditions. A score for each cost domain is calculated as the equally-weighted average of measure scores within the domain, for all measures that have the required minimum number of eligible cases or episodes. Performance is then summarized across the cost domains for which scores could be calculated. This summary score is standardized relative to the mean of summary scores within the TIN's peer group to create a TIN's Cost Composite Score. The information used in the calculation of your TIN's Cost Composite Score is shown in Exhibit 6, below.

Exhibits 6-A and B. Information Used in the Calculation of Your TIN's Cost Composite Score

A. Summary Cost Performance

Your TIN			All TINs in Peer Group	
Number of Domains Included	Summary Score (Mean Domain Score)	Cost Composite Score (Standardized Summary Score)	Benchmark (Peer Group Mean Summary Score)	Standard Deviation
0	0.00	0.00	0.00	0.00

B. Cost Domain Scores

Domain	Number of Measures Included in Domain Score	Domain Score
Costs for All Attributed Beneficiaries	0	0.00
Costs for Beneficiaries with Specific Conditions	0	0.00

All cost measures are risk-adjusted based on the mix of beneficiaries attributed to your TIN; payment-standardized to account for differences in Medicare payments across geographic regions due to variations in local input prices; and specialty-adjusted to reflect the mix of specialties among eligible professionals within a TIN.

The exhibits below show your TIN's cost domain scores and the cost measures calculated for your TIN in each cost domain, if your TIN had at least one measure with at least one eligible case or episode. The exhibits also show which measures are included in the domain scores, and therefore, your TIN's Cost Composite Score. A measure is included in the domain score and the Cost Composite Score only if your TIN had the required minimum number of eligible cases or episodes for the measure.

For more information about your TIN's cost measures and the data underlying their computation, including breakdowns of cost by categories of service and beneficiary-level data, please refer to the following tables on the CMS Enterprise Portal:

- Table 3A. Per Capita Costs, by Categories of Service, for the Per Capita Costs for All Attributed Beneficiaries Measure
- Table 3B. Costs of Services Provided by Your TIN and Other TINs: Beneficiaries Attributed to Your TIN for the Cost Measures (except Medicare Spending per Beneficiary) and Claims-Based Quality Outcome Measures

- Table 4A. Per Capita Costs, by Categories of Service, for Beneficiaries with Diabetes
- Table 4B. Per Capita Costs, by Categories of Service, for Beneficiaries with Chronic Obstructive Pulmonary Disease (COPD)
- Table 4C. Per Capita Costs, by Categories of Service, for Beneficiaries with Coronary Artery Disease (CAD)
- Table 4D. Per Capita Costs, by Categories of Service, for Beneficiaries with Heart Failure

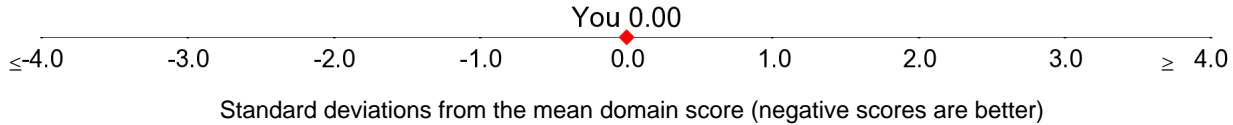
For more information about your TIN's Medicare Spending per Beneficiary hospitalization episodes, including the hospitals where your TIN's beneficiaries were treated, breakdowns of cost by categories of service, and episode-level data, please refer to the following tables:

- Table 5A. Admitting Hospitals: Episodes of Care Attributed to Your TIN for the Medicare Spending per Beneficiary (MSPB) Measure
- Table 5B. Beneficiaries and Episodes Attributed to Your TIN for the Medicare Spending per Beneficiary (MSPB) Measure
- Table 5C. Costs per Episode, by Categories of Service, for the Medicare Spending per Beneficiary (MSPB) Measure
- Table 5D. Medicare Spending per Beneficiary (MSPB) Costs, by Episode and Service Category

<i>Glossary Terms</i>
<i>Attribution</i>
<i>Benchmark</i>
<i>Beneficiary</i>
<i>Chronic Conditions</i>
<i>Cost Composite Score</i>
<i>Cost domains</i>
<i>Eligible professional</i>
<i>Measure populations</i>
<i>Medicare claims data used in the cost measures</i>
<i>Medicare Spending per Beneficiary</i>
<i>Payment standardization</i>
<i>Peer group</i>
<i>Per Capita Costs for All Attributed Beneficiaries</i>
<i>Per Capita Costs for Beneficiaries with Specific Conditions</i>
<i>Risk adjustment</i>
<i>Specialty adjustment</i>
<i>Standard deviation</i>
<i>Taxpayer Identification Number (TIN)</i>

Exhibit 7-AAB. Costs for All Attributed Beneficiaries Domain

Domain Score

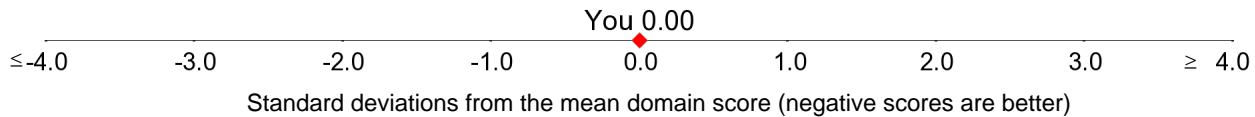


Cost Measure	Your TIN				All TINs in Peer Group	
	Number of Eligible Cases or Episodes	Per Capita or Per Episode Costs	Standardized Cost Score	Included in Domain Score?	Benchmark (National Mean)	Standard Deviation
Per Capita Costs for All Attributed Beneficiaries	0	—	0.00	No	\$0	\$0
Medicare Spending per Beneficiary	0	—	0.00	No	\$0	\$0

Note: Only the measures for which your TIN had the minimum number of eligible cases or episodes are included in the domain score. For the Per Capita Costs for All Attributed Beneficiaries measure, the minimum number of eligible cases is 20. For the Medicare Spending per Beneficiary measure, the minimum number of eligible episodes is 125. The benchmark for a cost measure is the case-weighted national mean cost among all TINs in the measure's peer group during calendar year 2016. For the Per Capita Costs for All Attributed Beneficiaries measure, the peer group is defined as all TINs nationwide that had at least 20 eligible cases. For the Medicare Spending per Beneficiary measure, the peer group is defined as all TINs nationwide that had at least 125 eligible episodes.

