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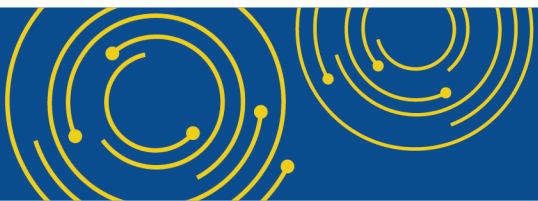
Review of the 2016 Annual Quality and Resource Use Reports

October 19, 2017



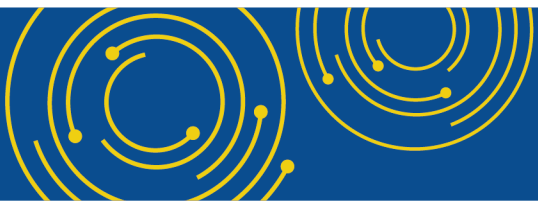
Acronyms in this presentation

- ACO: Accountable Care Organization
- AF: Adjustment Factor
- AMA: American Medical Association
- CCN: CMS Certification Number
- CNS: Clinical Nurse Specialist
- CRNA: Certified Registered Nurse Anesthetist
- CPC: Comprehensive Primary Care
- CPT: Current Procedural Terminology
- DOB: Date of Birth
- EIDM: Enterprise Identity Management
- EP: Eligible Professional
- ESRD: End-stage Renal Disease
- FFS: Fee-for-Service
- GPRO: Group Practice Reporting Option
- HCC: Hierarchical Condition Category
- HHS: Health and Human Services
- HIC: Health Insurance Claim
- MIPS: Merit-based Incentive Payment System
- MSPB: Medicare Spending per Beneficiary
- NP: Nurse Practitioner
- NPI: National Provider Identifier
- PA: Physician Assistant
- PECOS: Provider Enrollment, Chain, and Ownership System
- PFS: Physician Fee Schedule
- PQRS: Physician Quality Reporting System
- QRUR: Quality and Resource Use Report
- TIN: Taxpayer Identification Number
- VM: Value Modifier

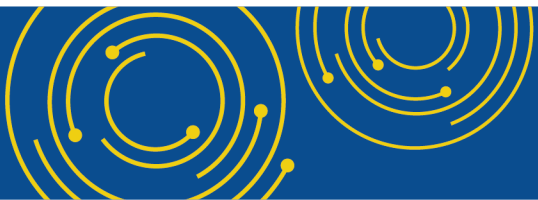


Agenda and Learning Objectives

- Overview of the 2016 Annual Quality and Resource Use Report (QRUR)
- Overview of the 2018 Value Modifier (VM)
- Quality, Cost & Utilization Information Contained in the 2016 Annual QRUR
- Accompanying Tables for the 2016 Annual QRUR
- How to Access Your QRUR
- How to Request an Informal Review of Your TIN's 2018 VM Payment Adjustment
- Next Steps and Technical Assistance
- Question and Answer Session

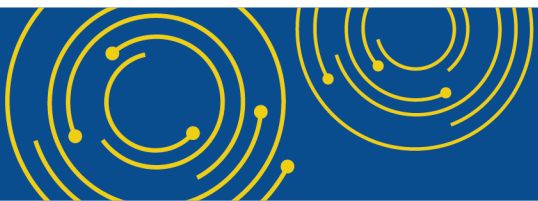


Overview of the 2016 Annual Quality and Resource Use Report (QRUR)

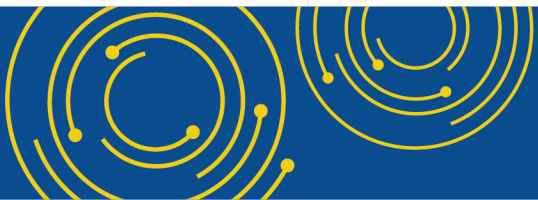


What is the 2016 Annual QRUR?

- The 2016 Annual Quality and Resource Use Report (QRUR) is a report that shows how a group or solo practitioner, as identified by Medicare-enrolled Taxpayer Identification Number (TIN), performed in 2016 relative to the TIN's peers on the quality and cost measures used to calculate the 2018 Value Modifier (VM). The QRUR also shows how the VM will apply to Medicare Physician Fee Schedule (PFS) payments for items and services provided by physicians, nurse practitioners (NPs), physician assistants (PAs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs) in 2018.
- The 2016 Annual QRUR is based on services provided from January 1, 2016 through December 31, 2016.
 - Claims-based cost, quality outcome, and utilization data are based on services provided to a TIN's attributed beneficiaries.
 - Quality data also include Physician Quality Reporting System (PQRS) quality data submitted by the TIN.
- All TINs nationwide that had at least one eligible professional (EP) bill Medicare under the TIN in 2016—including TINs not subject to the 2018 VM—received a full 2016 QRUR.

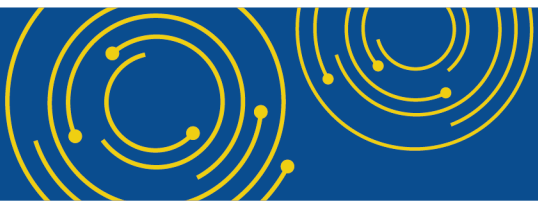


Overview of the 2018 Value Modifier (VM)



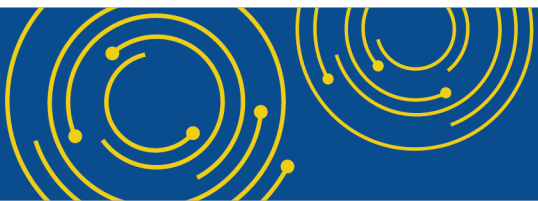
Policies for the 2018 VM

- Applies at the TIN level to all physicians, NPs, PAs, CNSs, and CRNAs who bill Medicare PFS claims in 2018.
- Based on quality and cost performance in 2016 and aligned with the PQRS program.
- Waived for a TIN if at least one EP who billed for Medicare PFS items or services under the TIN during 2016 participated in the Pioneer Accountable Care Organization (ACO) Model, the Comprehensive Primary Care (CPC) initiative, the Next Generation ACO Model, the Oncology Care Model, or the Comprehensive End Stage Renal Disease (ESRD) Care Model in 2016.
- 2018 is the last payment adjustment year under the VM program.
- The VM program is being replaced by the Merit-based Incentive Payment System (MIPS) under the new Quality Payment Program. The first performance period of the Quality Payment Program is January 1, 2017 through December 31, 2017, and the first payment adjustment year under the Quality Payment Program will be 2019.
- To prepare for success in the Quality Payment Program, we encourage EPs to review their PQRS Feedback Report, review their Annual QRUR, and visit <https://qpp.cms.gov> to learn about the Quality Payment Program.



Policies for the 2018 VM (cont.)

- The 2018 VM payment adjustments shown in the 2016 Annual QRURs are based on proposals included in the 2018 Medicare PFS Proposed Rule. Information on the Proposed Rule can be found at <https://federalregister.gov/d/2017-14639>.
- The proposals include:
 - Reducing by half the automatic downward VM payment adjustment for TINs that did not meet the minimum quality reporting requirements;
 - Holding TINs that met the minimum quality reporting requirements harmless from downward VM payment adjustments based on performance; and
 - Reducing the maximum upward VM payment adjustment based on performance for TINs with at least 10 EPs to align with the maximum upward VM payment adjustment for TINs with fewer than 10 EPs, including solo practitioners.
- If the policies are not finalized as proposed, then we will provide an update to report recipients.

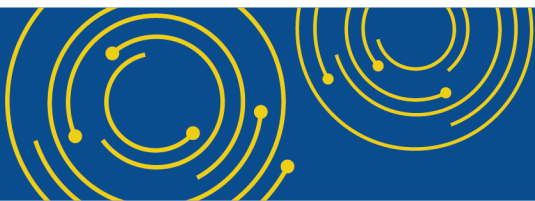


What is an EP?

