Understanding PQRS and the Value-Based Modifier: CMS’ Plan to Achieve High Value Care through Transforming Payment Systems

Dr. Ashby Wolfe, Chief Medical Officer
Centers for Medicare and Medicaid Services, Region 9

Right Care Initiative / University of Best Practices
Los Angeles, CA
June 26, 2015
Overview

• A History of “Paying for Value”: how did we get here?
  – Medicare Stars Program
  – Transition from Fee-For-Service to Value-Based-Service

• Overview of Value Based Payment Programs
  – PQRS
  – Value Based Modifier
  – EHR Incentive Program
  – Review of the QRUR

• Successful transition & what is next under MACRA

• Questions
Paying for Value

So we will continue to work across sectors and across the aisle for the goals we share: better care, smarter spending, and healthier people.
Patients who reported that YES, they were given information about what to do during their recovery at home

Why is this important?

Hide Graph
HOW MANY STARS ★★★★★
Does Your Medicare Plan Have?

USE THE MEDICARE STAR QUALITY RATING SYSTEM
FROM THE CENTERS FOR MEDICARE & MEDICAID SERVICES

What the number of stars represents:
- EXCELLENT performance
- ABOVE AVERAGE performance
- AVERAGE performance
- BELOW AVERAGE performance
- POOR performance

50+ CARE AND SERVICE QUALITY MEASURES ARE RATED including:
- Staying Healthy
- Managing Chronic Conditions
- Member Satisfaction
- Customer Service
- Pharmacy Services

Medicare-eligible members can enroll in, or upgrade to a 5-star Medicare health plan nearly all year long — from now through November 30, 2014

IMPORTANT FACTS:

Only 11 out of 431* rated Medicare plans received 5 stars for 2014.

MEDICARE ADVANTAGE PLANS AND RATINGS

<table>
<thead>
<tr>
<th>Total Plans</th>
<th>5 stars</th>
<th>4.5 stars</th>
<th>4 stars</th>
<th>3.5 stars</th>
<th>3 stars</th>
<th>2 stars</th>
</tr>
</thead>
<tbody>
<tr>
<td>431</td>
<td>11</td>
<td>64</td>
<td>87</td>
<td>143</td>
<td>109</td>
<td>16</td>
</tr>
</tbody>
</table>
Exhibit 13

NOTE: Percentages are unweighted by enrollment.
The future of MA Stars

<table>
<thead>
<tr>
<th>Star Rating</th>
<th>2016 QBP Percentage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3 stars</td>
<td>0%</td>
</tr>
<tr>
<td>3 stars</td>
<td>0%</td>
</tr>
<tr>
<td>3.5 stars</td>
<td>0%</td>
</tr>
<tr>
<td>4 stars</td>
<td>5%</td>
</tr>
<tr>
<td>4.5 stars</td>
<td>5%</td>
</tr>
<tr>
<td>5 stars</td>
<td>5%</td>
</tr>
</tbody>
</table>

*The QBP percentage is a percentage point increase to the applicable percentage for a county in a qualifying plan’s service area.
CMS support of health care Delivery System Reform

Key characteristics
- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

Systems and Policies
- Fee-For-Service Payment Systems

Key characteristics
- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

Systems and Policies
- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency

Public and Private sectors

Historical state

Evolving future state
Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provide better care at lower cost across the health care system.

Source: Burwell SM. Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.
### Framework of payment to clinicians

<table>
<thead>
<tr>
<th>Category 1: Fee for Service – No Link to Value</th>
<th>Category 2: Fee for Service – Link to Quality</th>
<th>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery</td>
<td>Some payment is linked to the effective management of a population or an episode of care</td>
<td>Payment is not directly triggered by service delivery so volume is not linked to payment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk</td>
<td>Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Medicare Fee-for-Service examples
- Limited in Medicare fee-for-service
- Majority of Medicare payments now are linked to quality
- Hospital value-based purchasing
- **Physician Value Modifier**
- Readmissions / Hospital Acquired Condition Reduction Program
- Accountable Care Organizations
- Medical homes
- Bundled payments
- Comprehensive Primary Care initiative
- Comprehensive ESRD
- Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model
- Eligible Pioneer Accountable Care Organizations in years 3-5
- Maryland hospitals

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January 2015: HHS announced goals for value-based payments within Medicare FFS

**Medicare Fee-for-Service**

**GOAL 1:**
Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018

GOAL 1: **30%**

**GOAL 2:**
Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018

GOAL 2: **85%**

**NEXT STEPS:**
- Testing of new models and expansion of existing models will be critical to reaching incentive goals
- Creation of a Health Care Payment Learning and Action Network to align incentives for payers

**STAKEHOLDERS:**
- Consumers
- Businesses
- Payers
- Providers
- State Partners

Set internal goals for HHS

Invite private sector payers to match or exceed HHS goals
Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018

### Historical Performance

- **2011**: ~70%
- **2014**: >80%
- **2016**: 85%
- **2018**: 90%

### Goals

- **2011**: 0%
- **2014**: ~20%
- **2016**: 30%
- **2018**: 50%

Alternative payment models (Categories 3-4)

FFS linked to quality (Categories 2-4)

All Medicare FFS (Categories 1-4)
CMS will achieve Goal 1 through alternative payment models where providers are accountable for both cost and quality.

<table>
<thead>
<tr>
<th>Major APM Categories</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable Care Organizations</td>
<td>Medicare Shared Savings Program ACO*</td>
<td>Pioneer ACO*</td>
<td>Comprehensive ESRD Care Model</td>
<td>Next Generation ACO</td>
<td></td>
</tr>
<tr>
<td>Bundled Payments</td>
<td>Bundled Payment for Care Improvement*</td>
<td></td>
<td>Specialty Care Models</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Primary Care</td>
<td>Comprehensive Primary Care*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Multi-payer Advanced Primary Care Practice*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Models</td>
<td>Maryland All-Payer Hospital Payments*</td>
<td></td>
<td>ESRD Prospective Payment System*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CMS will continue to test new models and will identify opportunities to expand existing models.

* MSSP started in 2012, Pioneer started in 2012, BPCI started in 2013, CPC started in 2012, MAPCP started in 2011, Maryland All Payer started in 2014 ESRD PPS started in 2011
CMS will reach Goal 2 through more linkage of FFS payments to quality or value

### Hospitals, % of FFS payment at risk (maximum downside)

<table>
<thead>
<tr>
<th>Program</th>
<th>2014 (payment FY16)</th>
<th>2015 (FY17)</th>
<th>2016 (FY18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HVBP (Hospital Value-based Purchasing)</td>
<td>6.55</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>IQR/MU (Inpatient Quality Reporting / Meaningful Use)</td>
<td>1.75</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>HAC (Hospital-Acquired Conditions)</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

### Physician, % of FFS payment at risk (maximum downside)

<table>
<thead>
<tr>
<th>Program</th>
<th>2014 Performance period (payment FY16)</th>
<th>2015 Performance period (payment FY17)</th>
<th>2016 Performance period (payment FY18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician VM (Value Modifier)</td>
<td>6</td>
<td>9*</td>
<td>TBD</td>
</tr>
<tr>
<td>MU (Electronic Health Record Meaningful Use)</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>PQRS (Physician Quality Reporting System)</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

*Physician VM adjustment depends upon group size and can range from 2% to 4%*
Transforming FFS to Fee-for-Quality: CMS Value Based Payment Programs
Complete data is important

- ICD-9
  - Obesity (278.00)
  - Knee pain (719.46)

- Real World
  - 66 years old
  - Smoker
  - Limited exercise
  - Hypertension
  - Depression
  - Morbid Obesity
  - Debilitating knee pain
Making the data USABLE is even more important

- What are we doing?
  - Data capture
- How well are we doing it?
  - Quality measurement
- How consistently does it happen?
  - Alignment and guidelines
- Does it matter for the individual and population?
  - Comparable effectiveness and data analytics
Federal Initiatives

• PQRS
• Value Based Modifier
• Meaningful Use (EHR Incentive Program)
• ICD-10 Conversion
EHR Incentive Program

Certified EHR

Meaningful Use Measures

Clinical Quality Measures

PQRS Data

In some circumstances, the same data submission can meet PQRS and CQM requirements.