Exhibit 7-BSC. Costs for Beneficiaries with Specific Conditions Domain

Domain Score



Cost Measure	Your TIN				All TINs in Peer Group	
	Number of Eligible Cases	Per Capita Costs	Standardized Cost Score	Included in Domain Score?	Benchmark (National Mean)	Standard Deviation
Per Capita Costs for Beneficiaries with Diabetes	0	—	0.00	No	\$0	\$0
Per Capita Costs for Beneficiaries with Chronic Obstructive Pulmonary Disease	0	—	0.00	No	\$0	\$0
Per Capita Costs for Beneficiaries with Coronary Artery Disease	0	—	0.00	No	\$0	\$0
Per Capita Costs for Beneficiaries with Heart Failure	0	—	0.00	No	\$0	\$0

Note: Only the measures for which your TIN had the minimum number of eligible cases are included in the domain score. For the cost measures shown in this exhibit, the minimum number of eligible cases is 20. The benchmark for a cost measure is the case-weighted national mean cost among all TINs in the measure's peer group during calendar year 2016. For the cost measures shown in this exhibit, the peer group is defined as all TINs nationwide that had at least 20 eligible cases for each measure.

Accompanying Tables

Table 1. Physicians and Nonphysician Eligible Professionals Identified in Your Medicare-Enrolled Taxpayer Identification Number (TIN), Selected Characteristics

Table 2. Beneficiaries and Hospital Admissions (except Medicare Spending per Beneficiary)

- 2A. Beneficiaries Attributed to Your TIN for the Cost Measures (except Medicare Spending per Beneficiary) and Claims-Based Quality Outcome Measures, and the Care that Your TIN and Other TINs Provided
- 2B. Admitting Hospitals: Beneficiaries Attributed to Your TIN for the Cost Measures (except Medicare Spending per Beneficiary) and Claims-Based Quality Outcome Measures
- 2C. Hospital Admissions for Any Cause: Beneficiaries Attributed to Your TIN for the Cost Measures (except Medicare Spending per Beneficiary) and Claims-Based Quality Outcome Measures

Table 3. Per Capita Costs for All Attributed Beneficiaries

- 3A. Per Capita Costs, by Categories of Service, for the Per Capita Costs for All Attributed Beneficiaries Measure
- 3B. Costs of Services Provided by Your TIN and Other TINs: Beneficiaries Attributed to Your TIN for the Cost Measures (except Medicare Spending per Beneficiary) and Claims-Based Quality Outcome Measures

Table 4. Per Capita Costs for Beneficiaries with Specific Conditions

- 4A. Per Capita Costs, by Categories of Service, for Beneficiaries with Diabetes
- 4B. Per Capita Costs, by Categories of Service, for Beneficiaries with Chronic Obstructive Pulmonary Disease (COPD)
- 4C. Per Capita Costs, by Categories of Service, for Beneficiaries with Coronary Artery Disease (CAD)
- 4D. Per Capita Costs, by Categories of Service, for Beneficiaries with Heart Failure

Table 5. Medicare Spending per Beneficiary (MSPB)

- 5A. Admitting Hospitals: Episodes of Care Attributed to Your TIN for the Medicare Spending per Beneficiary (MSPB) Measure
- 5B. Beneficiaries and Episodes Attributed to Your TIN for the Medicare Spending per Beneficiary (MSPB) Measure
- 5C. Costs per Episode, by Categories of Service, for the Medicare Spending per Beneficiary (MSPB) Measure
- 5D. Medicare Spending per Beneficiary (MSPB) Costs, by Episode and Service Category

Table 6. Shared Savings Program

- 6A. Hospital Admissions for Any Cause: Beneficiaries Attributed to Your TIN for the Cost Measures (except Medicare Spending per Beneficiary) - Shared Savings Program ACO TINs Only
- 6B. Hospital Admissions for Any Cause: Beneficiaries Assigned to Your ACO for the All-Cause Hospital Readmission Measure and Attributed to Your TIN for the Cost Measures - Shared Savings Program ACO TINs Only

Table 7. Individual Eligible Professional Performance on the 2016 PQRS Measures

ABOUT THE 2018 VALUE MODIFIER

- In 2018, the Value Modifier will apply to all physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists who bill under the Medicare Physician Fee Schedule.
- The Value Modifier applies to groups and solo practitioners, as identified by their Medicare-enrolled TIN, based on their participation in the PQRS.
- Calendar year 2016 is the performance period for the Value Modifier that will be applied in 2018.
- For a TIN that participated in a Medicare Shared Savings Program ACO in 2016, its 2018 Value Modifier is based on the ACO's quality performance in 2016.
- For TINs subject to the 2018 Value Modifier, the amount of the payment adjustment is based on a proposal that was included in the 2018 Medicare Physician Fee Schedule Proposed Rule (82 FR 34124) and is subject to change. Information on the Proposed Rule can be found at <https://federalregister.gov/d/2017-14639>.
- If the ACO successfully reported quality data to the PQRS through the GPRO Web Interface to avoid the 2018 PQRS payment adjustment, then the TIN's 2018 Value Modifier will be calculated based on the ACO's quality performance in 2016, using the quality-tiering methodology. Depending on the ACO's performance, this could result in an upward or neutral payment adjustment in 2018 for clinicians subject to the Value Modifier.
- If the ACO did not successfully report quality data through the GPRO Web Interface, the TIN's 2018 Value Modifier will result in a neutral payment adjustment if:
 - a group avoided the 2018 PQRS payment adjustment by reporting quality data to the PQRS as a group through the GPRO, or
 - at least 50 percent of the eligible professionals in the group avoided the 2018 PQRS payment adjustment as individuals, or
 - a solo practitioner avoided the 2018 PQRS payment adjustment as an individual
- If the ACO did not successfully report quality data through the GPRO Web Interface, the TIN's 2018 Value Modifier will result in an automatic downward adjustment if:
 - a group did not avoid the 2018 PQRS payment adjustment by reporting quality data through the GPRO as a group and less than 50 percent of the eligible professionals in the group avoided the 2018 PQRS payment adjustment as individuals, or
 - a solo practitioner did not avoid the 2018 PQRS payment adjustment as an individualThe amount of the automatic adjustment for clinicians subject to the Value Modifier will be:
 - negative one percent (-1.0%) for TINs composed of only nonphysician eligible professionals or TINs with fewer than ten eligible professionals (including solo practitioners) in 2016
 - negative two percent (-2.0%) for TINs with at least one physician and ten or more eligible professionals in 2016
- Information on Shared Savings Program reporting requirements can be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality-Measures-Standards.html>.

WHAT'S NEXT?

- 2018 will be the final year that Medicare will apply the Value Modifier to clinician payments for services billed under the Medicare Physician Fee Schedule.
- On January 1, 2017, CMS began implementation of the Quality Payment Program, which is part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Quality Payment Program modernizes Medicare through reforms that pay for the quality of care beneficiaries receive while also reducing the administrative burden previously placed on clinicians.
- There are two tracks to choose from to participate in the Quality Payment Program:
 - Advanced Alternative Payment Models (APMs); or
 - The Merit-based Incentive Payment System (MIPS)
- In 2019, the Quality Payment Program payment adjustment will be based on the 2017 performance year.
- Clinicians who participate in an Advanced APM in calendar year 2018 may earn a 2019 incentive payment for participating in an innovative payment model.
- MIPS applies to any physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified registered nurse anesthetist who bills Medicare more than \$30,000 a year and provides care for more than 100 Medicare patients a year.
- More information on the Quality Payment Program can be found at <https://qpp.cms.gov>.