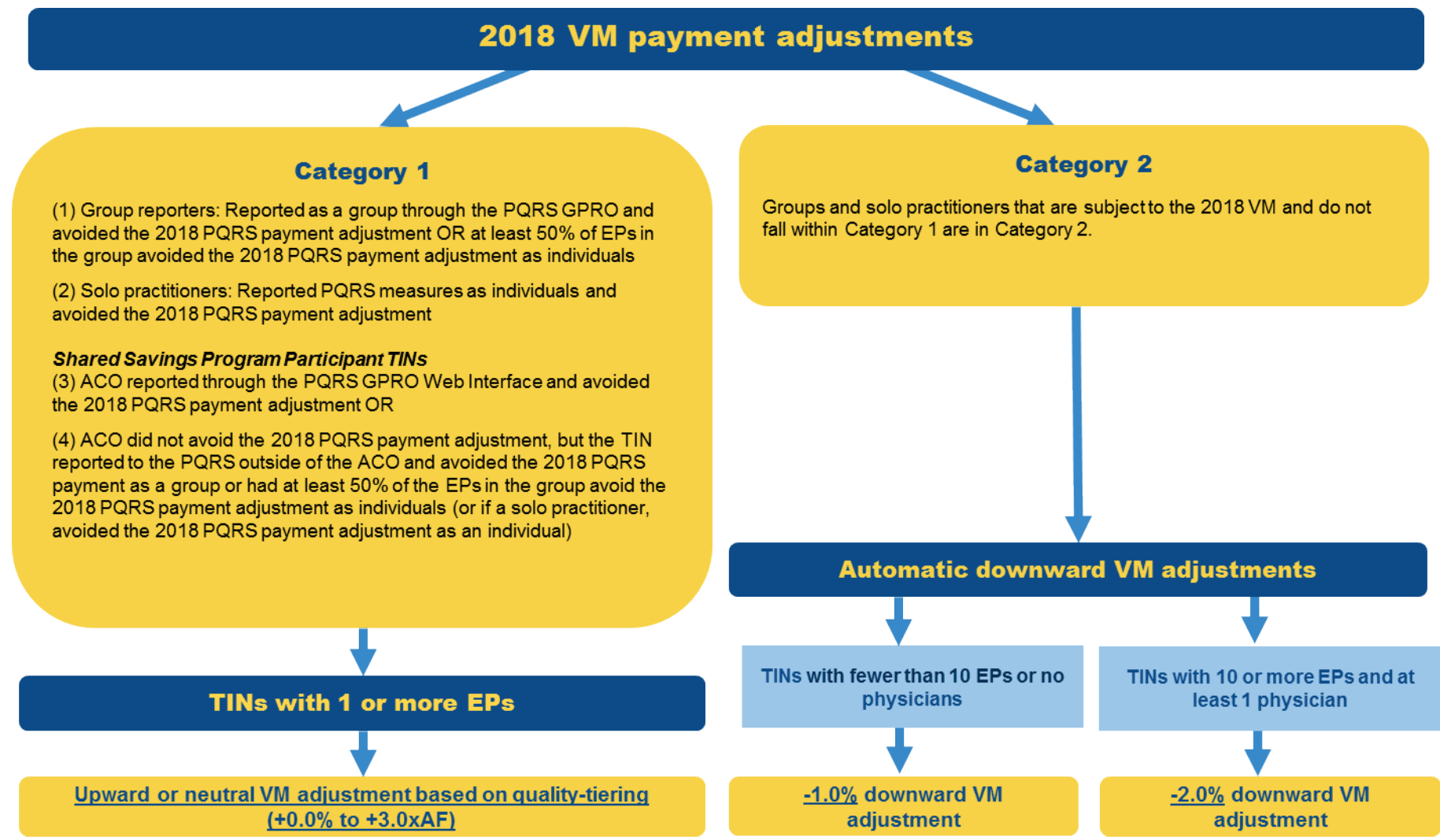
For the purpose of determining TIN size and PQRS reporting status, an EP is defined as a:

- Physician
 - **Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Oral Surgery, Doctor of Dental Medicine, and Doctor of Chiropractic**
- Practitioner
 - **Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist**, Anesthesiologist Assistant, Certified Nurse Midwife, Clinical Social Worker, Clinical Psychologist, Registered Dietician\Nutrition Professional, and Audiologist
- Therapist
 - Physical Therapist, Occupational Therapist, and Qualified Speech-Language Therapist

Only the bolded EP types are subject to the 2018 VM.



2018 VM and 2016 PQRS Interaction

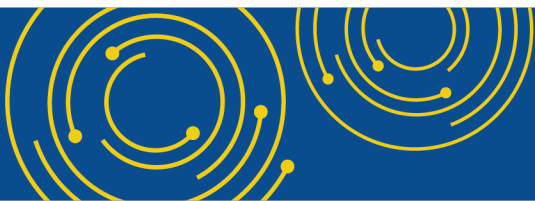


Quality-tiering Approach for Category 1 TINs

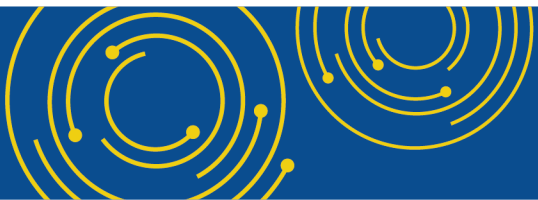
- The maximum upward VM payment adjustment is +3.0 multiplied by the adjustment factor (AF) and low-performing TINs that meet minimum quality reporting requirements will be held harmless from downward VM payment adjustments.
- The table below indicates the 2018 VM payment adjustments under quality-tiering for all Category 1 TINs, regardless of size

| | Low Quality | Average Quality | High Quality |
|--------------|-------------|-----------------|--------------|
| Low Cost | +0.0% | +1.0 x AF* | +2.0 x AF* |
| Average Cost | +0.0% | +0.0% | +1.0 x AF* |
| High Cost | +0.0% | +0.0% | +0.0% |

** indicates a TIN may be eligible for an additional +1.0 x AF if the TIN's average beneficiary risk score was in the top 25 percent of all beneficiary risk scores nationwide.*

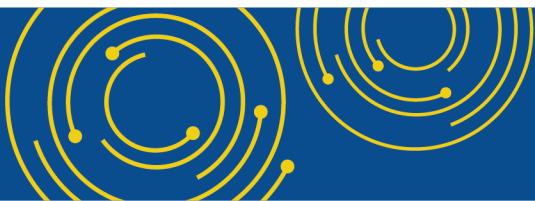


Quality, Cost & Utilization Information Contained in the 2016 Annual QRUR



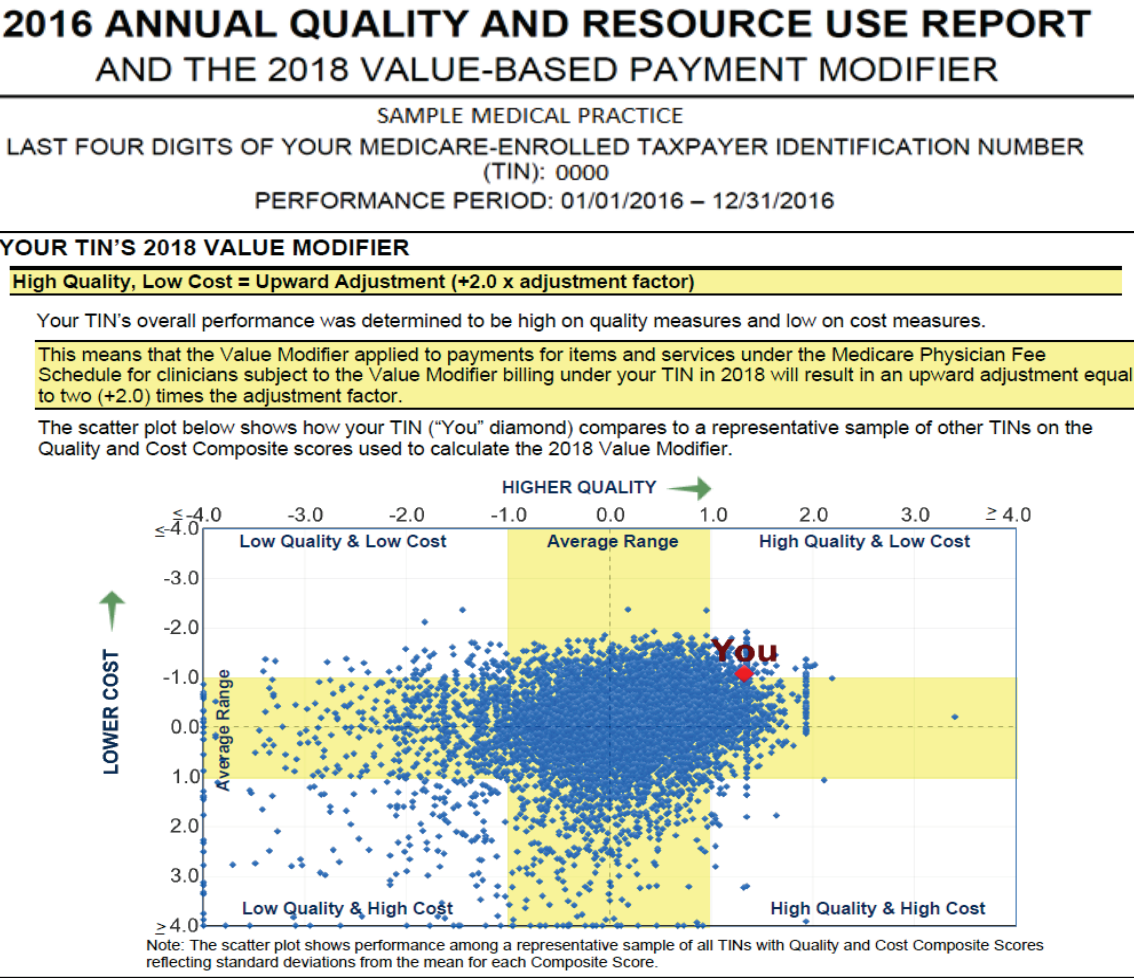
What information is contained in the 2016 Annual QRUR?