PQRS

Physician Compare (Public Reporting)

Value Modifier

Non-PQRS Outcome Measures (from claims)

Cost Measures (from claims)

Quality Composite Score

Cost Composite Score

Private Feedback Report

Value Modifier Adjustment

Quality & Resource Use Reports (QRUR)

Payment Adjustment based on scores (Quality Tiering)

Yellow = EHR Data  Gray = Data supplied by physician groups  Green = Data Calculated by CMS
PQRS & the Value Based Modifier
What is PQRS?

- A quality reporting program previously known as PQRI
  - created under the Tax Relief and Health Care Act of 2006 as voluntary
  - The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 made the program permanent
    - Authorized incentive payments through 2010
  - Patient Protection and Affordable Care Act
    - Extended incentive payments through 2014
    - Established mandatory reporting beginning in 2015

- Applicable to those physicians providing care to Medicare beneficiaries under Part B covered professional services under the Medicare Physician Fee Schedule
  - Beginning in 2014, professionals who reassign benefits to a Critical Access Hospital that bills at a facility level can now participate in PQRS (except for claims billing)
PQRS Basics

• Reporting on the quality of care to Medicare began in 2007
  – Feedback reports (ongoing)
  – Negative payment adjustments (beginning 2015)

• Eligible Providers (EPs) can participate:
  – as individuals analyzed by their rendering/individual National Provider Identifier (NPI);
  
  OR
  – register to report as a group under the group practice reporting option (GPRO), analyzed by their Tax Identification Number (TIN)
Beginning in 2015, the program will apply a negative payment adjustment to individuals and PQRS group practices who do not satisfactorily report data on quality measures for Medicare Part B Physician Fee Schedule (MPFS) covered professional services.

Those who report satisfactorily for the 2015 program year will avoid the 2017 PQRS negative payment adjustment.
2015 Reporting Period: Jan 1 – Dec 31

- Individual physicians do not need to sign up or pre-register in order to participate in PQRS as an individual professional

- **April 1, 2015:** First day to register through PV-PQRS Registration System to participate in PQRS 2015 via GPRO

- **June 30, 2015:** Last day to register through the PV-PQRS Registration System to participate in PQRS 2015 via GPRO

- **December 31, 2015:** Reporting for the 2015 PQRS program year ends for both group practices and individuals

- 2015 reporting will influence 2017 payment adjustment
www.cms.gov

➔ search “PQRS”

• Timelines
• Technical assistance
• Implementation guides and resources for staff
• Worksheets
• Power point presentations
• Listserv
• Help desk
Reporting for PQRS: Quality Domains

- Requirement is to report 9 measures across 3 National Quality Strategy (NQS) domains
  1. Patient Safety
  2. Person and Caregiver-Centered Experience and Outcomes
  3. Communication and Care Coordination
  4. Effective Clinical Care
  5. Community/Population Health
  6. Efficiency and Cost Reduction

- Alignment → same domains as the Clinical Quality Measures domains for meaningful use aka the EHR Incentive program

- Striving for alignment among the reporting programs
Reporting for PQRS: Measures

• TIME FRAME for reporting:
  – Each measure or measure group has a unique reporting frequency or timeframe requirement
    • report each visit (i.e., smoking status)
    • once during the reporting period (i.e., preventive screening)
    • each episode of care (i.e., VTE prophylaxis if hospitalized)
  – Each measure specification set has specific instructions detailing the timeframe of reporting
  – Ensure that all members of the team understand and capture this information in the patients’ medical record to facilitate reporting
In 2015, a measure group is defined as a subset of 6 or more PQRS measures that have a particular clinical condition or focus in common. All measures within the group must be reported at least once for all patients in the sample seen by the EP during the reporting period.

<table>
<thead>
<tr>
<th>Measure Group</th>
<th>Subgroup 1</th>
<th>Subgroup 2</th>
<th>Subgroup 3</th>
<th>Subgroup 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Chronic Kidney Disease</td>
<td>Preventive Care</td>
<td>Coronary Artery Bypass Graft</td>
<td>Rheumatoid Arthritis</td>
</tr>
<tr>
<td>Acute Otitis Externa (AOE)</td>
<td>Cataracts</td>
<td>Hepatitis C</td>
<td>Heart Failure</td>
<td>Coronary Artery Disease</td>
</tr>
<tr>
<td>Optimizing Patient Exposure to Ionizing Radiation</td>
<td>HIV/AIDS</td>
<td>Asthma</td>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>Inflammatory Bowel Disease</td>
</tr>
<tr>
<td>Sleep Apnea</td>
<td>Dementia</td>
<td>Parkinson’s Disease</td>
<td>Sinusitis</td>
<td>General Surgery</td>
</tr>
<tr>
<td></td>
<td>Oncology</td>
<td>Total Knee Replacement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Diabetes Measure Group Reporting

DIABETES MEASURES GROUP OVERVIEW

2015 PQRS OPTIONS FOR MEASURES GROUPS:

2015 PQRS MEASURES IN DIABETES MEASURES GROUP:
#1 Diabetes: Hemoglobin A1c Poor Control
#110 Preventive Care and Screening: Influenza Immunization
#117 Diabetes: Eye Exam
#119 Diabetes: Medical Attention for Nephropathy
#163 Diabetes: Foot Exam
#226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

INSTRUCTIONS FOR REPORTING:

- It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group-specific intent G-code has been created for registry only measures groups for use by registries that utilize claims data.

G8485: I intend to report the Diabetes Measures Group

- Report the patient sample method:
  20 Patient Sample Method via registries: 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2015).
Measure #1 (NQF 0059): Diabetes: Hemoglobin A1c Poor Control -- National Quality Strategy Domain: Effective Clinical Care

DESCRIPTION:
Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period

NUMERATOR:
Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control. Patient is numerator compliant if most recent HbA1c level >9% or is missing a result or if an HbA1c test was not done during the measurement year.

Numerator Options:
Performance Met: Most recent hemoglobin A1c level > 9.0% (3046F)
OR
Performance Met: Hemoglobin A1c level was not performed during the performance period (12 months) (3046F with 8P)

OR
Performance Not Met: Most recent hemoglobin A1c (HbA1c) level < 7.0% (3044F)
OR
Performance Not Met: Most recent hemoglobin A1c (HbA1c) level 7.0 to 9.0% (3045F)
Specialty Measure Sets

• CMS is collaborating with specialty societies to ensure that the measures represented within Specialty Measure Sets accurately illustrate measures associated within a particular clinical area (suggested, NOT required)

1. Cardiology
2. Emergency Medicine
3. Gastroenterology
4. General Practice/Family
5. Internal Medicine
6. Multiple Chronic Conditions
7. Obstetrics/Gynecology
8. Oncology/Hematology
9. Ophthalmology
10. Pathology
11. Radiology
12. Surgery
<table>
<thead>
<tr>
<th>PQRS# CMS# GPRO#</th>
<th>NQF#</th>
<th>Reporting Method</th>
<th>National Quality Strategy Domain</th>
<th>Measure Title: Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 CMS122v2</td>
<td>0059</td>
<td>Claims, Registry, EHR, GPRO Web Interface/ACO, Measures Group (DM)</td>
<td>Effective Clinical Care</td>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt;9%): Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c &gt; 9.0% during the measurement period</td>
</tr>
<tr>
<td>5 CMS135v2</td>
<td>0081</td>
<td>Registry, EHR, Measures Group (HF)</td>
<td>Effective Clinical Care</td>
<td>Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD): Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) &lt; 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at each hospital discharge</td>
</tr>
<tr>
<td>9 CMS128v2</td>
<td>0105</td>
<td>EHR</td>
<td>Effective Clinical Care</td>
<td>Anti-depressant Medication Management: Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported. • Effective Acute Phase Treatment: Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks) • Effective Continuation Phase Treatment: Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months)</td>
</tr>
</tbody>
</table>
Measure #1 (NQF 0059): Diabetes: Hemoglobin A1c Poor Control -- National Quality Strategy Domain: Effective Clinical Care

DESCRIPTION:
Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period

NUMERATOR:
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OR
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OR
Performance Not Met: Most recent hemoglobin A1c (HbA1c) level < 7.0% (3044F)
OR
Performance Not Met: Most recent hemoglobin A1c (HbA1c) level 7.0 to 9.0% (3045F)
<table>
<thead>
<tr>
<th>NQS Domain</th>
<th>Measure Title</th>
<th>Claims</th>
<th>CSV</th>
<th>Registry</th>
<th>EHR</th>
<th>GRPO Web Interface</th>
<th>Measures Group</th>
<th>Other Quality Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community/Population Health</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>ACO MU2</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Documentation of Current Medications in the Medical Record</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>ACO MU2</td>
</tr>
<tr>
<td>Communication and Care Coordination</td>
<td>Pain Assessment and Follow-Up</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
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<td>X</td>
<td></td>
</tr>
<tr>
<td>Community/Population Health</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>ACO MU2</td>
</tr>
<tr>
<td>Communication and Care Coordination</td>
<td>Functional Outcome Assessment</td>
<td>X</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community/Population Health</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>ACO MU2 Million Hearts</td>
</tr>
</tbody>
</table>
DESCRIPTION:
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.

