2015 ANNUAL QUALITY AND RESOURCE USE REPORT

AND THE 2017 VALUE-BASED PAYMENT MODIFIER

SOUTHEAST TEXAS MEDICAL ASSOCIATES LLP

LAST FOUR DIGITS OF YOUR MEDICARE-ENROLLED TAXPAYER IDENTIFICATION NUMBER (TIN): 7095

PERFORMANCE PERIOD: 01/01/2015 – 12/31/2015

ABOUT THIS REPORT FROM MEDICARE

The 2015 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 2015 on the quality and cost measures used to calculate the Value-Based Payment Modifier (Value Modifier) for 2017.

In 2017, the Value Modifier will apply to all physicians in groups with two or more eligible professionals and to physicians who are solo practitioners who bill under the Medicare Physician Fee Schedule. It will not apply to eligible professionals who are not physicians.

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.

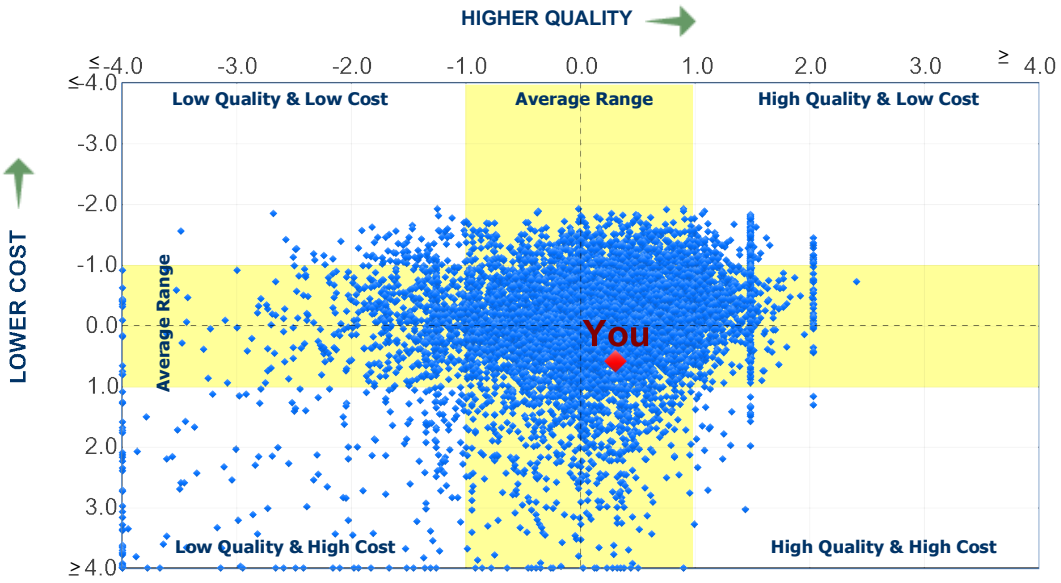
YOUR TIN'S 2017 VALUE MODIFIER

Average Quality, Average Cost = Neutral Adjustment (0.0%)

Your TIN's overall performance was determined to be average on quality measures and average on cost measures.

This means that the Value Modifier applied to payments for items and services under the Medicare Physician Fee Schedule for physicians billing under your TIN in 2017 will result in a neutral adjustment, meaning no adjustment (0.0%).

The scatter plot below shows how your TIN ("You" diamond) compares to a representative sample of other TINs on the Quality and Cost Composite scores used to calculate the 2017 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 2017 and you disagree with the Value Modifier calculation indicated above in the "Your TIN's 2017 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 2017 Value Modifier and 2015 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/2015-QRUR.html.

YOUR TIN'S 2017 VALUE MODIFIER

How does the Value Modifier apply to your TIN in 2017?

The Value Modifier will apply to your TIN because at least one physician billed Medicare under your TIN in 2015, and no eligible professional billing under your TIN participated in the Pioneer Accountable Care Organization (ACO) Model or the Comprehensive Primary Care initiative in 2015. In 2015, your TIN had 37 eligible professional(s).

Your TIN reported quality data to the Physician Quality Reporting System (PQRS) through the Group Practice Reporting Option (GPRO) via electronic health record and met the criteria to avoid the 2017 PQRS payment adjustment as a group. This also qualifies your TIN to avoid an automatic Value Modifier downward adjustment in 2017. CMS used its quality-tiering methodology to calculate your TIN's 2017 Value Modifier based on the number of eligible professionals in your TIN and your TIN's performance on quality and cost measures during 2015.

