

## **The Physician Quality Reporting System & the Value-based Payment Modifier: What Medicare Eligible Professionals Need to Know in 2015**

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### **Video title slide with Intro Music**

#### **Introduction – Patrick Hamilton**

Hello, and welcome to the CMS *Physician Quality Reporting System and Value-based Payment Modifier: What Medicare Eligible Professionals Need to Know in 2015* presentation. My name is Patrick Hamilton, a Health Insurance Specialist from the Centers for Medicare and Medicaid Services. The purpose of today's presentation is to give an overview of the Physician Quality Reporting System, or PQRS, and how your participation in PQRS in 2015 will determine how the Value-Based Payment Modifier will be applied to physicians' reimbursement in 2017. This MLN Connects video is part of the Medicare Learning Network.

2015 is a very important year for PQRS as it is the performance year to determine if eligible professionals will be assessed the 2 percent payment adjustment for PQRS in 2017. Equally as important is that 2015 is also the year in which performance in PQRS will determine the application of the Value-based payment modifier in 2017 for physicians in groups of all sizes, as well as for physicians who are solo practitioners. CMS has taken a phased-in approach in assessing the value modifier, with physicians in groups of 100 or more eligible professionals being the first segment of the Medicare provider population to be subject to the modifier in 2015, physicians in groups of 10 or more eligible professionals will be assessed the value modifier in 2016, and physicians in groups of 2-9 EPs as well as individual physicians who are solo practitioners will be incorporated into the program in 2017. So for physicians who are part of a group practice of any size, and for solo physician practitioners, your PQRS performance in 2015 will determine the value modifier that will be added to your Part B fee for service reimbursement in 2017. CMS has continued its outreach efforts with the Medicare provider community to ensure that you have the most up-to-date knowledge and information available to assist you in understanding PQRS and the value-based payment modifier.

#### **Slide 2**

In this presentation we will review the updates to the PQRS program for 2015; discuss the incentive payments that are available for the EHR meaningful use program for participating in that program in 2015, as well as the payment adjustments associated with PQRS and with the value modifier. We will go into detail regarding the various reporting methods for PQRS in 2015, for both those EPs reporting as individuals and for those groups that choose the group practice reporting option, or "GPRO". Next, we will review the Value-based Payment modifier policies for 2015, including how the value modifier will be applied to physicians' reimbursement in 2017, how quality tiering will work in 2017, and how your PQRS activity in 2015 will determine your value modifier in 2017. We will also briefly discuss how the value modifier will be applied to EPs who are participating in the shared savings program and other Innovation Center models. In closing, we will discuss the new informal inquiry process for the VM when there is a potential error in calculations, and review what information will be publicly reported on the physician compare.

**Slide 3**

We'll begin with the updates to the Physician Quality Reporting System for 2015.

**Slide 4**

The changes to the PQR program for 2015 were done through the regular annual rule making process for the 2015 Medicare physician fee schedule. CMS published the proposed rule for the 2015 MPFS on July 11, 2014, with a 60 day comment period. The final rule, which included the updates to the PQR and VM programs was published on November 13, 2015.

CMS added 23 new measures for 2015, both as individual measures and some that were included in measures groups. 50 individual measures, along with 38 measures that were in various measures groups in previous years were retired for the 2015 program.

For those using the registry reporting option and reporting measures groups, 2 new measures groups have been developed: Sinusitis and Acute Otitis Externa, and 4 groups have been retired: perioperative care, back pain, cardiovascular prevention, and ischemic vascular disease. Also for the registry reporting option, the 6-month reporting option previously available is no longer available, so all reporting periods in 2015 are for 12-months.

And starting in 2015, EPs in critical access hospitals who elect the method II of billing can use all options, including claims, to participate in the program.

**Slide 5**

In discussing the incentives and the payment adjustments that are associated with the quality programs we are discussing today, it is important to keep in mind that while there are no longer incentives available for PQR starting in 2015, your successful participation in PQR will impact your value modifier in 2017, which could be an upward, neutral or downward adjustment. We'll go into more detail as to how a little later. Also, there are still incentives available for meaningful use in 2015, which we will briefly describe.