| Annual QRUR Report Section | Exhibit | Purpose of the Information in Your Report: |
|---------------------------------|---------|---|
| Cover Page | - | <ul style="list-style-type: none">Indicates whether your TIN is subject to the 2018 VM, and if so, displays the 2018 VM payment adjustmentExplains how a TIN subject to the 2018 VM can file an Informal Review request |
| Your TIN's 2018 Value Modifier | 1 | <ul style="list-style-type: none">Explains how the VM applies to your TIN in 2018Explains whether the high-risk bonus adjustment applies to your TIN |
| Performance on Quality Measures | 2, 3, 4 | <ul style="list-style-type: none">Indicates your TIN's Quality Composite ScoreShows how your TIN's Quality Composite Score was calculated from quality domain scoresShows how your TIN performed on quality measures within each domain |
| Performance on Cost Measures | 5, 6, 7 | <ul style="list-style-type: none">Indicates your TIN's Cost Composite ScoreShows how your TIN's Cost Composite Score was calculated from cost domain scoresShows how your TIN performed on cost measures within each domain |



Cover Page

The cover page shows your 2018 VM payment adjustment and how your TIN compares to its peers.



How does the VM apply to your TIN in 2018?

This section of the QRUR explains how the VM applies to your TIN. For TINs subject to the VM in 2018, this section explains whether your TIN was classified as Category 1 or 2.

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; (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); and (3) no eligible professional billing under your TIN participated in the Pioneer Accountable Care Organization (ACO) Model, the Comprehensive Primary Care initiative, the Next Generation ACO Model, the Oncology Care Model, or the Comprehensive End-Stage Renal Disease (ESRD) Care Model (Value Modifier-waived Innovation Models) in 2016. In 2016, your TIN had 70 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>.

At least 50 percent (82.85%) of the eligible professionals in your TIN reported quality data to the Physician Quality Reporting System (PQRS) as individuals and avoided the 2018 PQRS payment adjustment (or, if a solo practitioner, you avoided the 2018 PQRS payment adjustment as an individual). This also qualifies your TIN to avoid an automatic Value Modifier downward payment adjustment in 2018. CMS used its quality-tiering methodology to calculate your TIN's 2018 Value Modifier based on your TIN's performance on quality and cost measures during 2016.

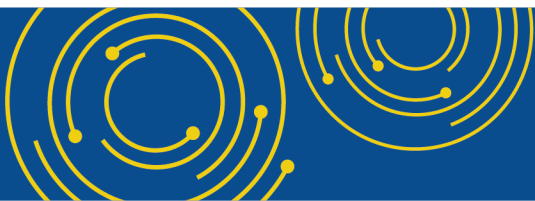


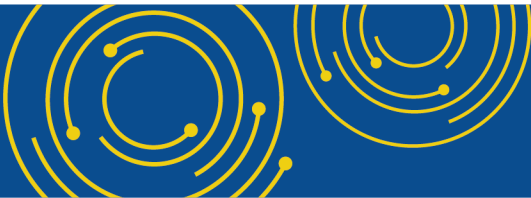
Exhibit 1. 2018 VM Payment Adjustment under Quality-Tiering

Exhibit 1 displays the 2018 VM calculated for your TIN.

Exhibit 1. 2018 Value Modifier Payment Adjustments under Quality-Tiering

| | Low Quality | Average Quality | High Quality |
|--------------|-------------|-----------------|--------------|
| Low Cost | 0.0% | +1.0 x AF | +2.0 x AF |
| Average Cost | 0.0% | 0.0% | +1.0 x AF |
| High Cost | 0.0% | 0.0% | 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 2018 VM 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.



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

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 attributed to your TIN is at the 38th 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 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 TIN did not meet these criteria.

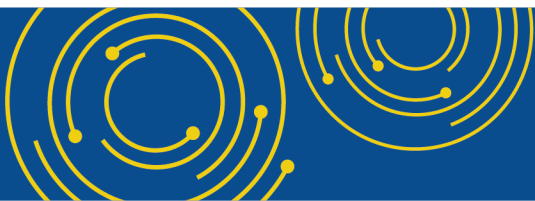
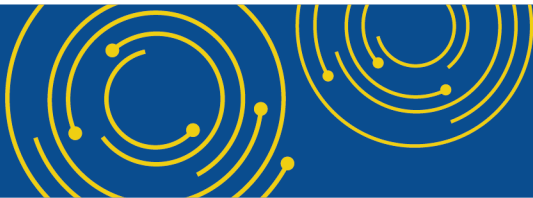
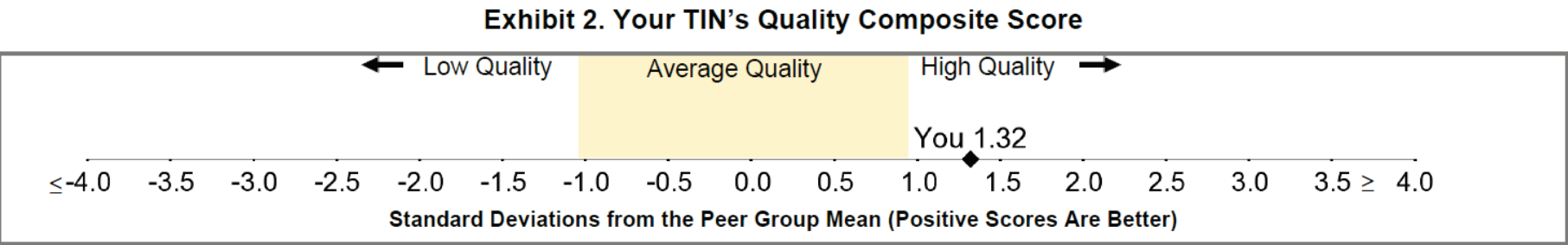


Exhibit 2. Your TIN's Quality Composite Score (compared to peers)

PERFORMANCE ON QUALITY MEASURES

Your TIN's Quality Tier: High



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

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 reported by 50 percent or more of the eligible professionals in your TIN who avoided the 2018 PQRS payment adjustment as individuals, and
- Up to three quality outcome measures that Medicare calculates from Medicare fee-for-service claims submitted for services provided in 2016 to beneficiaries attributed to your TIN.

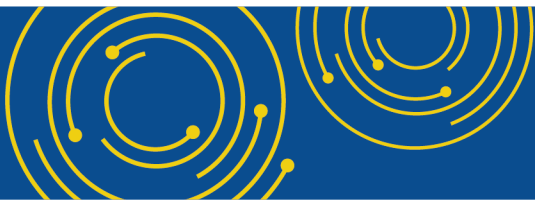


Exhibit 3. Information used in the calculation of your TIN's Quality Composite Score

A. Summary Quality Performance

| Your TIN | | | 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 |
| 4 | 1.21 | 1.32 | 0.30 | 0.69 |

B. Quality Domain Scores

| Domain | Number of Measures Included in Domain Score | Domain Score |
|---|---|--------------|
| Effective Clinical Care | 1 | 1.21 |
| Person and Caregiver-Centered Experience and Outcomes | 0 | -- |
| Community/Population Health | 4 | 1.30 |
| Patient Safety | 2 | 0.75 |
| Communication and Care Coordination | 3 | 1.57 |
| Efficiency and Cost Reduction | 0 | -- |

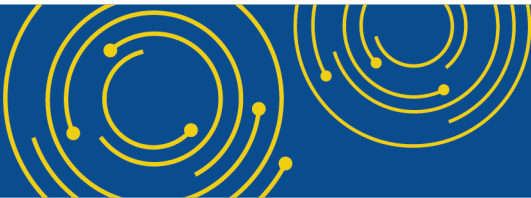
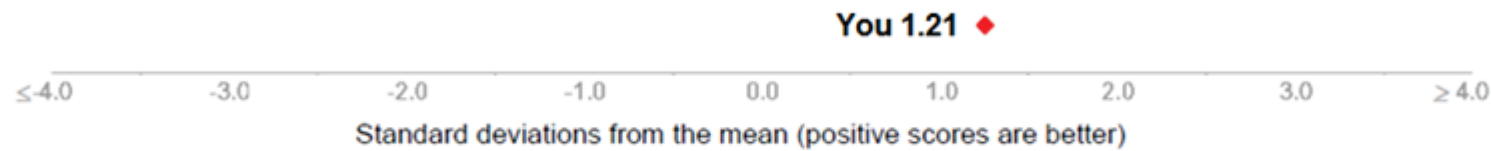