NUMERATOR:
Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user.

Definitions:
Tobacco Use – Includes use of any type of tobacco.
Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy.

NUMERATOR NOTE: In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling report 4004F with 8P.

Numerator Options:
Performance Met: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (4004F)
OR
Performance Met: Current tobacco non-user (1036F)
OR
Medical Performance Exclusion: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reasons) (4004F with 1P)
OR
Performance Not Met: Tobacco screening OR tobacco cessation intervention not performed, reason not otherwise specified (4004F with 8P)
<table>
<thead>
<tr>
<th>Measures</th>
<th>Select Aligned Initiatives</th>
</tr>
</thead>
</table>
| Aspirin Use (NQF 0068)                       | • PQRS Measure #204  
• MU Stage 1 – optional  
• MU Stage 2 core  
• ACO measure |
| Blood Pressure Control (NQF 0018)            | • PQRS Measure #236  
• MU Stage 1 – optional  
• MU Stage 2 core  
• ACO measure  
• Medicare Advantage  
• IHA*                                                  |
| Cholesterol Management - IVD (NQF 0075)      | • PQRS Measure #241  
• MU Stage 1 – optional  
• MU Stage 2 – optional  
• ACO measure  
• Medicare Advantage  
• IHA                                                  |
| Smoking Cessation (NQF 0028)                 | • PQRS Measure #226  
• MU Stage 1 – core  
• MU Stage 2 core  
• ACO measure |

*new this year
Participating as an individual

- Individual clinicians may choose to report information on individual PQRS quality measures or measures groups using the following mechanisms:
  - Medicare Part B claims
  - Qualified PQRS registry
  - Direct electronic health record (EHR) using certified EHR technology (CEHRT)
  - CEHRT via data submission vendor
  - Qualified clinical data registry (QCDR).

- Individual physicians do not need to sign up or pre-register in order to participate in PQRS

- Individuals who meet the criteria for satisfactory submission of PQRS quality measures will avoid the 2017 negative PQRS payment adjustment (-2%) for covered professional services
2015 PQRS: Reporting Via Claims

- Requirement is to report 9 measures across 3 National Quality Strategy (NQS) domains
  1. Patient Safety
  2. Person and Caregiver-centered Experience and Outcomes
  3. Communication and Care Coordination
  4. Effective Clinical Care
  5. Community/Population Health
  6. Efficiency and Cost Reduction

- Same domains as the Clinical Quality Measures (CQM) domains for meaningful use

- Required to report one “cross-cutting” measure if at least one Medicare face-to-face encounter

- Measure-applicability validation (MAV) process will be used to determine if EP should have chosen a cross-cutting measure when he/she did not
I WANT TO PARTICIPATE IN 2015 PQRS
TO AVOID THE 2017 NEGATIVE PAYMENT ADJUSTMENT

SELECT REPORTING METHOD
(Refer to the 2015 Physician Quality Reporting System Measures List for a listing of all 2015 measures and associated NQS domains for a specific reporting method. Also review the appropriate measure specifications for the selected reporting method(s) 2015 for PQRS.)

CHOSE CLAIMS-BASED REPORTING OPTIONS TO AVOID 2017 PQRS NEGATIVE PAYMENT ADJUSTMENT

- REGISTRY-BASED REPORTING
- EHR-BASED REPORTING
- GROUP PRACTICE REPORTING OPTION
- QUALIFIED CLINICAL DATA REGISTRY-BASED REPORTING

< 9 MEASURES COVERING 3 NQS DOMAINS APPLY

1. REPORT ON 1-8 INDIVIDUAL MEASURES
   12 MONTHS 1/1/15-12/31/15

REPORT ≥ 50% OF APPLICABLE MEDICARE PART B FFS PATIENTS

IF EP SEES AT LEAST 1 MEDICARE PATIENT IN FACE TO FACE ENCOUNTER, REPORT AT LEAST 1 CROSS-CUTTING MEASURE

Measures with a 0% performance rate will be considered in analysis but will not be considered satisfactorily reported for incentive eligibility

Subject to Claims-based Measure Applicability Validation (MAV)

≥ 9 MEASURES COVERING 1-2 NQS DOMAINS APPLY

2. REPORT ON ≥ 9 INDIVIDUAL MEASURES COVERING APPLICABLE DOMAINS
   12 MONTHS 1/1/15-12/31/15

REPORT ≥ 50% OF APPLICABLE MEDICARE PART B FFS PATIENTS

IF EP SEES AT LEAST 1 MEDICARE PATIENT IN FACE TO FACE ENCOUNTER, REPORT AT LEAST 1 CROSS-CUTTING MEASURE

Measures with a 0% performance rate will be considered in analysis but will not be considered satisfactorily reported for incentive eligibility

Subject to Claims-based Measure Applicability Validation (MAV)

≥ 9 MEASURES COVERING 3 OR MORE NQS DOMAINS APPLY

3. REPORT ON ≥ 9 INDIVIDUAL MEASURES
   12 MONTHS 1/1/15-12/31/15

REPORT ≥ 50% OF APPLICABLE MEDICARE PART B FFS PATIENTS

IF EP SEES AT LEAST 1 MEDICARE PATIENT IN FACE TO FACE ENCOUNTER, REPORT AT LEAST 1 CROSS-CUTTING MEASURE

Measures with a 0% performance rate will be considered in analysis but will not be considered satisfactorily reported for incentive eligibility

Subject to Claims-based Measure Applicability Validation (MAV)
2015 PQRS: Reporting Via Qualified Registry

- Can report either individual claims (9 measures across 3 quality domains) or measures groups
- Requirement to report on at least one cross-cutting measure if the EP has at least one Medicare face-to-face encounter
- 6-month reporting period option has been removed
- Deadline extended to March 31, 2016 to submit quality measures data for the 2015 reporting period
I WANT TO PARTICIPATE IN 2015 PQRS TO AVOID THE 2017 NEGATIVE PAYMENT ADJUSTMENT

SELECT REPORTING METHOD
(Refer to the 2015 Physician Quality Reporting System Measures List for a listing of all 2015 measures and associated NQS domains for a specific reporting method. Also review the appropriate measure specifications for the selected reporting method(s) 2015 for PQRS.)

CLAIMS-BASED REPORTING

CHOOSE REGISTRY-BASED REPORTING OPTIONS TO AVOID 2017 PQRS NEGATIVE PAYMENT ADJUSTMENT

EHR-BASED REPORTING

GROUP PRACTICE REPORTING OPTION

QUALIFIED CLINICAL DATA REGISTRY-BASED REPORTING

INDIVIDUAL MEASURES

< 9 MEASURES COVERING 3 OR MORE NQS DOMAINS APPLY

REPORT ON 1-8 INDIVIDUAL MEASURES

12 MONTHS
1/1/15-12/31/15

REPORT ≥ 50% OF APPLICABLE MEDICARE PART B FFS PATIENTS

IF EP SEES AT LEAST 1 MEDICARE PATIENT IN FACE TO FACE ENCOUNTER, REPORT AT LEAST 1 CROSS-CUTTING MEASURE

Measures with a 0% performance rate will not be counted

Subject to Registry-based Measure Applicability Validation (MAV)

≥ 9 MEASURES COVERING 1-2 NQS DOMAINS APPLY

REPORT ON ≥ 9 INDIVIDUAL MEASURES COVERING APPLICABLE DOMAINS

12 MONTHS
1/1/15-12/31/15

REPORT ≥ 56% OF APPLICABLE MEDICARE PART B FFS PATIENTS

IF EP SEES AT LEAST 1 MEDICARE PATIENT IN FACE TO FACE ENCOUNTER, REPORT AT LEAST 1 CROSS-CUTTING MEASURE

Measures with a 0% performance rate will not be counted

Subject to Registry-based Measure Applicability Validation (MAV)

