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# **Quality and Resource Utilization Report (QRUR): The Value Modifier Report Card**

Sharon Phelps, RN, CHTS-CP, CPHIMS  
October 25, 2016 (2-3 pm MDT)

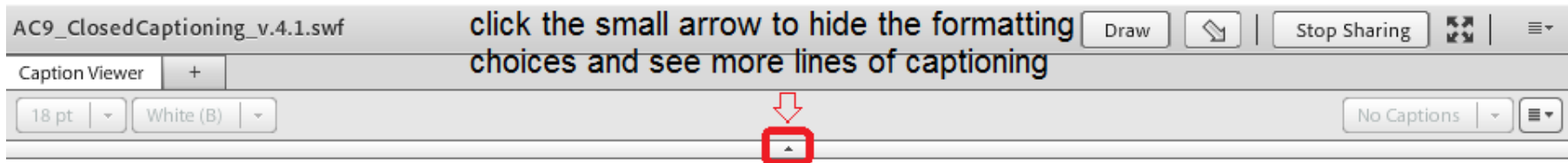


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  - Funded by Centers for Medicare & Medicaid Services (CMS)
  - Quality Innovation Network-Quality Improvement Organization (QIN-QIO)
  - Serves Montana, Wyoming, Alaska and Hawaii
- **HTS is a department of Mountain-Pacific**
  - Has assisted 1480 providers and 50 critical access hospitals to reach Meaningful Use under CMS EHR Incentive program
  - Assists health care facilities with utilizing health information technology (HIT) to improve health care, quality, efficiency and outcomes



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## **Introducing Sharon Phelps, RN, Quality Improvement Specialist, with Mountain-Pacific Quality Health**



# Poll Question

What method and what mechanism did you use for reporting PQRS in 2015?

- GPRO – Web Interface
- GPRO – EHR
- GPRO – Registry
- GPRO – QCDR, Qualified Clinical Data Registry
- Individual – Claim
- Individual – EHR
- Individual – Registry
- Individual – QCDR- Qualified Clinical Data Registry
- Through ACO
- Did not report



# Goals/Agenda

**At the end of this session, you will be able to:**

- Briefly describe CMS Incentive and Pay-for-Performance Programs
- Understand QRUR and supporting documents
- Understand Quality and Cost components
- Discuss important items to review in QRUR
- Explain Informal Review request process





# PQRS and Value Modifier Overview



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# A Quick Overview

- **Physician Quality Reporting System (PQRS)**
  - Started as “incentive” program in 2006, with 2014 being last year for an incentive
  - Currently “all or none” program
  - Applied at Tax Identification Number–National Provider Identifier (TIN-NPI) level
- **Value Modifier (VM)**
  - Budget neutral pay-for-performance program mandated by Affordable Care Act in 2010
  - Uses data submitted under PQRS combined with claims data
  - Affects sub-group of eligible professional (EP) types
  - Applied at TIN level



# PQRS for 2015 Reporting Year

- Successful PQRS reporting on quality measure performance in 2015 **avoids** negative adjustment for **PQRS adjustment** in 2017 payment year
- Unsuccessful reporting of quality measures or failure to report quality measures triggers automatic **negative 2.0% PQRS payment adjustment** on Medicare Part B payments at TIN-NPI level



# Value Modifier for CY2017

- Applies to all **physicians** in groups with 2+ eligible professionals (EPs) and to physician solo practitioners, as identified by Medicare-enrolled Taxpayer Identification Number (TIN)
- Based on participation in Physician Quality Reporting System (PQRS) in 2015
- For TINs subject to 2017 VM, QRUR shows how VM will apply to physician payments under Medicare PFS for physicians who bill under TIN in 2017

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html>



# How is the Value Modifier calculated?

The attribution method focuses on the delivery of primary care services

- Beneficiaries are assigned to provider group where they received **plurality** of primary care services from **primary care physicians** during the year
- If beneficiary received no primary care services from primary care provider, he/she is assigned to group where he/she received **plurality** of his/her primary care services from either **specialists or non-physician providers**

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-03-25-Attribution-Fact-Sheet.pdf>



# The QRUR

Quality and Resource Utilization Report



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# Poll Questions

Have you successfully obtained your 2015 Annual QRUR?

- Yes
- No

Were you surprised by the results?

- Yes, we will be filing an informal review
- Yes, we will not be filing an informal review
- No, our results are what we expected, or we do not believe an informal review will change our quality tier results





# QRURs and Feedback Report

- Annual QRUR

<http://mpqhf.com/blog/hts-pqrs-whats-in-my-qrur/>

- MidYear QRUR

- Supplemental Reports

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Episode-Costs-and-Medicare-Episode-Grouper.html>

- PQRS Feedback Report

[https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015\\_PQRS\\_FeedbackReportUG.pdf](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_PQRS_FeedbackReportUG.pdf)





# What is the 2015 Annual QRUR?

- Shows performance in **2015** at the TIN level
- Shows how VM will apply to **physician payments** under Medicare PFS for physicians who bill under TIN in **2017**
- Based on all services provided from:
  - January 1, 2015 thru December 31, 2015
- **Cost** is based on administrative claims data
- **Quality** is based on:
  - Quality measures submitted under PQRS
  - 3 claims-based quality outcomes measures from claims calculated by CMS



