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National Provider Call

Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Final Rule

December 8, 2015



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Agenda

- 2016 Medicare Physician Fee Schedule (MPFS) Final Rule
 - Physician Quality Reporting Program (PQRS)
 - Electronic Health Record (EHR) Incentive Program
 - Aligned Reporting
 - Value-Based Payment Modifier (VM)
 - Medicare Shared Savings Program (SSP)
 - Public Reporting
- Resources & Who to Call for Help
- Question & Answer Session
- Appendices

[Acronyms](#)

Physician Quality Reporting System (PQRS)

Presenter: Alexandra Mugge

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PQRS Overview

- CY2018 payment adjustments, based on PY2016 reporting: -2.0% MPFS
- Changes to PQRS
 - Definition of eligible professional (EP) for purposes of participating in PQRS
 - Changes to the requirements for the qualified clinical data registry (QCDR) and qualified registries
 - QCDRs and qualified registries have more time in which to self-nominate
 - Revised auditing requirements for entities submitting PQRS quality measures data (qualified registries, QCDR, direct EHR, or direct Data Submission Vendor [DSV] product)

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Definition of an Eligible Professional (EP)

Under PQRS, an EP is defined as one of the following types of professionals:

- Medicare physicians
 - Doctor of Medicine
 - Doctor of Osteopathy
 - Doctor of Podiatric Medicine
 - Doctor of Optometry
 - Doctor of Oral Surgery
 - Doctor of Dental Medicine
 - Doctor of Chiropractic
 - Practitioners
 - Physician Assistant
 - Nurse Practitioner*
 - Clinical Nurse Specialist*
 - Certified Registered Nurse Anesthetist* (and Anesthesiologist Assistant)
 - Certified Nurse Midwife*
 - Therapists
 - Clinical Social Worker
 - Clinical Psychologist
 - Registered Dietician
 - Nutrition Professional
 - Audiologists
- *Includes Advanced Practice Registered Nurse (APRN)
- *View the [2016 PQRS List of Eligible Professionals](#) on the PQRS webpage.

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Changes to PQRS Reporting Criteria

- Changes to group practice reporting option (GPRO):
 - New QCDR reporting option
 - Optional Consumer Assessment of Healthcare Providers and Systems (CAHPS) reporting for groups of 25-99 EPs
 - Required CAHPS reporting for groups of 100 or more EPs regardless of reporting mechanism
- Changes for QCDR Vendors
 - Support tax identification number (TIN)-level reporting
 - New process for self-nomination and attestation
 - Revised auditing requirements
- Changes Registry Vendors
 - New process for self-nomination and attestation
 - Revised auditing requirements
- EHR
 - Revised auditing requirements

[Acronyms](#)

Individual Reporting

- Available reporting mechanisms for 2016 program year:
 - Claims
 - Registry
 - EHR (Direct or Data Submission Vendor)
 - QCDR

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Individual Reporting: Claims

- There were no changes for claims reporting for individual EPs

9 measures covering at least 3 National Quality Strategy (NQS) domains **OR** if <9 measures or <3 domains apply, report on each applicable measure

AND report each measure for at least 50% of the Medicare Part B Fee-for-Service (FFS) patients for which the measure applies

- If an EP sees one Medicare patient in a face-to-face encounter, they must report on at least 1 cross-cutting measure (included in the 9 measures)
- Measures with 0% performance rate will not count

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Individual Reporting: Registry and Measures Groups via Registry

- There were no changes for registry-based reporting for individual EPs

9 measures covering at least 3 NQS domains **OR** if <9 measures or <3 domains apply, report on each applicable measure

AND report each measure for at least 50% of the Medicare Part B FFS patients for which the measure applies

- There were no changes for measures groups via registry reporting for individual EPs

1 measures group for 20 applicable patients of each EP

- A majority of patients (11 out of 20) must be Medicare Part B FFS patients
- Measures groups containing a measure with a 0% performance rate will not be counted

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Individual Reporting: EHR (Direct or DSV)

9 measures covering at least 3 of the NQS domains. **If** an EP's EHR does not contain patient data for at least 9 measures covering at least 3 domains, then the EP must report on all the measures for which there is Medicare patient data.

Report on at least 1 measure for which there is Medicare patient data.

- Certified EHR Technology (CEHRT) Requirement for Electronic Clinical Quality Measures (CQM) reporting
 - Providers must use technology that is CEHRT
 - Providers must create an electronic file using CEHRT that can be accepted by CMS for reporting

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Individual Reporting: QCDR

9 measures (PQRS measures and/or non-PQRS measures) available for reporting under a QCDR covering at least 3 NQS domains

AND each measure for at least 50% of the EP's patients

- Of these measures, EP would report on at least 2 outcome measures

OR

- If 2 outcome measures are not available, report on at least 1 outcome measure and at least 1 resource use, patient experience of care, efficiency/appropriate use, or patient safety measure

[Acronyms](#)

Group Practice Reporting Option (GPRO)