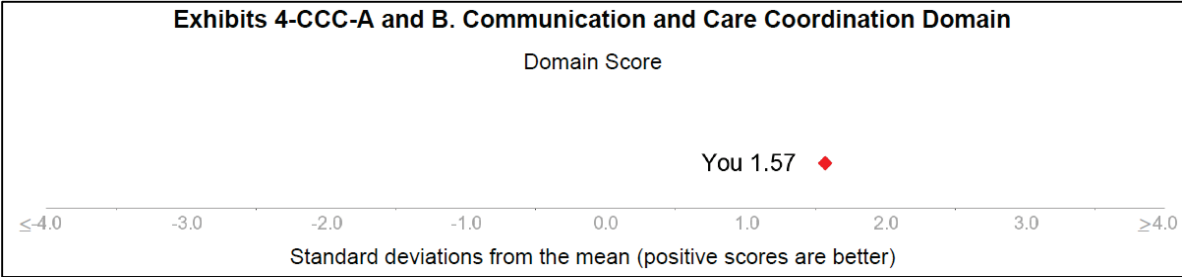
Exhibit 4. Information used in the calculation of your TIN's Quality Composite Score (by quality domain)

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



| Measure Identification Number(s) | Measure Name | Your TIN | | | | 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 |
| 113 | Colorectal Cancer Screening | 258 | 85.00 | 1.21 | Yes | 67.32 | 14.61 |

Exhibit 4. Information used in the calculation of your TIN's Quality Composite Score (by quality domain) (cont.)



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

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

| Performance Category | Measure Identification Number | Measure Name | Your TIN | | | | All TINs in Peer Group | |
|---|-------------------------------|--|--------------------------|------------------|--------------------------------|---------------------------|---------------------------|--------------------|
| | | | 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 | 70 | 0.64 | 1.12 | Yes | 7.17 | 5.82 |
| | - | Bacterial Pneumonia | 70 | 0.99 | — | — | 9.45 | 8.60 |
| | - | Urinary Tract Infection | 70 | 0.16 | — | — | 6.53 | 7.51 |
| | - | Dehydration | 70 | 0.76 | — | — | 5.50 | 5.64 |
| | CMS-2 | Chronic Conditions Composite | 43 | 11.43 | 1.56 | Yes | 48.42 | 23.75 |
| | - | Diabetes (composite of 4 indicators) | 35 | 3.03 | — | — | 17.33 | 20.49 |
| | - | Chronic Obstructive Pulmonary Disease (COPD) or Asthma | 10 | 18.91 | — | — | 62.26 | 40.15 |
| Hospital Readmission | - | Heart Failure | 5 | 20.03 | — | — | 105.05 | 52.47 |
| | CMS-3 | All-Cause Hospital Readmission | 38 | 13.04% | 1.42 | No | 15.29% | 1.59 |

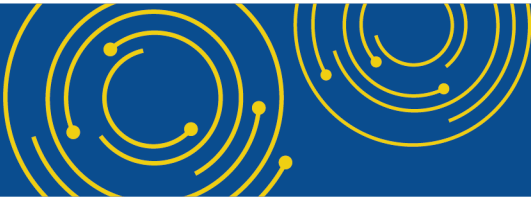
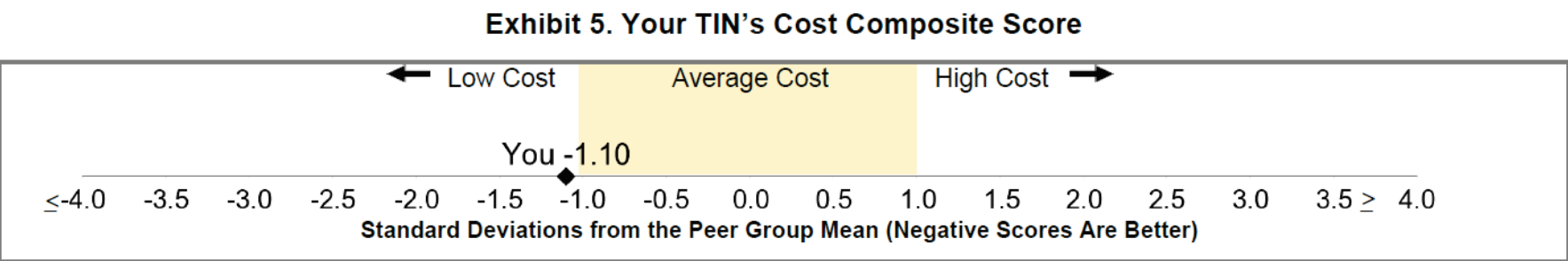


Exhibit 5. Your TIN's Cost Composite Score (compared to peers)

PERFORMANCE ON COST MEASURES

Your TIN's Cost Tier: Low



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

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

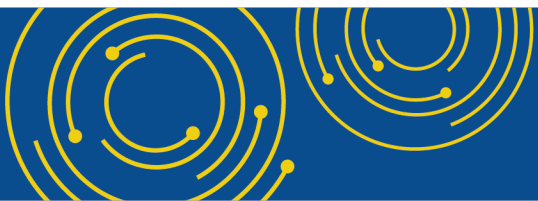


Exhibit 6. Information used in the calculation of your TIN's Cost Composite Score

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

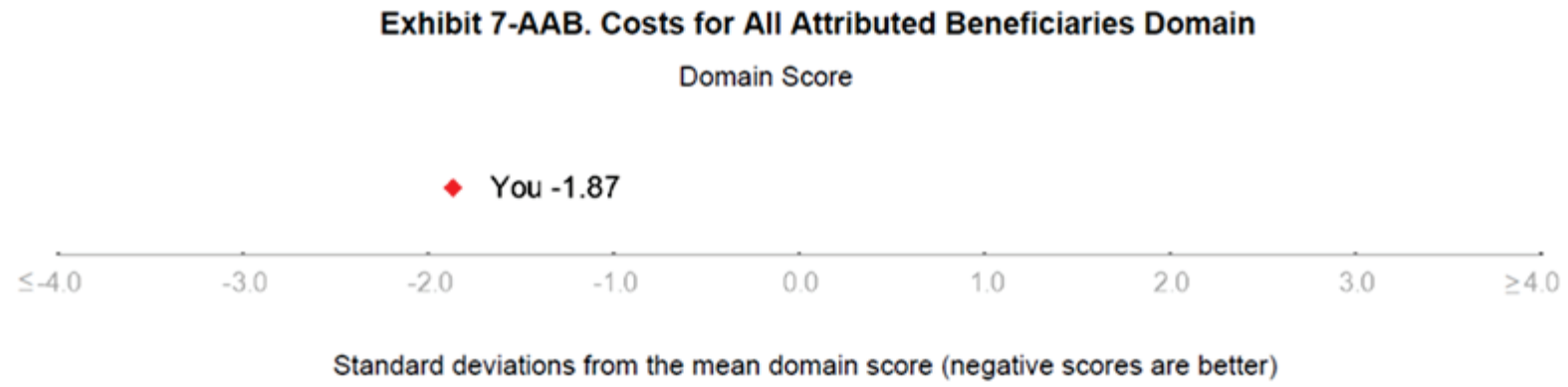
A. Summary Cost Performance

| 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 |
| 2 | -1.84 | -1.10 | -0.24 | 1.45 |

B. Cost Domain Scores

| Domain | Number of Measures Included in Domain Score | Domain Score |
|--|---|--------------|
| Costs for All Beneficiaries | 1 | -1.87 |
| Costs for Beneficiaries with Specific Conditions | 4 | -1.80 |

Exhibit 7. Information used in the calculation of your TIN's Cost Composite Score (by cost domain)



| 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 | 70 | \$5,587 | -1.87 | Yes | \$12,380 | \$3,631 |
| Medicare Spending per Beneficiary | 35 | \$16,154 | -3.49 | No | \$20,411 | \$1,220 |

Accompanying Tables for the 2016 Annual QRUR

(The following tables can be downloaded as Excel spreadsheets)

Note: The Health Insurance Claim (HIC) numbers and National Provider Identifiers (NPIs) shown in the screenshots are not real.

