Obtaining and Understanding Your QRUR: Why Quality Ratings Matter Webinar Transcript

September 23, 2015

April: The Quality Insights Quality Innovation Network team welcomes you to today's webinar, Obtaining and Understanding Your QRUR: Why Quality Ratings Matter. My name is April Faulkner and I would like to take just a moment to review a few housekeeping items. First, all participant lines have been muted and will remain in a listen-only mode during the presentation. There will be a question-and-answer session following the presentation. If a question comes to mind during the presentation, feel free to type it in the chat window on the right of your screen, and we will address it during the Q&A session. Note we will unmute all the phone lines during the Q&A session, so you will be able to ask questions at that time if you prefer.

Please note that this webinar is being recorded. The slide deck was emailed to all participants earlier today, and it is also posted on our website under the events tab as an archived event. Now, I would like to introduce today's presenters.

Dr. Barbara Connors serves as chief medical officer at the Centers for Medicare and Medicaid Services region 3, and has served as the acting associate regional administrator for the division of survey and certification in CMS Northeast Consortium region 1, 2 and 3. As the chief medical officer, she is responsible for ensuring the provider community is cognizant of CMS healthcare quality improvement initiative, including current legislative issues that impact the provider community. Dr. Connors graduated from the Newark College of Osteopathic Medicine and received her masters of public health from the Medical College of Wisconsin. Dr. Connors is board certified by the American Board of Internal Medicine and the American Board of Preventive Medicine.

Patrick Hamilton is a health insurance specialist for the Centers for Medicare and Medicaid Services. Patrick has been with the Philadelphia regional office since October of 1998. He has worked in the area of provider outreach for the past 13 years, where he has served as the outreach specialist for providers in the states of Delaware, Maryland, Pennsylvania, Virginia, and West Virginia, as well as the District of Columbia.

In addition to his outreach responsibilities, Patrick works closely with providers, beneficiaries, and congressional officers in resolving inquiries dealing with Part A and Part B issues. Patrick currently is the regional point of contact for the Medicare quality programs, including the physician quality reporting system and high tech meaningful use for the Philadelphia regional office, as well as rural health coordinator for the region 3 states. Patrick received a bachelor of arts in political science from St. Joseph's University in Philadelphia in 1996 and a master’s in public administration from Villanova University in 1999.

Patrick and Dr. Connors, thank you so much for joining us today. I will turn over the presentation to you.

Patrick: Thank you, April. This is Patrick. I'm going to start off with our presentation. I want to thank everyone for joining us today. This is a very timely and important presentation that we're going to be talking about in terms of the value-based payment modifier, and more specifically obtaining your quality and resource use report, or QRUR.

It's very important because we are now in the time were you can actually go and access your QRUR reports to see how you participated, how you fared in PQRS last year because that will determine your value-based payment modifier for 2016. It's also important that you get this information no, because you're within the time period that you can review your report and importantly request an informal review from CMS should you find any information that doesn't look right to you when you review your information.

To that end, we are going to be going over a lot of information. We have a lot of slides in the slide deck that was provided prior to the call. We also have a number of documents that Dawn and April have also made available on the website that we'll be referencing throughout the presentation. There's going to be a number of screen shots that are going to be included, especially in the second half of the presentation that Dr. Connors is going to go over so that you get an idea of what you're going to be looking at and what you should be looking for when you access your QRUR reports.

I'm going to start with just giving a brief overview of the value-based payment modifier, the policies that are in place in 2016. Again, if you've been on these calls before we've talked about PQRS, when we've talked about meaningful use, when we talk about the value-based payment modifier, we've always talked about this two-year look back period. Your 2016 value-based payment modifier is going to be based in part on your participation and the physician quality reporting system, or PQRS, last year in 2014. That's how those two years interact with one another.

We'll tell you how to access your annual QRUR report if not already done so. We'll tell you the information that is contained within the report. We will give you a brief overview of how you should be interpreting the stuff that's in that report. Dr. Connors is going to go through all the extra exhibits because you're not only going to get the document that is your report, but there is a number of supplementary exhibits that supplement or give additional information and show the calculations as to how your scores were derived for both the quality and the cost composite portions of your report.

We'll also talk about the informal review process that we're in and how you can actually go about and request an informal review. Then we should have time at the end for questions and answers.

Moving to the overview of the 2016 VM, or the value-based payment modifier, hopefully, by this point you are well aware of what the value-based payment modifier is. In case you are not or if you are new to the practice or just new to the whole idea of the

value-based payment modifier, this was something that was actually included in the Affordable Care Act when it was passed in 2010. What Section 3007 of the ACA said is that, "CMS was mandated begin to implement a value based payment modifier to all physician reimbursement starting in 2015, and to complete that imposition of the value-based modifier for physician payments no later than 2017."