**Slide 6**

The charts on this slide and the next slide show the incentives that are available in 2015, as well as the payment adjustments that will be assessed in 2017 based on your participation in the various programs included for all eligible professionals. This slide focused on physicians, with the green columns indicating potential incentives, and the red columns indicating potential payment adjustments, all of which would be assessed in 2017.

For PQR, as I mentioned previously, 2014 was the final year for incentives, so starting in 2015, your successful reporting in PQR will enable you to avoid the 2 percent payment adjustment in 2017. For the value modifier, the assessment of the upward, neutral, or downward adjustment will depend on the size of the group in which the physician practices (or if he or she is a solo practitioner). For physicians in groups with 2-9 EPs, and for physicians who are solo practitioners, since this is the first year in which your PQR activity will determine your VM in 2017, you will be held harmless this year to any downward adjustment, meaning that, if you successfully report for PQR, then you would be subject

only to an upward or neutral adjustment. We'll go into detail as to how that upward adjustment is calculated later. For physicians in groups of 10 or more EPs, you will be subject to upward, neutral or downward adjustments based on quality tiering for those who report for PQRS in 2015. The upward adjustment will be explained on a later slide, but the downward adjustment that these physicians could be assessed is either 2% or 4%. Regardless of the size of the group, or solo status, non-reporting of PQRS in 2015 means an automatic downward adjustment...for solo physicians and for physicians in groups of 2-9 EPs, the automatic VM downward adjustment is 2% for non-reporting, for physicians in groups of 10 or more EPs, the automatic VM reduction is 4% . This is in addition to the 2% reduction for PQRS.

Though we are not going into detail for the meaningful use program in this presentation, it is important to note that incentives are still available in 2015 for participating in the MU program. If you are a successful meaningful user in 2015, you can earn an incentive in the Medicare MU program of anywhere between \$4,000 and \$12,000, depending on when you started the program. If you are participating in the Medicaid MU program in 2015, your incentive could be \$21,250 if you are starting this year, or up to \$8,500 if you are already along your way in MU. For those physicians who are eligible professionals in the Medicare MU program and who do not successfully report in 2015, the MU payment adjustment is 3 percent.

So as you can see in the final column, it is critical that physicians participate in PQRS and MU in 2015, so that you can maximize the incentives that are available and avoid the payment adjustments associated with each program in 2017.

#### **Slide 7**

The next slide shows the same programs and how they will affect reimbursement for non-physician practitioners. As for PQRS, all EPs listed are subject to payment adjustments for PQRS in 2017 if they do not successfully report in 2015. For the value modifier, non-physician EPs will not be subject to the VM in 2017 based on their 2015 PQRS activity, however, that will change in 2018 in that these EPs will have the VM assessed to their reimbursement, most likely based on 2016 PQRS reporting, subject to future rulemaking. So for these professionals, CMS recommends that you start PQRS reporting this year if you have not already done so. Additionally, these non-physician practitioners are included when CMS calculates the size of the group for purposes of assessing the VM to physicians. So, for example, when we say "physicians in groups of 10 or more EPs," we mean the total number of EPs, both physicians and non-physician practitioners that constitute the entire group (even though currently we are only assessing the VM to the reimbursement of the physicians in that group).

Non-physician practitioners are not eligible for the Medicare MU program, so the Medicare payment adjustments would not apply to these EPs, and for the Medicaid MU program, PAs, NPs, and CNMWs can earn an incentive if they meet the criteria. There are no payment adjustments in the Medicaid MU program. So the maximum payment adjustment for non-physician practitioners in 2017 is 2.0%.

#### **Slide 8**

Next, we will look at the various methods of reporting for PQRS in 2015, for both individual EPs and for groups who choose to report using the Group Practice Reporting Option.