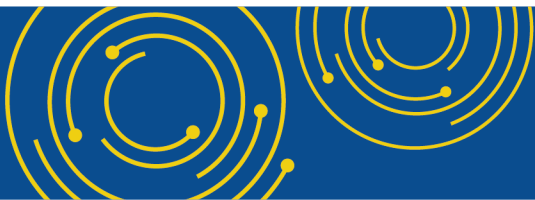


Table 1. Physicians and Non-Physician Eligible Professionals Identified in Your Medicare-Enrolled Taxpayer Identification Number (TIN), Selected Characteristics

The EP-level table provides a listing of the EPs in your TIN.

| NPI | Name | Physician† | Nonphysician Eligible Professional Subject to the 2018 Value Modifier† | Nonphysician Eligible Professional Not Subject to the 2018 Value Modifier† |
|----------|-------------|------------|--|--|
| XXXXXXXX | CLINICIAN A | No | Yes | No |
| XXXXXXXX | CLINICIAN B | No | Yes | No |
| XXXXXXXX | CLINICIAN C | No | Yes | No |
| XXXXXXXX | CLINICIAN D | Yes | No | No |
| XXXXXXXX | CLINICIAN E | Yes | No | No |
| XXXXXXXX | CLINICIAN F | Yes | No | No |

(Table continued from above)

| Specialty Designation† | Identified via PECOS† | Identified via Billings† | Date of Last Claim Billed Under TIN |
|------------------------|-----------------------|--------------------------|-------------------------------------|
| Nurse Practitioner | Yes | Yes | 12/22/2016 |
| Nurse Practitioner | No | Yes | 05/26/2016 |
| Physician Assistant | Yes | Yes | 12/05/2016 |
| Gastroenterology | Yes | No | - |
| Gastroenterology | Yes | No | - |
| Gastroenterology | No | Yes | 12/03/2016 |

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

| Beneficiaries Attributed to Your TIN | | | | | | | Your TIN's Medicare FFS Claims | | |
|--------------------------------------|--------|------------|-----------|-------------------------|--------------|---|--------------------------------|----------------------------------|--|
| HIC | Gender | DOB | Index† | HCC Percentile Ranking† | Died in 2016 | Basis for Attribution (Step 1 or Step 2)† | Date of Service on Last Claim | Number of Primary Care Services† | Percent of Total Primary Care Charges† |
| XXXXXXXX | M | 02/08/1943 | 112560576 | 14 | No | 1 | 03/17/2016 | 14 | 100.00% |
| XXXXXXXX | M | 03/02/1941 | 106962777 | 21 | No | 1 | 03/14/2016 | 8 | 70.24% |

(Table continued on next slide)

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 (cont.)

| Eligible Professional in Your TIN Who Billed Most Primary Care Services† | | | | Eligible Professional in Your TIN Who Billed Most Non-Primary Care Services† | | | |
|--|-------------|--------------------|-------------------------------|--|-------------|--------------------|-------------------------------|
| National Provider Identifier (NPI) | Name | Specialty | Date of Service on Last Claim | NPI | Name | Specialty | Date of Service on Last Claim |
| XXXXXXXX | Clinician A | Nurse Practitioner | 03/17/2016 | XXXXXXXX | Clinician C | Nurse Practitioner | 05/17/2016 |
| XXXXXXXX | Clinician B | Nurse Practitioner | 03/14/2016 | XXXXXXXX | Clinician D | Nurse Practitioner | 05/17/2016 |

| Eligible Professional Outside Your TIN Who Billed Most Primary Care Services† | | | | Eligible Professional Outside Your TIN Who Billed Most Non-Primary Care Services† | | | | Hospital Admission | Chronic Condition Subgroup† | | | |
|---|-------------|--------------------|-------------------------------|---|-------------|--------------------|-------------------------------|---------------------------------|-----------------------------|---------------------------------------|-------------------------|---------------|
| NPI | Name | Specialty | Date of Service on Last Claim | NPI | Name | Specialty | Date of Service on Last Claim | Date of Last Hospital Admission | Diabetes | Chronic Obstructive Pulmonary Disease | Coronary Artery Disease | Heart Failure |
| XXXXXXXX | Clinician E | Orthopedic Surgery | 12/08/2016 | XXXXXXXX | Clinician G | Orthopedic Surgery | 12/08/2016 | 12/29/2016 | No | No | No | No |
| XXXXXXXX | Clinician F | Rheumatology | 01/21/2016 | XXXXXXXX | Clinician H | Practice | 03/03/2016 | - | Yes | No | No | No |

(Table continued from previous slide)

- Table 5B contains similar information for the MSPB measure.

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 2B identifies the hospitals where at least five percent of your TIN’s attributed beneficiaries’ inpatient stays occurred.

| Hospital Name | Hospital CMS Certification Number | Hospital Location | Number of Stays | Percentage of All Stays |
|---------------|-----------------------------------|-------------------|-----------------|-------------------------|
| Total | | | 22 | 100.00% |
| HOSPITAL A | XXXXXX | PHILADELPHIA, PA | 17 | 77.27% |
| HOSPITAL B | XXXXXX | PHILADELPHIA, PA | 3 | 13.64% |

- Table 5A contains similar information for the episodes of care attributed to your TIN for the MSPB measure.

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

| Attributed Beneficiaries Admitted to the Hospital | | | | Characteristics of Hospital Admission | | | | | | | |
|---|--------|------------|-----------|---------------------------------------|--|--------|--------------|----|---|---|-------------------------|
| HIC | Gender | DOB | Index† | Date of Admission | Admitting Hospital (Name, CCN, City, State) | | | | Principal Diagnosis† (Code, Description) | | Admission Via the ED |
| XXXXXXXX | M | 07/06/1944 | 121683322 | 06/20/2016 | HOSPITAL A | XXXXXX | PHILADELPHIA | PA | M1611 | Unilateral primary osteoarthritis, right hip | No |
| XXXXXXXX | M | 07/06/1944 | 121683322 | 12/29/2016 | HOSPITAL B | XXXXXX | PHILADELPHIA | PA | E8342 | Hypomagnesemia | Yes |

(Table continued from above)

| | | Discharge Disposition | | |
|-----------------|--|-----------------------|--|-----------------------|
| ACSC Admission† | Followed by Unplanned All-Cause Readmission within 30 Days of Discharge† | Date of Discharge | Discharge Status† (Code, Description) | |
| - | No | 06/23/2016 | 03 | Disch to Medicare SNF |
| - | No | 12/30/2016 | 01 | Disch Home |

- Tables 6A and 6B are similar to Table 2C, but only apply to TINs in a Shared Savings Program ACO that successfully reported ACO quality data to the PQRS.

Table 3A. Per Capita Costs, by Categories of Service, for the Per Capita Costs for All Attributed Beneficiaries Measure

| Service Category | Your TIN | | | All TINs in Peer Group† | | How Much Higher or (Lower) Your TIN's Costs Were than TINs in Peer Group |
|---|---|--|--|--|--|--|
| | Number of Attributed Beneficiaries Using any Service in this Category | Percentage of Beneficiaries Using any Service in this Category | Per Capita Costs for Attributed Beneficiaries‡ | Benchmark (National Mean) Percentage of Beneficiaries Using Any Service in This Category | Benchmark (National Mean) Per Capita Costs | |
| ALL SERVICES | 70 | 100.00% | \$5,587 | 100.00% | \$12,380 | (\$6,793) |
| Outpatient Evaluation and Management Services, Procedures, and Evaluation & Management Services Billed by Eligible Professionals | 70 | 100.00% | \$1,313 | 100.00% | \$1,991 | (\$679) |
| Billed by Your TIN | 70 | 100.00% | \$352 | 99.99% | \$496 | (\$144) |
| Primary Care Physicians | 0 | 0.00% | \$0 | 61.33% | \$341 | (\$341) |
| Medical Specialists | 70 | 100.00% | \$352 | 17.81% | \$55 | \$297 |
| Surgeons | 0 | 0.00% | \$0 | 7.79% | \$22 | (\$22) |
| Other Eligible Professionals | 0 | 0.00% | \$0 | 22.13% | \$78 | (\$78) |
| Billed by Other TINs | 63 | 82.80% | \$382 | 81.13% | \$664 | (\$283) |
| Primary Care Physicians | 0 | 0.00% | \$0 | 24.05% | \$55 | (\$55) |
| Medical Specialists, Surgeons, and Other Eligible Professionals | 63 | 82.80% | \$382 | 79.21% | \$609 | (\$227) |
| Major Procedures Billed by Eligible Professionals | 5 | 5.38% | \$89 | 9.87% | \$185 | (\$96) |
| Billed by Your TIN | 0 | 0.00% | \$0 | 1.58% | \$23 | (\$23) |
| Primary Care Physicians | 0 | 0.00% | \$0 | 0.24% | \$1 | (\$1) |

(Table truncated to fit slide)

- Tables 4A-4D are similar to Table 3A and provide information on the various types of services performed by providers both within and outside your TIN for the beneficiaries included in the Per Capita Costs for Beneficiaries with Specific Conditions measures.
- Table 5C contains similar information for the MSPB measure.