# Who gets a QRUR?

- Provided by CMS to all groups and solo practitioners nationwide who had at least one EP bill Medicare-covered services under TIN in 2015
- TINs that did not have at least one EP bill Medicare PFS under TIN in 2015 will have QRUR for informational purposes only, and Value Modifier will not affect their payments under Meditech PFS in 2017



# How do I obtain a QRUR?

- In **CMS Enterprise Identity Management System (EIDM) Portal** under Physician Value-Physician Quality (PV-PQRS) section  
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-QRUR-Guide.pdf>

**PQRS Feedback Reports and QRURs can be accessed at <https://portal.cms.gov> using same EIDM account**

# CMS Portal (EIDM)

Health Care Quality Improvement System Provider Resources

CMS Portal > **Welcome to CMS Portal**

## Welcome to CMS Enterprise Portal

The CMS Enterprise Portal is a gateway being offered to allow the public to access a number of systems related to Medicare Advantage, Prescription Drug, and other CMS programs.



## CMS Secure Portal

To log into the CMS Portal a CMS user account is required.



**Login to CMS Secure Portal**

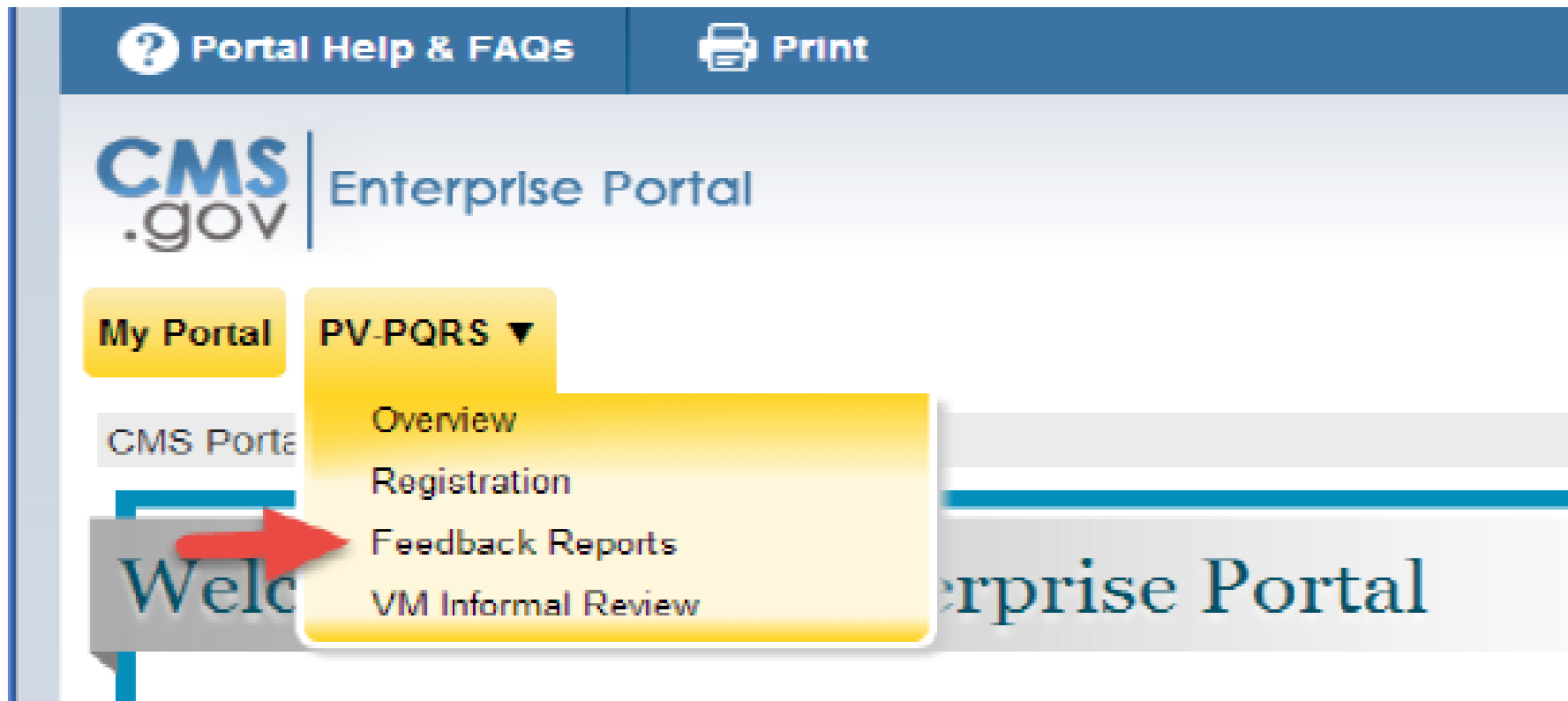
[Forgot User ID?](#)

[Forgot Password?](#)

[New User Registration](#)

[CMS Enterprise Portal](#) [MACBIS](#) [Medicare Shared Savings Program](#) [Physician Value](#) [ASP](#) [Open Payments](#) [QMAT](#) [CPC](#) [Innovation Center](#)

# EIDM – Feedback Reports



# Finding the QRUR

My Portal Open Payments ▼ PV-PQRS ▼

CMS Enterprise Portal >

Welcome to Physician V

A field with an asterisk (\*)

\*Select a Year?