- Available reporting mechanisms for 2016 program year:
 - Web Interface (WI)
 - Registry
 - EHR (Direct or DSV)
 - QCDR
 - CAHPS for PQRS is:
 - **Optional** for PQRS group practices of 2-99 EPs reporting electronically, using a QCDR, or a Qualified Registry
 - **Optional** for PQRS group practices of 25-99 EPs reporting via GPRO WI
 - **Required** all PQRS group practices of 100 or more EPs, regardless of reporting mechanism
- Groups must register to report via the GPRO

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GPRO Reporting: Web Interface (WI)

PQRS Group Practices not reporting CAHPS for PQRS:

- Report on all measures included in the WI for the first 248 consecutively ranked and assigned beneficiaries or 100% of assigned beneficiaries if fewer than 248 are assigned to the group
- Must report on at least 1 measure for which there is Medicare patient data**

PQRS Group Practices reporting CAHPS for PQRS*:

- Report ALL CAHPS for PQRS survey measures via a certified survey vendor **AND**
- Report on all measures included in the WI for the first 248 consecutively ranked and assigned beneficiaries or 100% of assigned beneficiaries if fewer than 248 are assigned to the group
- Must report on at least 1 measure for which there is Medicare patient data**

*CAHPS is required for groups of 100+ EPs

**If a group practice has no Medicare patients for which any of the GPRO WI measures are applicable, the group practice will not meet the criteria for satisfactory reporting using the GPRO WI

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GPRO Reporting: Registry

PQRS Group Practices not reporting CAHPS for PQRS:

- Report at least 9 measures, covering at least 3 of the NQS domains
 - Of these measures, if a group practice has an EP that sees at least 1 Medicare patient in a face-to-face encounter, the group practice must report at least 1 measure in the PQRS cross-cutting measures set
 - If < 9 measures covering 1-3 NQS domains apply, group practices must report on each applicable measure, AND report each measure for at least 50% of the PQRS group practice's Medicare Part B FFS patients seen during the reporting period
 - Subject to Measure-Applicability Validation (MAV)
- Measures with 0% performance rate will not be counted

PQRS Group Practices reporting CAHPS for PQRS*:

- Report ALL CAHPS for PQRS survey measures via a certified survey vendor, AND
- Report ≥ 6 additional measures, outside of the CAHPS for PQRS survey, covering ≥ 2 NQS domains using the qualified registry
 - If < 6 measures covering < 2 NQS domains apply, report each applicable measure
 - CAHPS for PQRS fulfills the cross-cutting measure requirement; PQRS group practices do not need to report an additional cross-cutting measure

*CAHPS is required for groups of 100+ EPs

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GPRO Reporting: EHR (Direct or DSV)

PQRS Group Practices not reporting CAHPS for PQRS:

- Report on 9 measures covering ≥ 3 NQS domains,
 - If the direct EHR product or DSV does not contain patient data for ≥ 9 measures covering ≥ 3 NQS domains then report measures for which there is patient data
 - Must report on at least 1 measure for which there is Medicare patient data

PQRS Group Practices reporting CAHPS for PQRS*:

- Report ALL CAHPS for PQRS survey measures via a certified survey vendor, **AND**
- Report at least 6 additional measures (outside CAHPS for PQRS), covering ≥ 2 NQS domains using an EHR. If < 6 measures apply, report all applicable measures
 - Of the non-CAHPS PQRS measures reported, a group must report on at least 1 measure for which there is Medicare patient data

*CAHPS is required for groups of 100+ EPs

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GPRO Reporting: QCDR

New for 2016

- 2+ EPs participating in the GPRO have an option to report quality measures via a QCDR
- For group practices of 2-99 EPs, same criterion as individual EPs to satisfactorily participate in a QCDR for the 2018 PQRS payment adjustment
- Reporting period: January 1 - December 31, 2016 for group practices participating in the GPRO, to satisfactorily participate in a QCDR to avoid the 2018 payment adjustment. This would be for the CY 2016 reporting period

[Acronyms](#)

GPRO Reporting: QCDR

PQRS Group Practices not reporting CAHPS for PQRS via a QCDR:

- Report on 9 measures covering ≥ 3 NQS domains
 - Of these measures, must report 2 outcome measures
 - If < 2 outcome measures apply, then must report at least 1 outcome measure and 1 of the following other measure types:
 - 1 resource use, OR patient experience of care, OR efficiency appropriate use, OR patient safety measure.