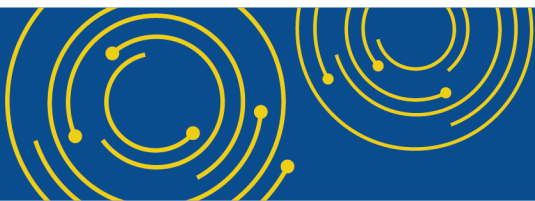


Table 3B. Costs of Services Provided by Your TIN and Other TINs: Beneficiaries Attributed to Your TIN for the Cost Measures (except Medicare Spending per Beneficiary) and Claims-Based Quality Outcome Measures

| Beneficiaries Attributed to Your TIN | | | | | | Chronic Condition Subgroup† | | | | Included in Per Capita Costs for All Attributed Beneficiaries Measure† | Total Payment-Standardized† Medicare FFS Costs |
|--------------------------------------|--------|------------|-----------|-------------------------|--------------|-----------------------------|---------------------------------------|-------------------------|---------------|--|--|
| HIC | Gender | DOB | Index† | HCC Percentile Ranking† | Died in 2016 | Diabetes | Chronic Obstructive Pulmonary Disease | Coronary Artery Disease | Heart Failure | | |
| XXXXXXXX | M | 02/08/1943 | 112560576 | 14 | No | No | No | No | No | Yes | \$567 |
| XXXXXXXX | M | 03/02/1941 | 106962777 | 21 | No | Yes | No | No | No | Yes | \$310 |

| Total Costs by Category of Services Furnished by All Providers | | | | | |
|--|--|--|--|---|---|
| Evaluation & Management* Services Billed by Eligible Professionals in Your TIN | Evaluation & Management* Services Billed by Eligible Professionals in Other TINs | Major Procedures* Billed by Eligible Professionals in Your TIN | Major Procedures* Billed by Eligible Professionals in Other TINs | Ambulatory/Minor Procedures* Billed by Eligible Professionals in Your TIN | Ambulatory/Minor Procedures* Billed by Eligible Professionals in Other TINs |
| \$98 | \$469 | \$0 | \$0 | \$0 | \$0 |
| \$144 | \$62 | \$0 | \$0 | \$0 | \$0 |

(Table continued on next slide)

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 (cont.)

| Total Costs by Category of Services Furnished by All Providers | | | | | | | | |
|--|---------------------|--------------------------------------|--|--|---|---------------------|---------|--------------------|
| Outpatient Physical, Occupational, or Speech and Language Pathology Therapy* | Ancillary Services* | Inpatient Hospital Facility Services | Eligible Professional Services During Hospitalization Billed by Your TIN | Eligible Professional Services During Hospitalization Billed by Other TINs | Emergency Services Not Included in a Hospital Admission | Post-Acute Services | Hospice | All Other Services |
| \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| \$0 | \$104 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |

(Table continued from previous slide)

- Table 5D provides similar information about the costs of the care provided to each Medicare beneficiary with an MSPB episode attributed to your TIN.

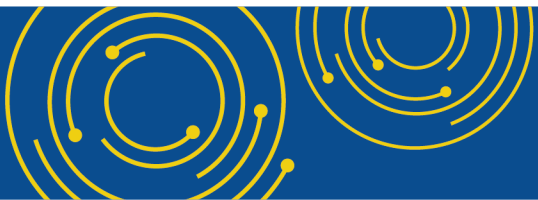
Table 7. Individual Eligible Professional Performance on the 2016 PQRS Measures

| Summary: Eligible Professionals (EPs) Reporting to PQRS as Individuals | | | |
|--|----------------------------|--|--|
| Number of EPs in your TIN who avoided the 2018 PQRS payment adjustment as individuals† | Number of EPs in your TIN† | Percentage of EPs in your TIN who avoided the 2018 PQRS payment adjustment as individuals† | Did 50% or more EPs in your TIN avoid the 2018 PQRS payment adjustment as individuals? |
| 58 | 70 | 82.85% | Yes |

| NPI | Eligible Professional Name† | Did eligible professional avoid the 2018 PQRS payment adjustment? | PQRS or QCDR Performance Measure | |
|------------|-----------------------------|---|----------------------------------|-----------------------------|
| | | | Measure Reference | Measure Name |
| XXXXXXXXXX | Clinician A | No | 113 | Colorectal Cancer Screening |
| XXXXXXXXXX | Clinician B | Yes | 113 | Colorectal Cancer Screening |
| XXXXXXXXXX | Clinician C | Yes | 113 | Colorectal Cancer Screening |

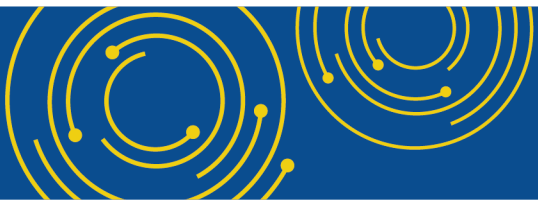
| Quality Domain | Eligible Professional Performance | | | Benchmark† (National Mean) |
|-------------------------|-----------------------------------|---------------------------|------------------|-------------------------------|
| | Reporting Mechanism† | Number of Eligible Cases† | Performance Rate | |
| Effective Clinical Care | Claims | 230 | 64.40 | 53.22 |
| Effective Clinical Care | Claims | 159 | 100.00 | 53.22 |
| Effective Clinical Care | Claims | 228 | 99.72 | 53.22 |

How to Access Your QRUR




Payment Adjustment and Reports Lookup Feature

- There is a new feature available at <https://portal.cms.gov> that will allow a representative of a TIN to:
 - (1) look up the TIN's current and prior years' VM and PQRS payment adjustments, and
 - (2) find out which feedback reports are available for the TIN (i.e., the Annual, Mid-year and Supplemental QRURs, and the PQRS Feedback Reports).
- An EIDM account is not needed to use this feature.
- Instructions for using this feature are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2017_08_04_Guide_for_Accessing_The_2016_Lookups_Page.pdf.



Payment Adjustment and Reports Lookup Feature (cont.)

CMS Enterprise Portal > PV Landing Page



Physician Value

Secure Links:

[Registration](#)[Feedback Reports](#)[Value Modifier Informal Review](#)

Note: Secure Links require an EIDM account. You may [register](#) for an EIDM account at the EIDM home page.

About PV

PQRS Feedback Reports

Value Modifier Informal Review

▶ Lookups

Contact Information

PV Helpdesk
Phone: 1-888-734-6433
Email: pvhelpdesk@cms.hhs.gov

Payment Adjustment

Reports

Payment Adjustment Lookup

Select the Payment Year and enter a TIN or TIN/NPI combination to check if you or your organization received a payment adjustment.

Note: A field with an asterisk (*) before denotes it is a required field.

*Payment Year:


*TIN:



NPI:

Search

Clear

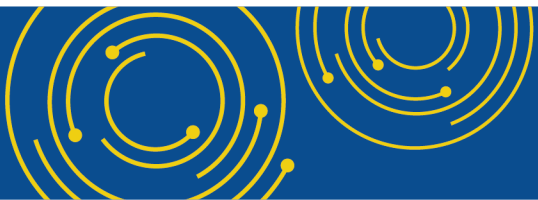
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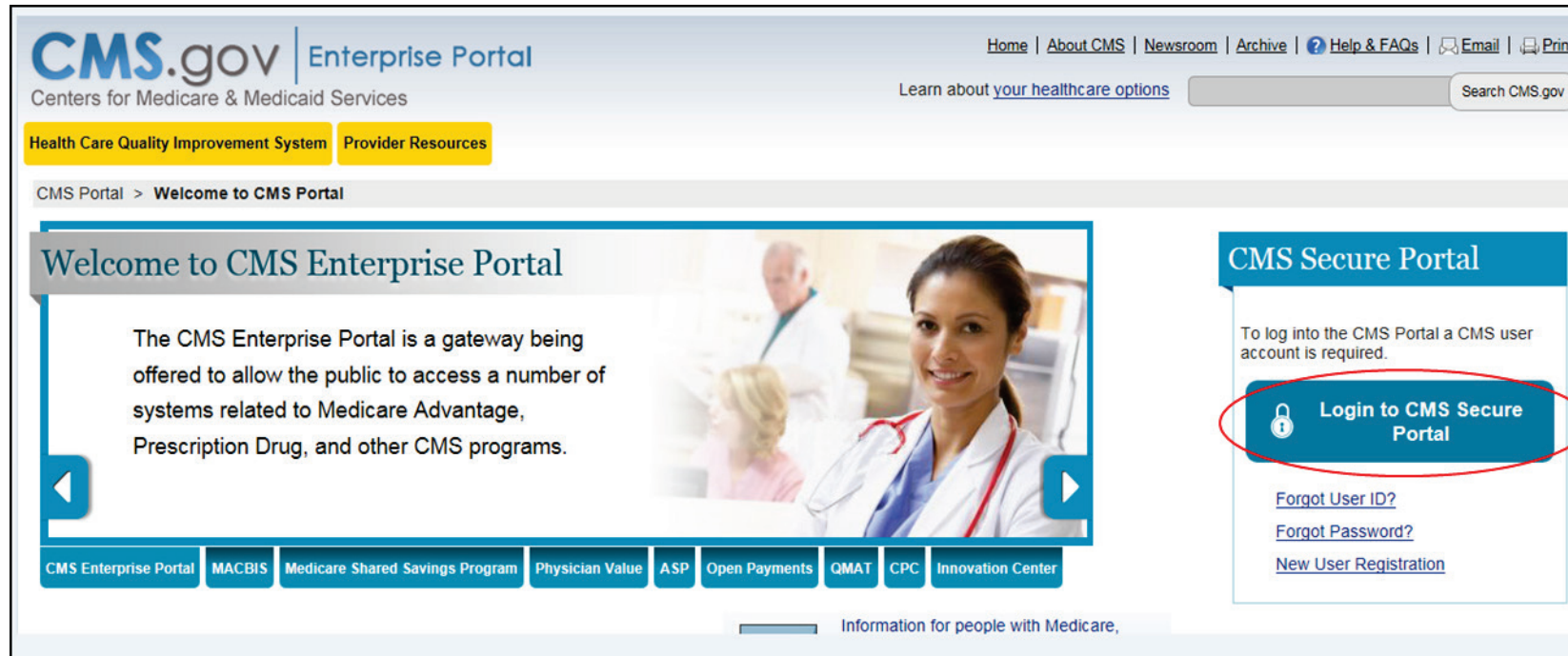
Enterprise Identity Management (EIDM) Introduction