QUESTIONS?

- Contact the Physician Value Help Desk at 1-888-734-6433 (select option 3) or at pvhelpdesk@cms.hhs.gov with questions or feedback about this report.
- For more information about the 2018 Value Modifier and 2016 Annual QRUR, please visit: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2016-QRUR.html>.

GLOSSARY OF TERMS

Note: ALL CAPS FONT indicates terms used in a definition that are defined elsewhere in the glossary. Throughout the glossary and the Quality and Resource Use Reports, groups and solo practices are identified by their Medicare-enrolled TAXPAYER IDENTIFICATION NUMBERS, or TINs.

ADJUSTMENT FACTOR (AF).

The AF is determined after the close of the performance period. It is based on the estimated aggregate amount of downward payment adjustments from Medicare-enrolled TAXPAYER IDENTIFICATION NUMBERS (TINs) that fail to avoid the automatic downward adjustment under the VALUE MODIFIER and is redistributed to CLINICIANS SUBJECT TO THE VALUE MODIFIER in high performing TINs. The AF for the 2018 VALUE MODIFIER will be posted at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2016-QRUR.html>.

ALL-CAUSE HOSPITAL READMISSION.

The All-Cause Hospital Readmission measure is one of three claims-based QUALITY OUTCOME MEASURES that the Centers for Medicare & Medicaid Services calculates from Medicare claims. The measure is a risk-standardized readmission rate for BENEFICIARIES age 65 or older who were hospitalized at a short-stay acute care hospital and experienced an unplanned readmission for any cause to an acute care hospital within 30 days of discharge. Details of measure specifications, including RISK ADJUSTMENT and exclusions, may be found in the 30-day All-Cause Hospital Readmission Measure Information Form available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-ACR-MIF.pdf>.

AMBULATORY CARE-SENSITIVE CONDITIONS (ACSCs).

The Centers for Medicare & Medicaid Services calculates two composite measures of hospital admissions for ACSCs — one for acute conditions and one for CHRONIC CONDITIONS — as QUALITY OUTCOME MEASURES based on Medicare Part A claims:

- CMS-1: Acute Conditions Composite
- CMS-2: Chronic Conditions Composite

The Acute Conditions Composite and Chronic Conditions Composite measures are the risk-adjusted rates at which Medicare BENEFICIARIES are hospitalized for an established set of acute and chronic ACSCs, respectively, that are potentially preventable given appropriate primary and preventive care.

These measures are not included in the calculation of the QUALITY COMPOSITE SCORE for the 2018 VALUE MODIFIER for Medicare-enrolled TAXPAYER IDENTIFICATION NUMBERS (TINs) that participated in Medicare SHARED SAVINGS PROGRAM Accountable Care Organizations in 2016. Details of measure specifications, including RISK ADJUSTMENT and exclusions, may be found in the Measure Information Form: Ambulatory Care-Sensitive Condition (ACSC) Composite Measures used in the 2018 Value Modifier, available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-ACSC-MIF.pdf>.

ATTRIBUTION.

The method of attributing BENEFICIARIES (or hospital episodes of care) to Medicare-enrolled TAXPAYER IDENTIFICATION NUMBERS (TINs) for the purpose of assigning responsibility for the cost and quality of their care varies for different types of quality and cost measures included in this report.

- **Per capita cost measures and claims-based QUALITY OUTCOME MEASURES**

For PER CAPITA COSTS FOR ALL ATTRIBUTED BENEFICIARIES (one measure), PER CAPITA COSTS FOR BENEFICIARIES WITH SPECIFIC CONDITIONS (four measures), ALL-CAUSE HOSPITAL READMISSION (one measure), and hospitalization rates for AMBULATORY CARE-SENSITIVE CONDITIONS (ACSCs) (two measures), Medicare attributes each beneficiary to the single TIN that provided more PRIMARY CARE SERVICES to that beneficiary (as measured by Medicare-allowed charges in 2016) than did any other TIN, through a two-step attribution process:

- Step 1: A beneficiary is assigned to a TIN in the first step if the beneficiary received more primary care services from primary care PHYSICIANS, nurse practitioners, physician assistants, and clinical nurse specialists in that TIN than in any other TIN.
- Step 2: If a beneficiary did not receive a primary care service from any primary care physician, nurse practitioner, physician assistant, or clinical nurse specialist in 2016, the beneficiary is assigned to a TIN in the second step if the beneficiary received more primary care services from specialist physicians in that TIN than in any other TIN.

For additional details on the two-step attribution methodology, please see the Fact Sheet for Attribution in the 2018 VALUE MODIFIER, available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-Attribution-Fact-Sheet.pdf>.

- **MEDICARE SPENDING PER BENEFICIARY**

For this cost measure, an episode of care surrounding a hospital admission for a Medicare fee-for-service 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. For additional details on this attribution methodology, please see Measure Information Form: Medicare Spending per Beneficiary Measure available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-MSPBM-MIF.pdf>.

BENCHMARK.

For the 2018 VALUE MODIFIER, the benchmark for a quality measure, except the ALL-CAUSE HOSPITAL READMISSION measure, is the case-weighted national mean performance rate among all Medicare-enrolled TAXPAYER IDENTIFICATION NUMBERS (TINs) in the measure’s PEER GROUP during calendar year 2016. The benchmark for the All-Cause Hospital Readmission measure is the case-weighted national mean performance rate among all TINs and Accountable Care Organizations (ACOs) in the measure’s peer group during calendar year 2016. For additional details, please see Quality Benchmarks for the 2018 Value Modifier and 2016 Annual Quality and Resource Use Reports available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2016-QRUR.html>.

The benchmark for a cost measure is the case-weighted national mean cost among all TINs in the measure’s peer group during calendar year 2016.

BENEFICIARY.

The term “beneficiary” in the Annual Quality and Resource Use Report refers to any individual entitled to benefits or enrolled under Medicare Part A and enrolled under a Part B plan who resides in the United States and had Medicare-allowed charges during 2016.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) CERTIFICATION NUMBER (CCN).

A facility’s CCN is the identification number linked to its Medicare provider agreement. CMS uses this number to identify hospitals admitting BENEFICIARIES who are attributed to a Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN).

CHRONIC CONDITIONS.