CMS decided to take a phased-in approach. In 2015, this year, this is the first year in which a value-based payment modifier is being applied to physicians' reimbursement. The first group of physicians who have the value modifier being applied to their reimbursement are for those physicians who work in groups of 100 or more EPs. I'll explain in the next slide how we define an EP and how we define the size of those groups to determine who those physicians are.

We're phasing in the value modifier. In 2015, the first year physicians in group of groups of 100 or more EPs are being assessed the value modifier. It's based on their 2013 PQRS activity. In 2016, we expand the physician pool to those who work groups of 10 or more Eps, and it's based on what those physicians and what those practitioners did in 2014 in PQRS, as well as other claims-based quality information which I'll explain, and some cost information as well. Then in 2017, those physicians who are solo practitioners and who work in small groups of 2 to 9 eligible professionals, they will have their value modifier assessed starting in 2017 based on their performance and PQRS this year.

I assume that this is nobody on this call, but if for whatever reason you are in a practice where any of your EPs are not participating in PQRS, it is absolutely critical that they start doing so this year. We're also going to get into a little bit of a discussion later on about what happens after 2018 when the value modifier itself as its own entity or its own program sunsets, and we move into the world of merit-based incentive payment system, or MIPS. That's part of the new MACRO legislation that was passed in April. Dr. Connors will go into a little bit of a discussion as to why it's so important.

The value modifier assesses both the quality of care and the cost of that care furnished to Medicare beneficiaries. When we talk about the value modifier and how it is actually assessed, we're always talking about Medicare Part B deeper service claim that are billed to the physician fee schedule. The value modifier is an adjustment that's made on a per-claim basis to payments under the Medicare physician fee schedule for all items and services.

Again, the law stipulated that it would be assessed to physicians, physicians in groups of 100 or more starting this year, 10 or more next year, which is what we're talking about now, and then for the rest of the physicians, in 2017. I can tell you that we proposed for in the 2016 Medicare physician fee schedule proposed rules, and I can say this because this is on a the final slide of the presentation that's been cleared, the proposal is to expand that in 2018 to physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists.

Pending the finalization of the 2016 physician fee schedule final rules, in 2018 the value modifier would be expanded to those four non-physician specialties, or non-physicians EP types. That would be based on how those EPs participate in PQRS next year in 2016.

The value modifier is calculated at the TIN level, taxpayer identification number level, and I said will apply to all the physicians in groups of 10 or more EPs, who fall under a particular TIN. In 2016, next year, the value modifier will not apply to groups who had at least one physician that participated in either the Medicare shared savings program, the pioneer accountable care organization, or ACO model, or the Comprehensive Primary Care Initiative.

For the CPCI, that does not include anybody in West Virginia as that initiative is only in 7 states, so that wouldn't apply. Now, that last bullet point will, pending the final rule, will change for 2017. The value modifier will apply to those who are in shared savings, the ACO, the CPCI, starting in 2017.

It's important that everyone understands who an eligible professional is because again the eligible professionals in a group under a tax identification number, under a TIN determines the size of the group. We talked about the first set being groups of 100 or more EPs. The second group is 10 or more EPs. The third group is 2 to 9 EPs and all solo practitioners. All of the EPs that are listed on this slide are included when we look at a tax identification number to determine the size of the group even though we are assessing the value modifier for the first 3 years in 2015, '16, and '17, only to the physicians who are in those groups.

This next slide, slide number 7, gives a brief schematic of how the value modifier will be assessed, and again, these are two physicians in groups of 10 or more EPs. Starting on the right-hand side of the column, and this is the side of the column you don't want to fall into, these are what we call the group 2 or category 2, and these are non-PQRS reporters. If you have EPs or you have physicians who just said, "You know what, I didn't do PQRS last year," they get an automatic 2% downward adjustment for the value modifier starting in 2016, which is in addition to the PQRS downward adjustment of 2% for not doing PQRS.

You're getting dinged twice in 2016 if you do not report PQRS measures. That is the right-hand side of the column. You don't want to be on the right-hand side of the column because it's just an automatic 2% downward value modifier payment adjustment regardless of whether you're in a group of 10 or more or 100 or more EPs.

Moving over to the left-hand side, the left-had side incorporates all of those EPs that did report PQRS through either the GPRO reporting option or if at least 50% of the EPs that in your TIN decided the group didn't want to report PQRS through the Group Practice Reporting Option. All of the EPs in the TIN wanted to do PQRS individually. They had that option to do so, but at least 50% of all the EPs in that group had to have participated in PQRS in order to avoid the payment adjustment for next year.

If they met those criteria then for the physicians who are in TINs of 100 or more eligible professionals, since 2016 will be the second year that you will be assessed the value modifier, based on quality tiering, which we'll go into, you can be subject either to an upward, a neutral, or a downward payment adjustment. For the physicians in the groups that have 10 to 99 eligible professionals, 10 to 99, since 2016 is the first year that you will be assessed the value modifier, as long as you did your PQRS reporting in 2014, you can be subject based on quality tiering to either an upward or a neutral value modifier payment adjustment, based on quality tiering. You're held harmless to that downward adjustment for the first year, so long as you did your PQRS reporting in 2014.