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 physicians billing under your TIN in 2017 will result in a neutral adjustment, meaning no adjustment (0.0%).

Exhibit 1. 2017 Value Modifier Payment Adjustments under Quality-Tiering
(TINs with 10 or More Eligible Professionals)

	Low Quality	Average Quality	High Quality
Low Cost	0.0%	+2.0 x AF	+4.0 x AF
Average Cost	-2.0%	**0.0%**	+2.0 x AF
High Cost	-4.0%	-2.0%	0.0%

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 2017 Value Modifier will be posted at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-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 met the criteria to avoid the PQRS payment adjustment (if applicable) -- please refer to the following tables on the CMS Enterprise Portal:

- Table 1. Physicians and Non-Physician Eligible Professionals in Your Medicare-Enrolled Taxpayer Identification Number (TIN), Selected Characteristics
- Table 7. Individual Eligible Professional Performance on the 2015 PQRS Measures

Glossary Terms
Adjustment factor (AF)
Comprehensive Primary Care initiative
Eligible Professional
Group practice reporting mechanisms
Group Practice Reporting Option (GPRO)
Physician
Physician Quality Reporting System (PQRS)
Pioneer Accountable Care Organization (ACO) Model
PQRS payment adjustment
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 2017 Value Modifier equal to one (1.0) times the adjustment factor, if they served a disproportionate share of high-risk beneficiaries in 2015. The average risk for all beneficiaries attributed to your TIN is at the 79th percentile of beneficiaries nationwide.

Medicare determined your TIN's eligibility for the high-risk bonus adjustment based on whether your TIN met (✓) or did not meet (✗) both of the following criteria in 2015:

- ✗ 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 2017 Value Modifier because your TIN 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:

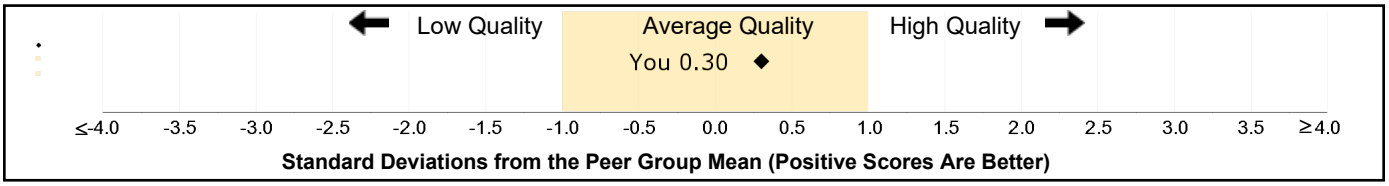
- Table 2A. Beneficiaries Attributed to Your TIN for the Cost Measures (except Medicare Spending per Beneficiary) and Claims-Based Quality Outcome Measures, and the Care that Your TIN and Other TINs Provided
- Table 5B. Beneficiaries and Episodes Attributed to Your TIN for the Medicare Spending per Beneficiary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

Glossary Terms
Beneficiary
High-risk bonus adjustment
Quality-tiering
Risk score
Value Modifier (Value-Based Payment Modifier)

PERFORMANCE ON QUALITY MEASURES

Your TIN's Quality Tier: Average

Exhibit 2. Your TIN's Quality Composite Score



Your TIN's Quality Composite Score (Exhibit 2) indicates that your TIN's overall performance on quality measures is 0.30 standard deviation from the mean for your TIN's peer group. Because your TIN's Quality Composite Score is less than one standard deviation from the mean, your TIN's quality performance is classified as Average 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 subject to the 2017 Value Modifier for which a Quality Composite Score could be calculated.

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
Quality Composite Score
Quality-tiering
Standard deviation
Statistical significance
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 2015:

- Quality measures your TIN reported to the PQRS as a group through the Group Practice Reporting Option (GPRO) via electronic health record in order to avoid the 2017 PQRS payment adjustment, and
- Up to three quality outcome measures that Medicare calculates from Medicare fee-for-service claims submitted for services provided in 2015 to beneficiaries attributed to your TIN.