Chronic health conditions are diseases or illnesses that are commonly expected to last at least six months, require ongoing monitoring to avoid loss of normal life functioning, and are not expected to improve or resolve without treatment. For this report, PER CAPITA COSTS FOR BENEFICIARIES WITH SPECIFIC CONDITIONS were calculated for four chronic conditions common to the Medicare population: diabetes, coronary artery disease, chronic obstructive pulmonary disease, and heart failure. In addition, the Chronic Conditions Composite measure of hospitalization rates for AMBULATORY CARE-SENSITIVE CONDITIONS (ACSCs) includes hospitalizations for diabetes, chronic obstructive pulmonary disease or asthma, and heart failure.

CLINICIANS SUBJECT TO THE VALUE MODIFIER.

In 2018, the Value Modifier will apply to all of the following clinicians in Medicare-enrolled TAXPAYER IDENTIFICATION NUMBERS (TINs) who bill under the Medicare Physician Fee Schedule: PHYSICIANS, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists.

COMPREHENSIVE END-STAGE RENAL DISEASE (ESRD) CARE MODEL.

The Comprehensive ESRD Care Model brings dialysis clinics, nephrologists and other providers together to coordinate care for Medicare beneficiaries with ESRD, both in and outside of the dialysis clinic. The 2018 VALUE MODIFIER will be waived for a Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN) if one or more ELIGIBLE PROFESSIONALS who billed for Medicare Physician Fee Schedule items and services under the TIN in 2016 participated in the Comprehensive ESRD Care Model in 2016 (unless the TIN participated in a SHARED SAVINGS PROGRAM Accountable Care Organization in 2016). For more information, please refer to the Comprehensive ESRD Care Model website at <https://innovation.cms.gov/initiatives/comprehensive-esrd-care/>.

COMPREHENSIVE PRIMARY CARE INITIATIVE.

The Comprehensive Primary Care initiative is a four-year multi-payer initiative launched in October 2012 designed to strengthen primary care. The initiative is testing whether provision of comprehensive primary care functions at each practice site—supported by multi-payer payment reform, the continuous use of data to guide improvement, and meaningful use of health information technology—can achieve improved care, better health for populations, and lower costs, and can inform future Medicare and Medicaid policy. The 2018 VALUE MODIFIER will be waived for a Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN) if one or more ELIGIBLE PROFESSIONALS who billed for Medicare Physician Fee Schedule items and services under the TIN in 2016 participated in the Comprehensive Primary Care initiative (unless the TIN participated in a SHARED SAVINGS PROGRAM Accountable Care Organization in 2016). For more information, please refer to the Comprehensive Primary Care initiative website at <https://www.innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/>.

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS).

The CAHPS for PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) survey and the CAHPS for Medicare SHARED SAVINGS PROGRAM Accountable Care Organizations (ACOs) patient experience survey are based on the Clinician & Group (CG) CAHPS survey developed by the Agency for Healthcare Research and Quality and assesses patients' experiences with health care providers and office staff. In 2016, Medicare-enrolled TAXPAYER IDENTIFICATION NUMBERS (TINs) with two or more ELIGIBLE PROFESSIONALS that elect or are required to report the CAHPS for PQRS survey could decide whether to include the results of their 2016 CAHPS for PQRS survey in the calculation of their 2018 VALUE MODIFIER. To meet the criteria to avoid the 2018 PQRS PAYMENT ADJUSTMENT, Shared Savings Program ACOs were required to collect CAHPS for ACOs data in 2016.

COST COMPOSITE SCORE.

The Cost Composite Score is one of two composite scores used to calculate the VALUE MODIFIER under QUALITY-TIERING. It summarizes the performance of a Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN) on up to six cost measures within two equally-weighted COST DOMAINS: COSTS FOR ALL ATTRIBUTED BENEFICIARIES and COSTS FOR BENEFICIARIES WITH SPECIFIC CONDITIONS. Performance within a domain represents the equally-weighted average of STANDARDIZED PERFORMANCE SCORES for all measures within the domain that have the minimum number of required eligible cases (or episodes). Standardized performance scores reflect how much a TIN's performance differs from the BENCHMARK on a measure-by-measure basis. The standardized Cost Composite Score reflects how much a TIN's performance differs from the mean composite cost performance within the PEER GROUP.

COST DOMAINS.

Cost domains are categories of cost performance used to calculate the COST COMPOSITE SCORE for the VALUE MODIFIER. Six individual cost measures are organized into two cost domains: COSTS FOR ALL ATTRIBUTED BENEFICIARIES and COSTS FOR BENEFICIARIES WITH SPECIFIC CONDITIONS. Each cost domain score is the equally-weighted average of STANDARDIZED PERFORMANCE SCORES for measures within the domain that have the minimum required number of eligible cases or episodes.

ELIGIBLE PROFESSIONAL.

An eligible professional is an individual provider, as identified by his or her individual National Provider Identifier, who provides services to Medicare fee-for-service BENEFICIARIES that are paid under the Medicare Physician Fee Schedule. Eligible professionals consist of PHYSICIANS, practitioners, physical or occupational therapists, qualified speech-language pathologists, or 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: certified registered nurse anesthetist, anesthesiologist assistant, certified nurse midwife, clinical nurse specialist, clinical social worker, clinical psychologist, nurse practitioner, physician assistant, registered dietician or nutrition professional, or audiologist.

In 2018, the VALUE MODIFIER will apply to all PHYSICIANS, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists in Medicare-enrolled TAXPAYER IDENTIFICATION NUMBERS (TINs) who bill under the Medicare Physician Fee Schedule.

An eligible professional's medical specialty is based on the specialty associated with the most allowed charges on claims files for Medicare Part B services furnished by that eligible professional during 2016. If specialty information is not included in the claims files, then the specialty listed for that eligible professional in the PROVIDER ENROLLMENT, CHAIN, AND OWNERSHIP SYSTEM (PECOS) when the data for this report were downloaded is used instead.

GROUP PRACTICE REPORTING MECHANISMS.

In 2016, group practices participating in the PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) through the GROUP PRACTICE REPORTING OPTION (GPRO) could register to report quality measures through one of four reporting mechanisms: (1) a qualified PQRS registry, (2) GPRO Web Interface (for groups with 25 or more ELIGIBLE PROFESSIONALS), (3) electronic health record (EHR) [via direct EHR using certified EHR technology (CEHRT) or CEHRT via a Data Submission Vendor], or (4) a qualified clinical data registry (QCDR). In addition, in 2016, the CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS) for PQRS survey was required for groups with 100 or more eligible professionals, but was optional for groups with 2-99 eligible professionals. The CAHPS for accountable care organizations (ACOs) was also required for Medicare SHARED SAVINGS PROGRAM ACOs in 2016. More information on GPRO reporting options and requirements is available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/>.

GROUP PRACTICE REPORTING OPTION (GPRO).