\*Select a Report

\*Select an Action

Select a Report

## 2015 Annual QRUR

2015 Annual Quality and Resource Use Report (QRUR)

Table 1. Physicians and Non-Physician Eligible Professionals Identified in Your Medicare-

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

Table 3. Per Capita Costs for All Beneficiaries

Table 4. Per Capita Costs for Selected Conditions

Table 5. Medicare Spending Per Beneficiary (MSPB)

Table 6. Medicare Shared Savings Program

Table 7. Individual Eligible Professional Performance on the 2015 PQRS Measures

## 2015 PQRS Feedback Reports

PQRS Payment Adjustment Feedback Report for Groups

PQRS Payment Adjustment Measure Performance Detail Report for Groups

# Downloading

CMS Enterprise Portal > PV-PQRS > Feedback Reports

## Welcome to Physician Value Physician Quality Reporting Portal

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

\*Select a Year?

2015

\*Select a Report

2015 Annual Quality and Resource Use Report (QRUR)

\*Select an Action

Select an Action

Select an Action

View Online

Download this report in PDF format

Note: This selection will only download the report you selected. In order to download the tables, please select the appropriate table from the Select a Report drop down.

## 2015 ANNUAL QUALITY AND RESOURCE USE REPORT AND THE 2017 VALUE-BASED PAYMENT MODIFIER

Sample Medical Practice

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

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.





# The Big Picture

Seeing your performance according to CMS



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# How to Read QRUR

## Step 1

### Your TIN's 2017 Value Modifier

Look at the front page for the big picture

- Adjustment, if applicable, will apply to payments for all items and services paid under Medicare PFS for **physicians** billings under your TIN in 2017
- 2017 VM does NOT affect payments to other eligible professional who are NOT physicians

# Front Page - Example #1

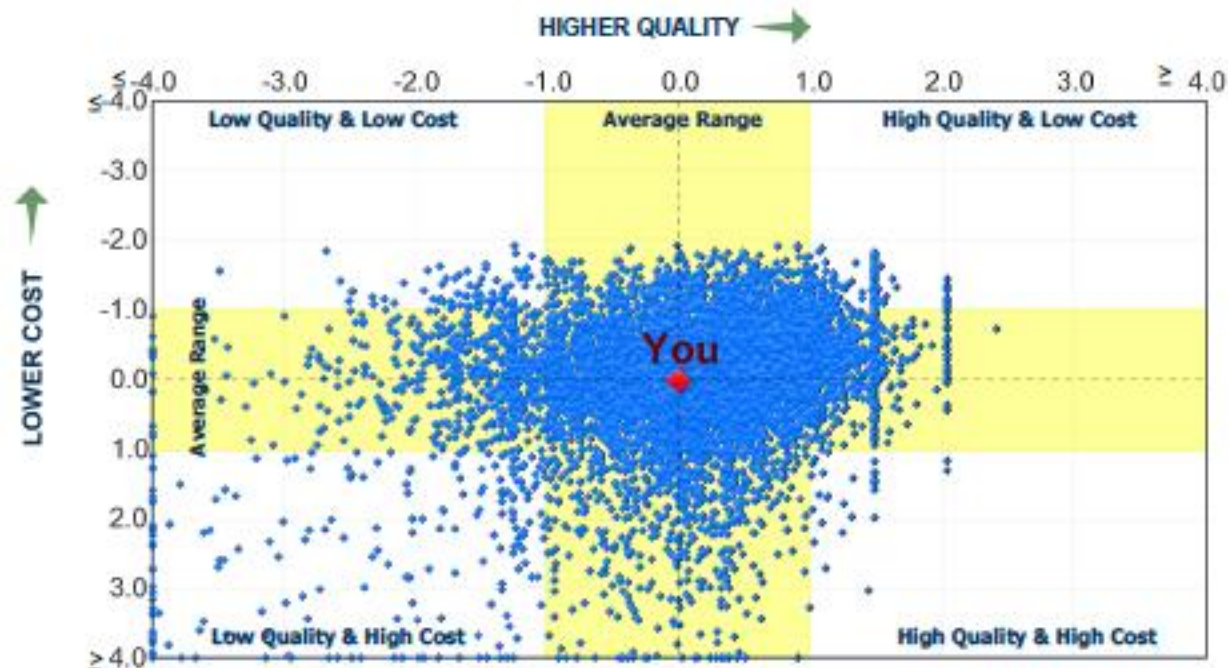
## YOUR TIN'S 2017 VALUE MODIFIER

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.