≥ 9 MEASURES COVERING 3 NQS DOMAINS APPLY

REPORT ON ≥ 9 INDIVIDUAL MEASURES COVERING 3 NQS DOMAINS

12 MONTHS
1/1/15-12/31/15

REPORT ≥ 50% OF APPLICABLE MEDICARE PART B FFS PATIENTS

IF EP SEES AT LEAST 1 MEDICARE PATIENT IN FACE TO FACE ENCOUNTER, REPORT AT LEAST 1 CROSS-CUTTING MEASURE

Measures with a 0% performance rate will not be counted

Subject to Registry-based Measure Applicability Validation (MAV)

MEASURES GROUP(S)

SUBMIT ≥ 1 MEASURES GROUP FOR

12 MONTHS
1/1/15-12/31/15

FOR ≥ 20 APPLICABLE PATIENTS FOR A MEASURES GROUP
(Only a majority [11] must be Medicare Part B FFS patients)

Measures Groups containing a measure with a 0% performance rate will not be counted
CMS continues to encourage electronic reporting using an EHR or DSV to fulfill requirements of both PQRS and Meaningful Use

EHRs and DSVs must comply with QRDA-I and QRDA-III file formats

EPs and group practices reporting electronically are required to use the July 2014 version of the eCQMs for 2015 reporting

EP’s certified system does NOT need to be tested and certified to the most recent version of measures
I WANT TO PARTICIPATE IN 2015 PQRS TO AVOID THE 2017 NEGATIVE PAYMENT ADJUSTMENT
SELECT REPORTING METHOD
(Refer to the 2015 Physician Quality Reporting System Measures List for a listing of all 2015 measures and associated NQS domains for a specific reporting method. Also review the appropriate measure specifications for the selected reporting method(s) 2015 for PQRS.)

- CLAIMS-BASED REPORTING
- REGISTRY-BASED REPORTING
- CHOOSE EHR-BASED REPORTING OPTIONS TO AVOID 2017 PQRS NEGATIVE PAYMENT ADJUSTMENT
- GROUP PRACTICE REPORTING OPTION
- QUALIFIED CLINICAL DATA REGISTRY-BASED REPORTING

PHYSICIAN QUALITY REPORTING SYSTEM - MEDICARE EHR INCENTIVE PROGRAM

DIRECT EHR-BASED PRODUCT THAT IS CEHRT OR EHR DATA SUBMISSION VENDOR THAT IS CEHRT

REPORT ON ≥ 9 MEASURES COVERING 3 NQS DOMAINS DOMAINS

If an EP’s CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the EP must report the measures for which there is Medicare patient data. An EP must report on at least 1 measure for which there is Medicare patient data.

12 MONTHS
1/1/15-12/31/15

Note: Successful submission of CQM data will qualify EP for the PQRS incentive and meet the CQM component of the Medicare EHR Incentive Program

Refer to the EHR Incentive Program website documents for a listing of 2015 CQMs for EPs and supporting documentation
2015 PQRS: Reporting Via Qualified Clinical Data Registry (QCDR)

• EPs must report on 2 outcome measures, or if less than 2 are available report 1 outcome measure and 1 additional of the following:
  – Patient Safety
  – Resource Use
  – Patient experience of care
  – Efficiency/appropriate use

• May submit quality measures for up to 30 non-PQRS measures

• Beginning with the 2015 reporting period, QCDRs must publicly report the quality measure data collected and provide a link to those data to CMS to include on Physician Compare OR the QCDR must provide data to Physician Compare to consider for public reporting
I WANT TO PARTICIPATE IN 2015 PQRS TO AVOID THE 2017 NEGATIVE PAYMENT ADJUSTMENT

SELECT REPORTING METHOD

(Refer to the 2015 Physician Quality Reporting System Measures List for a listing of all 2015 measures and associated NQS domains for a specific reporting method. Also review the appropriate measure specifications for the selected reporting method(s) 2015 for PQRS.)

CHOOSE TO PARTICIPATE IN QUALIFIED CLINICAL DATA REGISTRY-BASED OPTION TO AVOID 2017 NEGATIVE PAYMENT ADJUSTMENT

≥ 9 MEASURES COVERING 3 NQS DOMAINS APPLY

1. REPORT ON ≥ 9 INDIVIDUAL MEASURES COVERING 3 NQS DOMAINS AND REPORT
2. ≥ 50% OF APPLICABLE MEDICARE PART B FFS PATIENTS
   +
   OF THESE MEASURES, REPORT AT LEAST 2 OUTCOME MEASURES, OR IF 2 OUTCOME MEASURES ARE NOT AVAILABLE, REPORT ON AT LEAST 1 OUTCOME MEASURE AND AT LEAST 1 ADDITIONAL RESOURCE USE, PATIENT EXPERIENCE OF CARE, PATIENT SAFETY, OR EFFICIENCY/APPROPRIATE USE MEASURE

12 MONTHS
1/1/15-12/31/15

EPs participating via qualified clinical data registry are not limited to PQRS measures (maximum 30 non-PQRS – all payers)
Participating in a group

• Clinicians can also participate within a group. Group practices must register to take part in PQRS GPRO by June 30, 2015.
  – Registration must be completed online through the Physician Value-Physician Quality Reporting System (PV-PQRS) Registration System.
  – During registration, group practices must indicate their reporting method as well as CAHPS for PQRS participation.

• Groups may choose to report information on PQRS quality measures using:
  – Qualified PQRS registry
  – Web Interface (for groups of 25+ only)
  – Direct EHR using CEHRT
  – CEHRT via data submission vendor
  – CAHPS for PQRS via CMS-certified survey vendor (2+ physician groups)

• Groups who meet the criteria for satisfactory submission of PQRS quality measures will avoid negative PQRS payment adjustments in 2017
2015 PQRS: Group Practice Reporting Option (GPRO)

- Group practices will be able to register for the PQRS GPRO between April 1, 2015 and June 30, 2015
- Size of the group will determine the GPRO options
  - GPRO Web Interface available for groups of 25+ EPs
- Starting in 2015, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS is mandatory for groups of 100+ EPs
GPRO Reporting Criteria for the 2017 Payment Adjustment

Qualified Registry

Group Practice Size?

2-99 EPs

Can the group report at least 9 measures covering at least 3 domains?

Yes

Report at least 9 measures covering at least 3 NQS domains

No

Report 1—8 measures covering 1—3 NQS domains

---

If group practice sees at least 1 Medicare patient in a face-to-face encounter, must report on at least 1 cross-cutting measure AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.
GPRO Reporting Criteria for the 2017 Payment Adjustment

Direct EHR product that is CEHRT
-OR-
EHR data submission vendor that is CEHRT

Group Practice Size?

2-99 EPs

Report 9 measures covering at least 3 of the NQS domains. If a group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.
Starting in 2015, CAHPS is mandatory for groups of 100+ EPs (in addition to other reporting methods)

Optional for groups of 2-99 EPs

Group practices required to contract with a CMS certified vendor and bear administrative costs for the CAHPS survey

The CMS-certified survey vendor will administer and collect 12 summary survey modules on behalf of the group practice’s patients

12 survey modules are the same as the 2014 survey
GPRO Reporting Criteria for the 2017 Payment Adjustment

Groups of 2-99 EPs: Optional Methods Below
Groups of 100+ EPs: MANDATORY....MUST CHOOSE ONE OF THESE OPTIONS

Report all CAHPS for PQRS survey measures via a CMS-certified survey vendor PLUS:

- Qualified Registry
- GPRO Web Interface (25+ EPs only)
- Direct EHR product that is CEHRT
- OR-
- EHR data submission vendor that is CEHRT

Report at least 6 additional measures outside of CAHPS for PQRS, covering at least 2 NQS domains; if less than 6 apply to group, report up to 5 measures. If EP in group sees at least 1 Medicare patient in face-to-face encounter, must report at least 1 cross-cutting measure.

Report on all measures included on web interface; AND populate data fields for first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group’s sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then report on 100 percent of assigned beneficiaries.