#### **Slide 9**

For individual EPs who choose to report using claims, the requirement for 2015 is to choose 9 measures

that come from at least 3 of the 6 National Quality Strategy, which include patient safety, person and caregiver-centered experience and outcomes, communication and care coordination, effective clinical care, community and population health, and efficiency and cost reduction. These are the same domains that were in place for the 2014 PQRS program, and are the same 6 quality domains for the clinical quality measures component of the meaningful use program. New in 2015 is the requirement to report on at least 1 cross cutting measure, which are listed in upcoming slides. These cross cutting measures must be reported if the EP has at least one face-to-face encounter with a Medicare beneficiary. Face to face encounters are identified by billable codes, and generally include office visits, outpatient visits and some surgical procedures. Services rendered using telehealth technology are not considered face to face encounters.

In the instance in which an EP cannot choose at least 9 measures from at least 3 of the quality domains, CMS will use the measures applicability validation process for EPs who report less than 9 measures, or measures from less than 3 of the quality domains. Note that the claims reporting option is available only to individual EPs, not to group practices reporting under the GPRO.

#### **Slide 10**

We have developed a set of decision trees, similar to the ones that were used in last year's presentations to help providers determine if they meet the criteria for the various reporting methods. The first decision tree we will look at is for individual EPs who are using the claims method of reporting. The measure type that is available for claims are individual measures (as opposed to measures groups). The requirement again is at least 9 measures from at least 3 of the quality domains. If you are able to choose at least 9 measures from at least 3 domains, then that is what you will submit. If you cannot select 9 measures from at least 3 domains, then you will choose 1 to 8 measures from 1 to 3 of the domains. In either case, if there is at least one face to face encounter as described previously, you must report one cross cutting measure. You also must report each measure for at least 50 percent of your Medicare Part B fee for service patients seen during the entire 12-month reporting period, and any measure that has a 0% performance rate would not count toward your total.

#### **Slides 11-13**

The following slides give a listing of the cross cutting measures that are to be reported if an EP has at least one face to face encounter with a Medicare Part B fee for service patient during the reporting period. As you can see, all of the cross cutting measures are taken from each of the 6 quality domains. Please pay close attention to the reporting method that each cross cutting measure can be used to submit. An updated list of the codes that are considered face to face encounters can be found on the PQRS page of the CMS website, by clicking on Measures Codes on the left hand side of the page and scrolling to the section titled "2015 Cross-Cutting Measures Requirement."

#### **Slide 14**

The use of a qualified registry is another way that both individuals and groups can report PQRS measures in 2015. It is also the only method that individual EPs can use who wish to report measures groups. Those using a registry and reporting on individual measures are also held to the requirement of reporting on at least one cross cutting measure if there is at least one face to face encounter with a Medicare patient as previously discussed. Also previously mentioned is the removal of the 6-month reporting option for measures group using a registry, as had been available in past years. In 2015, the reporting period for registries is a full 12 months. CMS extended the deadline for reporting quality measures data through registries to March 31, 2016 for this year's program, which is an extension from

the previous deadline of February 28th.

**Slide 15**

For individuals using a qualified registry, the first question to ask is “which types of measures will you be reporting?” If you are reporting individual measures, then can you report at least 9 measures from at least 3 domains? If so, then that is what you will report. If you cannot find 9 measures from at least 3 domains, then then you will choose 1 to 8 measures from 1 to 3 of the domains. As with the claims option, in either case, if there is at least one face to face encounter, you will report one cross cutting measure, and the same 50 percent rule applies. If you are in a practice that is able to report on one of the measures groups, and that is the route you go, then you may select one of the measures groups, which are listed on the next slide, report each measure contained within that group for at least 20 patients, with a majority of those patients being Medicare Part B fee for service patients. Any measure with a 0 performance rate would not be counted. So for example, if you choose a sample size of 20 patients, 11 of those patients must be Medicare Part B fee for service patients (Medicare advantage patients do not count in this total). As with the claims reporting option, any EP submitting less than 9 measures from 1 to 3 domains would be subject to the validation process.