# Front Page – Example #2

## YOUR TIN'S 2017 VALUE MODIFIER

**High Quality, Average Cost = Upward Adjustment (+3.0 x adjustment factor)**

Your TIN's overall performance was determined to be high 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 an upward adjustment equal to three (+3.0) times the adjustment factor.

The scatter plot below shows how your TIN ("You" diamond) compares to a representative sample of other TINs on the Quality 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.



# How to Read QRUR

## Step 2

Look at page 2 next.

- This page shows how Value Modifier will be applied to TIN in 2017
- Value Modifier is applied based on group size:
  - 2 to 9 EPs in group or solo practitioners
  - 10 or more EPs in group
- Three adjustment possibilities:
  - Upward (positive)
  - Neutral (no change)
  - Downward (negative)

# VM Payment Adjustment CY2017

*VM is applied to solo physicians and physician groups depending upon size.*

CY 2017 VM Payment Adjustment Amounts for Groups with Two-Nine Eligible Professionals and Solo Practitioners

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

CY 2017 VM Payment Adjustment Amounts for Groups with Ten or More Eligible Professionals

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

"x" refers to a payment adjustment factor yet to be determined



# The Adjustment Factor (AF)

- Derived from actuarial estimates of projected billings
- Will determine precise size of reward for higher performing TINs in a given year
- AF for 2017 Value Modifier will be posted at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html>





# Value Modifier (Example #1)

## YOUR TIN'S 2017 VALUE MODIFIER

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

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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 8 eligible professional(s).

At least 50 percent (100%) of the eligible professionals in your TIN reported quality data to the Physician Quality Reporting System (PQRS) as individuals and met the criteria to avoid the 2017 PQRS payment adjustment (or, if a solo practitioner, you met the criteria as an individual). This also qualifies your TIN to avoid an automatic Value Modifier downward payment 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.

# Exhibit #1 (Example #1)

## 2017 Value Modifier Payment Adjustments under Quality-Tiering (TINs with fewer than 10 EPs)

	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%



# How to Read QRUR

## Step 3: The High Risk Bonus (Example #2)

### 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 82nd 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 receive the high-risk bonus adjustment to the 2017 Value Modifier because your TIN met these criteria.**

This additional upward adjustment is reflected in the Value Modifier payment adjustment for your TIN (Exhibit 1).

# Exhibit #2 (Example #2)

## 2017 Value Modifier Payment Adjustments under Quality-Tiering (TINs with **10 or more** EPs)

	Low Quality	Average Quality	High Quality	
Low Cost	0.0%	$+3.0^* \times \text{AF}$	$+5.0^* \times \text{AF}$	
Average Cost	-2.0%	0.0%	$+3.0^* \times \text{AF}$	$2.0 + 1.0 =$ $+3.0 \times \text{AF}$
High Cost	-4.0%	-2.0%	0.0%	



# Risk Adjustment

## How is the cost data risk-adjusted?

- Patient risk is assessed using standard, CMS risk-adjustment methodology using **Hierarchical Condition Categories (HCCs)**
  - Includes pulling diagnosis codes from claims for **up to one year prior** to event in question and determining predicted patient costs based on those diagnoses

[http://mpqhf.com/corporate/wp-content/uploads/2016/08/Quality-Payment-Program-LAN-8\\_24\\_16.pdf](http://mpqhf.com/corporate/wp-content/uploads/2016/08/Quality-Payment-Program-LAN-8_24_16.pdf)



# Quality Component



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# How to Read QRUR

## Step 4

### Your TIN's Quality Tier

Next, look on page 4, Exhibit 2

- Top line (your TIN's Quality Composite Score) is same value we just saw for quality on front page
- Shows how your overall Quality Composite Score compared to other groups
  - Average Quality Composite Score is calculated as average of measures within each domain that was reported

# Quality Composite Score

## PERFORMANCE ON QUALITY MEASURES

Your TIN's Quality Tier: High

Exhibit 2. Your TIN's Quality Composite Score

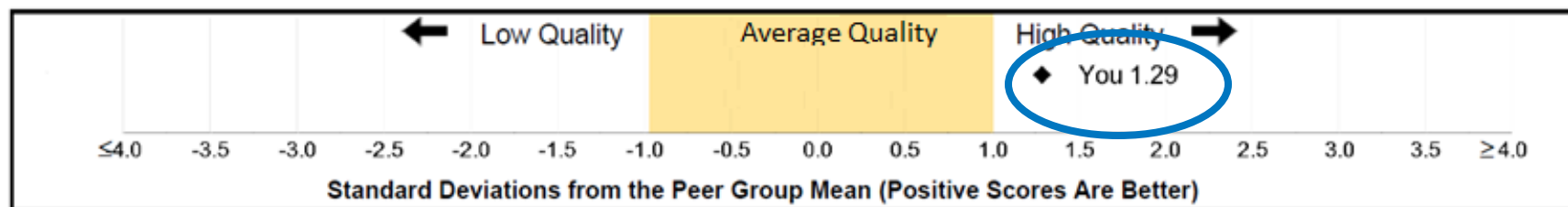


Exhibit 2 will contain indicator of where your quality performance lands compared to benchmark for your peer group

- More than one standard deviation **above** mean (positive score) puts you in **High Quality** category
- More than one standard deviation **below** mean (negative score) puts you in **Low Quality** category

# Quality Score Calculation

---

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

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The following measures were used to calculate your TIN's Quality Composite Score based on performance in 2015:

- Quality measures reported by 50 percent or more of the eligible professionals in your TIN who met the criteria to avoid the 2017 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 2015 to beneficiaries attributed to your TIN.