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 2014 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 exhibits below show your TIN's quality domain scores and the quality measures reported by your TIN in each quality domain, if your TIN had at least one measure with at least one eligible case. Additionally, Exhibit 3-CCC-B shows how your TIN performed on the claims-based quality outcome measures calculated by CMS, if your TIN had at least one eligible case for at least one outcome 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 TIN had the required minimum number of eligible cases for the measure and a 2014 benchmark (national mean) is available for the measure.

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

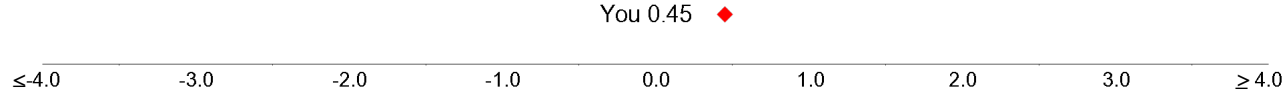
- Table 2A. Beneficiaries Attributed to Your TIN for the Cost Measures (except Medicare Spending per Beneficiary) and Claims-Based Quality Outcome Measures, and the Care that Your TIN and Other TINs Provided
- Table 2B. Admitting Hospitals: Beneficiaries Attributed to Your TIN for the Cost Measures (except 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 2015 PQRS Measures

Glossary Terms
All-Cause Hospital Readmission
Ambulatory Care-Sensitive Conditions (ACSCs)
Attribution
Benchmark
Beneficiary
Chronic Conditions
Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Physician Quality Reporting System (PQRS)
Group practice reporting mechanisms
Group Practice Reporting Option (GPRO)
Measure populations
National Quality Strategy
Peer group
Physician Quality Reporting System (PQRS)
Quality Composite Score
Quality domains

Quality outcome measures
Standardized performance score

Exhibit 3-ECC. Effective Clinical Care Domain Quality Indicator Performance

Domain Score



Standard deviations from the mean (positive scores are better)

		Your TIN				All TINs in Peer Group	
Measure Identification Number(s)	**Measure Name**	Number of Eligible Cases	**Performance Rate**	Standardized Performance Score	Included in Domain Score?	**Benchmark (National Mean)**	Standard Deviation
119 (CMS134v3)	Diabetes: Medical Attention for Nephropathy	6,197	**88.58%**	0.55	Yes	**76.06%**	22.93
204 (GPRO IVD-2, CMS164v3)	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	4,905	**72.66%**	-0.28	Yes	**79.60%**	25.03
236 (GPRO HTN-2, CMS165v3)	Controlling High Blood Pressure	15,162	**71.88%**	0.19	Yes	**69.03%**	14.78
241 (CMS182v4)	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL-C Control (< 100 mg/dL)	4,010	**77.88%**	1.34	Yes	**51.53%**	19.66
316 (CMS61v4)	Preventive Care and Screening: Cholesterol - Fasting Low Density Lipoprotein (LDL-C) Test Performed	27,545	**74.51%**	—	No	**—**	—
316 (CMS64v4)	Preventive Care and Screening: Risk-Stratified Cholesterol - Fasting Low Density Lipoprotein (LDL-C)	21,299	**75.67%**	—	No	**—**	—

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 TIN 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 2014. The peer group is defined as all TINs nationwide that reported the measure and had at least 20 eligible cases during calendar year 2014. 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 3-PCE. Person and Caregiver-Centered Experience and Outcomes Domain Quality Indicator Performance

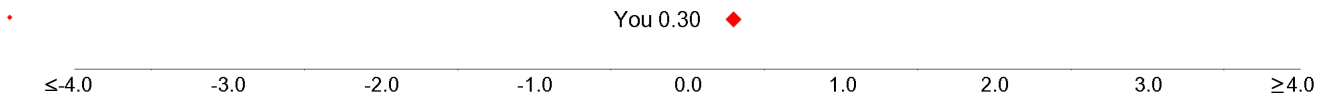
Domain Score

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

Exhibit 3-PCE is not displayed because your TIN did not have at least one eligible case for at least one measure in this domain.