PQRS Group Practices reporting CAHPS for PQRS* via a QCDR:

- Report ALL CAHPS for PQRS survey measures via a certified survey vendor
- Must report at least 6 additional measures, outside of CAHPS for PQRS, covering at least 2 NQS domains
 - At least 1 of these measures must be an outcome measure

*CAHPS is required for groups of 100+ EPs

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Measure-Applicability Validation (MAV)

For Claims and Registry Reporting of Individual Measures:

- MAV will apply to those who report on <9 measures or fewer than 3 NQS domains.
- For more information: <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/analysisandpayment.html>

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Requirements for the QCDR Vendor

A QCDR must perform the following functions:

- Submit quality measures data or results on behalf of its EPs or PQRS group practices
 - The QCDR XML file must be used to submit data for PQRS
 - The quality data reporting architecture (QRDA) III file must be used to submit data for PQRS and the EHR Incentive Program
- Submit quality measures data on multiple payers, not just Medicare patients
- Provide timely feedback, at least four times a year, on the measures for which the QCDR reports on the EP's or PQRS group practice's behalf
- Possess benchmarking capacity that compares the quality of care an EP or PQRS group practice provides with those performing the same or similar functions
- A QCDR must have in place mechanisms for the transparency of data elements and specifications, risk models, and measures

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Changes for QCDR Vendors and Qualified Registries

Self-nomination Period Timeframe:

- Begins on December 1 of the prior year and ends on January 31; allows more time (one additional month) for entities to self-nominate

Attestation Statements:

- In lieu of submitting an attestation statement via email, beginning in 2016, we will require registries to attest during the submission period
- Selecting the web-based check box mechanism verifies that the quality measure results and any and all data including numerator and denominator data provided to CMS are accurate and complete

Changes for QCDR Vendors and Qualified Registries (cont.)

Data Validation Requirements:

- CMS is adding the following requirements for QCDRs to the existing guidance on validation strategy:
 - Organization name, program year, and vendor type
 - Methods for data collection, TIN verification, data reporting and verification, rate calculation, and PQRS measure specification confirmation
 - Process for data auditing and sampling methodology
- 2016 PQRS QCDR Criteria Toolkit is available on the [PQRS Qualified Clinical Data Registry Reporting webpage](#).

Quality Measures Updates

- **New Measures:**

- 4 additional cross cutting measures (being added to the existing cross-cutting measures)
- 37 for individual reporting
- NQS domains covered

2016 Finalized New Measures by Domain	
Domain	Total
Effective Clinical Care	18
Patient Safety	9
Efficiency and Cost Reduction	4
Community/ Population Health	1
Communication and Care Coordination	3
Person and Caregiver-Centered Experience and Outcomes	2

- **Measures for Removal:**

- 10 total removals from PQRS
- 9 measures being removed from claims and/or registry

- **Changes to Existing Measures:**

- 18 measures have a reporting mechanism update

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Revised Auditing Requirements

- **Revised auditing requirements for the following entities submitting PQRS quality measures data:**
 - Qualified Registries
 - QCDR
 - Direct EHR
 - Direct DSV product
- **Beginning in 2016, any vendor submitting quality measures data for the PQRS must comply with the following requirements:**
 - The vendor make available to CMS the contact information of each EP on behalf of whom it submits data. The contact information will include, at a minimum, the EP practice's phone number, address, and if applicable email
 - The vendor must retain all data submitted to CMS for the PQRS program for a minimum of seven years

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EHR Incentive Program

Presenter: Alexandra Mugge

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Certification Requirements for Electronic Reporting of Clinical Quality Measures

Certified EHR Technology (CEHRT) Requirement for Electronic Reporting of Clinical Quality Measures (CQM)

In 2016 and 2017, CEHRT is required and providers electing electronic reporting must create an electronic file that can be accepted by CMS.

In 2018, CEHRT is required and all providers must create an electronic file that can be accepted by CMS.

For any CY before 2018:

Providers must use electronic reporting via EHR technology certified to the 2014 Edition or the 2015 Edition certification criteria.

For 2018 and subsequent years:

providers must use electronic reporting via EHR technology certified to the 2015 Edition certification criteria (certified to meet QRDA I and III standards).

Once the technology has been certified, it does not need to be recertified each time an annual update to the form and manner requirements (QRDA Implementation Guide) is made.

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PQRS Criteria: EHR Incentive Program Electronic Reporting

EPs must report using the most recent version of the electronic specifications for the CQMs if they choose to electronically report CQMs for the Medicare EHR Incentive Program.

Medicare CY2018 payment adjustment for the failure to demonstrate meaningful use under the EHR Incentive Program is -3.0% MPFS, based on PY2016 reporting.

For a reporting period in 2016, to avoid the 2018 payment adjustment:

- Report 9 measures covering at least 3 of the NQS domains.
- Providers may report results including zeroes in numerator/denominator

Providers choosing to submit their CQMs electronically must use the CMS form and manner requirements to submit CQMs. If the provider completes a single electronic submission of CQM data that meets the requirements for both PQRS and the EHR Incentive Program, the single submission may count for both programs.

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Clinical Quality Measures (CQMs)

We have taken steps to establish alignments among various quality reporting and payment programs that include the submission of CQMs.

Under section 1848(o)(2)(A)(iii) of the Act and the definition of “meaningful EHR user” under 42 CFR 495.4, eligible professionals must report on CQMs selected by CMS using CEHRT, as part of being a meaningful EHR user under the Medicare EHR Incentive Program.