In accordance with section 1848(m)(3)(C) of the Social Security Act, the Centers for Medicare & Medicaid Services created a Group Practice Reporting Option (GPRO) for the PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) in 2010. Group practices participating in PQRS GPRO that satisfactorily report data on PQRS measures for a particular reporting period avoid a negative PQRS PAYMENT ADJUSTMENT equal to a specified percentage of the group practice's total estimated Medicare Part B Physician Fee Schedule allowed charges for covered professional services furnished during the reporting period. Groups that qualify to avoid the PQRS payment adjustment in 2018 also qualify to avoid an automatic downward adjustment under the 2018 VALUE MODIFIER. More information on GPRO and GPRO reporting requirements can be found here: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/>.

HIGH-RISK BONUS ADJUSTMENT.

Medicare-enrolled TAXPAYER IDENTIFICATION NUMBERS (TINs) that qualify for an upward adjustment based on QUALITY-TIERING under the VALUE MODIFIER are eligible to receive an additional upward adjustment to their 2018 VALUE MODIFIER equal to one (1.0) times the ADJUSTMENT FACTOR, if they served a disproportionate share of high-risk Medicare fee-for-service BENEFICIARIES (defined as having an average beneficiary RISK SCORE at or above the 75th percentile of all beneficiary risk scores nationwide) in 2016. Beneficiaries included in the calculation of the average risk score are those attributed to the TIN for all the per capita cost measures, claims-based QUALITY OUTCOME MEASURES, and MEDICARE SPENDING PER BENEFICIARY measure. For TINs that participated in the Medicare SHARED SAVINGS PROGRAM in 2016, the high-risk bonus adjustment is based on all beneficiaries assigned to the Shared Savings Program Accountable Care Organization in which the TIN participated.

INNOVATION MODELS.

The Center for Medicare & Medicaid Innovation, a component of the Centers of Medicare & Medicaid Services (CMS), supports the development and testing of innovative health care payment and service delivery models (Innovation Models) for individuals who receive Medicare, Medicaid, or Children's Health Insurance Program benefits. The 2018 VALUE MODIFIER will be waived for a Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN) if one or more ELIGIBLE PROFESSIONALS who billed for Medicare Physician Fee Schedule items and services under the TIN in 2016 participated in the following Innovation Models: the COMPREHENSIVE PRIMARY CARE INITIATIVE, the PIONEER ACCOUNTABLE CARE ORGANIZATION (ACO) MODEL, the NEXT GENERATION ACO MODEL, the ONCOLOGY CARE MODEL, or the COMPREHENSIVE END-STAGE RENAL DISEASE (ESRD) CARE MODEL. However, the 2018 Value Modifier will apply to all TINs that participated in a Medicare SHARED SAVINGS PROGRAM ACO in 2016. For more information, please refer to the Innovation Center website at <https://innovation.cms.gov/index.html>.

MEASURE POPULATIONS.

The population of Medicare BENEFICIARIES included in the calculation of quality and cost measures in this report varies for different types of measures (see also ATTRIBUTION).

- **PER CAPITA COSTS FOR ALL ATTRIBUTED BENEFICIARIES (one measure) and PER CAPITA COSTS FOR BENEFICIARIES WITH SPECIFIC CONDITIONS (four measures)**

The measure population for the PER CAPITA COSTS FOR ALL BENEFICIARIES measure includes all Medicare beneficiaries attributed according to the two-step attribution process. The measure population for each of the four PER CAPITA COSTS FOR BENEFICIARIES WITH SPECIFIC CONDITIONS measures includes only those attributed beneficiaries with each condition. For more information, see Measure Information Form: Overall Total Per Capita Cost Measure used in the 2018 VALUE MODIFIER and Measure Information Form: Condition-Specific Total Per Capita Cost Measures used in the 2018 Value Modifier, both available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2016-QRUR.html>.

- **Hospitalization rates for AMBULATORY CARE-SENSITIVE CONDITIONS (ACSCs) (two measures) and ALL-CAUSE HOSPITAL READMISSION (one measure)**

The measure population for the Acute Conditions Composite rate of hospitalization for ACSCs includes all Medicare beneficiaries attributed according to the two-step attribution process after measure exclusions have been applied. The measure population for the Chronic Conditions Composite rate of hospitalization for ACSCs includes only those beneficiaries with the specific CHRONIC CONDITIONS included in the composite. The measure population for the All-Cause Hospital Readmission measure includes only those attributed beneficiaries who were hospitalized during calendar year 2016. For more information, see Measure Information Form: 30-Day All-Cause Hospital Readmission Measure used in the 2018 Value Modifier and Measure Information Form: Ambulatory Care-Sensitive Condition (ACSC) Composite Measures used in the 2018 Value Modifier, both available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2016-QRUR.html>.

- **MEDICARE SPENDING PER BENEFICIARY**

The population included in this cost measure is comprised of those Medicare fee-for-service beneficiaries hospitalized in 2016 for which the Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN) furnished more Part B-covered services (as measured by Medicare-allowed charges) during the hospital stay than any other TIN. For more information, please see Measure Information Form: Medicare Spending per Beneficiary Measure, available at <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 measure populations for the PQRS quality measures vary by measure. For more information, please see 2016 Physician Quality Reporting System (PQRS): Implementation Guide, available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016_PQRS_ImplementationGuide.pdf.

MEDICARE CLAIMS DATA USED IN THE COST MEASURES.

The cost measures displayed in this report are based on all Medicare Parts A and B claims data submitted by ELIGIBLE PROFESSIONALS for care furnished in 2016 to Medicare fee-for-service BENEFICIARIES attributed to the Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN). These data include inpatient hospital, outpatient hospital, hospice, skilled nursing facility, home health, and durable medical equipment claims, as well as claims submitted by individual (non-institutional) providers and suppliers to their Part B Medicare Administrative Contractors. Part D prescription drug costs are not included in the cost measures.

MEDICARE SPENDING PER BENEFICIARY.

The Medicare Spending per Beneficiary measure is one of two cost performance measures included in the Costs for All Attributed Beneficiaries COST DOMAIN. This measure assesses resource use surrounding a Medicare BENEFICIARY'S hospital stay, from 3 days prior to admission through 30 days post-discharge. For additional information, please see Measure Information Form: Medicare Spending per Beneficiary Measure available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-MSPBM-MIF.pdf>.

NATIONAL QUALITY STRATEGY.

Established as part of the Affordable Care Act, the National Quality Strategy (led by the Agency for Healthcare Research and Quality on behalf of the U.S. Department of Health and Human Services) serves as a guide for a nationwide focus on quality improvement efforts and approach to measuring quality.

All quality measures are classified into six QUALITY DOMAINS that are used to calculate the QUALITY COMPOSITE SCORE for the VALUE MODIFIER. The domains are 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. More information about the National Quality Strategy is available here: <https://www.ahrq.gov/workingforquality/about.html>.

NEXT GENERATION ACCOUNTABLE CARE ORGANIZATION (ACO) MODEL.