Exhibit 3-CPH. Community/Population Health Domain Quality Indicator Performance

Domain Score



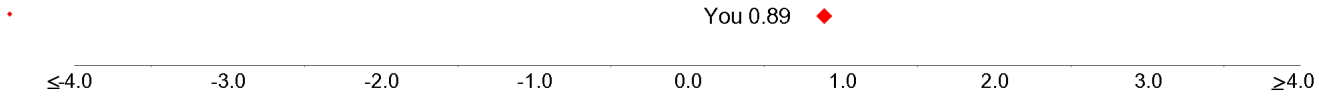
Standard deviations from the mean (positive scores are better)

		Your TIN				All TINs in Peer Group	
Measure Identification Number(s)	**Measure Name**	Number of Eligible Cases	**Performance Rate**	Standardized Performance Score	Included in Domain Score?	**Benchmark (National Mean)**	Standard Deviation
128 (GPRO Prev-9, CMS69v3)	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	28,052	**86.43%**	0.84	Yes	**63.92%**	26.66
226 (GPRO Prev-10, CMS138v3)	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	22,733	**84.17%**	-0.25	Yes	**89.05%**	19.34

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 TIN 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 2014. The peer group is defined as all TINs nationwide that reported the measure and had at least 20 eligible cases during calendar year 2014. If a dash (–) appears in the Benchmark column, this indicates that no benchmark is available for this measure.

Exhibit 3-PS. Patient Safety Domain Quality Indicator Performance

Domain Score



Standard deviations from the mean (positive scores are better)

		Your TIN				All TINs in Peer Group	
Measure Identification Number(s)	**Measure Name**	Number of Eligible Cases	**Performance Rate**	Standardized Performance Score	Included in Domain Score?	**Benchmark (National Mean)**	Standard Deviation
130 (GPRO Care-3, CMS68v4)	Documentation of Current Medications in the Medical Record	101,486	**87.45%**	0.15	Yes	**83.63%**	25.09
318 (GPRO Care-2, CMS139v3)	Falls: Screening for Fall Risk	10,221	**90.10%**	1.62	Yes	**47.27%**	26.41

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 TIN 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 2014. The peer group is defined as all TINs nationwide that reported the measure and had at least 20 eligible cases during calendar year 2014. If a dash (–) appears in the Benchmark column, this indicates that no benchmark is available for this measure.

Exhibits 3-CCC-A and B. Communication and Care Coordination Domain

Domain Score

Standard deviations from the mean (positive scores are better)

A. Communication and Care Coordination Domain Quality Indicator Performance

Exhibit 3-CCC-A is not displayed because your TIN 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 3-CCC-B provides information on the three quality outcome measures calculated from Medicare Part A and Part B claims data.

			Your TIN				All TINs in Peer Group	
Performance Category	**Measure Identification Number(s)**	**Measure Name**	Number of Eligible Cases	**Performance Rate**	Standardized Performance Score	Included in Domain Score?	**Benchmark (National Mean)**	Standard Deviation
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care-Sensitive Conditions	CMS-1	Acute Conditions Composite	5,175	**11.53**	-0.85	Yes	**6.90**	5.44
	-	Bacterial Pneumonia	5,175	**11.12**	—	—	**9.96**	8.73
		Urinary Tract Infection	5,175	**12.38**	—	—	**7.02**	7.76
		Dehydration	5,175	**11.04**	—	—	**3.69**	4.18
	CMS-2	Chronic Conditions Composite	2,973	**46.32**	0.32	Yes	**54.56**	25.83
	-	Diabetes (composite of 4 indicators)	2,026	**20.62**	—	—	**17.98**	20.11
		Chronic Obstructive Pulmonary Disease (COPD) or Asthma	1,067	**59.81**	—	—	**76.29**	47.75
		Heart Failure	1,211	**85.61**	—	—	**112.54**	54.80
Hospital Readmission	CMS-3	All-Cause Hospital Readmission	1,103	**15.56%**	-0.17	Yes	**15.32%**	1.43

Note: CMS-1, CMS-2, and CMS-3 are calculated by the Centers for Medicare & Medicaid Services using Medicare Part A and Part B claims data. Lower performance rates for these measures indicate 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. Only those measures for which your TIN had the minimum number of eligible cases are included in the domain score. For CMS-1 and CMS-2, the minimum number of eligible cases is 20. For CMS-3, the minimum number of eligible cases is 200. CMS-3 is not included in the domain score for TINs with fewer than 10 eligible professionals. The benchmark for CMS-1 and CMS-2 is the case-weighted national mean performance rate among all TINs in the measure's peer group during calendar year 2014. The peer groups for CMS-1 and CMS-2 are defined as all TINs nationwide that had at least 20 eligible cases for each measure. The benchmark for CMS-3 is the case-weighted national mean performance rate among all TINs and ACOs in the measure's peer group during calendar year 2014. 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 Medicare Shared Savings Program with at least 1 eligible case.