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Aligned Reporting: CPC and the Medicare EHR Incentive Program

Presenter: Sarah Arceo

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Comprehensive Primary Care (CPC) Initiative Practice Sites

In PY 2016, CPC practice sites, including first year EPs, will satisfy the CQM requirements of the Medicare EHR Incentive Program, if the sites:

- Report 9 of 13 CPC CQMs across 3 NQS domains;
- Successfully meet CPC reporting requirements;
- Submit measures electronically via QRDA 3 to the PQRS Portal or via Attestation to CPC ; and
- Submit measures for a full calendar year (January 1 – December 31)

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Comprehensive Primary Care (CPC) Initiative Practice Sites (cont.)

- First year EPs beginning their participation in the Medicare EHR Incentive Program during CY **2016** must also successfully attest to continuous 90-day CQM data by October 1, 2016 or apply for a significant hardship exemption to avoid the CY **2017** payment adjustment
- CPC practice site EPs have the option to separately report CQMs in accordance with the requirements established for the Medicare EHR Incentive Program

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Value-Based Payment Modifier (VM)

Presenter: Fiona Larbi

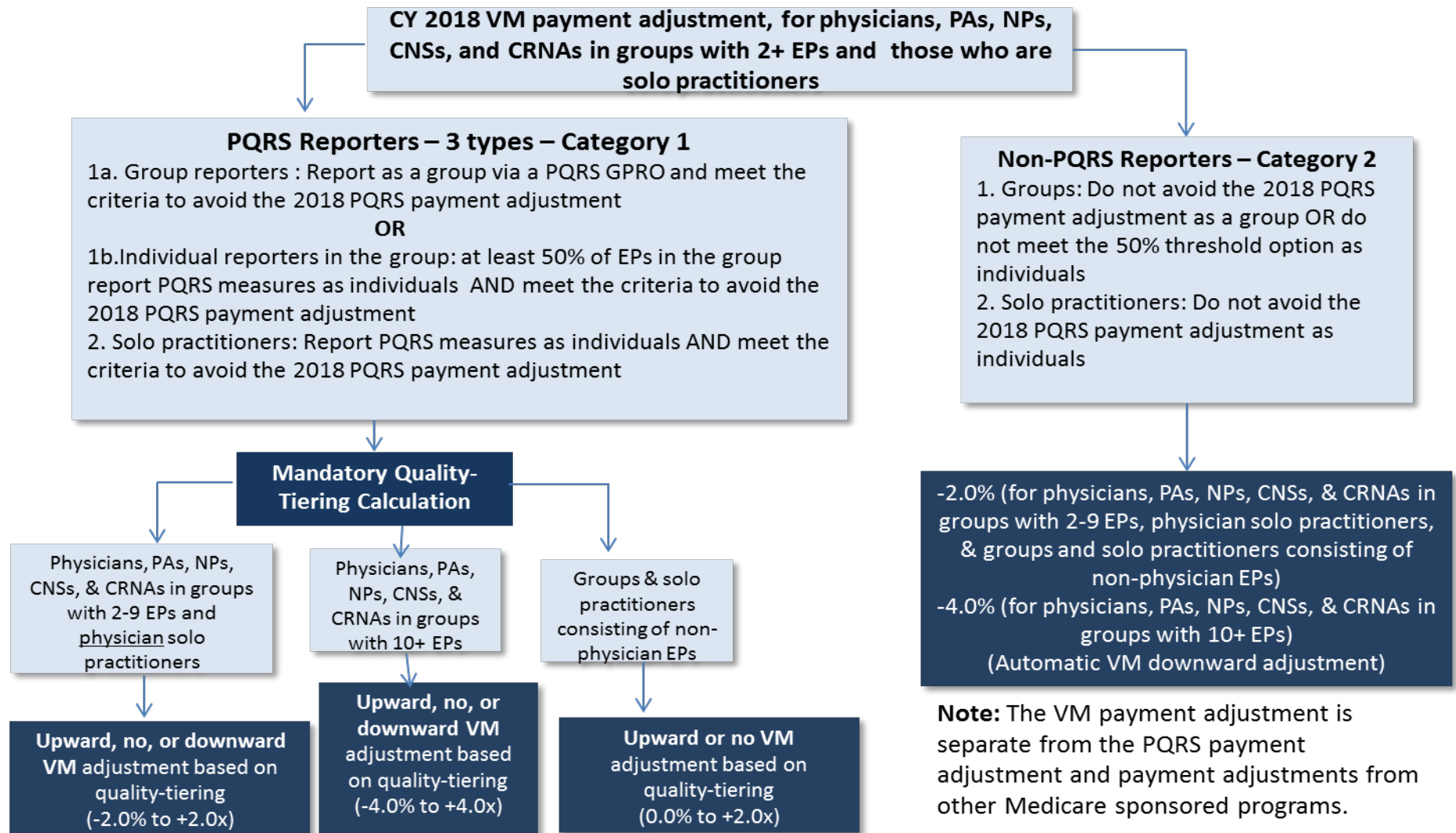
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Final Policies for the 2018 VM