## Quality Measure Calculations:

- Calculated for each domain for which there is a minimum number of eligible cases
- Score = average across all measures

**See Exhibit 3  
for table for  
each domain  
to see how  
you compared  
to benchmark.**


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

## Domain Score

◆ You -0.38

≤-4.0      -3.0      -2.0      -1.0      0.0      1.0      2.0      3.0      ≥4.0

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
2 (CMS163v3)	Diabetes: Low Density Lipoprotein (LDL-C) Control (< 100 mg/dL)	82		-0.32	Yes	51.27%	23.25
5 (CMS135v3)	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	9		0.37	No	83.01%	15.94
7 (CMS145v3)	Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)	12		0.12	No	88.37%	26.85
8 (GPRO HF-6, CMS144v3)	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	11		0.28	No	86.35%	16.04
113 (GPRO Prev-6, CMS130v3)	Colorectal Cancer Screening	358		-0.81	Yes	47.55%	31.31
163 (CMS123v3)	Diabetes: Foot Exam	4		-0.20	No	57.19%	36.76
236 (GPRO HTN-2, CMS165v3)	Controlling High Blood Pressure	211		-0.02	Yes	69.03%	14.78



# Outcome Quality Measures

## 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.

Performance Category	Measure Identification Number(s)	Measure Name	Number of Eligible Cases	Your TIN			All TINs in Peer Group	
				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	0	—	—	No	6.90	5.44
	-	Bacterial Pneumonia	0	—	—	—	9.96	8.73
		Urinary Tract Infection	0	—	—	—	7.02	7.78
		Dehydration	0	—	—	—	3.69	4.18
	CMS-2	Chronic Conditions Composite	0	—	—	No	54.56	25.83
	-	Diabetes (composite of 4 indicators)	0	—	—	—	17.98	20.11
		Chronic Obstructive Pulmonary Disease (COPD) or Asthma	0	—	—	—	76.29	47.75
		Heart Failure	0	—	—	—	112.54	54.80
Hospital Readmission	CMS-3	All-Cause Hospital Readmission	0	—	—	No	15.32%	1.43



# Cost Component



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# How to Read QRUR

## Step 5

### Your TIN's Cost Tier

#### Now look at Exhibit 4

- Similar to Exhibit 2 except cost component of modifier
- Again, Standardized Cost Composite Score goes into modifier on front page; shows how your Average Cost Composite Score compares to your peers
- In this instance...
  - **Negative standardized scores** indicate **lower costs** (better performance)
  - **Positive scores** indicate **higher costs** (worse performance)

# Cost Composite Score

## PERFORMANCE ON COST MEASURES

Your TIN's Cost Tier: Average

Exhibit 4. Your TIN's Cost Composite Score

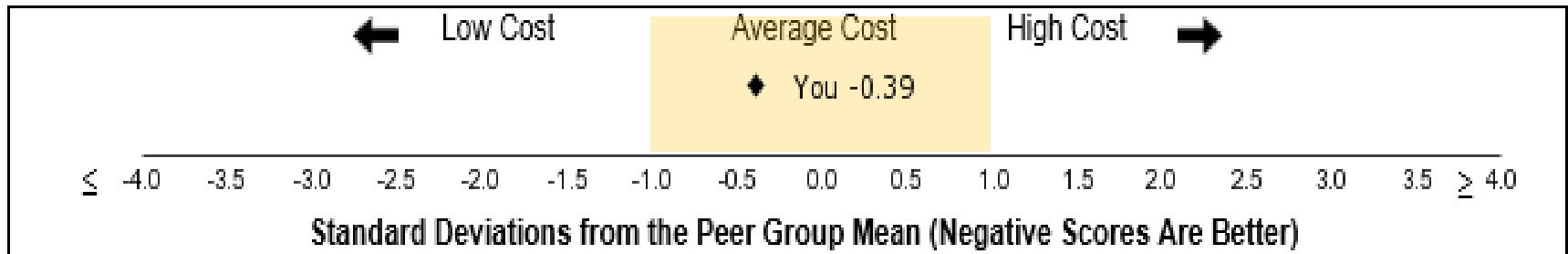


Exhibit 4 will contain indicator of where your cost performance lands compared to benchmark for your peer group.