Exhibit 3-ECR. Efficiency and Cost Reduction Domain Quality Indicator Performance

Domain Score

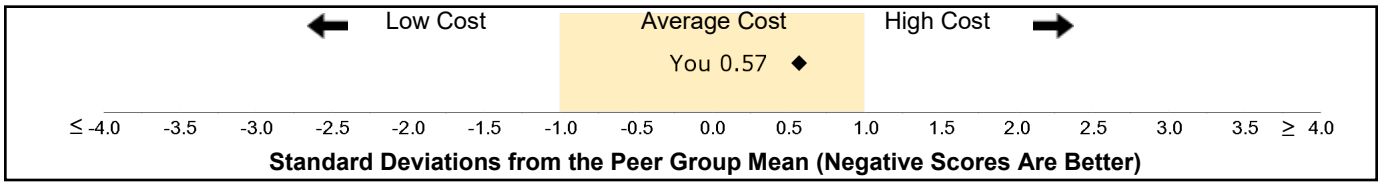
No domain score was calculated because your TIN did not have at least one measure that had the minimum number of eligible cases to be included in the domain score.

Exhibit 3-ECR is not displayed because your TIN 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

Exhibit 4. Your TIN's Cost Composite Score



Your TIN's Cost Composite Score (Exhibit 4) indicates that your TIN's overall performance on cost measures is 0.57 standard deviation from the mean for your TIN's peer group. Because your TIN's Cost Composite Score is less than one standard deviation from the mean, your TIN's cost performance is classified as Average Cost under quality-tiering.

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 2017 Value Modifier for which a Cost Composite Score could be calculated, with the exception of TINs that participated in the Shared Savings Program in 2015.

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
Cost Composite Score
Quality-tiering
Standard deviation
Statistical significance
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 2015:

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 2015, 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 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.

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 Patients 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

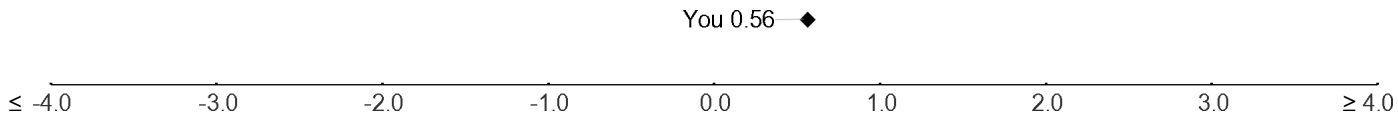
For more information about your TIN's Medicare Spending Per Beneficiary hospitalization episodes, including the hospitals where your TIN's beneficiaries were treated, breakdowns of cost by categories of service, and episode-level data, please refer to the following tables:

- 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

Glossary Terms
Attribution
Benchmark
Beneficiary
Chronic Conditions
Cost Composite Score
Cost domains
Measure populations
Medicare claims data used in the cost measures
Medicare Spending per Beneficiary
Payment standardization
Peer group
Per Capita Costs for All Beneficiaries
Per Capita Costs for Beneficiaries with Specific Conditions
Risk adjustment
Specialty adjustment

Exhibit 5-AAB. Costs for All Attributed Beneficiaries Domain

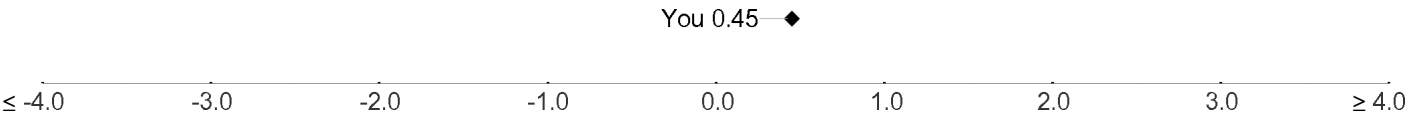


Standard deviations from the mean domain score (negative scores are better)

	Your TIN				All TINs in Peer Group	
Cost Measure	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	5,173	**$14,320**	0.54	Yes	**$12,326**	$3,665
Medicare Spending per Beneficiary	668	**$21,310**	0.57	Yes	**$20,599**	$1,254