- Performance year is 2016
- Applies to physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs) in groups with 2+ EPs and those who are solo practitioners, as identified by their TIN
- Quality-tiering is mandatory
 - TINs that consist of non-physician EPs only will be held harmless from downward adjustments
 - All other TINs will be subject to upward, neutral, or downward adjustments
 - All TINs receiving an upward adjustment are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25 percent of all beneficiary risk scores nationwide
- 2018 will be the final year of the VM

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Final Policies for the 2018 VM



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Final Cost and Quality Policies

- Beginning with the 2017 VM, increase the minimum Medicare Spending Per Beneficiary (MSPB) measure episodes for inclusion in the cost composite from 20 to 125 episodes
- For the 2018 VM, include hospitalizations at Maryland hospitals as an index admission for the MSPB measure
- For the 2017 VM, when determining whether a group will be included in Category 1, we will consider whether the 50 percent threshold option was met regardless of whether the group registered for a PQRS GPRO
- Beginning with the 2017 VM, the all-cause hospital readmissions measure will not be applied to groups with 2-9 EPs and solo practitioners
- Beginning with the 2016 VM, assign “average” quality under quality-tiering if there is not at least one quality measure that meets the minimum number of cases required for the measure to be included in the quality composite
- Beginning with the 2018 VM, create separate eCQM benchmarks, based on the CMS eMeasure ID

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2018 VM Final Policies for Physicians, NPs, PAs, CNSs, & CRNAs in Groups of Physicians with 10+ EPs

- Maintain the 2017 VM payment adjustment levels
- An automatic -4.0% VM downward adjustment will be applied for not meeting the satisfactory reporting criteria to avoid the 2018 PQRS payment adjustment
- Under quality-tiering, the maximum upward adjustment is up to +4.0x ('x' represents the upward VM adjustment factor), and the maximum downward adjustment is -4.0% payment

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

** Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25% of all beneficiary risk scores*

2018 VM Final Policies for Physicians, PAs, NPs, CNSs, & CRNAs in Groups of Physicians with 2-9 EPs and Physician Solo Practitioners

- Maintain the 2017 VM payment adjustment levels, except apply both upward and downward adjustments under quality-tiering
- An automatic -2.0% VM downward adjustment will be applied for not meeting the satisfactory reporting criteria to avoid the 2018 PQRS payment adjustment
- Under quality-tiering, the maximum upward adjustment is up to +2.0x ('x' represents the upward VM payment adjustment factor), and the maximum downward adjustment is -2.0%

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

** Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25% of all beneficiary risk scores*

[Acronyms](#)

2018 VM Final Policies for PAs, NPs, CNSs, & CRNAs who are Solo Practitioners or in Groups Consisting of Non-Physician EPs only

- An automatic -2.0% VM downward adjustment will be applied for not meeting the satisfactory reporting criteria to avoid the 2018 PQRS payment adjustment
- Under quality-tiering, the maximum upward adjustment is up to +2.0x ('x' represents the upward VM payment adjustment factor) and held harmless from any downward adjustments for poor performance
 - This policy is consistent with how the VM is applied to groups and solo practitioners during the first year in which they are subject to the VM

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

** Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25% of all beneficiary risk scores*

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Finality of the VM Upward Adjustment Factor

- Finalized our proposal to not recalculate the upward payment adjustment factor 'x' for a given payment adjustment after the value of the 'x' is made public, unless CMS determines that a significant error was made in the calculation of the adjustment factor

Determining Group Size for Applying the VM

- Beginning with the 2016 VM, a TIN's size would be based on the lower of the number of EPs indicated by the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)-generated list or our analysis of the claims data for purposes of determining the payment adjustment amount under the VM
- For the 2018 VM:
 - Identify TINs as non-physician EP TINs if *either* the PECOS-generated list *or* our analysis of the claims data shows that the TIN contains no physicians or that no physicians billed under the Medicare PFS during the performance period.
 - The VM will not be applied to TINs if either the PECOS-generated list or claims analysis shows that the TIN consists only of non-physician EPs who are not PAs, NPs, CNSs, or CRNAs

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Application of the VM to TINs participating in the Pioneer ACO Model, CPC Initiative, or Other Similar Innovation Center Models

In 2017 and 2018, the application of the VM is waived for groups and solo practitioners, as identified by their TIN, if at least one EP who billed for PFS items and services under the TIN during the applicable VM performance period participated in the Pioneer ACO Model, CPC Initiative, or other similar Innovation Center models (e.g., the Next Generation ACO Model, Oncology Care Model, Comprehensive ESRD Care Initiative).