- More than one standard deviation **above** mean (positive score) puts you in **High Cost** category
- More than one standard deviation **below** mean (negative score) puts you in **Low Cost** category



# Cost Score

- Six cost measures are classified into two cost domains:
  - (1) Costs for All Beneficiaries
  - (2) Costs for Beneficiaries with Specific Conditions
- Score for each cost domain is calculated as equally-weighted average of measure scores within domain for all measures that have required minimum number of eligible cases or episodes



# Cost Measures

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## 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



Exhibits 5-AAB and 5-BSC show your TIN's performance on cost measures, by domain, used to calculate Cost Composite Score



# Cost for All Attributed Beneficiaries

## Exhibit 5-AAB. Costs for All Attributed Beneficiaries Domain

### Domain Score

*A domain score was not calculated because your TIN did not have at least one cost measure with the minimum number of eligible cases or episodes to be included in the domain score.*

	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	0	—	—	No	\$12,326	\$3,665
Medicare Spending per Beneficiary	0	—	—	No	\$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.

# Costs for Specific Conditions

## Exhibit 5-BSC. Costs for Beneficiaries with Specific Conditions Domain

### Domain Score

*A domain score was not calculated because your TIN did not have at least one cost measure with the minimum number of eligible cases to be included in the domain score.*

Cost Measure	Your TIN				All TINs in Peer Group	
	Number of Eligible Cases	Per Capita Costs	Standardized Cost Score	Included in Domain Score?	Benchmark (National Mean)	Standard Deviation
Per Capita Costs for Beneficiaries with Diabetes	0	—	—	No	\$18,273	\$5,691
Per Capita Costs for Beneficiaries with Chronic Obstructive Pulmonary Disease	0	—	—	No	\$29,758	\$9,769
Per Capita Costs for Beneficiaries with Coronary Artery Disease	0	—	—	No	\$21,900	\$6,956
Per Capita Costs for Beneficiaries with Heart Failure	0	—	—	No	\$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.





# Supporting Documents

Tables, supplemental reports, PQRS feedback reports



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# What else is in the QRUR?

Table	Contents Description
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)
Table 3	Per Capita Costs for All Beneficiaries
Table 4	Per Capita Costs for Selected Conditions
Table 5	Medicare Spending per Beneficiary (MSPB)
Table 6	Shared Savings Program
Table 7	Individual Eligible Professional Performance on the 2015 PQRS Measures



# Supplemental Reports

- Reports include 4 exhibits and 3 drill down tables
- 2015 Supplemental QRUR
  - Exhibits provide results for sum of all instances of episodes attributed to group
  - Drill down tables provide detailed information for each instance of episodes attributed to group
  - Appendices provide definitions for key terms and service categories included in reports



# PQRS Feedback Reports

- Provide individual EPs and group practice with final determination on whether or not they met PQRS criteria to avoid 2017 PQRS negative payment adjustment
- Provide detailed information about quality data submitted by provider/group
- Reflect data from Medicare PFS claims with dates of service January 1, 2015 thru December 31, 2015 and received by February 26, 2016



# PQRS Feedback Reports

PQRS Payment Adjustment Feedback

PQRS Payment Adjustment Measure  
Performance Detail Report

# PQRS Payment Adjustment Report

NPI	NPI Name	Provider Specialty Type	Critical Access Hospital CCN (1)	Total Part B PFS Allowed Charges (2,3)	Subject to 2017 PQRS Payment Adjustment?	Eligible for 2017 PQRS Payment Adjustment Assessment ?	Payment Adjustment Assessment Rationale
6729174185	Physician A	Chiropractor	N/A	\$15,586.03	Yes	Yes	Insufficient number and type of measures were reported
6002115926	Physician B	Physical Therapist	N/A	\$25,288.81	No	Yes	Sufficient number of measures and domains, and patients were reported to avoid the payment adjustment
6022116295	Physician C	Obstetrics & Gynecology	N/A	\$4,749.97	No	Yes	Sufficient number of measures and domains, and patients were reported to avoid the payment adjustment
6022128317	Physician D	Clinical	N/A	\$18,516.93	No	Yes	Sufficient number of measures and domains, and patients were reported to avoid the payment adjustment
6022282768	Physician E	Obstetrics & Gynecology	N/A	\$682.35	No	Yes	Sufficient number of measures and domains, and patients were reported to avoid the payment adjustment
6022342338	Physician F	Neurological Surgery	N/A	\$27,091.95	No	Yes	Sufficient number of measures and domains, and patients were reported to avoid the payment adjustment

Adjustment Summary Tab



# PQRS Payment Adjustment Report

<b>Payment Adjustment Assessment Rationale</b>	<b>Exempt from 2017 PQRS Payment Adjustment due to Provider Specialty?</b>	<b>Exempt from 2017 PQRS Payment Adjustment due to services not payable under the Medicare Physician Fee Schedule (MPFS)? (2,3)</b>	<b>Exempt from 2017 PQRS Payment Adjustment due to services do not fall into the denominator for any measures? (4)</b>	<b>Exempt from 2017 PQRS Payment Adjustment due to NPI working at an Independent Diagnostic Testing Facility (IDTF) or Independent Laboratory (IL)?</b>
Insufficient number and type of measures were reported	No	No	No	No
Sufficient number of measures and domains, and patients were reported to avoid the payment adjustment	No	No	No	No
Sufficient number of measures and domains, and patients were reported to avoid the payment adjustment	No	No	No	No
Sufficient number of measures and domains, and patients were reported to avoid the payment adjustment	No	No	No	No
Sufficient number of measures and domains, and patients were reported to avoid the payment adjustment	No	No	No	No
Sufficient number of measures and domains, and patients were reported to avoid the payment adjustment	No	No	No	No