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 2015. 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 5-BSC. Costs for Beneficiaries with Specific Conditions Domain



Standard deviations from the mean domain score (negative scores are better)

	Your TIN				All TINs in Peer Group	
Cost Measure	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	2,026	**$21,238**	0.52	Yes	**$18,273**	$5,691
Per Capita Costs for Beneficiaries with Chronic Obstructive Pulmonary Disease	944	**$34,539**	0.49	Yes	**$29,758**	$9,769
Per Capita Costs for Beneficiaries with Coronary Artery Disease	1,802	**$26,071**	0.60	Yes	**$21,900**	$6,956
Per Capita Costs for Beneficiaries with Heart Failure	1,211	**$35,836**	0.18	Yes	**$33,871**	$11,178

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 2015. 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 Non-Physician 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 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 Selected 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

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 2015 PQRS Measures

ABOUT THE 2017 VALUE MODIFIER

- In 2017, the Value Modifier will apply to all physicians in groups with two or more eligible professionals and to physicians who are solo practitioners who bill under the Medicare Physician Fee Schedule. It will not apply to eligible professionals who are not physicians.
- 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 2015 is the performance period for the Value Modifier that will be applied in 2017.
- The 2017 Value Modifier is waived for physicians in a TIN, if at least one eligible professional who billed for Medicare Physician Fee Schedule items and services under the TIN in 2015 participated in the Pioneer ACO Model or the Comprehensive Primary Care initiative in 2015.
- If a TIN with two or more eligible professionals met the criteria to avoid the 2017 PQRS payment adjustment by reporting quality data to the PQRS as a group through the GPRO, or if at least 50 percent of the eligible professionals in the TIN met the criteria to avoid the 2017 PQRS payment adjustment as individuals, then the TIN's 2017 Value Modifier will be calculated based on its quality and cost performance in 2015, using the quality-tiering methodology. If a TIN with one eligible professional met the criteria to avoid the 2017 PQRS payment adjustment as an individual, then the TIN's 2017 Value Modifier will be calculated based on its quality and cost performance in 2015, using the quality-tiering methodology. Depending on performance, this could result in an upward or neutral payment adjustment in 2017 for physicians in TINs with fewer than ten eligible professionals, or an upward, neutral, or downward payment adjustment for physicians in TINs with ten or more eligible professionals.
- If a TIN with two or more eligible professionals did not meet the criteria to avoid the 2017 PQRS payment adjustment by reporting quality data to the PQRS as a group through the GPRO and less than 50 percent of the eligible professionals in the TIN met the criteria to avoid the 2017 PQRS payment adjustment as individuals, then the TIN's 2017 Value Modifier will result in an automatic downward adjustment of two percent (-2.0%) for physicians in TINs with fewer than ten eligible professionals, or an automatic downward adjustment of four percent (-4.0%) for physicians in TINs with ten or more eligible professionals in 2017. If a TIN with one eligible professional did not meet the criteria to avoid the 2017 PQRS payment adjustment as an individual, then the TIN's 2017 Value Modifier will result in an automatic downward adjustment of two percent (-2.0%) in 2017.
- Information on the criteria to avoid the 2017 PQRS payment adjustment can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html.

WHAT'S NEXT?

- In 2018, the Value Modifier will apply to all physicians, nurse practitioners, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists in groups with two or more eligible professionals, and to physicians, nurse practitioners, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists who are solo practitioners and bill under the Medicare Physician Fee Schedule.

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, or TINs, that either fail to avoid the automatic downward adjustment under the VALUE MODIFIER or receive downward payment adjustments under the QUALITY-TIERING methodology) and is redistributed to PHYSICIANS in high performing TINs. The AF for the 2017 VALUE MODIFIER will be posted at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-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/2015-QRUR.html.

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 2017 VALUE MODIFIER for Medicare-enrolled TAXPAYER IDENTIFICATION NUMBERS (TINs) that participated in Medicare SHARED SAVINGS PROGRAM Accountable Care Organizations in 2015. 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 2017 Value Modifier, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html.

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 2015) 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 2015, 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 2017 VALUE MODIFIER, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html.

- **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/2015-QRUR.html.

BENCHMARK.