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VM Informal Review

- The Informal Review submission period will occur during the 60 days following the release of the QRURs for the 2016 VM and subsequent years
- Reclassify a TIN as Category 1 when PQRS determines on informal review that at least 50% of the TIN's EPs meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the relevant CY PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS QCDR for the relevant CY PQRS payment adjustment
- We note that if the group was initially classified as Category 2, then we do not expect to have data for calculating their quality composite, in which case they'd be classified as "average quality"; however, if the data is available in a timely manner, then CMS would recalculate the quality composite

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Actions for Groups with 2+ EPs and Solo Practitioners in 2016 for the 2018 VM

- Be sure to satisfactorily report quality data under the PQRS for 2015
- Choose a PQRS reporting mechanism and become familiar with the measures **AND** data submission timeframes
 - <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html>
- Decide whether and how to participate in the PQRS in 2016
 - Group reporting - Register for the 2016 PQRS GPRO between **Spring 2016 and June 30, 2016**
 - <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html>
 - Individual reporting – No registration necessary
- Download your 2014 Annual QRUR at: <https://portal.cms.gov>
 - <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html>
- Watch for announcements about availability of the 2015 Mid-Year QRUR and 2015 Annual QRUR to understand your TIN's current quality and cost performance
- Review quality measure benchmarks under the VM; understand what is required for above average performance; and identify measures for distinguishing your performance
 - <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>

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Medicare Shared Savings Program

Presenter: Rabia Khan, MPH

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Overview of Medicare Shared Savings Program

- ACOs create incentives for health care providers to work together voluntarily to coordinate care and improve quality for their patient population
- CMS assesses ACO performance yearly on quality performance and against a financial benchmark to determine shared savings
- Meeting the program's requirements for quality reporting and performance aligns with the following quality reporting programs for EPs participating in an ACO:
 - PQRS
 - Medicare EHR Incentive Program
 - Value-based Payment Modifier

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2016 Physician Fee Schedule Final Rule Updates

The Shared Savings Program makes annual updates to the quality reporting requirements in the annual MPFS rule. The CY 2016 MPFS Final Rule includes public comments and finalized updates specific to certain sections of the Shared Savings Program regulations. CMS finalized the following proposals:

- Adding a measure of Statin Therapy for the Prevention and Treatment of Cardiovascular Disease in the Preventive Health domain of the Shared Savings Program to align with PQRS
 - This increases the Shared Savings Program measure set from 33 to 34 quality measures
 - The measure will be scored as a single measure and remain pay-for-reporting
 - There will be an oversample of 750 beneficiaries for the measure when reporting via the GPRO Web Interface. However, the consecutive reporting requirement for measures remains 248 beneficiaries
- Preserving flexibility to maintain or revert measures to pay for reporting if a measure owner determines the measure no longer aligns with updated clinical practice or causes patient harm

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2016 Physician Fee Schedule Final Rule Updates (cont.)

- Clarifying how PQRS EPs participating within an ACO meet their PQRS reporting requirements when their ACO satisfactorily reports quality
- Amending the definition of primary care services used in the beneficiary assignment methodology to include claims submitted by Electing Teaching Amendment (ETA) hospitals and exclude claims submitted by Skilled Nursing Facilities (SNFs) when the claim contains the place-of-service (POS) 31 modifier

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2017 VM Final Policies for Shared Savings Program Participants

- Beginning with the 2017 VM:
 - For TINs that participate in multiple Savings Program ACOs during the performance period, use the quality composite score of the ACO that has the highest quality composite score
 - Determine the VM for TINs who participated in a Shared Savings Program ACO in the performance period using policies established for Shared Savings Program participants, regardless of whether any EPs under the TIN also participated in an Innovation Center model or CMS initiative during the performance period
 - Apply an additional upward payment adjustment of +1.0x to Shared Savings Program participant TINs that are classified as “high quality” under the quality-tiering methodology, if the ACOs in which the TINs participated in during the performance period have an attributed patient population with has an average beneficiary risk score that is in the top 25 percent of all beneficiary risk scores nationwide as determined under the VM methodology

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2018 VM Final Policies for Shared Savings Program Participants

- Groups and solo practitioners participating in an ACO under the Shared Savings Program in the 2016 performance period will have their Value Modifier calculated as follows for the 2018 VM:
 - Cost Composite: Average
 - Quality Composite: Based on ACO's quality data submitted through the GPRO web interface and the ACO all-cause hospital readmissions measure as calculated under the Shared Savings Program
 - Include the CAHPS for ACOs Survey in the quality composite of the 2018 VM for TINs participating in ACOs in the Shared Shaving Program in 2016
 - ACO quality measures will be benchmarked under the VM methodology in determining the quality composite
- If the ACO does not successfully report quality data as required by the Shared Savings Program, then all groups and solo practitioners participating in the ACO will fall in Category 2 for the VM and be subject to the automatic downward adjustment

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Physician Compare

Presenter: Alesia Hovatter

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2016 Physician Fee Schedule Final Rule

- **We are continuing existing policies for Physician Compare**
- **The following 2016 measures are available for public reporting:**
 - All PQRS measures for individual EPs and group practices
 - All CAHPS for PQRS measures for groups of 2 or more EPs who meet the specified sample size requirements and collect data via a CMS-specified certified CAHPS vendor
 - All ACO measures, including CAHPS for ACOs

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2016 Physician Fee Schedule Final Rule

We are **finalizing** the following proposals:

- Include Certifying Board, and specifically add American Board of Optometry (ABO) Board Certification and American Osteopathic Association (AOA) Board Certification
- Include an indicator on profile pages for individual EPs who satisfactorily report the new PQRS Cardiovascular Prevention measures group in support of Million Hearts