The quality measures, as I mentioned, there are quality and there are cost measures. In terms of quality, the quality measures that you actually have to proactively report are the measures that you reporting through PQRS. As I mentioned, you could either have reported PQRS as a group for any of the GPRO reporting mechanisms, which was the web interface, your EHR system, the CAHPS survey, which is the patient survey, or through a registry.

If you did not opt to report, your group did not choose to report through the GPRO reporting mechanism, as I mentioned, if at least 50% of all the professionals in the group successfully reported on an individual basis. There may be reasons why a group would choose to do so, namely because a lot of people still like to report through claims. You can only report through claims for PQRS if you do so on an individual basis. You can't do the claims reporting as a group. In 2014, when we were talking about PQRS, that's a lot what we heard about. They were opting for the individual and 50% option.

That is the stuff that you're proactively reporting to CMS that we're taking into consideration for the quality score. We're also looking at three outcome measures. This is based on your claims data. CMS reviews this administratively, and you are not responsible for having to report anything additional over and above your PQRS measures for these outcome measures. Those outcome measures are all-cause readmission. We have two composites. One is of acute prevention quality indicators, and we're looking specifically bacterial, pneumonia, UTI, and dehydration. We're also looking at chronic prevention quality indicators. The three things we're looking at specifically are COPD, heart failure, and diabetes.

Also last year it was optional for most groups to include the patient experience of care measure, or you may know the acronym, CAHPS. This is a 12-point survey that was first developed for use in the shared savings program. We adopted it for PQRS, I think, in 2013. It might have been in 2014, but it started in shared savings. We incorporated it into the PQRS. It gave an additional opportunity for groups that had the survey data to submit it to CMS, and to have it included in the calculation of their quality score.

Pay attention to the note at the bottom of the slide. Due to an unforeseen circumstance, any PQRS measures that were submitted in 2014 via the qualified clinical data registry, which was a new way of reporting measures last year, or through the EHR reporting option, are not included in this year's QRUR, and will not be used to calculate the 2014 value modifier.

You will not be held liable for any downward or negative results because of that. We've built in, for this year only, some fail-safe devices that should this absence of your QCDR or your EHR reporting data cause you to have a lower score, then you will maintain an average score for that part of your quality measure. We have more information on that if you happen to fall into that category. This was something that we did not foresee. This is something that we are not foreseeing happening in the future years of the program. It was just a blip that came up, and we made some provisions to make sure that you're held harmless against any negative calculations.

Turning to the cost measures, as I mentioned we have quality and we have costs. We're looking at total per capita cost measures for Part A and B, and then we're looking at four chronic conditions. We're looking at per capita costs for beneficiaries who are submitting claims for COPD, for heart failure, for coronary artery disease, and for diabetes.

A new measure that was incorporated into this year's calculation in your QRUR report is the Medicare spending per beneficiary, or the MSPB measure. What that looks at are the 30 days before and the 30 days after an inpatient stay. The claims for that time period are attributed to the group who provide a plurality of the Part B services during the time that beneficiary is the hospital. All the costs measures, and we will go into a little bit of detail, and this is actually going to be the calculations are in your supplement exhibits to the report, are payments standardized and risk adjusted. The cost measures, we do take into account the specialties of the EPs, who are in the group.

Each group in order to get your value modifier and to determine what you payment adjustments are going to be, whether it's going to be upward, neutral, or downward, you're going to get two composite scores. One's going to be for quality, and one is costs. We use a couple of steps in order to create each composite. For each measure that is included in PQRS, we create a standardized score for each measure. Your performance rate will be the benchmark divided by the standard deviation. Then we equally weight each measure standardized score within each domain.

It could be, and is very likely will be, the case that you will not have measures cover all 6 domains. You may have measures that only cover 3 domains. If that is the case then each of those domains will count as a third. Within each of those domains, you may have a different number of measures. Each of the measures within the individual domains are all equally weighted. If you have 2 measures in the communication domain, then each of those measures are weighted at 50%, to give you a communication score. That communication domain, if it's one of your 3, for example, I have a graph on the next slide I believe or in 2 slides, would be weighted for one-third.

In terms of the cost measure attribution, as I mentioned, we have 5 total per capita costs measures, but we have to assign the beneficiaries to come up with that cost measure. The first thing we do is that we identify all the beneficiaries who had least one primary care service rendered by a physician in your group. We identify the physician by the NPI number under the TIN in your PECOS registration information.

The assignment process is listed here in slide 11. We first assign beneficiaries who had a plurality of the primary care services, and that is defined by allowed charges, rendered by primary care physicians. Then after we go through that process, for any beneficiaries that still are unassigned, we assign those beneficiaries who have received a plurality of primary care services rendered by any eligible professional. First we assign based on services rendered by primary care physicians, and then for anyone who's left over, by any EP that's in the group.