**Slide 16**

The table on slide 16 shows the 22 measures groups that are available for registry reporting in 2015. Each group contains at least 6 associated measures that are related to a particular condition. If an EP chooses a measures group, then all of the measures that are included within that group must be reported at least once for all patients included in the sample. CMS has developed specification documents for all measures groups, which can be found on the Measures Codes section of the PQRS page of the CMS website.

**Slide 17**

CMS has been working diligently to assist specialty providers find appropriate measures for PQRS reporting that pertain to the specialty scope of practice. To that end, we have worked with numerous specialty societies to develop a suggested (not required) list of measures that could be chosen for reporting purposes. The 12 specialties that are listed on slide 17 currently have suggested measures lists that can aid an EP in these fields to successfully meet the reporting requirements for this year’s program. Details for these measures sets can be found on the Measures Codes section of the PQRS webpage.

**Slide 18**

CMS continues to strongly encourage the reporting of PQRS quality measures through an EP’s certified EHR system, or through use of a data submission vendor. Doing so is the best way to enable a provider who needs to report quality measures for both PQRS and for meaningful use to have the opportunity to report measures one time and receive credit for both programs. Those who opt to use their certified EHR or a DSV must comply with Quality Data Reporting Architecture categories 1 or 3, and are required to use the July 2014 version of electronic clinical quality measures. Though the July 2014 versions of the eCQMS are required, CMS is not requiring a separate test of the certified system.

**Slide 19**

The decision tree on slide 19 reviews the requirements for individuals choosing to report using a certified EHR or DSV. The measure type that can be reported using this method is individual measures. And the requirement is to report 9 measures from at least 3 of the quality domains. If the certified system or DSV used by the EP does not have patient data to meet the 9 measure/3 domain requirement, then the provider would report on all measures for which there is Medicare patient data. Keep in mind that an EP's certified EHR will include data for the entire patient population. To that end, the EP must report on at least one measure that has Medicare patient data.

**Slide 20**

The qualified clinical data registry, or QCDR, was a new way to report PQRs measures starting in 2014 and continues to be an approved reporting method in 2015. QCDRs are available to individual EPs only in 2015, and EPs who choose to use a QCDR must report on at least 2 outcome measures as part of the quality codes they are submitting. If there are less than 2 outcome measures available to report, then the EP would report one outcome measure, and one additional measure from either the patient safety, the resource use, the patient experience of care or the efficiency/appropriate use quality domains. More information about the outcome measures can be found in the PQRs Implementation Guide on the PQRs page of the CMS website.

CMS increased the number of non-PQRs quality measures that can be included in a QCDR to 30 in 2015. QCDRs will be required in 2015 to make publicly available, via the Physician Compare website, the quality measures data that is collected for the PQRs. CMS expects to have the list of approved QCDRs available by Summer 2015.

**Slide 21**

EPs using a QCDR in 2015 will have the opportunity to report on both PQRs measures, and non-PQRs measures (up to 30) that are included to be reported in a qualified clinical data registry. A QCDR that is approved to be included in the PQRs will have at least 9 measures covering at least 3 of the quality domains and each measure must be reported for at least 50% of the EP's applicable patients during the 12-month period to which the measure applies. We reviewed the requirement regarding the outcome measures on the previous slide.

**Slide 22**

Now we will detail the reporting criteria for groups who choose to register for the group practice reporting option, or GPRO in 2015.

**Slide 23**

Group practices that wish to participate in the GPRO in 2015 must register in the PV-PQRs system between April 1 and June 30, 2015. There is no requirement that groups must participate in the GPRO, though groups who have the capability to find measures that are applicable to all EPs in the practice are encouraged to do so. The size of the group, that is the total number of all eligible professionals under the TIN of the group, will determine which reporting methods are available for reporting purposes. For example, only groups of 25 or more EPs may use the GPRO web interface. Also, starting in 2015, all

groups that register for the GPRO that have more than 100 EPs will be required to submit patient survey data via the Consumer Assessment of Healthcare Providers and Systems, or CAHPS survey.