Report at least 6 additional measures outside of CAHPS for PQRS, covering at least 2 NQS domains; if less than 6 apply to group, report up to 5 measures. Group practice required to report on at least 1 measure for which there is Medicare patient data.
How to Report Once for 2015 Medicare Quality Reporting Programs

February 2015; Revised March 2015, April 2015

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How to Report Once for 2015 Medicare Quality Reporting Programs: Individual Eligible Professionals

I Am An Individual Eligible Professional

- Review the list of eligible professionals on the ‘How to Get Started’ page of the CMS PQRS Website
- Must participate in PQRS as an individual (not a member of a group practice who has registered or self-nominated for the group practice reporting option (GPRO) via PQRS)

CHOOSE PQRS ELECTRONIC REPORTING USING AN EHR or *QUALIFIED CLINICAL DATA REGISTRY:

DIRECT EHR PRODUCT THAT IS CERTIFIED EHR TECHNOLOGY (CEHRT) or EHR DATA SUBMISSION VENDOR THAT IS CEHRT

*Reports at least 9 of the CQMs as finalized in the 2015 Medicare Physician Fee Schedule (MPFS) final rule for the full 12-month reporting period

REPORT ON 9 CQMs COVERING AT LEAST 3 OF THE NATIONAL QUALITY STRATEGY DOMAINS

If an eligible professional’s CEHRT does not contain patient data for at least 9 CQMs covering at least 3 National Quality Strategy (NQS) domains, then the eligible professional must report the CQM for which there is Medicare patient data. An eligible professional must report at least one CQM containing Medicare patient data.

12 MONTHS
1/1/15 – 12/31/15

Refer to the EHR incentive Program website documents for a listing of measures that satisfy the CQM component, then utilize the eCQMs for those measures.
Satisfactorily report under PQRS for 2015

- Avoid the 2017 PQRS negative payment adjustment (-2.0%)
- Satisfy the CQM component of the Medicare EHR Incentive Program
- **Physicians in groups of 2-9 EPs and solo practitioners** could receive an upward or neutral VM payment adjustment based on quality-tiering in 2017 (+0.0% to +2.0x of MPFS, where ‘x’ represents the VM adjustment factor), if at least 50% of the EPs in the group or the solo practitioners satisfactorily report under PQRS as individuals
- **Physicians in groups of 10+ EPs** could receive an upward, neutral, or downward VM payment adjustment based on quality-tiering in 2017 (-4.0% to +4.0x of MPFS, where ‘x’ represents the VM adjustment factor), if at least 50% of the EPs in the group satisfactorily report under PQRS as individuals
- In 2017, groups and solo practitioners receiving an upward VM adjustment under quality-tiering are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25% of all beneficiary risk scores nationwide.

---

Subject to the 2017 PQRS negative payment adjustment (-2.0%)
- Will not satisfy the CQM component of the Medicare EHR Incentive Program
- Subject to the VM automatic downward payment adjustment if a non-PQRS reporter:
  - -2.0% (for physicians in groups with 2-9 EPs and physician solo practitioners, if at least 50% of the EPs in the group or the solo practitioners do not satisfactorily report under PQRS as individuals)
  - -4.0% (for physicians in groups with 10+ EPs, if at least 50% of the EPs in the group or the solo practitioners do not satisfactorily report under PQRS as individuals)

**NOTE:** You will still be required to report the other meaningful use objectives through the Medicare and Medicaid EHR Incentive Programs Registration and Attestation System.
## 2015 Incentive Payments and 2017 Payment Adjustments

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<td><strong>Oral Sur</strong></td>
<td>-2.0% of MPFS</td>
<td>+2.0 (x), +1.0(x), or neutral</td>
<td>-2.0% of MPFS</td>
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<td><strong>Pod.</strong></td>
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<td><strong>Medicare Inc. (2015)</strong></td>
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<td><strong>Medicaid Inc. (2015)</strong></td>
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<td><strong>Medicare Pay Adj (2017)</strong></td>
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<tr>
<td><strong>Physicians in groups of 2-9 EPs &amp; Solo physicians</strong>:</td>
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<td>$8,500 or $21,250 (based on when EP did A/I/U)</td>
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<tr>
<td><strong>Physicians in groups of 10+ EPs</strong>:</td>
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<td></td>
<td></td>
<td></td>
<td>$4,000-$12,000 (based on when EP did A/I/U)</td>
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<tr>
<td><strong>-3.0% of MPFS</strong></td>
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Physician Value-Based Payment Modifier

• A new *per-claim adjustment* under the Medicare Physician Fee Schedule that is applied at the group (Taxpayer Identification Number “TIN”) level to physicians billing under the TIN.

• Assesses the quality of care furnished *and* the cost of that care, based on what is reported in PQRS.

• **Timeframe of Implementation**
  • 2015 – CMS will apply the VM to groups of physicians with 100 or more eligible professionals (EPs) based on 2013 performance.
  • 2016 - CMS will apply the VM to groups of physicians with 10 or more EPs based on 2014 performance.

CMS is required to apply the VM to all physicians and groups starting in 2017 (based on 2015 performance).
How does the VM work?

1. CMS Collects Cost, Quality Data
   - Providers report performance on PQRS¹, CG-CAHPs² measures
   - CMS track per capita costs for Medicare parts A and B

2. CMS Groups Providers into Quality Tiers
   - Provider, group performance risk-adjusted, compared to national averages
   - Final scores tiered, assigned modifiers

3. Medicare Payment Adjusted Based on Tiering
   - High performing groups will receive payment boosts, low performers will see payment reduction
   - Failure to participate in PQRS results in maximum penalty
Quality-Tiering Approach for 2017 (Based on 2015 PQRS Performance): Solo Practitioners and Groups of 2-9 EPs

- An automatic -2.0% VM downward adjustment will be applied for not meeting the satisfactorily reporting criteria to avoid the 2017 PQRS payment adjustment.
- Under quality-tiering, the maximum upward adjustment is up to +2.0x (‘x’ represents the upward VM payment adjustment factor).
- Groups with 2-9 EPs and physician solo practitioners are held harmless from any downward adjustments under quality-tiering in 2017.

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
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</thead>
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<td>+1.0x*</td>
<td>+2.0x*</td>
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<tr>
<td>Average Cost</td>
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<tr>
<td>High Cost</td>
<td>+0.0%</td>
<td>+0.0%</td>
<td>+0.0%</td>
</tr>
</tbody>
</table>

*Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores*
Quality-Tiering Approach for 2017 (Based on 2015 PQRS Performance): Groups of 10+ EPs

- An automatic -4.0% VM downward adjustment will be applied for not meeting the satisfactory reporting criteria to avoid the 2017 PQRS payment adjustment.
- Under quality-tiering, the maximum upward adjustment is up to +4.0x (‘x’ represents the upward VM payment adjustment factor), and the maximum downward adjustment is -4.0%.

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>+0.0%</td>
<td>+2.0x*</td>
<td>+4.0x*</td>
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<td>Average Cost</td>
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<td>+2.0x*</td>
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<tr>
<td>High Cost</td>
<td>-4.0%</td>
<td>-2.0%</td>
<td>+0.0%</td>
</tr>
</tbody>
</table>

* Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores
2015 Updates to the Value-based Payment Modifier

- The 2015 MPFS Final rule further expands the application of the VM in CY 2017
- Physicians in groups with 2-9 EPs and physician solo practitioners receive only the upward or neutral VM adjustment under quality-tiering
- Physicians in groups with 10+ EPs can receive upward, neutral, or downward VM adjustment under quality-tiering
- VM will apply to physicians in TINs that participate in the Shared Savings Program, Pioneer ACO Model, CPC Initiative, or other similar Innovation Center models or CMS initiatives during the CY 2015 performance period
- Beginning in CY 2018, the VM will apply to non-physician EPs in groups with 2+ EPs and to non-physician EPs who are solo practitioners
How Does 2015 PQRS Participation Affect the VM in 2017?

1. Do you plan to report for PQRS in 2015?
   - Yes
     - Are you a solo EP or part of a group?
       - Solo
         - Are you a physician?
           - Yes
             - Physician will avoid 2017 PQRS payment adjustment
             - Upward or neutral VM adjustment in 2017
           - No
             - EP will avoid 2017 PQRS payment adjustment
             - VM does not apply to non-physician EPs in 2017
       - Group
         - Does the group plan to report PQRS as a group?
           - Yes
             - Does group meet 50% threshold?
               - Yes
                 - All EPs in group report PQRS to avoid 2017 PQRS payment adjustment. For the 50% threshold option, at least 50% of the EPs must report to avoid the 2017 PQRS payment adjustment
               - No
                 - All EPs (solo and in groups of 2+ EPs) will be subject to the 2017 PQRS payment adjustment of -2.0%
           - No
             - All solo physicians and physicians in groups of 2-9 EPs will be subject to the 2017 VM downward adjustment of -2.0%
         - No
           - All physicians in groups of 10+ EPs will be subject to the 2017 VM downward adjustment of -4.0%

2. No
### How Can I Report PQRS in 2015 and What Does It Mean for 2017?

<table>
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<tr>
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<th>Claims</th>
<th>Qualified Registry</th>
<th>EHR/DSV</th>
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<th>GPRO Web Interface</th>
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<td>Upward/Neutral/Downward adj (+4.0x, +2.0x, 0.0%, -2.0%, 4.0%)</td>
<td>-4.0% Downward adj</td>
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</table>
What is the 2014 Mid-Year QRUR?