For the Medicare spending per beneficiary measure, we attribute the hospitalization, the actual inpatient stay, to the group of physicians who provided the plurality of the Part B services during the inpatient stay.

Slide 12, this gives you a very quick schematic of how the value modifier is actually calculated. As I mentioned, there are 6 quality domains. If you are familiar with PQRS or with clinical quality measures, these are the same 6 domains that we have been talking about for the past couple of years. Depending on who many measure you have in each of those domains, each measure is weighted equally within the individual domain. Then each domain is that is covered by your measures, they are all weighted equally to give you a quality composite score.

I will mention that the 3 CMS calculated claims-based quality measures, so the all-cause readmission, and the two composites, as well as the PQRS surveys, the patient survey data, if you chose to include that last year, they all fall under the communication and care coordination domain. That's why I highlighted that there in yellow. If you're wondering how the stuff that CMS calculates is brought into the mix of the calculation of quality, it's put under the communication and care coordination domain.

As you can see for the cost composite score, we're looking at 5 measures, but they fall under 2 domains. They are all weighted equally. The quality of care composite and the cost composite are both given 50% weight to come up with your value modifier amount. That will determine where you fall in terms of your upward, neutral, or downward payment adjustment.

Your QRUR, the Quality Resource Use Report, was disseminated a couple of weeks ago, I think, on September 6th. It was the beginning of September. Basically, what I always tell people it's like your quality reporting report card. It shows how the groups who are identified by their TIN fared in terms of the PQRS reporting and also the quality and cost measures that CMS calculates. A report is provided for each tax identification number. For those TINs, for this year's reports, the ones that disseminated in September that are subject to the value modifier, the reports are going to go into detail as to how the value modifier will apply to the physician payments for all physicians who bill under that tax identification number in 2016.

For everybody else who receives the report, it's for informational purposes only, and the TIN payments would not be affected by the value modifier in 2016. Based on your group size, and your provider type, you could be assessed in either 2017 or 2018.

Anyone who had at least one physician or a non-physician EP bill under the TIN in calendar year 2014, and had at least one eligible case for at least one quality or cost measure included in the annual QRUR report was issued a report. It will tell you exactly how you can get that report. If you do not meet both of those criteria, then you've got a one-page summary explanatory QRUR to give you very basic information. Also, any tax identification numbers that have providers or physicians that were either in shared savings, pioneer ACO, or the CPCI received a 2014 QRUR report as well.

I'm not going to go through in too much detail how to access the report because one of the documents that we included on the website is how to access the report. This just gives you a very brief rundown. One thing I will mention. Hopefully, you're aware that the IACS system, I-A-C-S, is now the enterprise identity data management, or EIDM. If you are still trying to figure out how to get into the IACS system, it's no longer what we use. You want to get yourself into the EIDM if you have not already done so.

You can see the link there that tells you exactly how you can access it. I believe that one of the documents also that I sent is a specific guide to accessing your EIDM report. I went through the process. You will actually have to put in your EIDM user ID and password twice because we have a built-in layer security. That will be something that will be new if you either accessed your midyear report or if you accessed a report last year. You will see that there is an additional logon page, and that was strictly for security purposes.

This gives you the instructions on how to do that. The PV-PQRS tab. You click feedback reports. You select 2014 as your year, and then your QRUR report. You complete your role attestation. Select your TIN. Only the TINs that are associated with your EIDM login will be available. You will not have access to everybody's reports. Then the reports themselves, the supplements, can be downloaded directly from the website where they can be saved as PDF files.

The next couple of slides just tell you everything that is available. It's not only the report itself, but there are a number of exhibits. Dr. Connors is going to go through some of those exhibits. This just gives you an idea of some of the very minute details, the very important details. For example, when we talk about the hospitalization stuff, we actually give you a listing of the beneficiaries and the hospitals that they were assigned to. We give you detailed information about the cost data that was used to determine your cost score.

A lot of information at your fingertips, and it's very important that the person who is best suited to look at this information, to digest it, to comprehend it, and to understand it does so because it's the data that's in those exhibit materials that you really want to sit down, take a look at, verify to make sure that all the calculations that we came up with are accurate. As I will mention at the end, you have, I think, until November 9th in order to make your request for an informal review.

I'm going to end on these two slides. The cover page, and these are usually the stuff that people look at to see we're not going to get a downward adjustment. We did pretty

well. You're going to get a quality composite score. You're going to get your cost composite score right there on the front page. Then that scatter plot is going to tell you where you fall in terms of an upward, neutral, or downward adjustment. The best that can you do is to have high quality at low cost, which would yield an upward adjustment of a factor of 2. The worst that you could do is to have low quality at high costs, which would yield a 2% payment adjustment for groups of 100 or more EPs next year.