**Slide 24**

Groups of all sizes that register for the GPRO can report measures using a qualified registry, but for purposes of this decision tree, we are going to focus on groups of 2-99 EPs, as the requirements for groups of 100+ EPs are slightly different and will be discussed in a few slides. For groups of 2-99 EPs, again, the requirement would be similar to the requirement for individuals using a qualified registry...reporting 9 measures from at least 3 of the quality domains. If the group can do so, that is what they will report. If 9 measures from at least 3 domains is not possible for the group, then the group can report 1-8 measures covering 1, 2 or 3 of the quality domains. The validation process would apply in this instance. And as with the individuals, for groups the requirement for one cross-cutting measure if there is at least one Medicare patient face-to-face encounter is in place, as is the requirement to report each measure for at least 50% of the Medicare Part B FFS patients.

**Slide 25**

For groups that will use their certified EHR system, or use a data submission vendor and again here we will focus on groups of 2-99 EPs, as the requirement for groups of 100 or more EPs is slightly different, the requirement is to report 9 measures covering at least 3 of the quality domains, just as it is for EPs reporting as individuals. If 9 measures from the 3 domains cannot be reported, then the group will report the measures for which there is Medicare patient data. Keep in mind that at least one measure reported must pertain to Medicare patients.

**Slide 26**

As mentioned, groups of 25 or more EPs can use the GPRO Web Interface in 2015 to submit quality measures. In previous years, the size of the beneficiary sample that was to be developed to populate data fields depended on the size of the group. After analyzing data from groups of different sizes, CMS determined that the beneficiary sample size should be the same for groups of all sizes, which has been set at 248 beneficiaries. If a group using the GPRO web interface has less than 248 patients to include in the sample, then 100% of the patients for the group would be included. Important note: if the group does not have any Medicare patients for any of the measures that are included in the Web interface, then the group should choose another method of reporting.

**Slide 27**

The requirements for the GPRO web interface is the same for all groups of 25 or more EPs. All groups will report on all of the measures in the GPRO interface (17 in all), and they will populate the data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the sample for each module or preventive care measure. As mentioned if there are fewer than 248 patients available, then the group will report on 100 % of their patients. And at least one measure in the web interface must have Medicare beneficiary data.

For groups of 100 or more EPs, in addition to reporting on all of the measures in the web interface, these groups will be required in 2015 to report the CAHPS survey measures as well.

**Slide 28**

The CAHPS survey that is required for groups of 100 or more EPs is an optional method of reporting for other groups comprising of 2-99 EPs if they wish to include the patient survey data as part of their

quality measures. Regardless of group size, groups who are using the CAHPS survey will be required to contract with a certified vendor who will collect the survey data and submit that data to CMS on behalf of the group. Starting in 2015, groups will be responsible for the cost of administering the survey. The measures that are included in the 2015 CAHPS survey are the same 12 measures that were included in the survey in 2014, which include measures such as getting timely care, communication, shared decision making, care coordination, helpfulness of office staff, among others.

**Slide 29**

Groups who submit the CAHPS survey data, either voluntarily or because it is mandatory, will do so in conjunction with one of the other reporting methods for submission of additional quality measures. Groups opting for the qualified registry will be required to report on just 6 measures from at least 2 of the quality domains. If the group cannot report on at least 6 measures from at least 2 domains, then they may report on 1-5 measures, with a cross cutting measure being included. The validation process would apply in this case

Groups choosing to use the GPRO web interface, the requirement is the same...reporting on all measures, adhering to the patient sample size and the other parameters discussed earlier. Finally, for groups using a certified EHR system or a data submission vendor, they would report 6 measures from at least 2 domains, or up to 5 measures if 6 do not apply to the scope of the group's practice. And at least one measure reported must contain Medicare patient data.

**Slide 30**

We'll now move into the updates to the Value-based payment modifier.