• Disseminated in April 2015
  – Interim information to TINs about performance on three quality outcome and six cost measures
  – Calculated directly from Medicare claims billed July 1 2013 through June 30 2014

• For information purposes only and will not affect TIN’s payments under the Medicare PFS

• Clinicians should use the data to identify opportunities to improve quality and efficiency of the care they provide

• The following data are not included:
  – Information about future payment adjustments in 2016
  – Quality and cost composite scores for 2016
  – Quality measures data reported under PQRS
What is the 2014 Annual QRUR?

• Disseminated in the FALL of 2015
  – Complete information regarding TINs performance on all available quality and cost measures used to calculate payment adjustments in 2016 (under the Value Modifier)
  – Calendar year 2014 is the performance period for payment adjustments in 2016

• For physicians in TINs with 10 or more eligible professionals, the Annula QRUR will provide information on how the TINS’s quality and cost performance will affect their Medicare payments in 2016
How Can I Access My Report?

- You can access a QRUR on behalf of a group or solo practitioner (as identified by TIN) at [https://portal.cms.gov](https://portal.cms.gov).
- QRURs are provided for each TIN.
- First, you or one person from your TIN will need to obtain an Individuals Authorized Access to the CMS Computer Services (IACS) account with the correct role.
- For TINs with two or more eligible professionals:
  - PV-PQRS Group Security Official (primary or back-up)
  - PV-PQRS Group Representative
- For solo practitioners (TINs with one eligible professional):
  - PV-PQRS Individual (primary or back-up)
  - PV-PQRS Individual Representative
- Refer to the “How to Obtain a QRUR” webpage [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html)
How Can I Access My Report? (continued)

2. Select “Login to CMS Secure Portal”, accept the “Terms and Conditions” and enter your IACS user ID and password to login.
3. Select the “PV-PQRS” tab, and the “QRUR-Reports” option.
4. Select a “Year” and desired “Report”.
5. Complete your role attestation.
6. Select your TIN.
## What Information is Contained in the 2014 Mid-Year QRUR?

<table>
<thead>
<tr>
<th>Mid-Year QRUR Report Section</th>
<th>Exhibit</th>
<th>Use the Information in the Report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cover Page</td>
<td>-</td>
<td>Understand why you received a 2014 Mid-Year QRUR</td>
</tr>
<tr>
<td>About the Data in this Report</td>
<td>-</td>
<td>Read a summary of the report methodology and retrieve links to supplementary exhibits and glossary items (if viewing the report dashboard)</td>
</tr>
<tr>
<td>Eligible Professionals Billing to Your Taxpayer Identification Number (TIN)</td>
<td>1</td>
<td>Understand how many eligible professionals billed under your TIN during the performance period</td>
</tr>
<tr>
<td>Attribution of Medicare Beneficiaries and Episodes to Your TIN</td>
<td>2-4</td>
<td>Understand how Medicare FFS beneficiaries and episodes of hospital care were attributed to your TIN</td>
</tr>
<tr>
<td>Performance on Quality</td>
<td>5</td>
<td>Review your performance on the three, CMS-calculated outcome measures</td>
</tr>
<tr>
<td>Hospitals Admitting Your Patients</td>
<td>6</td>
<td>Identify the hospitals that accounted for at least five percent of your attributed beneficiaries’ inpatient stays during the performance period</td>
</tr>
<tr>
<td>Performance on Costs</td>
<td>7-8</td>
<td>Review your performance on costs across two performance categories, and understand the dollar difference between your attributed beneficiaries’ payment-standardized and risk-adjusted per capita costs, by category, and the corresponding costs for your peer group for the Per Capita Costs for All Attributed Beneficiaries measure</td>
</tr>
</tbody>
</table>

**Note:** All references to “episodes” in this presentation indicate episodes of hospital care for the Medicare Spending per Beneficiary measure.
Quality Performance Section of the Mid-Year QRUR

- CMS-1, CMS-2, and CMS-3 are risk-adjusted quality outcome measures calculated by CMS using administrative claims data.
- Lower performance rates on these measures indicate better performance.
- The peer group for the quality measures is all TINs nationwide with at least 20 eligible cases for each quality measure.

### Exhibit 5. CMS-Calculated Outcome Measure Performance

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Measure Number</th>
<th>Measure Name</th>
<th>Your Eligible Cases</th>
<th>Your Performance Rate</th>
<th>Benchmark</th>
<th>Benchmark -1 Standard Deviation</th>
<th>Benchmark +1 Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care Sensitive Conditions</td>
<td>CMS-1</td>
<td>Acute Conditions Composite</td>
<td>383</td>
<td>12.02</td>
<td>7.53</td>
<td>1.81</td>
<td>13.24</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>Bacterial Pneumonia</td>
<td>383</td>
<td>16.89</td>
<td>11.20</td>
<td>1.76</td>
<td>20.63</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>Urinary Tract Infection</td>
<td>383</td>
<td>13.35</td>
<td>7.25</td>
<td>0.00</td>
<td>15.08</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>Dehydration</td>
<td>383</td>
<td>6.08</td>
<td>4.10</td>
<td>0.00</td>
<td>8.58</td>
</tr>
<tr>
<td></td>
<td>CMS-2</td>
<td>Chronic Conditions Composite</td>
<td>142</td>
<td>0.00</td>
<td>50.43</td>
<td>26.19</td>
<td>74.66</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>Diabetes (composite of 4 indicators)</td>
<td>56</td>
<td>0.00</td>
<td>18.07</td>
<td>0.00</td>
<td>38.07</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>Chronic Obstructive Pulmonary Disease (COPD) or Asthma</td>
<td>24</td>
<td>0.00</td>
<td>70.23</td>
<td>25.43</td>
<td>115.03</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>Heart Failure</td>
<td>90</td>
<td>0.00</td>
<td>99.75</td>
<td>48.72</td>
<td>150.77</td>
</tr>
<tr>
<td>Hospital Readmissions</td>
<td>CMS-3</td>
<td>All-Cause Hospital Readmissions</td>
<td>64</td>
<td>18.16%</td>
<td>15.94%</td>
<td>14.55%</td>
<td>17.34%</td>
</tr>
</tbody>
</table>

Compare your quality outcome performance to that of your peers nationwide.
Cost Performance Section of the Mid-Year QRUR

• Costs data for the Per Capita Costs for All Attributed Beneficiaries measure and the four Per Capita Costs for Beneficiaries with Specific Conditions measures are based on payments for Medicare Parts A and B claims submitted by all providers for Medicare beneficiaries attributed to a TIN for a given measure.
• For the Medicare Spending per Beneficiary measure, per episode costs are based on Parts A and B expenditures surrounding specified inpatient hospital stays (3 days prior to admission through 30 days post-discharge).
• Part D-covered prescription drug costs are not included.
• All cost measures have been payment-standardized, risk-adjusted, and adjusted for the TIN’s mix of medical specialties (specialty-adjusted).
• The peer group for the cost measures is all TINs nationwide with at least 20 eligible cases for each cost measure.
Cost Performance Section of the Mid-Year QRUR

- Exhibit 7 shows the payment-standardized, risk-adjusted, and specialty-adjusted per capita or per episode costs for the beneficiaries attributed to your TIN.