That is what you're looking at. As you can see there are 9 squares in which you could fall, 1, 2, 3, 4, 5, 6, 7, 8, 9. It's all based on the combination of high, low, and average cost and quality. Also there is a high risk bonus adjustment if you are above the 75th percentile of beneficiaries nationwide, and again, the TINs value modifier at the bottom of the first page tells you exactly where you fall. This particular group had average quality, but they had a high cost. Based on quality tiering, this particular group received a 1% downward adjustment. As you can see, if you fall within other confines of that graph, you can get an upward or a neutral adjustment.

Now, I'm going to turn it over to Dr. Connors, and she is going to go into some detail about some of the things you can find on the supplementary reports of your QRUR, and she's also going to discuss why it is vitally important that you take a look at your report, understand what's in the report, and what it means for 2019 and beyond.

Barbara: I think it's a good time to answer the question from Cheryl Kelly.

Patrick: We are a group with a dynamic number of EPs. At what point in time do you calculate the number of EPs? In 2013, we had fewer than 100 EPs, but now we are well over that. At what point in time do you calculate the number of EPs? Okay, that's a good question. In order to determine the size of the group, we do two things. The first thing that we do is in October, we look at the PECOS enrollment system. We can identify. First, if you enrolled in the GPRO, the Group Practice Reporting Option, then we know the size of your group. In order to validate it, in October we take a list of all of the tax identification numbers in PECOS that have either 10 or more TINs or 100 or more TINs. We come up with a list.

At the end of March, because there could be a lag in submitting claims for a given calendar year, at the end of March, I think we say March 31st in 2016, we look at all the claims that were submitted under that TIN. We see how many separate NPIs actually submitted claims. Let's say for example that in October of 2015, we run the PECOS report, and we have a listed TIN. Let's say for a given TIN, they had 20 NPIs. Based on that list, they would fall into the 10 or more EP category, which means they would be subject to the value modifier in 2016.

However, we will wait until the end of March for claims to be submitted, and we will actually look to see how many NPIs submitted claims. Let's say that only 8 NPIs submitted claims under that TIN. Then we take that group off of the list, and they would not be subject to the value modifier. The answer to the question is we look in October for a master list. We wait until the end of March, and then we calculate all the NPIs who

submitted claims at the end of March, and that is the group of TINs that would be subject to the value modifier the following year.

Barbara: A good practice for the practice would be to go in and ensure that all of the NPIs under the TIN are accurate. For example, if NPIs leave a practice in July, they should have that information updated.

Patrick: That information will also be included in your QRUR report.

Barbara: Now, the devil is always in the details. [inaudible 00:35:09] Now we'll go into the detail. Okay, how would you look at to ensure that the eligible professionals in your TIN that is attributing your value modifier is correct? You would go in, and look at exhibit 1. Exhibit 1 lists the number of physicians or EPs under physician that are identified. This says PECOS, but again, that acronym is changed now. Number of claims and percentage identified in the claims. Underneath, your non-physician EPs. Those physicians that are billing Medicare and are eligible, and will be subject to the value modifier come 2018.

This is a larger picture of what you'd be looking at. This is really a very important page, and we do receive inquiries regarding this typically because practices are not keeping their information up to date. Okay.

Patrick: One second. [inaudible 00:36:50]

Barbara: Okay, so moving on to exhibit 2 and 3, as Patrick referenced there are per capita costs measures and claims-based quality outcome measures. I want to stop for a minute because I've received questions on this, and it can be very confusing. There's two types of cost measures. One is the Medicare spending per beneficiary. That's really Part B. Your per capita includes Part A and Part B. Those costs are lumped together to arrive at the value modifier. If you hear sometimes Part B and other times Part A and B, it's really that actual cost measure.

For the 5 per capita cost measure, and the 3 claims-based quality outcome measures, the Medicare beneficiaries are attributed to a TIN using the 2-step attribution. I believe Patrick went into that. When we talk about plurality of care, it's the bulk of services, or the services that are billed under that TIN more often than other TINs that are managing those patients.

It's a 2-step process. One is the primary care providers that are providing most of the services. The other step 2 would be for beneficiaries who did not receive a primary care service from a primary care physician during that period, but received at least one primary care service from a physician of any specialty within the TIN, and received a plurality of the primary care services from specialist physicians, nurse practitioners, PAs, and clinical nurse specialists within that TIN. One of the attachments for you to download are Frequently Asked Questions. Page 13 on the FAQs lists the common procedure codes that identify those primary care services.

This is a schematic of what you would see when you look at the attribution of beneficiaries to your TIN that received either all beneficiaries, and then underneath, the attributed to the TIN under the primary care services. That would be step 1, and then underneath, that would be step 2, the attributed services to the TIN specialist physicians or non-physician practitioners that provided the most primary care services. Again, page 13 on FAQs lists those codes.