For the 2017 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 2014. The peer group is defined as all TINs nationwide that reported the measure and had at least 20 eligible cases during calendar year 2014. 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 2014. The peer group for the All-Cause Hospital Readmission measure is defined as all TINs nationwide with 10 or more ELIGIBLE PROFESSIONALS that had at least 200 eligible cases and all ACOs in the Medicare SHARED SAVINGS PROGRAM with at least 1 eligible case. For additional details, please see Quality Benchmarks for the 2017 Value Modifier and 2015 Annual Quality and Resource Use Reports available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.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 2015. For the PER CAPITA COSTS FOR ALL ATTRIBUTED BENEFICIARIES measure and the PER CAPITA COSTS FOR BENEFICIARIES WITH SPECIFIC CONDITIONS measures, 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.

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 2015.

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.

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).

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 2017 VALUE MODIFIER will not apply to PHYSICIANS billing under a Medicare-enrolled TAXPAYER IDENTIFICATION NUMBER (TIN) if at least one ELIGIBLE PROFESSIONAL who billed for Medicare Physician Fee Schedule items and services under the TIN also participated in the Comprehensive Primary Care initiative in 2015 (unless one or more of the eligible professionals participated in a Medicare SHARED SAVINGS PROGRAM Accountable Care Organization in 2015). For more information, please refer to the Comprehensive Primary Care initiative website at https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/.

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS) FOR PHYSICIAN QUALITY REPORTING SYSTEM (PQRS).

The CAHPS for PQRS survey is 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 2015, 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 2015 CAHPS for PQRS survey in the calculation of their 2017 VALUE MODIFIER.

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.

For the purposes of this report, 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 2017, the VALUE MODIFIER will apply to all physicians in Medicare-enrolled TAXPAYER IDENTIFICATION NUMBERS (TINS) who bill under the Medicare Physician Fee Schedule. It will not apply to eligible professionals who are not physicians.

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 2015. 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 2015, 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 three reporting mechanisms: (1) a qualified PQRS registry, (2) GPRO Web Interface (for groups with 25 or more ELIGIBLE PROFESSIONALS), or (3) electronic health record (EHR) [via direct EHR using certified EHR technology (CEHRT) or CEHRT via a Data Submission Vendor]. In addition, in 2015, 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. 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.html.

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 2017 also qualify to avoid an automatic downward adjustment under the 2017 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/Group_Practice_Reporting_Option.html.

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 2017 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 2015. 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 2015, the high-risk bonus adjustment is based on all beneficiaries assigned to the Shared Savings Program Accountable Care Organization in which the TIN participated.

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 2017 Value Modifier and Measure Information Form: Condition-Specific Total Per Capita Cost Measures used in the 2017 Value Modifier, both available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-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 2015. For more information, see Measure Information Form: 30-Day All-Cause Hospital Readmission Measure used in the 2017 Value Modifier and Measure Information Form: Ambulatory Care-Sensitive Condition (ACSC) Composite Measures used in the 2017 Value Modifier, both available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html.

- **MEDICARE SPENDING PER BENEFICIARY**

  The population included in this cost measure is comprised of those Medicare fee-for-service beneficiaries hospitalized in 2015 for which 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/2015-QRUR.html.

- **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 2015 Physician Quality Reporting System (PQRS): Implementation Guide, available at https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/downloads/2015_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 2015 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/2015-QRUR.html.

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.htm.

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 2014. 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 2015. 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 2017 VALUE MODIFIER, a TIN’s peer group includes only those TINs subject to the 2017 Value Modifier for which a Quality Composite Score could be calculated. For TINs not subject to the 2017 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 the PIONEER ACO MODEL or the COMPREHENSIVE PRIMARY CARE INITIATIVE IN 2015.

To calculate the COST COMPOSITE SCORE under quality-tiering for TINs subject to the 2017 Value Modifier, a TIN’s peer group includes only those TINs subject to the 2017 Value Modifier for which a Cost Composite Score could be calculated, with the exception of TINs that participated in the Shared Savings Program in 2015. For TINs not subject to the 2017 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, Pioneer ACO Model, or the Comprehensive Primary Care initiative in 2015.

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 2015 (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 2017 Value Modifier, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html.

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 2017 Value Modifier, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html.

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 2017, the VALUE MODIFIER will apply to all physicians in Medicare-enrolled TAXPAYER IDENTIFICATION NUMBERS (TINs) who bill under the Medicare Physician Fee Schedule. It will not apply to eligible professionals who are not physicians.