The Next Generation ACO Model is an initiative for ACOs that are experienced in coordinating care for populations of patients. It will allow these provider groups to assume higher levels of financial risk and reward than are available under the current PIONEER ACO MODEL and Medicare SHARED SAVINGS PROGRAM. The 2018 VALUE MODIFIER will be waived for a Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN) if one or more ELIGIBLE PROFESSIONALS who billed for Medicare Physician Fee Schedule items and services under the TIN in 2016 participated in the Next Generation ACO Model in 2016 (unless the TIN participated in a Shared Savings Program ACO in 2016). For more information, please refer to the Next Generation ACO Model website at <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>.

ONCOLOGY CARE MODEL.

The Oncology Care Model provides an incentive to participating PHYSICIAN practices to comprehensively and appropriately address the complex care needs of the BENEFICIARY population receiving chemotherapy treatment, and heighten the focus on furnishing services that specifically improve the patient experience or health outcomes. The Centers for Medicare and Medicaid Services (CMS) is partnering with commercial payers in the model. The 2018 VALUE MODIFIER will be waived for a Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN) if one or more ELIGIBLE PROFESSIONALS who billed for Medicare Physician Fee Schedule items and services under the TIN in 2016 participated in the Oncology Care Model in 2016 (unless the TIN participated in a Medicare SHARED SAVINGS PROGRAM Accountable Care Organization in 2016). For more information, please refer to the Oncology Care Model website at <https://innovation.cms.gov/initiatives/oncology-care/>.

PAYMENT STANDARDIZATION.

Payment standardization facilitates comparison of Medicare costs across similar providers by eliminating variations in certain payment rates unrelated to resource use, such as differences due to geographic location or add-on payments for special programs (for example, payments to “disproportionate share” hospitals serving large numbers of Medicaid or uninsured individuals). Further information about payment standardization is available in the CMS Price (Payment) Standardization – Basics and the CMS Price (Payment) Standardization - Detailed Methods documents located on the Quality Net website, at <http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772057350>.

PEER GROUP.

The term “peer group” refers to the comparison group used to determine comparative BENCHMARKS for scoring purposes in this report. With the exception of the ALL-CAUSE HOSPITAL READMISSION measure that the Centers for Medicare & Medicaid Services calculates from Medicare claims, the peer group for all quality measures is defined as all Medicare-enrolled TAXPAYER IDENTIFICATION NUMBERS (TINs) that had at least 20 eligible cases for a given measure in calendar year 2016. The peer group for the All-Cause Hospital Readmission measure is defined as all Accountable Care Organizations (ACOs) in the Medicare SHARED SAVINGS PROGRAM with at least 1 eligible case and all non-Shared Savings Program TINs nationwide with 10 or more ELIGIBLE PROFESSIONALS that had at least 200 eligible cases. For all cost measures except MEDICARE SPENDING PER BENEFICIARY, the peer group is defined as all TINs nationwide that had at least 20 eligible cases for the measure in calendar year 2016. For the Medicare Spending per Beneficiary measure, the peer group is defined as all TINs nationwide with at least 125 eligible episodes.

To calculate the QUALITY COMPOSITE SCORE under QUALITY-TIERING for TINs subject to the 2018 VALUE MODIFIER, a TIN's peer group includes only those TINs for which a Quality Composite Score was calculated and used to determine the 2018 Value Modifier. For TINs not subject to the 2018 Value Modifier, the peer group for the Quality Composite Score includes all TINs for which a Quality Composite Score could be calculated, with the exception of TINs that participated in Value Modifier-waived INNOVATION MODELS in 2016 and TINs that participated in a Shared Savings Program ACO that did not successfully report ACO quality data to the PQRS.

To calculate the COST COMPOSITE SCORE under QUALITY-TIERING for TINs subject to the 2018 Value Modifier, a TIN's peer group includes only those 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 TINs not subject to the 2018 Value Modifier, the peer group for the Cost Composite Score includes all TINs for which a Cost Composite Score could be calculated, with the exception of TINs that participated in the Shared Savings Program or in Value Modifier-waived Innovation Models in 2016.

PER CAPITA COSTS FOR ALL ATTRIBUTED BENEFICIARIES.

Per Capita Costs for All Attributed Beneficiaries is one of two cost measures included in the Costs for All Attributed Beneficiaries COST DOMAIN. The cost measure represents the average (mean) of all Medicare Part A and B payments to all providers for beneficiaries attributed to a Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN) during calendar year 2016 (see ATTRIBUTION). For more information about how this measure is calculated, please see Measure Information Form: Overall Total Per Capita Cost Measure used in the 2018 Value Modifier, available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-TPCC-MIF.pdf>.

PER CAPITA COSTS FOR BENEFICIARIES WITH SPECIFIC CONDITIONS.

The term refers to the four cost measures that comprise the Costs for Beneficiaries with Specific Conditions COST DOMAIN. These are per capita cost measures for each of four CHRONIC CONDITIONS: diabetes, coronary artery disease, chronic obstructive pulmonary disease, and heart failure. These condition-specific per capita cost measures include all Medicare Part A and B costs for attributed beneficiaries with those conditions and are not limited to costs associated with treating the condition itself. For more information about how these measures are calculated, please see Measure Information Form: Condition-Specific Total Per Capita Cost Measures used in the 2018 Value Modifier, available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-CSTPCC-MIF.pdf>.

PHYSICIAN.

For the purposes of this report, a physician is an ELIGIBLE PROFESSIONAL who 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.

In 2018, the VALUE MODIFIER will apply to all PHYSICIANS and to physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists in Medicare-enrolled TAXPAYER IDENTIFICATION NUMBERS (TINs) who bill under the Medicare Physician Fee Schedule.

PHYSICIAN QUALITY REPORTING SYSTEM (PQRS).

The PQRS is a quality reporting program that encourages individual ELIGIBLE PROFESSIONALS and group practices to report information on the quality of care to Medicare. This gives individual eligible professionals and group practices the opportunity to assess the quality of the care they provide and ensures that patients get the right care at the right time. The program will apply a negative payment adjustment in 2018 to individual eligible professionals and group practices that did not satisfactorily report data on quality measures for Medicare Part B Physician Fee Schedule covered professional services furnished to Medicare BENEFICIARIES in 2016. Physicians may participate in PQRS as individuals or as a group through the GROUP PRACTICE REPORTING OPTION (GPRO). More information about participating in the PQRS is available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>.

THE PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) PAYMENT ADJUSTMENT.