Attribution of Medicare spending per beneficiary episodes, or the MSPB measure, it provides information on the total episodes of hospital care attributed to your TIN, and the number of unique Medicare fee-for-service beneficiaries associated with the attributed episodes, or the measure. A hospitalization episode is attributed to a TIN if during the hospitalization the TIN provided more Part B services than any other TIN. Again, here's the Medicare spending per beneficiary measure. That includes the Part B services and later on you will see where there are also Part A and Part B services included in the QRUR.

Let's move on to slide 32. Regarding quality measures, groups with 2 or more EPs, measures reported for the PQRS, GPRO, or individual PQRS measures reported by at least 50% of the EPs is one portion of the quality measures. Additionally, the 3 claims-based outcome measures, including the all-cause hospital readmissions, a composite of the presentable hospitalizations for the acute conditions, which is pneumonia, UTI, and dehydration, as well as a composite of the preventable hospitalizations for the chronic conditions, including COPD, heart failure, diabetes.

If you did report the CAHPS surveys, that would be included, as well as share savings programs, participant TINs for ACO-level GPRO, web interface measures, and the ACO-level all-cause hospital readmissions, pioneer ACO, and CPCI is listed. I'm going to read the remainder of the page to you, but let's move on to the schematic as to what it looks like.

We really wanted you to see what you will be look for when you're assessing, accessing this information. Going back to the PQRS measures, you'll look at the number of quality measures based in the composite of those 6 domains. If you remember, when you're choosing your PQRS measures, you're choosing your domains, effective clinical care, person and center caregiver experience, community population health, patient safety, communication and care coordination, and efficiency and cost reduction. You would choose. You're required to choose 3 or more domains if it applies to your practice.

All the way over the right, under standard performance score, you're not going to see every column populated. It would be populated by those measures that you've reported. In this case, the TIN actually reported measures that fall under 4 domains. This just reiterates what I just discussed.

Let's go into performance and quality measures by domain. Exhibit 6 displays your TIN's performance on each quality measure by the domain. Again, for example for population health, you can have several measures listed. Only the measures for which benchmark is available, and for which the TIN had 20 or more eligible cases are included in the

domain scores. At the measure level, the benchmark is the case-weighted average performance rate, or the peer group, based on 2013 data. It's a year earlier.

I'd just like to caution you. If you're participating in the PQRS, and you did so in 2014, and your numbers look pretty good in accessing that information, keep in mind that every year more and more providers participate. Where you fall at the benchmark this year may not be where you fall next year. It's really important to look at all of the measures that you're reporting.

Let's see what it looks like. On this slide, you'll see preventative care and screening, for example. Influenza immunization, preventative care and screening, body mass index. These are your preventative measures. In the second column, you would see your TIN's performance rate. This practice is actually doing fairly well except for preventive care and screening for depression and follow-up planning. Over to the next column, you'll see what the overall benchmark is for that practice, for each measure.

Moving on to the right, the benchmark 1 minus standard deviation, and the benchmark 1 plus standard deviation, this number defines average. If you're falling within 1 plus from 1 minus standard deviation, you will be reported as average. Here is the standardized score. It would be listed in the domain if, again, there were at least 20 measures from that TIN reported. In this case, there is one measure, hep C. Hep A vaccination in patients with hepatitis C. There were only 11 cases reported. This particular measure was not included in the domain. This really gives you a good sense of where you fall in your quality outcome performance to that of your TIN's peers.

Let's look at the information on the hospitals admitting your TINs attributed beneficiary. Exhibit 7 identifies the hospitals, where at least 5% of your TIN's attributed beneficiaries inpatient stays occurred. You want to look this, and make sure that this information is accurate as well. This exhibit includes only the beneficiaries attributed to your TIN for the 3 claims-based outcome measures and 5 per capita cost measures. Again, the 3 claims-based would the all-cause hospital readmissions, the composite of the acute preventive, and the per capita costs, or A and B for COPD, heart failure, coronary artery disease, and diabetes, as well as the Medicare spending per beneficiary 3 days prior, and 30 days after discharge.

Exhibit 8 identifies the hospital that account for at least 5% of your attributed inpatient episodes of care surrounding a hospital admission during the performance period for you TIN. Why is this information important? It really helps with care coordination. If you are not the sole TIN or within your TIN, if several providers are managing patients that are hospitalized or that are moving in and out of the hospital, this is really where you're going to get some substantive information regarding your group's practice.

Let's look at cost performance. Cost measures used to calculate the 2016 value modifier is shown in the QRURs includes cost data for the per capita costs for all your attributed beneficiaries measure and the 4 per capita costs for beneficiaries with those 4 specific conditions, COPD, heart failure, coronary artery disease, diabetes, based on charges for Part A and Part B. This is different than the Medicare spending per beneficiary because

you now are the TIN that is managing the bulk of that inpatient hospitalization, so you are the TIN that can manage the care coordination within the hospital the best. Part D covered costs are not included in this calculation.