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 2017 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 2015. 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.

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 2017 VALUE MODIFIER will not apply to PHYSICIANS in 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 2015 participated in the Pioneer ACO Model in 2015 (unless one or more of the eligible professionals participated in an ACO in the Shared Savings Program in 2015). For more information, please refer to the Pioneer ACO Model website at https://innovation.cms.gov/initiatives/Pioneer-aco-model.

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 2017 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 2017 PQRS payment adjustment as individuals will be subject to an automatic downward adjustment under the 2017 VALUE MODIFIER. Solo practitioners that fail to meet the criteria to avoid the 2017 PQRS payment adjustment as an individual will also be subject to an automatic downward adjustment under the 2017 Value Modifier. Information on the criteria to avoid the 2017 PQRS payment adjustment can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html.

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 2017 Value Modifier, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html.

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 2017 VALUE MODIFIER, is determined based on the lower of the number of eligible professionals indicated by a query of PECOS on July 10, 2015 and the number of eligible professionals that submitted claims to Medicare under the TIN during calendar year 2015. 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 2017 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 2017 PQRS payment adjustment as individuals, then the TIN's 2017 Value Modifier will be calculated based on its quality and cost performance in 2015, using the quality-tiering methodology. If a TIN with one eligible professional met the criteria to avoid the 2017 PQRS payment adjustment as an individual, then the TIN's 2017 Value Modifier will be calculated based on its quality and cost performance in 2015, using the quality-tiering methodology. Depending on the TIN's performance, this could result in an upward or neutral payment adjustment in 2017 for physicians in TINs with fewer than 10 eligible professionals, or an upward, neutral, or downward payment adjustment for physicians in TINs with 10 or more eligible professionals.

For a TIN that participated in an Accountable Care Organization (ACO) in the Medicare SHARED SAVINGS PROGRAM in 2015, if the ACO successfully reported quality data to the PQRS through the GPRO Web Interface to avoid the 2017 PQRS payment adjustment, then the TIN's 2017 Value Modifier will be calculated based on the ACO's quality performance in 2015, using the quality-tiering methodology. Depending on the ACO's performance, this could result in an upward or neutral payment adjustment in 2017 for physicians in TINs with fewer than 10 eligible professionals, or an upward, neutral, or downward payment adjustment for physicians in TINs with 10 or more eligible professionals. Details on quality-tiering may be found in the Computation of the 2017 Value Modifier Fact Sheet available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html.

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/2015-QRUR.html.

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 2017 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.

Beginning in calendar year 2017, the VALUE MODIFIER will apply to PHYSICIANS in Medicare-enrolled TAXPAYER IDENTIFICATION NUMBERS (TINs) that participate in an Accountable Care Organization (ACO) in the Medicare SHARED SAVINGS PROGRAM in 2015. For TINs that participated in a Shared Savings Program ACO in 2015, its 2017 Value Modifier is based on the ACO's quality performance in 2015. For more information, please refer to the Computation of the 2017 Value Modifier Fact Sheet available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html 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/2015-QRUR.html.

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 2015.

The number of eligible professionals in the TIN, for purposes of applying the 2017 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 10, 2015 and the number of eligible professionals that submitted claims to Medicare under the TIN during calendar year 2015.

VALUE MODIFIER (VALUE-BASED PAYMENT MODIFIER).

In calendar year 2017, Medicare will apply the Value Modifier under section 1848(p) of the Social Security Act to PHYSICIAN payments under the Medicare Physician Fee Schedule for physicians in groups with two or more eligible professionals and to physician solo practitioners, identified by their Medicare-enrolled TAXPAYER IDENTIFICATION NUMBERS (TINs). Calendar year 2015 is the performance period for the Value Modifier that will be applied in 2017. The 2015 Annual Quality and Resource Use Report (QRUR) shows how a TIN performed in calendar year 2015 on the quality and cost measures used to calculate the 2017 Value Modifier. The 2017 Value Modifier is waived for physicians in a TIN if at least one eligible professional who billed for Medicare Physician Fee Schedule items and services under the TIN in 2015 participated in the PIONEER ACCOUNTABLE CARE ORGANIZATION MODEL or the COMPREHENSIVE PRIMARY CARE INITIATIVE in 2015. More information about the 2015 Annual QRUR and how the 2017 Value Modifier is calculated is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html.