The PQRS payment adjustment is a negative payment adjustment applied to individual ELIGIBLE PROFESSIONALS and group practices that do not satisfactorily report data on quality measures for covered Medicare Physician Fee Schedule services furnished to Medicare BENEFICIARIES. Groups that fail to meet the criteria to avoid the 2018 PQRS payment adjustment by reporting quality data to the PQRS as a group through the GROUP PRACTICE REPORTING OPTION (GPRO) and also have less than 50 percent of the eligible professionals in the group meet the criteria to avoid the 2018 PQRS payment adjustment as individuals will be subject to an automatic downward adjustment under the 2018 VALUE MODIFIER. A solo practitioner that fails to meet the criteria to avoid the 2018 PQRS payment adjustment as an individual will also be subject to an automatic downward adjustment under the 2018 Value Modifier. All PHYSICIANS, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists in the identified Medicare-enrolled TAXPAYER IDENTIFICATION NUMBERS (TINs) who bill under the Medicare Physician Fee Schedule will be subject to the automatic downward adjustment to the 2018 Value Modifier. Information on the criteria to avoid the 2018 PQRS payment adjustment can be found at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html>.

PIONEER ACCOUNTABLE CARE ORGANIZATION (ACO) MODEL.

The Pioneer ACO Model is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. It will allow these provider groups to move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the Medicare SHARED SAVINGS PROGRAM. It is designed to work in coordination with private payers by aligning provider incentives, which will improve quality and health outcomes for patients across the ACO, and achieve cost savings for Medicare, employers and patients. The 2018 VALUE MODIFIER will be waived for a Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN) if one or more ELIGIBLE PROFESSIONALS who billed for Medicare Physician Fee Schedule items and services under the TIN in 2016 participated in the Pioneer ACO Model in 2016 (unless the TIN participated in an ACO in the Shared Savings Program in 2016). For more information, please refer to the Pioneer ACO Model website at <https://www.innovation.cms.gov/initiatives/Pioneer-aco-model>.

PRIMARY CARE SERVICES.

For the purposes of this report, primary care services are defined as Part B Medicare services billed under one of the Healthcare Common Procedure Coding System (HCPCS) codes listed in Exhibit G-1, below. For more information, please see the Fact Sheet for Attribution in the 2018 Value Modifier, available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-Attribution-Fact-Sheet.pdf>.

Exhibit G-1. Healthcare Common Procedure Coding System (HCPCS) Primary Care Service Codes Criteria

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 or established patient, initial nursing facility care
99307–99310	New or established patient, subsequent nursing facility care
99315–99316	New or established patient, discharge day management service
99318	New or established patient, other nursing facility service
99324–99328	New patient, domiciliary, rest home, or custodial care visit
99334–99337	Established patient, domiciliary, rest home or custodial care 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-G0439	Annual wellness visit
G0463	Hospital outpatient clinic visit (Electing Teaching Amendment hospitals only)

Note: Labels are approximate. See the American Medical Association's Current Procedural Terminology and the Centers for Medicare & Medicaid Services website (<https://www.cms.gov>) for detailed definitions.

PROVIDER ENROLLMENT, CHAIN, AND OWNERSHIP SYSTEM (PECOS).

PECOS is a data system that supports the Medicare provider and supplier enrollment process by allowing registered users to securely and electronically submit and manage Medicare enrollment information.

The number of ELIGIBLE PROFESSIONALS billing under a TAXPAYER IDENTIFICATION NUMBER (TIN), for purposes of applying the 2018 VALUE MODIFIER, is determined based on the lower of the number of eligible professionals indicated by a query of PECOS on July 16, 2016 and the number of eligible professionals that submitted claims to Medicare under the TIN during calendar year 2016. More information on PECOS is available at <https://pecos.cms.hhs.gov/pecos/login.do>.

QUALITY COMPOSITE SCORE.

The Quality Composite Score is one of two composite scores used to calculate the VALUE MODIFIER under QUALITY-TIERING. It summarizes a Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN)'s performance on quality measures across up to six equally-weighted QUALITY DOMAINS. Performance within a domain represents the equally-weighted average of STANDARDIZED SCORES for all measures within the domain that have the minimum number of required eligible cases. Standardized performance scores reflect how much a TIN's performance differs from the BENCHMARK on a measure-by-measure basis. The standardized Quality Composite Score reflects how much a TIN's performance differs from the mean composite quality performance within the PEER GROUP.

QUALITY DOMAINS.

Quality domains are categories of performance used to calculate the QUALITY COMPOSITE SCORE for the VALUE MODIFIER. 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. Each quality domain score is calculated as the equally-weighted average of STANDARDIZED PERFORMANCE SCORES for measures within the domain that have the minimum required number of eligible cases.

QUALITY OUTCOME MEASURES.

The Centers for Medicare & Medicaid Services calculates three claims-based quality outcome measures from Medicare fee-for-service claims submitted for Medicare BENEFICIARIES attributed to a Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN): the ALL-CAUSE HOSPITAL READMISSION measure and two composite measures of hospital admissions for acute and chronic AMBULATORY CARE-SENSITIVE CONDITIONS (ACSCs).

QUALITY-TIERING.

Quality-tiering is the methodology that is used to evaluate the performance of a Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN) on quality and cost measures for the VALUE MODIFIER. If a TIN with two or more ELIGIBLE PROFESSIONALS met the criteria to avoid the 2018 PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) PAYMENT ADJUSTMENT by reporting quality data to the PQRS as a group through the GROUP PRACTICE REPORTING OPTION (GPRO), or if at least 50 percent of the eligible professionals in a TIN met the criteria to avoid the 2018 PQRS payment adjustment as individuals, then the TIN's 2018 Value Modifier will be calculated based on its quality and cost performance in 2016, using the quality-tiering methodology. If a TIN with one eligible professional met the criteria to avoid the 2018 PQRS payment adjustment as an individual, then the TIN's 2018 Value Modifier will be calculated based on its quality and cost performance in 2016, using the quality-tiering methodology. Depending on the TIN's performance, this could result in an upward or neutral payment adjustment in 2018 for CLINICIANS SUBJECT TO THE VALUE MODIFIER.

For a TIN that participated in an Accountable Care Organization (ACO) in the Medicare SHARED SAVINGS PROGRAM in 2016, if the ACO successfully reported quality data to the PQRS through the GPRO Web Interface to avoid the 2018 PQRS payment adjustment, then the TIN's 2018 Value Modifier will be calculated based on the ACO's quality performance in 2016, using the quality-tiering methodology. Depending on the ACO's performance, this could result in an upward, neutral, or downward payment adjustment. If the ACO did not successfully report quality data through the Group Practice Reporting Option (GPRO) Web Interface to avoid the 2018 PQRS payment adjustment, but the TIN successfully reported quality data to the PQRS as a group or as individual eligible professionals, the TIN will receive a neutral payment adjustment. Details on quality-tiering may be found in the Computation of the 2018 Value Modifier Fact Sheet available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2018-VM-factsheet.pdf>.

RISK ADJUSTMENT.