Here would be your TIN's performance by 2014 by cost domain. Per capita costs for all attributed beneficiaries and per capita costs for beneficiaries with the specific conditions. Again, average would be within the standard deviation, 1 standard deviation of the mean.

Let's go on and look at per capita costs per episode. Exhibit 10 shows the payment standardized, risk adjusted, and specialty adjusted per capita, or per episode cost, for each cost measure based on the beneficiaries attributed to your TIN. Again, this is beholden to at least 20 or more eligible cases or episodes.

Let's see what this looks like. On the left you have in your first column your per capita costs for all attributed beneficiaries. That includes per capita costs for all the beneficiaries and Medicare spending per beneficiary, as well as per capita costs for the beneficiaries with those 4 conditions. Here you can compare your TIN's per capita costs with the benchmark or the TIN's peers. Again, here's your 1 plus, 1 minus standard deviation, where your score is, and whether again your measures are including in the domain based on the number of episodes of care, 20 or more for that measure.

Exhibit 11 shows the differences between the per capita costs for all attributed beneficiaries and the beneficiaries with the specific conditions, and the mean per capita costs among the TINs. On the left is the service category. For example, the first one, E&M, billed by EPs in the TIN. The numerator for each one of these calculations is the total costs for a category of service used by the attributed patients. The denominator is the total number of Medicare patients attributed to the TIN, not just the patients that use the service. You'll see, again, for the service category is based on total number of beneficiaries as a denominator, the numerator being the beneficiaries that utilize the service.

Exhibit 12 includes the differences between your per capita, per episode costs for the Medicare spending per beneficiary measure, the mean per episode costs. Let's see what that would look like. Under service category, you'll have E&M. You'll have major procedures, ambulatory minor procedures, ancillary services, hospital inpatient services. This shows the differences between your TIN's per episode costs and mean per episode costs among your peer TINs with this measure by category of service. Are you utilizing more, or are you utilizing less?

There is a 13 screen and exhibit 13 that includes hospital readmissions. I did not have access to a screen shot of that, but if you have patients that are admitted to the hospital, and you are looking at exhibits 11 and 12, then you would want to look at exhibit number 13. There are screen shots listed in the how to interpret the QRUR, and I hope you all manage to follow me because this is difficult.

What I found is most helpful to the practices is not only the individuals that are managing the TINs and the NPIs to sit down and look at it, but most importantly, you must have physician leadership, EP leadership in the practice looking at these numbers and looking at some of the areas where you're not faring as well as your peer TINs. The reason why this is so important is it may be going away as a value modifier acronym or program, but it's being rolled into a program where pay will be tied to your successful participation, either in one of two programs, in the MIPS program, which is combining PQRS, value modifier, and meaningful use, in addition to 4 other criteria for successful participation, or in an alternate payment program.

This is as a result of doing away with the SGR and really moving towards alternate payment models, the APM, or the MIPs. Patrick, did you have anything to add on that?

Patrick: No, that's just … We really wanted to have the main takeaway that even though you probably heard that the adjustments for meaningful use, PQRS, value modifier, are all sunsetting in 2018, it doesn't mean that they're going away per se. As Dr. Connors said, they're being rolled into this new program starting in 2019. This stuff is still very important, and an iteration of this will be included. I think that this part of it is 25% of the score once that comes into fruition in 2019. We'll have more information about that with webinars in the coming months.

Just to wrap up. Again, the informal review request period is happening right now. You have until November 9, 2015, and that would be for any TIN. The TIN itself, the tax identification number of the group is who would be the entity that would be requesting the informal review, and we have instructions on how you would do so. You go through the portal.

Your next step, if you haven't already done so, is to download your TIN's QRUR at the portal and review all the methodologies, the fact sheets, the FAQs, and everything that we shared with you today. In terms of phasing in the value modifier, right now, we are in the informal review process at the end of 2015. The application of the value modifier will go in effect starting January 1st of 2016 for the physicians who are in groups of 10 or more EPs. In 2017, it will be applied to physicians who are in groups of all sizes, 2 or more, or for solo practitioners.

Then as I also mentioned, pending the finalization of the 2016 Medicare physician fee schedule final rule, in 2018, we will be applying the value modifier to not only physicians, but also to PAs, NPs, CNSs, and to certified registered nurse anesthetists. A lot of additional information in terms of technical assistance is located here on this slide. If you have any questions you can call the Physician Value Help Desk at 888-734-6433. Select option 3. They also have an email address specifically for the value modifier and more educational documents are located on the CMS website at these various web links. Of course, our contact information. We're always here to answer any questions that you might have.

I know we're right at the top at the hour, but April, if there are any questions that any people have on the phone, we'd be happy to stick around for a few minutes to try and

answer any questions. If there's anything we can't answer, we will get the information, send it back to April, make sure that she disseminates it to the group.

April: Okay. Thank you very much. We did actually receive some questions through the chat box. I will go ahead and read those. If you get to a point, Patrick and Dr. Connors, that you want to cut off the questions, like you said, we will proceed with answering them over email, and sending them out to all the attendees.