As required by MACRA, we are **finalizing** the following proposals:

- All individual and group-level QCDR measures are available for public reporting
- Adding utilization data to the public downloadable database

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2016 Physician Fee Schedule Final Rule

We are **finalizing** to publicly report an item-level benchmark for group practice and individual EP PQRS measures using the Achievable Benchmark of Care (ABC) methodology

- We will stratify the benchmark by reporting mechanism to ensure comparability and reduce the interpretation burden for consumers
- We will use this methodology to systematically assign stars for the Physician Compare 5 star rating

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2016 Physician Fee Schedule Final Rule

We are **finalizing** to add VM information to the downloadable database:

- Quality tiers for cost and quality noting if the group practice or EP is high, low, or neutral on cost and quality per the VM
- A notation of the payment adjustment received based on the cost and quality tiers
- An indication if the individual EP or group practice was eligible to but did not report quality measures to CMS

We are **not finalizing** to include a visual indicator on profile pages for group practices and individual EPs who receive an upward adjustment for the VM.

[Acronyms](#)

2016 Physician Fee Schedule Final Rule

- All data must meet the public reporting standards – measures must be statistically accurate, valid, reliable, and comparable and must resonate with consumers
- CMS can publicly report all measures submitted, reviewed, and deemed valid and reliable in the Physician Compare downloadable file
- Not all measures will be included on the Physician Compare profile pages

Who 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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html>

- **EHR Incentive Program Information Center:**

888-734-6433 (TTY 888-734-6563)

- **Physician Value Help Desk (for VM questions)**

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

Phone: 888-734-6433, press option 3

Email: pvhelpdesk@cms.hhs.gov

- **ACO Help Desk via the CMS Information Center:**

888-734-6433 Option 2 or cmsaco@cms.hhs.gov

- **Physician Compare Help Desk:**

E-mail: PhysicianCompare@Westat.com

[Acronyms](#)

Resources

MACRA: MIPS & APMs

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html>

2016 MPFS Final Rule

<https://www.federalregister.gov/articles/2015/11/16/2015-28005/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions>

PQRS Website

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS>

PQRS Payment Adjustment Information

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html>

PFS Federal Regulation Notices

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html>

Medicare Electronic Health Record (EHR) Incentive Program

<http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html>

Medicare EHR Incentive Program Payment Adjustments & Hardship Exceptions

https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/paymentadj_hardship.html

Medicare Shared Savings Program

<http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/QualityMeasuresStandards.html>

Value-based Payment Modifier (VM) Website

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

Comprehensive Primary Care Initiative

<http://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/>

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

https://public-dc2.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_520

[Acronyms](#)

Acronyms in this Presentation

ACO: Accountable Care Organization
APM: Alternative Payment Model
CAHPS: Consumer Assessment of Healthcare Providers & Systems
CEHRT: Certified EHR Technology
CMS: Centers for Medicaid & Medicare Services
CY: Calendar Year
DSV: Data Submission Vendor
eCQM: Electronic Clinical Quality Measure
EIDM: Enterprise Identity Management
EHR: Electronic Health Record
EP: Eligible Professional
FFS: Fee-for-Service
GPRO: Group Practice Reporting Option
IACS: Individuals Authorized Access to the CMS Computer Services
MACRA: Medicare Access and CHIP Reauthorization Act of 2015
MIPS: Merit-based Incentive Payment System
MLN: Medicare Learning Network
MPFS: Medicare Physician Fee Schedule
NPI: National Provider Identifier
PQRS: Physician Quality Reporting System
PY: Program Year
QCDR: Qualified Clinical Data Registry
QRDA: Quality Reporting Data Architecture
TIN: Taxpayer Identification Number
Value-Modifier: Value-based Payment Modifier
WI: Web Interface
XML: Extensible Markup Language

Question & Answer Session

[Acronyms](#)

CME and CEU

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

<http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/TC-L12082015-Marketing-Materials.pdf>

[Acronyms](#)

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- To complete the evaluation, visit <http://npc.blhtech.com> and select the title for today's call.

Thank You

- For more information about the MLN Connects® National Provider Call Program, please visit <http://cms.gov/Outreach-and-Education/Outreach/NPC/index.html>.
- For more information about the Medicare Learning Network®, please visit <http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html>.