Risk adjustment accounts for differences in BENEFICIARY-level risk factors that can affect quality outcomes or medical costs, regardless of the care provided. The Centers for Medicare & Medicaid Services uses risk adjustment when calculating the relative performance of a Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN) on the PER CAPITA COSTS FOR ALL ATTRIBUTED BENEFICIARIES, PER CAPITA COSTS FOR BENEFICIARIES WITH SPECIFIC CONDITIONS, MEDICARE SPENDING PER BENEFICIARY, ALL-CAUSE HOSPITAL READMISSION, and Acute and Chronic AMBULATORY CARE-SENSITIVE CONDITIONS (ACSC) Composite measures. Further information on risk adjustment for specific measures can be found in the Risk Adjustment Fact Sheet available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-RiskAdj-FactSheet.pdf>.

RISK SCORE.

A risk score predicts how a BENEFICIARY'S medical costs would be expected to compare with average (mean) costs among all Medicare fee-for-service beneficiaries. The Centers for Medicare & Medicaid Services' Hierarchical Condition Categories RISK ADJUSTMENT model generates a risk score for each Medicare FFS beneficiary, based on the presence of factors known to affect costs and utilization. Risk scores for all beneficiaries attributed to a Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN) are used to estimate, and adjust for, the independent effects of these factors on beneficiary costs in calculating risk-adjusted cost measures for the TIN. In addition, TINs that qualify for an upward adjustment under QUALITY-TIERING are eligible to receive an additional upward adjustment to their 2018 VALUE MODIFIER (HIGH-RISK BONUS ADJUSTMENT) if their average beneficiary risk score is at or above the 75th percentile of all beneficiary risk scores nationwide.

SHARED SAVINGS PROGRAM.

The 2018 VALUE MODIFIER will apply to Medicare-enrolled TAXPAYER IDENTIFICATION NUMBERS (TINs) that participate in an Accountable Care Organization (ACO) in the Medicare SHARED SAVINGS PROGRAM in 2016. For TINs that participated in a Shared Savings Program ACO that successfully reported quality data to the PQRS through the GPRO Web Interface to avoid the 2018 PQRS payment adjustment, the 2018 Value Modifier is based on the ACO's quality performance in 2016. If the ACO did not successfully report quality data to the PQRS through the GPRO Web Interface to avoid the 2018 PQRS payment adjustment, but the TIN successfully reported quality data to the PQRS as a group or as individual eligible professionals, the TIN will receive a neutral payment adjustment. For more information, please refer to the Computation of the 2018 Value Modifier Fact Sheet available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2018-VM-factsheet.pdf> and the Shared Savings Program website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/>.

SPECIALTY ADJUSTMENT.

Specialty adjustment enables a more accurate comparison of Medicare payments for a given Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN) to those of other TINs by accounting for specialty mix. All cost measures in this report have been adjusted to reflect the mix of specialties within a TIN. Additional information about specialty adjustment is available in the Specialty Adjustment Fact Sheet available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-SpecAdj-FactSheet.pdf>.

STANDARD DEVIATION.

Standard deviation is a statistic that measures how tightly clustered or spread out a distribution of observed values is. The smaller the standard deviation, the more tightly clustered the values are around the mean; the larger the standard deviation, the more spread out the values are. For all quality and cost measures in this report, performance scores are standardized based on how many standard deviations a score is from the BENCHMARK performance rate for that measure (see STANDARDIZED PERFORMANCE SCORE). To be considered either a high or low performer for purposes of QUALITY-TIERING, a Medicare-enrolled Taxpayer Identification Number (TIN)'s QUALITY COMPOSITE SCORE or COST COMPOSITE SCORE must be at least one standard deviation above or below the PEER GROUP mean and be different from the peer group mean at the five percent level of STATISTICAL SIGNIFICANCE.

STANDARDIZED PERFORMANCE SCORE.

Standardizing measure performance transforms measures with disparate scales to a common scale, which enables different measures to be compared and combined with one another into a composite. The standardized score reflects by how many STANDARD DEVIATIONS a Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN)'s performance on a given quality or cost measure differed from the BENCHMARK for that measure. For each measure, the standardized score is computed as the difference between the performance rate and the benchmark, divided by the standard deviation within the PEER GROUP. Standardized scores are reported for measures in all domains included in the QUALITY COMPOSITE SCORE and the COST COMPOSITE SCORE.

STATISTICAL SIGNIFICANCE.

A Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN)'S performance on quality and cost measures may differ from the PEER GROUP mean due to limitations of measurement, rather than actual differences in performance. For the purposes of calculating the VALUE MODIFIER, statistical significance is a concept that expresses whether a measurement is sufficiently precise to distinguish it from the peer group mean in the presence of these limitations. To be considered either a high or low performer under QUALITY-TIERING, a TIN's QUALITY COMPOSITE SCORE or COST COMPOSITE SCORE must be at least one STANDARD DEVIATION above or below the peer group mean and be statistically significantly different from the peer group mean at the five percent level. This means that the likelihood of observing a composite score that far from the mean (or farther) when there is actually no difference in performance is estimated to be five percent or less.

TAXPAYER IDENTIFICATION NUMBER (TIN).

A Medicare-enrolled TIN defines the single Medicare-enrolled provider entity to which Medicare BENEFICIARIES are attributed for the purpose of calculating quality and cost information in this report. The TIN is composed of all ELIGIBLE PROFESSIONALS who reassigned their billing rights to the TIN in 2016.

The number of eligible professionals in the TIN, for purposes of applying the 2018 VALUE MODIFIER, is determined based on the lower of the number of eligible professionals indicated by a query of the PROVIDER ENROLLMENT, CHAIN, AND OWNERSHIP SYSTEM (PECOS) on July 16, 2016 and the number of eligible professionals that submitted claims to Medicare under the TIN during calendar year 2016.

VALUE MODIFIER (VALUE-BASED PAYMENT MODIFIER).

In calendar year 2018, Medicare will apply the Value Modifier under section 1848(p) of the Social Security Act to payments under the Medicare Physician Fee Schedule for PHYSICIANS, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists in groups with two or more eligible professionals and to solo practitioners, identified by their Medicare-enrolled TAXPAYER IDENTIFICATION NUMBERS (TINs). Calendar year 2016 is the performance period for the Value Modifier that will be applied in 2018. The 2016 Annual Quality and Resource Use Report (QRUR) shows how a TIN performed in calendar year 2016 on the quality and cost measures used to calculate the 2018 Value Modifier. The 2018 Value Modifier is waived for a TIN if at least one eligible professional who billed for Medicare Physician Fee Schedule items and services under the TIN in 2016 participated in the COMPREHENSIVE PRIMARY CARE INITIATIVE, the PIONEER ACCOUNTABLE CARE ORGANIZATION (ACO) MODEL, the NEXT GENERATION ACO MODEL, the ONCOLOGY CARE MODEL, or the COMPREHENSIVE END-STAGE RENAL DISEASE (ESRD) CARE MODEL. However, the 2018 Value Modifier will apply to all TINs that participated in a Medicare SHARED SAVINGS PROGRAM ACO in 2016. More information about the 2016 Annual QRUR and how the 2018 Value Modifier is calculated is available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2016-QRUR.html>.