Adjustment Summary Tab – Rightmost columns



# PQRS Payment Adjustment Report

Payment Adjustment Assessment Rationale	Satisfactorily Reported via Reporting Method?	Total # Individual Measures Reported (4,11,12,16, 24)	Total # Individual Measures Satisfactorily Reported (2,4, 5,14,16,17,25, 29)	Total # Domains for Individual Measures Satisfactorily Reported (3,5,15,17,26)	Is MAV Criteria Applicable? (1,4,5,6,7,13, 16,17,18)	Passed MAV? (1,7,8,13,19, 20)	Total # Measures Groups Reported	Total # Measures Groups Satisfactorily Reported (23)
Insufficient number and type of measures were reported	No	2	1	1	No	N/A	N/A	N/A
Sufficient number of measures and domains, and patients were reported to avoid the payment adjustment	Yes	11	9	3	No	N/A	N/A	N/A
Sufficient number of measures and domains, and patients were reported to avoid the payment adjustment	Yes	12	9	3	No	N/A	N/A	N/A
Sufficient number of measures and domains, and patients were reported to avoid the payment adjustment	Yes	15	9	3	No	N/A	N/A	N/A
Sufficient number of measures and domains, and patients were reported to avoid the payment adjustment	Yes	2	2	2	Yes	Yes	N/A	N/A
Sufficient number of measures and domains, and patients were reported to avoid the payment adjustment	Yes	14	9	3	No	N/A	N/A	N/A

Individual Adjustment Detail tab

More columns   
(outcome, face to face,  
cross-cutting, etc.)





# Next Steps



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# What to do now?

- Obtain your QRUR and supporting documents
- Review your results and compare quality data to what you submitted
  - Start with PQRS Feedback reports
- Determine if there is a discrepancy
  - Call HELP desk
  - File informal review
- Review your performance on your quality measures now!



# Help Desks

## Physician Value Help Desk

- QRUR and VM questions
- Phone: **1-888-734-6433**  
(option 3)
  - Monday thru Friday
  - 8 AM to 8 PM Eastern
- Email:  
**[pvhelpdesk@cms.hhs.gov](mailto:pvhelpdesk@cms.hhs.gov)**

## QualityNet Help Desk

- PQRS and EIDM questions
- Phone: **1-866-288-8912**
  - Monday thru Friday
  - 8 AM to 8 PM Eastern
- Email:  
**[qnetsupport@hcqis.gov](mailto:qnetsupport@hcqis.gov)**

# Informal Review - PQRS

## Related Links

- [+ CMS](#)
- [+ Quality Improvement Resources](#)
- [+ Measure Development](#)
- [+ Consensus Organizations for Measure Endorsement/Approval](#)
- [- Communication Support Page](#)
  - [NPI Level Report Request](#)
  - [Informal Review Request](#)
  - [PQRS Informal Review](#)
  - [VM Informal Review](#)
  - [EHR Reconsiderations](#)
- [PQRS Lookup Functions](#)

## Guest Announcement

Information in the Taxpayer Identification Number (Tax ID or TIN-level) PQRS feedback reports is confidential. Your report is safely stored online and accessible only to you (and those you authorize) through the web application. TIN-level reports should be shared only with others within the practice who have a vested interest in the summarized quality data. Sharing of other PQRS participants' information is acceptable only if the individual EP has authorized the TIN to do so. Please ensure that these reports are handled appropriately and disposed of properly to avoid a potential Personally Identifiable Information (PII) exposure or Identity Theft risk.

PQRS Feedback Reports for program year 2014 and later can be accessed (when available) from the PV-PQRS portal. For instructions on how to access these Feedback Reports, please go to Physician Feedback Program website.

## Physician and Other Health Care Professionals Quality Reporting Portal

[Sign In](#) to your Portal

If you do not have an account, please register.

[Forgot your password?](#)

For assistance with new & existing EIDM accounts, review the [Quick Reference Guides](#).