- An EIDM account is required to access the QRUR.
- If you want to know whether there is already someone who can access your TIN's QRUR, contact the QualityNet Help Desk (phone: 1-866-288-8912 or email: qnetsupport@hcqis.org) and provide the name and number of the TIN.
- You can sign up for a new EIDM account, modify an existing EIDM account to add the correct role, or reset an EIDM account password (every 60 days) on the CMS Enterprise portal at <https://portal.cms.gov>.
- Refer to the Appendix for more information.

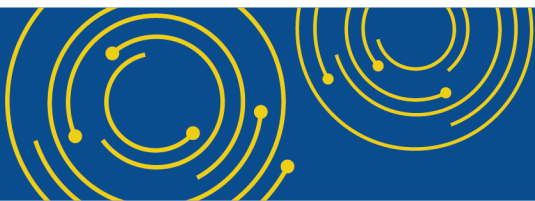


How can I access my QRUR?

- Go to <https://portal.cms.gov> and select “Login to CMS Secure Portal”



- Accept Terms and Conditions on the System Use Notification Screen and enter your EIDM User ID and Password.
- Instructions for setting up an EIDM account and accessing the 2016 Annual QRUR are available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html>.



Resources Page

Resources

Annual Quality and Resource Use Report (QRUR)

The 2016 Annual QRUR shows how a group or solo practitioner, 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 2018 Value Modifier. The Annual QRUR also shows how the Value Modifier will apply to payments under the Medicare Physician Fee Schedule in 2018 for services furnished by physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists billing under the TIN.

[Click for more information](#)

Value Modifier Informal Review Request

For groups and solo practitioners that are subject to the 2018 Value Modifier, CMS has established a 60-day Informal Review Period, to request a correction of a perceived error after the release of the 2016 Annual QRURs.

[Click for more information](#)

Physician Quality Reporting System (PQRS) Feedback Reports

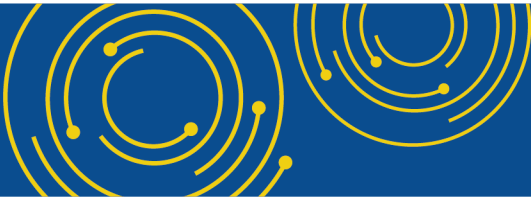
PQRS is a quality reporting program that encourages individual eligible professionals and group practices participating via the group practice reporting option, to report information on the quality of care to Medicare. Two types of PQRS feedback reports are available:

- PQRS Payment Adjustment Feedback Report
- PQRS Payment Adjustment Measure Performance Detail Report

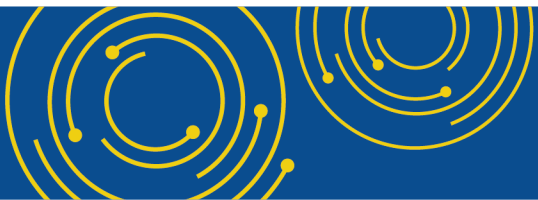
[Click for more information](#)

Contact Information

| | |
|--|---|
| Physician Value Help Desk (for questions related to the Value Modifier and QRURs) Monday - Friday: 8:00 am - 8:00 pm Eastern Time (ET) Phone: 1-888-734-6433 (option 3) Email: pvhelpdesk@cms.hhs.gov | QualityNet Help Desk (for questions related to the PQRS program and the PQRS Feedback Reports) Monday - Friday: 8:00 am - 8:00 pm Eastern Time (ET) Phone: 1-866-288-8912 / TTY: 1-877-715-6222 Fax: 1-866-329-7377 Email: qnetssupport@hcqis.org |
|--|---|

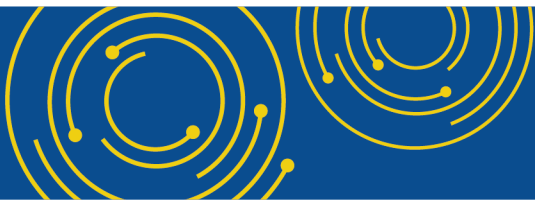


How to Request an Informal Review of Your TIN's 2018 VM Payment Adjustment



VM Informal Review Request

- If your TIN is subject to the VM in 2018 and you want to request a review of your VM payment determination, then a representative from your TIN can submit a request for an Informal Review through the CMS Enterprise Portal at <https://portal.cms.gov>.
- The Informal Review period is open now through **December 1, 2017 8:00 pm Eastern Time.**
- The same EIDM account User ID and Password can be used to access the QRURs and submit an Informal Review request.
- Instructions on how to request an informal review are available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2018-VM-IR-Quick-Ref-Guide.pdf>.



Requesting an Informal Review of your TIN's 2018 VM



Requesting an Informal Review of your TIN's 2018 VM (cont.)

Welcome to Physician Value Physician Quality Reporting Portal

Value Modifier Informal Review

Registration

Value Modifier History

If you are an authorized representative of a Taxpayer Identification Number (TIN) subject to the Value Modifier, please select 'View QRUR' to view your QRUR Report, or select 'Request Informal Review' to initiate an informal review of your Value Modifier information. Please ensure all your Value Modifier issues/questions and supporting documentation are included prior to submitting a Value Modifier informal review request during the informal review period.

| | Name | TIN | Performance/ Adjustment Year | Quality Composite Score | Cost Composite Score | Value Modifier Adjustment Percentage | Value Modifier Calculation/ Decision Date | Adjustment Factor | |
|--|--|------------|---------------------------------|-------------------------------|----------------------------|--|---|----------------------|---|
| | FQFRJQF FSJXYM/XNF FXXTHNFYJX RJQNHQ LWTZQ, NSH | XX-XXX6693 | 2016/2018 | N/A | N/A | 1.00 | N/A | N/A | <div><div>View QRUR</div><div>Request Informal Review</div></div> |

Requesting an Informal Review of your TIN's 2018 VM (cont.)

Informal Review Information

Note: There are no hardship exemptions included in the Value Modifier program; therefore, any hardship exemptions granted under other CMS programs do not apply to Value Modifier.

*Reason for Informal Review:?

Other

Related Exhibits:?

(select all that apply) N/A

*Justification for Review:?

Group Size - EPs Associated with TIN

*Justification Explanation:?

After reviewing our Annual Quality Resource Use Report (AQRUR), we believe that there are too many EPs assigned to our TIN which has negatively impacted our reported data.

Max 1500 characters, 1329 remaining

Add

Clear

Cancel



Requesting an Informal Review of your TIN's 2018 VM (cont.)

Supporting Documentation

Please attach any supporting documentation that supports the request of this informal review.

| Document Name | Size | Action |
|-------------------|------|--------|
| No records found. | | |

Add Supporting Documentation

Add Supporting Documentation

Click Choose to select the file to upload. Click Upload to complete the upload.

+ Choose

↗ Upload

⌂ Cancel

Close

Add Supporting Documentation

Click Choose to select the file to upload. Click Upload to complete the upload.