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Cost Measure</th>
<th>Your Eligible Cases or Episodes</th>
<th>Your Per Capita or Per Episode Costs</th>
<th>Benchmark - 1 Standard Deviation</th>
<th>Benchmark + 1 Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Capita Costs for All Attributed Beneficiaries</td>
<td>All Beneficiaries</td>
<td>354</td>
<td>$11,126</td>
<td>$7,962</td>
<td>$14,309</td>
</tr>
<tr>
<td></td>
<td>Medicare Spending per Beneficiary</td>
<td>772</td>
<td>$20,232</td>
<td>$18,651</td>
<td>$22,026</td>
</tr>
<tr>
<td>Per Capita Costs for Beneficiaries with Specific Conditions</td>
<td>Diabetes</td>
<td>54</td>
<td>$17,785</td>
<td>$11,243</td>
<td>$21,055</td>
</tr>
<tr>
<td></td>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>17</td>
<td>$25,805</td>
<td>$17,269</td>
<td>$33,088</td>
</tr>
<tr>
<td></td>
<td>Coronary Artery Disease (CAD)</td>
<td>36</td>
<td>$23,095</td>
<td>$12,780</td>
<td>$23,934</td>
</tr>
<tr>
<td></td>
<td>Heart Failure</td>
<td>82</td>
<td>$15,686</td>
<td>$19,188</td>
<td>$37,041</td>
</tr>
</tbody>
</table>

Compare your cost performance to that of your peers.
Next Steps: what you can do

- Decide whether and how to participate in the PQRS in 2015:
  - Group Reporting: Register for the 2015 PQRS GPRO between April 1, 2015 and June 30, 2015: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html)
  - Individual reporting: No registration necessary.


- Review quality measure benchmarks under the VM: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html)

“Mr. Osborne, may I be excused? My brain is full.”
# 2015 Incentive Payments and 2017 Payment Adjustments

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MD &amp; DO</strong></td>
<td>Pay Adj (2017)</td>
<td></td>
<td>2-9 EPs &amp; solo</td>
</tr>
<tr>
<td></td>
<td>PQRS-Reporting</td>
<td></td>
<td>10+ EPs</td>
</tr>
<tr>
<td></td>
<td>(2017)</td>
<td></td>
<td>EHR Incentive Program</td>
</tr>
<tr>
<td><strong>DDM</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Oral Sur</strong></td>
<td>-2.0% of MPFS</td>
<td></td>
<td>Medicare Inc. (2015)</td>
</tr>
<tr>
<td></td>
<td>+2.0 (x), +1.0(x), or neutral</td>
<td></td>
<td>Medicaid Inc. (2015)</td>
</tr>
<tr>
<td><strong>Pod.</strong></td>
<td></td>
<td></td>
<td>$4,000-$12,000 (based on when EP did A/I/U)</td>
</tr>
<tr>
<td><strong>Opt.</strong></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Chiro.</strong></td>
<td></td>
<td></td>
<td>-3.0% of MPFS</td>
</tr>
</tbody>
</table>

Physicians in groups of 2-9 EPs & Solo physicians: -7.0%

Physicians in groups of 10+ EPs: -9.0%

---

*Note: MPFS stands for Medicare Payment File.*
EHR Incentive Program (aka “Meaningful Use”)
“Meaningful Use” Basics

- The EHR Incentive Programs consist of 3 stages of meaningful use
  - Each stage has its own set of requirements

- On March 20, 2015 the proposed rule for Stage 3 of the Medicare and Medicaid Electronic Health Record Incentive Programs went on display. It will be published in the Federal Register on March 30, 2015.
  - more flexibility
  - simplifies requirements for providers
  - Comment period closed May 29th, final rule forthcoming

- Eligible professionals always begin participating under Stage 1 requirements.
  - Stage 1 requirements are focused on capturing patient data and
  - sharing that data either with the patient or with other professionals
## Two EHR Incentive Programs

<table>
<thead>
<tr>
<th>Medicare EHR Incentive Program</th>
<th>Medicaid EHR Incentive Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Run by CMS</td>
<td>Every state runs its own program</td>
</tr>
<tr>
<td><strong>Maximum incentive amount is $43,720</strong> (across 5 years of program participation)</td>
<td><strong>Maximum incentive amount is $63,750</strong> (across 6 years of program participation)</td>
</tr>
<tr>
<td>Payment reductions begin in 2015 for providers who are eligible but choose not to participate</td>
<td>No Medicaid payment reductions if you choose not to participate</td>
</tr>
<tr>
<td>In the first year and all remaining years, providers have objectives they must achieve to get incentive payments.</td>
<td>In the first year, providers can receive an incentive payment for adopting, implementing, or upgrading a certified EHR.</td>
</tr>
<tr>
<td>In all remaining years, providers have objectives to achieve, just like Medicare.</td>
<td></td>
</tr>
</tbody>
</table>
Participant Eligibility

• Incentive payments for the **Medicaid EHR Incentive Program** are made to individual providers, not to practices or medical groups
  – Meet Medicaid patient volume thresholds OR
  – Practice predominantly in an FQHC or Rural Health Clinic where 30% of volume is derived from Medicaid, CHIP, uncompensated care, or sliding scale

• Although a provider can designate a practice to receive the incentive funds on their behalf, it is up to the provider to make this decision

• The practice or medical group cannot claim the money or make the decision for the provider, even if the EHR belongs to the practice

• Eligible professionals who are **hospital-based cannot participate** in the EHR Incentive Programs
  – i.e., if he or she provides more than 90% of their covered services in either an inpatient or emergency department of a hospital.
  – CMS makes the determination if you are **hospital-based**. You will find out your status when you register for the program.
Getting Started

• To show CMS that they have meaningfully used their certified EHR, providers must meet all of the Stage 1 requirements that CMS has established

• For the first year they participate, eligible professionals have to meet the requirements for and report data on a continuous 90-day period during the calendar year (any 90 days from January 1st to December 31st)
• For the remaining years they participate, eligible professionals have to meet the requirements for the entire calendar year. Both of these are called the reporting periods

• If 2015 is your first year, you MUST attest or you will be subject to negative payment adjustments

• Steps:
  – Make sure you are eligible
  – Register
  – Get a certified EHR
  – Meaningfully use your EHR
  – Attest
Report & Attest

• **13 core objectives** that every eligible professional must meet
  – Provide patients with the ability to view, download, or transmit their health information online
  – Computerized provider order entry (CPOE) Drug-drug and drug-allergy checks
  – Maintain an up-to-date problem list E-Prescribing (eRx)
  – Maintain active medication list Maintain active medication allergy list
  – Record demographics Record and chart changes in vital signs
  – **Record smoking status for patients 13 yo +** Implement clinical decision support
  – Protect electronic health information Provide clinical summaries at each office visit

• **Choose 5 of the nine “menu” objectives**
  – One of 2 public health objectives (mandatory to pick one)
    • Electronic data to immunization registry
    • Submit electronic surveillance data to public health agencies
  – Drug formulary checks Incorporate clinical lab-test results
  – Generate lists of pts by specific conditions Send reminders for preventive/follow-up care
  – Patient-specific education resources Electronic access to health information for pts
  – Medication reconciliation Summary of care record for transitions of care

• **9 Clinical Quality Measures (CQMs)**
  Two recommended core sets of CQMs on high-priority health conditions and best-practices
  – 9 CQMs for **adult populations** that meet all of the program requirements
  – 9 CQMs for **pediatric populations** that meet all of the program requirements
# 2015 Incentive Payments and 2017 Payment Adjustments

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MD &amp; DO</strong></td>
<td>Pay Adj (2017)</td>
<td></td>
<td>2-9 EPs &amp; solo</td>
<td>10+ EPs</td>
</tr>
<tr>
<td>Oral Sur</td>
<td>-2.0% of MPFS</td>
<td>+2.0 (x), +1.0 (x), or neutral</td>
<td>PPRS-Reporting (Up or Neutral Adj) (2017)</td>
<td>Medicare Inc. (2015)</td>
</tr>
<tr>
<td>Chiro.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Total Medicare Payment Adjustment at Risk for Non-Participation in PQRS and Meaningful Use in 2017**
  - Physicians in groups of 2-9 EPs & Solo physicians: -7.0%
  - Physicians in groups of 10+ EPs: -9.0%
# 2015 Incentive Payments and 2017 Payment Adjustments

<table>
<thead>
<tr>
<th>Practitioners</th>
<th>PQRs Value Modifier</th>
<th>EHR Incentive Program</th>
<th>Total Medicare Payment Adjustments at Risk for Non-Participation in PQRS and Meaningful Use In 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Assistant</td>
<td>Groups of 2+ EPs</td>
<td>Medicare Inc.</td>
<td>$8,500 or $21,250 (based on when EP did A/I/U)</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td></td>
<td>Medicaid Inc. (2015)</td>
<td>N/A</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td></td>
<td>Medicare Pay Adj. (2017)</td>
<td>N/A</td>
</tr>
<tr>
<td>Certified Registered Nurse Anesthetist</td>
<td></td>
<td></td>
<td>-2.0% of MPFS</td>
</tr>
<tr>
<td>Certified Nurse Midwife</td>
<td></td>
<td></td>
<td>-2.0% of MPFS</td>
</tr>
<tr>
<td>Clinical Social Worker</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered Dietician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition Professional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audiologists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapists</td>
<td></td>
<td></td>
<td>-2.0% of MPFS</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified Speech-Language Therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*EPs included in the definition of “group” to determine group size for application of the value modifier in 2017 (2 or more EPs). In 2017, VM only applies to payments made to physicians under the MPFS.