The first one we received is, "We are a group with a dynamic number of EPs. At what point in time do you calculate the number of EPs? In 2013, we had fewer than 100 EPs, but now we are well over that."

Patrick: We answered that question. We look at the PECOS information in October. We come up with a list of the TINs and the number of NPIs that are under that TIN the following March. We will look at the claims that were submitted under that TIN. We'll see how many individual NPIs actually submitted claims, and then that will be the list of the groups by tax identification number that would be assessed the value modifier the following year.

Based on how many NPIs actually filed claims under those TINs, that is how we determine the size of the group. That is solely if the group did not register for the GPRO. If they registered for the GPRO, then during that registration practice, they tell us all of the NPIs that are under that TIN, and we have that information. We go through that two-step process in October, and then the following March, in order to find out who the groups are that did not participate in PQRS in the GPRO, and instead are opting for that 50% option. We will know generally sometime in April or May of the year prior to when the value modifier would be assessed who those groups are and what the size of the group is.

Barbara: Don't try to get into PECOS. Now it's called the Enterprise Identity Data Management, EIDM.

Patrick: No, IACS.

Barbara: IACS.

Patrick: IACS is now what's EIDM.

Barbara: They'd go into IACS.

Patrick: No, they go into … PECOS is still there.

Barbara: Right, but not [crosstalk 01:02:49]

Patrick: EIDM replaced IACS.

Barbara: Okay.

Patrick: April, do you have the next question?

April: Okay, the next one. We have new physicians joining our practice all the time. Do we inherit a provider's penalty if they are new to our group, and didn't participate in PQRS prior to joining us?

Patrick: It's based on the combination of the NPI and the TIN. For a given penalty year, if the provider in the practice was at the NPI and the TIN was a different combination, then they would not inherit the penalty.

Barbara: Unlike meaningful use.

Patrick: That's correct. Meaningful use is tracked strictly by the NPI, but for value modifier, for PQRS, always keep in mind that it is the TIN-NPI combination.

April: Okay. Next question. Is this reporting program applicable to palliative medicine and hospice specialists?

Barbara: This program is applicable to all physicians and EPs that bill Medicare.

Patrick: Under the Part B of Medicare physician fee schedule. We had a list of the eligible professionals in the beginning of the slide presentation. To the extent that they are billing Medicare Part B to the Medicare physician fee schedule, then reimbursement would be affected by a downward adjustment if they're not reporting claims. We do not look at place of service, so long as it is a Part B fee-for-service fee schedule claim.

Barbara: The E&M services that are included in the primary care services also include services in long-term care. For example, for palliative or hospice, they want to look at those PQRS measures. There are pain assessment measures. They may not have 9 measures to include in their billing or their reporting, but there are some measures.

Additionally, we have measure specifications for each measure listed, and that includes your billable codes, CPT codes, associated with that measure. If you're billing codes and not reporting that measure, and not participating, you would be penalized.

Patrick: We do depending on the method that a particular EP could report and chooses to report, we have a validation process that if they can't meet the minimum requirement reporting, quantity for example, 9 measures from 3 different domains, we have a validation process that looking at their claim submission. If we can validate that, no, they really did not have the opportunity to choose 9 claims, they would still pass and not be penalized.

Barbara: While we're on the subject, might I suggest that if this group is not yet participating, they should look at their EMR for reporting. We're really moving away from claims reporting altogether. I wouldn't start out with a program that we know is going to change considerably. If that practice is not reporting, they need to look at their

reimbursement information. They would be living with a penalty now, for this year, if they didn't participate in 2013 in PQRS. They should be aware of that. Next question?

April: All right. We have 4 more to go. Would you like me to proceed, or would you rather that we answer these over email.

Barbara: Let's do one more, and see how that goes.

April: Okay. Are all specialties required to report for PQRS? For example, hospitalists, anesthesiologists, the only information I have found says that anyone with a Medicare Part B claim.

Barbara: That is correct. Again, you would refer to the list of eligible professionals that was in the beginning of the slide presentation. Anyone that's billing Medicare Part B fee-for-service would be eligible. This is different from some of the exclusions in the meaningful use program. The law specifically carved out certain specialties. That is not the case with PQRS.

April: Okay. The remainder of the questions, then like I said, we will get to all of the attendees. We'll get the answers, and we'll email those out to everyone. I did want to thank you, Patrick and Dr. Connors, so much for sharing such an informative presentation with us. Thanks to everyone for joining today. If you have any additional questions, or if you're interested in receiving additional assistance with your QRURs, PQRS reporting, or interventions to address areas for improvement, please reach out to your local Quality Insights team member. The team member contact information in on your screen at this time.

In a few moments, you will receive an evaluation. Please take a moment to complete it. Your input helps us plan future programs. Thanks again for joining us, and have a great day. This session has now concluded.