**Slide 31**

The Value-Based Payment Modifier, which was part of the Affordable Care Act of 2010, is a measure of both the quality of care and the cost of that care that is provided to patients by Medicare physicians. CMS has taken a phased-in approach in assessing the value modifier, with physicians in groups of 100 or more eligible professionals being the first segment of the Medicare provider population to be subject to the modifier. For this group, the modifier will be assessed in 2015, based on 2013 performance in PQRS. The second segment of the Medicare provider population will be assessed the value modifier in 2016, based on 2014 performance in PQRS. Individual physicians and physicians in groups of fewer than 10 EPs will be the last to be incorporated into the program in 2017, based on their 2015 PQRS reporting.

For physicians in groups with 2-9 EPs, and for physicians who are solo practitioners, since 2015 is the first performance year for purposes of the value modifier to be assessed in 2017, they will be subject to only an upward or neutral adjustment, if they are PQRS reporters. Physicians in groups of 10 or more EPs will be subject to upward, neutral or downward VM adjustments based on quality tiering. Regardless, physicians in groups of all sizes and solo practitioners will be subject to an automatic downward adjustment for the VM if they do not report PQRS measures via one of the reporting methods discussed earlier. Keep in mind this would be in addition to the 2% PQRS downward adjustment.

CMS will also use the 2015 performance period to apply the VM to physicians participating in the Medicare Shared savings program, the pioneer ACO model, the comprehensive primary care initiative and other Innovation center models.

And in 2018, the VM will be applied to reimbursement of non-physician practitioners, based on future rulemaking.

**Slide 32**

The next three slides give an overview of how the VM policies have evolved since 2013, which was the first performance year for groups of 100 or more EPs. CMS adopted a two year look back period for the VM program, similar to other program such as PQRS, e-prescribing and meaningful use, meaning that we will look at the performance two years prior to the year in which the modifier would be assessed. So for the 2017 value modifier, CMS will look at performance in 2015 PQRS to determine what modifier will be applied.

As mentioned, CMS phased in the VM according to group size, with physicians in groups of 100 or more EPs being the first segment to be assessed the VM in 2015, groups of 10 or more EPs will be assessed the modifier in 2016, with all physicians being on board by 2017. We reviewed the reporting options available in 2015 for PQRS, and the downward adjustment that is possible for physicians in groups of all sizes and solo practitioners, based on both quality tiering and for non-reporting of PQRS.

The outcome measures, which were developed in 2013, continue to be the outcome measures that are used in the program today, those being all cause readmission; a composite of acute prevention quality indicators that include bacterial pneumonia, urinary tract infection and dehydration; and a composite of chronic prevention quality indicators, which includes COPD, heart failure and diabetes.

We discussed earlier the inclusion of the patient survey measures.

**Slide 33**

The cost measures that CMS will consider are the same measures that were used in 2014, which is a total per capita costs measure which are the annual payment-standardized and risk-adjusted Part A and Part b costs, and the total per capita costs for beneficiaries with the chronic conditions of COPD, heart failure, coronary artery disease and diabetes; as well as the Medicare spending per beneficiary for all A and B costs during the 3 days before and the 30 days after a Medicare inpatient hospital stay.

For both the quality and the costs measures, CMS will not differentiate according to group size, meaning all groups will be compared to everyone.

We will discuss tiering and how the VM will be applied to the EPs in other programs in a few slides.

**Slide 34**

CMS has made revisions to the informal review process, both in terms of the timeline for requesting an informal review and for how CMS will make corrections when an error in the calculation of either the cost or quality scores is discovered. We will go into detail on that process shortly. It is important to note that the timeline for requesting an informal review will be based on the release date of the group's Quality and Resource Use Report, or QRUR, so it is imperative that groups obtain the reports when they are made available, generally in the fall.

**Slide 35**

We'll now go into detail as to how quality tiering will be applied to physicians in groups of various sizes.

**Slide 36**

As we've mentioned earlier, physicians in groups of 2-9 EPs, as well as physicians who are solo practitioners will not be subject to the downward payment adjustment in quality tiering in 2017 so long as they report PQRS measures. Physicians in this category, however, will be subject to the automatic VM downward adjustment of 2% if they do not report for PQRS, in addition to the 2% PQRS adjustment.