+ Choose

↗ Upload

⌂ Cancel

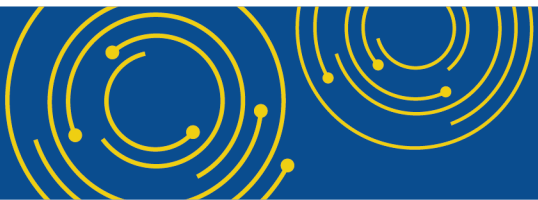
Supporting Documentation.docx1.1 MB

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Close

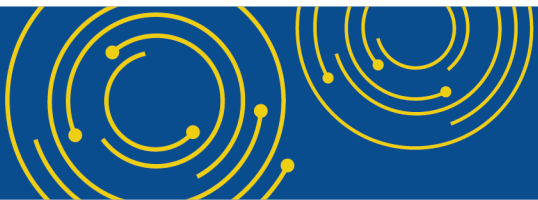


Next Steps and Technical Assistance



Next Steps: What You Can Do

- Download your TIN's 2016 Annual QRUR and 2016 PQRS Feedback Report at:
<https://portal.cms.gov>.
 - The same EIDM account can be used to access the Annual QRUR, the PQRS Feedback Report, and to file an Informal Review Request.
- Review the FAQs, Fact Sheets, Detailed Methodology, and other QRUR supporting documents at:
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2016-QRUR.html>.
- File an Informal Review request if you want your 2018 VM payment determination reviewed.



Technical Assistance Information

For QRUR and VM questions or to provide feedback on the content and format of the QRUR, contact the **Physician Value Help Desk**:

Phone: 1-888-734-6433 (select option 3)

Monday – Friday: 8:00 am – 8:00 pm EST

Email: pvhelpdesk@cms.hhs.gov

For PQRS and EIDM questions, contact the **QualityNet Help Desk**:

Phone: 1-866-288-8912

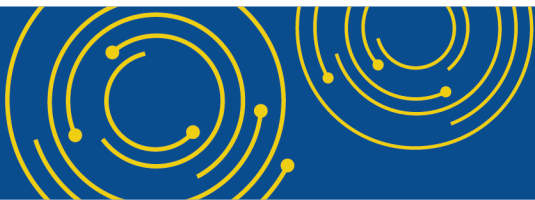
(TTY 1-877-715-6222)

Monday – Friday: 8:00 am – 8:00 pm EST

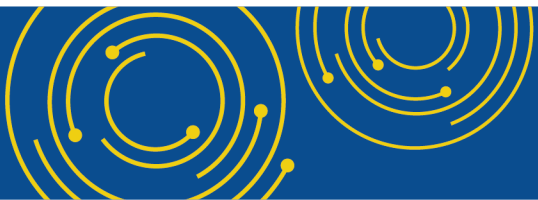
Email: qnetsupport@hcqis.org

Additional Resources

- 2016 QRUR Educational Documents: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2016-QRUR.html>
- How to obtain an EIDM account and access the QRUR: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html>
- VM Program: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>
- PQRS Program: <http://www.cms.gov/PQRS>



Question & Answer Session



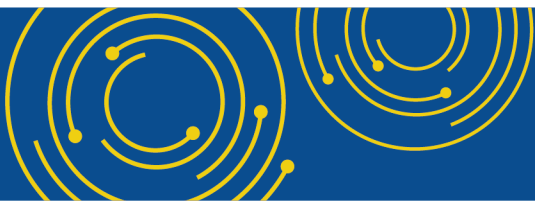
Thank you – please evaluate your experience

Share your thoughts to help us improve – [Evaluate](#) today's event.

Visit:

- [MLN Events](#) webpage for more information on our conference call and webcast presentations.
- [Medicare Learning Network](#) homepage for other free educational materials for health care professionals.

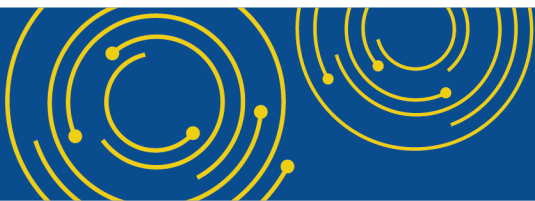
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CME and CEU

This call is being evaluated by CMS for CME and CEU continuing education credit. For more information about continuing education credit, review the CE Activity Information & Instructions document available at the link below for specific details:

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/CEInfo-TC-L10192017.pdf>



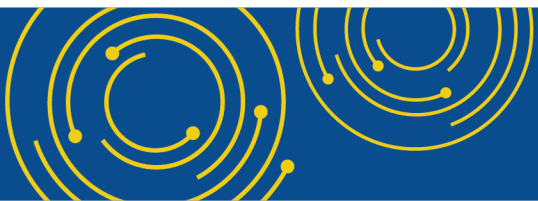
Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

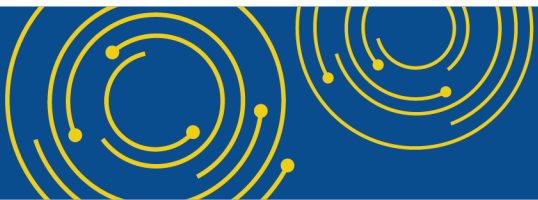
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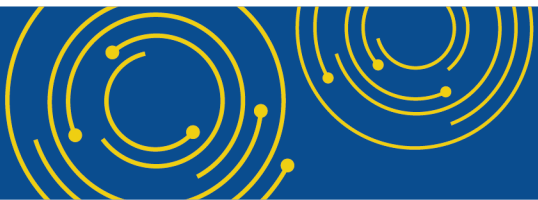
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Appendix



How to Set Up an EIDM Account



Steps to Sign Up for an EIDM Account

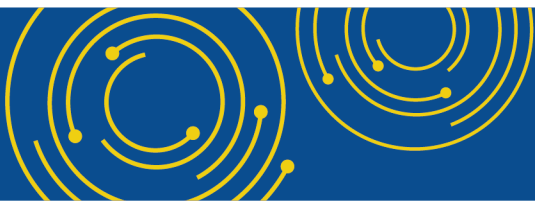
Gather, Enter, and Verify

1. Gather all of the required information you need to create an EIDM user ID and password.
2. Request role (see EIDM Roles for Groups and Solo Practitioners on subsequent slides).
3. Complete Remote Identity Proofing Verification and Multi-Factor Authentication process.
4. Associate with existing organization or create new organization.
5. Verify information and submit request.

Note: When signing up for an EIDM account, use an email address that you monitor regularly. Email notifications will be sent with your User ID, temporary password, and information about password resets and recertification.

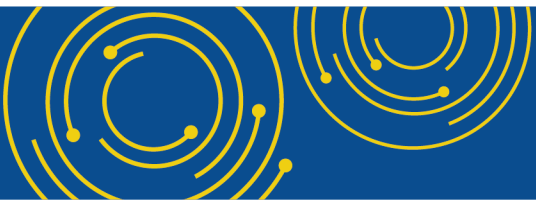
Quick reference guides that provide step-by-step instructions for requesting each role in EIDM for a new or existing EIDM account are available on the How to Obtain a QRUR website:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html>.



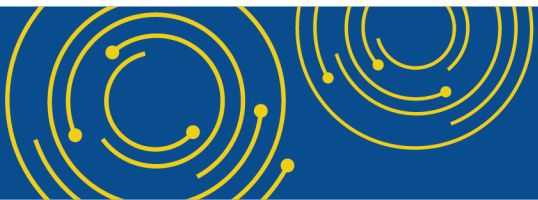
EIDM Roles for Groups

- Groups are identified in EIDM by their Medicare billing TIN and consist of two or more EPs (as identified by their National Provider Identifiers (NPIs)) that bill under the TIN.
- One person from the group must first sign up for an EIDM account with the **Security Official** role.
 - If additional persons need to access the QRUR, they can request the **Security Official** role or the **Group Representative** role in EIDM.
- For example, a group wants to give access to its QRUR to a vendor, ACO, or another third party. The third party may set up an EIDM account by submitting a request to the group's Security Official via the EIDM. The Security Official can approve the request and give the third party access to its report.



EIDM Roles for Solo Practitioners

- Solo practitioners are identified in the EIDM by their Medicare billing TIN and rendering NPI. A solo practitioner consists of only one EP (as identified by NPI) that bills under the TIN.
- One person must first sign up for an EIDM account with the **Individual Practitioner** role.
 - If additional persons need to access the QRUR, they can request the **Individual Practitioner** role or the **Individual Practitioner Representative** role in EIDM.



EIDM Roles for Groups and Solo Practitioners

The **Security Official or Individual Practitioner** role allows the user to:

1. Obtain the TIN's Annual QRUR and PQRS Feedback Report.
2. Obtain the TIN's Mid-Year QRUR, Annual QRUR, and Supplemental QRUR from prior years.
3. Submit a VM Informal Review request on behalf of the TIN.
4. Approve requests for the **Group Representative or Individual Practitioner Representative** role in EIDM.

The **Group Representative or Individual Practitioner Representative** role allows the user to perform tasks 1 and 2 listed above.