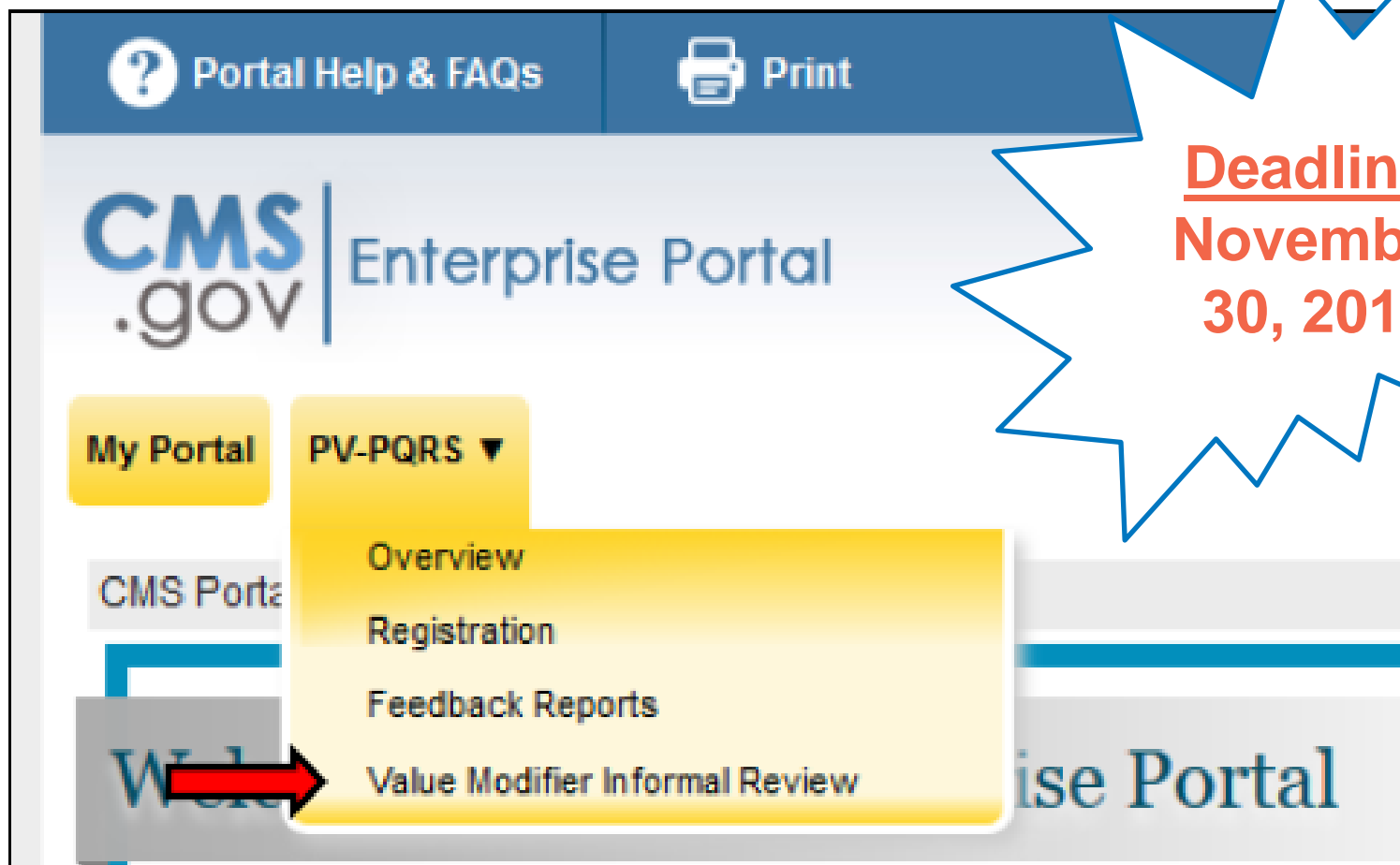
## Release Notes

[PQRS Release Notes](#)

## User Guides

**Deadline:  
November  
30, 2016**

# Informal Review - VM



<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2017-VM-IR-Quick-Ref-Guide.pdf>



# Poll Question

How confident are you that you can access the QRUR?

- Very confident
- Somewhat confident
- I am not sure, I could use more education.
- I am not at all confident that I will be able to access the reports.

# Holy MACRA

Yup – now that you’ve just got this all figured out... it is changing!!





# What's the future hold?

The Final Rule is here!

Find it at: [www.qpp.cms.gov](http://www.qpp.cms.gov)

**The Quality Payment Program  
has two tracks to choose from:**

## **Advanced Alternative Payment Models (APMs)**

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model

## **Merit-based Incentive Payment System (MIPS)**

If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.



# Questions?

- Sarah Leake
  - [sleake@mpqhf.org](mailto:sleake@mpqhf.org)
- Sharon Phelps
  - [sphelps@mpqhf.org](mailto:sphelps@mpqhf.org)
- Amber Rogers
  - [arogers@mpqhf.org](mailto:arogers@mpqhf.org)
- New Mountain-Pacific MACRA-QPP Blog
  - Sign up for automatic delivery at:  
<http://mpqhf.org/blog/>

Please complete the survey to help us better serve you and meet your needs!



# Acronyms

- ACO: Accountable Care Organization
- AF: Adjustment Factor
- CAHPS: Consumer Assessment of Healthcare Providers & Systems
- CPC: Comprehensive Primary Care
- EIDM: Enterprise Identity Management
- EP: Eligible Professional
- FFS: Fee-for-Service
- GPRO: Group Practice Reporting Option
- MSPB: Medicare Spending per Beneficiary
- NPI: National Provider Identifier
- 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-Based Payment Modifier



# THANK YOU!



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This material was developed by Mountain-Pacific Quality Health, the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Montana, Wyoming, Alaska, Hawaii and the U.S. Pacific Territories of Guam and American Samoa and the Commonwealth of the Northern Mariana Islands, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Contents presented do not necessarily reflect CMS policy. 11SOW-MPQHF-AS-D1-16-34