Additionally, if a group's average beneficiary risk score is in the top 25%, the group could be eligible for an additional upward adjustment of a factor of 1. You can see where your group's risk score falls on your annual QRUR report.

**Slide 37**

The cost and quality categories are the same for groups of 10 or more EPs, with the major difference being that these groups are subject to possible downward adjustments based on quality tiering in 2017. As you can see from the chart, physicians in these groups could see a reduction of 2 or 4%, but conversely can see an upward adjustment of a factor of 2x or 4x, based on their scoring. We've indicated what the exact negative adjustments are in this table, but we have not indicated exactly what the upward percentages are, because all of the value modifier adjustments have to be budget neutral. So we have to calculate how much money we have available to give for the upward adjustments. In order to ensure budget neutrality, we will first calculate the total amount of downward payment adjustments that will be applied. This includes the automatic downward Value Modifier payment adjustment for the "non-PQRS reporters" and also the downward adjustments for groups of 10 or more eligible professionals that are subject to quality tiering. Using the total downward payment adjustment amount, we will then solve for the upward payment adjustment factor (x), and apply accordingly. These groups are also eligible for an additional upward adjustment if the beneficiary risk score is in the top 25 percent.

**Slide 38**

The decision tree on slide 38 shows how an individual EP's or a group's decision to participate in PQRS in 2015 will determine the VM in 2017. The main question to ask is whether you will report for PQRS this year. If the EP or group does not, and hopefully this is not the decision you will make, all EPs will be subject to the 2% PQRS payment adjustment; additionally, all physicians on groups of 2-9 EPs and all physicians who are solo practitioners will be subject to an automatic 2% downward adjustment for the VM; all physicians in groups of 10 or more EPs will be subject to an automatic downward adjust of 4% for the VM.

If you do plan to report for PQRS this year, and we strongly encourage that you do, then you need to determine if you are reporting as a solo EP or as part of a group. If you are reporting as a solo practitioner, then are you a physician? If yes, then by reporting PQRS, you avoid the 2017 PQRS payment adjustment, and you will be assessed either an upward or neutral adjustment for the VM. If you are not a physician, but are reporting PQRS, then you also avoid the 2017 PQRS adjustment, but the VM does not apply to you in this performance year.

If the EP is part of a group (that is, registered as a group in the PECOS enrollment system, then the

decision will have to be made as to whether the group will participate in PQRS via the GPRO option by registering on PV-PQRS page between April 1st and June 30th, 2015, and if the group does so, and is successful in reporting, then all of the EPs under the TIN of the group will avoid the PQRS payment adjustment in 2017. I will discuss the 50% threshold option in a moment. For physicians in groups of 2-9 who register for the GPRO and are successful avoid the automatic downward VM adjustment, and will be assessed an upward or neutral adjustment. Physicians in groups of 10 or more EPs who register for the GPRO and report successfully avoid the automatic downward VM adjustment, but will be assessed an upward, neutral or downward adjustment based on quality tiering.

If the EP is in a group, but the group makes the decision for its EPs to report as individuals, as opposed to the GPRO, then you need to determine if the group meets the 50% threshold option. Since the 2017 VM is being applied to physicians in groups of 2 or more EPs (as well as solo docs) based on 2015 participation, we can easily identify groups of physicians who elect to participate in PQRS thru GPRO. But since there is no statutory requirement for groups that exist as a group in PECOS to participate in PQRS under the GPRO, those groups still need to be identified in order for the VM to be properly assessed in 2017. So CMS came up with 50 percent threshold. If you are in a group of 2 or more eligible professionals and your group decides not to report at the group level, then the EPs in your group can still report PQRS data individually. In this case, CMS will calculate a group quality score if at least 50% of the eligible professionals in your group report PQRS individually and successfully avoid the 2017 PQRS payment adjustment. An important note: the 50% threshold only applies to the adjustment for the VM. Meaning, that if the 50% threshold option is met, then all of the EPs under the group TIN will avoid the automatic VM downward adjustment (and will be subject to quality tiering); however, only those EPs who actually submitted quality data. And if the group does not register for the GPRO and does not meet the 50% threshold criteria, then they will see the same adjustments in the red box on the right.