Beginning in 2018, VM will also apply to non-physician EPs.
EHR Incentive Program

Certified EHR

Meaningful Use Measures

Clinical Quality Measures

PQRS = PQRS Data

In some circumstances, the same data submission can meet PQRS and CQM requirements.

PQRS

Physician Compare (Public Reporting)

Value Modifier

Non-PQRS Outcome Measures (from claims)

Cost Measures (from claims)

Quality Composite Score

Cost Composite Score

Private Feedback Report

Value Modifier Adjustment

Quality & Resource Use Reports (QRUR)

Payment Adjustment based on scores (Quality Tiering)

Data Sources:
- Yellow = EHR Data
- Gray = Data supplied by physician groups
- Green = Data Calculated by CMS
Support for a successful transition
How to Report Once for 2015 Medicare Quality Reporting Programs
February 2015; Revised March 2015, April 2015

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How to Report Once for 2015 Medicare Quality Reporting Programs: Individual Eligible Professionals ______ 3
How to Report Once for 2015 Medicare Quality Reporting Programs: Group Practices __________________________ 5
How to Report Once for 2015 Medicare Quality Reporting Programs: Medicare Shared Savings Program Accountable Care Organizations ___________________________________________ 7
How to Report Once for 2015 Medicare Quality Reporting Programs: Pioneer Accountable Care Organizations 9

Next Steps: what you can do

• Decide whether and how to participate in the PQRS in 2015:
  o Group Reporting: Register for the 2015 PQRS GPRO between April 1, 2015 and June 30, 2015: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html
  o Individual reporting: No registration necessary.

• Choose a PQRS reporting mechanism and become familiar with the measures and data submission time frames: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_2015_Measure-List_111014.zip

• Review quality measure benchmarks under the VM: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

Take Advantage of Technical Assistance

• Health Services Advisory Group is the Quality Improvement Network for CMS in CA, AZ, OH, FL
  – Tasked with providing technical assistance to clinicians participating in these programs

• For QRUR and VM questions, contact the Physician Value Help Desk:
  o Phone: 1-888-734-6433 (select option 3)
  o Monday – Friday: 8:00 am – 8:00 pm EST

• For PQRS and IACS questions, contact the QualityNet Help Desk:
  o Phone: 1-866-288-8912 (TTY 1-877-715-6222)
  o Monday – Friday: 8:00 am – 8:00 pm EST
  o Email: qnetsupport@hcqis.org
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) signed on April 16
- permanently repealed the Sustainable Growth Rate (SGR)
- institutes a stable period of annual updates (0.5% through 2019)
- Establishes new payment models

MACRA establishes the Merit-Based Incentive Payment System (MIPS), which combines PQRS, the Value Modifier and the EHR Meaningful Use programs
- “Alternative Payment Models (APMs)” also established

Individual payment adjustments for PQRS, VM and MU sunset in 2018
MIPS contains four categories of performance assessment (weighted into a composite score 0-100):
- Quality measures (30%)
- Resource use (30%)
- Meaningful use of EHRs (25%)
- Clinical Practice Improvement Activities (15%)

- Quality Measures based on existing programs
  - Changes subject to annual MPFS rulemaking process
- QCDRs and EHRs will be heavily emphasized as preferred method for submitting measures
- MIPS payment adjustments start in 2019
  - 2019: – 4%
  - 2020: – 5%
  - 2021: – 7%
  - 2022: – 9%
- Upward adjustments will also be available

Pay-for-Value: The Future #2
Cardiovascular Disease Risk Reduction Model
Background & Rationale

• **New Value-Based Model** through the Million Hearts Challenge
  – Heart attack and stroke (ASCVD) are leading causes of death and disability

• In the past
  – Risk reduction focused on specific process measure targets, i.e. LDL cholesterol level and blood pressure, with the same targets applied to all patients
  – Currently, risk factors are discussed as independent conditions rather than risk factors contributing to ASCVD
  – Patients have little idea of their actual risks of heart attack and stroke

• What the model will change
  – Uses data-driven, widely accepted predictive algorithm to give individualized 10-year risk score for ASCVD to each beneficiary
  – Providers get value-based payment depending on absolute risk drop across entire panel, necessitating population health management
Important Features of This Model

• First CMS model to incentivize reduction in a predicted future risk, paving way for future innovative approaches to value-based prevention (e.g. reduction in other preventable conditions)

• Focus on meaningful, patient-centered risk score

• Transparent, easily understood provider financial incentive

• Rigorous design, with clustering at practice level, at large scale (360 intervention and 360 control practices, enrolling almost 300,000 Medicare FFS beneficiaries)

• Path towards nationwide scaling if model test is successful

• **Letter of Intent due by September 4th**

http://innovation.cms.gov/initiatives/Million-Hearts-CVDRM/
Where to Call for Help

- **QualityNet Help Desk:**
  - 866-288-8912 (TTY 877-715-6222)
  - 7:00 a.m.–7:00 p.m. CST M-F or qnetsupport@hcqis.org
  - You will be asked to provide basic information such as name, practice, address, phone, and e-mail

- **Provider Contact Center:**
  - Questions on status of 2013 PQRS/eRx Incentive Program incentive payment (during distribution timeframe)
  - See Contact Center Directory at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

- **Medicare EHR Incentive Program Information Center:**
  - 888-734-6433 (TTY 888-734-6563)

- **ACO Help Desk via the CMS Information Center:**
  - 888-734-6433 Option 2 or cmsaco@cms.hhs.gov

- **Comprehensive Primary Care (CPC) Initiative Help Desk:**
  - 800-381-4724 or cpcisupport@telligen.org

- **Physician Value Help Desk (for VM questions)**
  - Monday – Friday: 8:00 am – 8:00 pm EST
  - Phone: 888-734-6433, press option 3

- **Physician Compare Help Desk**
  - Email: PhysicianCompare@westat.com
Online Resources

- 2015 MPFS Final Rule

- CMS PQRS Website
  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS

- Medicare and Medicaid EHR Incentive Programs

- Medicare Shared Savings Program
  http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html

- CMS Value-based Payment Modifier (VM) Website
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

- Physician Compare
  http://www.medicare.gov/physiciancompare/search.html

- Frequently Asked Questions (FAQs)
  https://questions.cms.gov/

- MLN Connects™ Provider eNews
  http://cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Index.html

- PQRS Listserv
What is ICD-10?

In 1990, the World Health Organization (WHO) approved the 10th Revision of the International Classification of Diseases (ICD), known as ICD-10.

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<th>What</th>
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<tr>
<td>• A method of coding:</td>
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<td>» The patient’s state of health and</td>
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<td>» Institutional procedures</td>
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<td>• In the U.S., ICD-10 includes:</td>
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<td>» ICD-10-CM: clinical modification of WHO standard for diagnoses that is maintained by NCHS and is for specific use in the U.S.</td>
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<td>» ICD-10-PCS: inpatient procedures developed and maintained by CMS</td>
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<tr>
<td>• ICD-10-CM and PCS are complete revisions of their U.S. developed ICD-9 counterparts, which were adopted in 1979</td>
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<tr>
<td>» More information per code</td>
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<tr>
<td>» Better support for care management, quality measurement, and analytics</td>
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<td>» Improved ability to understand risk and severity</td>
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<td>• Compliance Date: 10/1/15</td>
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<td>» Outpatient services are based on the Date of Service</td>
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<td>• All HIPAA-covered entities must use ICD-10</td>
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CMS website: www.cms.gov/icd10

• Features fact sheets, FAQs, and implementation guides, timelines, and checklists
Questions?

Ashby Wolfe, MD, MPP, MPH  
Chief Medical Officer, Region IX  
Centers for Medicare and Medicaid Services  
90 Seventh Street, Suite 5-300  
San Francisco, CA 94103  
(Ph) 415.744.3631  
ashby.wolfe1@cms.hhs.gov