**Slide 39**

As mentioned, 2017 will be the first year in which the VM will be applied to physicians who are participating in the Medicare shared savings program, the pioneer ACO model, the comprehensive primary care initiative as well as other programs established by the CMS Innovation Center.

**Slide 40**

2015 will be the performance year for individual EPs and groups participating in the shared savings program. For those EPs, cost composite will be given a score of "average," while the quality composite will be based on quality data that is submitted by the EP or group per the requirements of the shared savings program. CMS will determine if a group or individual EP is part of an Accountable Care Organization based on the TIN and whether that TIN was a shared savings ACO participant in 2015. The value modifier benchmarks will be applied to the ACO quality data that is submitted by the group through the web interface, and the ACO all cause hospital readmission measure will be used as calculated by the shared savings program.

If the ACO does not successfully report on the required quality measures, the groups and individual EPs will be subject to the applicable automatic downward VM adjustment.

**Slide 41**

For solo physicians and physician groups in which at least one EP is participating in the pioneer ACO model or the comprehensive primary care initiative in 2015, will have their 2017 VM calculated with a cost composite score of average and a quality composite score of average. As such, they will not be

subject to the 2017 VM downward adjustment.

And for EPs who are participating in other similar type initiatives established by the CMS Innovation Center, then the cost and quality scores will be calculated in a manner similar to the way those scores are calculated for the Pioneer ACO and CPCI participants.

**Slide 42**

The 2015 Medicare physician fee schedule also made changes to the process by which EPs and groups can request an informal review of the application of the VM.

**Slide 43**

For the 2015 VM, CMS established a February 28, 2015 deadline for groups to request any correction of a possible error in the calculation of their VM. Beginning in 2016, and continuing in 2017, the deadline for requesting any such review will be set at 60 days after the QRUR report has been made available to the EP or group, so again, it is important that you download your report as soon as it is available to you.

In the event that an error has been determined, in 2015, for quality, CMS will automatically set a group to a score of “average” quality, while an error in the cost composite will prompt a recalculation. Starting in 2016 and continuing in 2017, an error in the quality score will lead to a recalculation of the quality composite rather than an automatic default to an “average” score. Errors in cost will continue to prompt a recalculation of that composite. If for whatever reason CMS cannot do a recalculation of the quality composite in the event of an error, then a score of “average” will be given.

**Slide 44**

CMS continues to increase the amount of information made public via the Physician Compare as it relates to quality reporting.

**Slide 45**

For groups, the 2015 fee schedule final rule calls for the reporting of all PQRS measures that are reported through all reporting methods, including the GPRO web interface, certified EHRs or data submission vendors, or through registries. Groups who are in an Accountable Care Organization will have all ACO measures publicly reported, and groups who use the CAHPS patient survey will have all measures reported, both for PQRS and for ACOs.

For individual EPs, those who are reporting quality measures in support of the Million Hearts Initiative will have their measures publicly reported on Physician Compare, and all PQRS measures, whether reported through claims, a qualified registry, an EHR or DSV, or a qualified clinical data registry will have their results included on the Physician compare site. The only exclusion would be for measures in a QCDR that are first year measures. They will not be reported on the Physician Compare site for the first year.

**Slide 46**

Finally, we have provided this slide to give EPs and groups a quick overview of how you can participate in PQRS in the different reporting options, based on your status as an individual EP, being a physician or a non-physician practitioner, whether you will report as part of a group in the GPRO, and if so, the size of that group. The right hand side of the chart gives a summary of how PQRS reporting in 2015 will affect both the PQRS payment adjustment and the VM adjustment in 2017.

**Closing – Patrick Hamilton on camera**

And with that summary review, that will conclude our presentation. Thank you for viewing this MLN Connects video presentation on Physician Quality Reporting System and Value-based Payment modifier.

**Slides 47-49**

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