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[Acronyms](#)

APPENDIX A: PQRS Reference Slides

[Acronyms](#)

TABLE Q1: Summary of Finalized Requirements for the 2018 PQRS Payment Adjustment: Individual Reporting Criteria for the Satisfactory Reporting of Quality Measures Data via Claims, Qualified Registry, and EHRs and Satisfactory Participation Criterion in QCDRs

Reporting Period	Measure Type	Reporting Mechanism	Satisfactory Reporting/Satisfactory Participation Criteria
12-month (Jan 1– Dec 31, 2016)	Individual Measures	Claims	Report at least 9 measures, covering at least 3 of the NQS domains AND report each measure for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the EP sees at least 1 Medicare patient in a face-to-face encounter, the EP will report on at least 1 measure contained in the PQRS cross-cutting measure set. If less than 9 measures apply to the EP, the EP would report on each measure that is applicable , AND report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.
12-month (Jan 1– Dec 31, 2016)	Individual Measures	Qualified Registry	Report at least 9 measures, covering at least 3 of the NQS domains AND report each measure for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the EP sees at least 1 Medicare patient in a face-to-face encounter, the EP will report on at least 1 measure contained in the PQRS cross-cutting measure set. If less than 9 measures apply to the EP, the EP would report on each measure that is applicable, AND report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.

[Acronyms](#)

TABLE Q1: Summary of Finalized Requirements for the 2018 PQRS Payment Adjustment: Individual Reporting Criteria for the Satisfactory Reporting of Quality Measures Data via Claims, Qualified Registry, and EHRs and Satisfactory Participation Criterion in QCDRs (cont.)

Reporting Period	Measure Type	Reporting Mechanism	Satisfactory Reporting/Satisfactory Participation Criteria
12-month (Jan 1– Dec 31, 2016)	Individual Measures	Direct EHR Product or EHR Data Submission Vendor Product	Report 9 measures covering at least 3 of the NQS domains. If an EP's direct EHR product or EHR data submission vendor product does not contain patient data for at least 9 measures covering at least 3 domains, then the EP would be required to report all of the measures for which there is Medicare patient data. An EP would be required to report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1– Dec 31, 2016)	Measures Groups	Qualified Registry	Report at least 1 measures group AND report each measures group for at least 20 patients, the majority (11 patients) of which are required to be Medicare Part B FFS patients. Measures groups containing a measure with a 0% performance rate will not be counted.
12-month (Jan 1– Dec 31, 2016)	Individual PQRS measures and/or non-PQRS measures reportable via a QCDR	Qualified Clinical Data Registry (QCDR)	Report at least 9 measures available for reporting under a QCDR covering at least 3 of the NQS domains, AND report each measure for at least 50% of the EP's patients. Of these measures, the EP would report on at least 2 outcome measures, OR, if 2 outcomes measures are not available, report on at least 1 outcome measures and at least 1 of the following types of measures – resource use, patient experience of care, efficiency/appropriate use, or patient safety.

[Acronyms](#)

TABLE Q2: Summary of Finalized Requirements for the 2018 PQRS Payment Adjustment: Group Practice Reporting Criteria for Satisfactory Reporting of Quality Measures Data via the GPRO

Reporting Period	Size	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria
12-month (Jan 1–Dec 31, 2016)	25-99 EPs	Individual GPRO Measures in the GPRO Web Interface	GPRO Web Interface	Report on all measures included in the web interface; AND populate data fields for the 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 the group practice must report on 100 % of assigned beneficiaries. In other words, we understand that, in some instances, the sampling methodology we provide will not be able to assign at least 248 patients on which a group practice may report, particularly those group practices on the smaller end of the range of 25–99 EPs. If the group practice is assigned less than 248 Medicare beneficiaries, then the group practice must report on 100% of its assigned beneficiaries. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1–Dec 31, 2016)	100+ EPs (if CAHPS for PQRS applies)	Individual GPRO Measures in the GPRO Web Interface + CAHPS for PQRS	GPRO Web Interface + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor. In addition, the group practice must report on all measures included in the GPRO web interface; AND populate data fields for the 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 the group practice must report on 100% of assigned beneficiaries. A group practice will be required to report on at least 1 measure for which there is Medicare patient data. Please note that if the CAHPS for PQRS survey is applicable to a group practice who reports quality measures via the Web Interface, the group practice must administer the CAHPS for PQRS survey in addition to reporting the Web Interface measures.
12-month (Jan 1–Dec 31, 2016)	2-99 EPs	Individual Measures	Qualified Registry	Report at least 9 measures, covering at least 3 of the NQS domains. Of these measures, if a group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice would report on at least 1 measure in the PQRS cross-cutting measure set. If less than 9 measures covering at least 3 NQS domains apply to the group practice, the group practice would report on each measure that is applicable to the group practice, AND report each measure for at least 50 percent of the group's 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.

[Acronyms](#)

TABLE Q2: Summary of Finalized Requirements for the 2018 PQRS Payment Adjustment: Group Practice Reporting Criteria for Satisfactory Reporting of Quality Measures Data via the GPRO (cont.)

Reporting Period	Group Practice Size	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria
12-month (Jan 1–Dec 31, 2016)	2—99 EPs that elect CAHPS for PQRS; 100+ EPs that must report CAHPS for PQRS	Individual Measures + CAHPS for PQRS	Qualified Registry + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor, and report at least 6 additional measures, outside of the CAHPS for PQRS survey, covering at least 2 of the NQS domains using the qualified registry. If less than 6 measures apply to the group practice, the group practice must report on each measure that is applicable to the group practice. Of the additional measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, if any EP in the group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice must report on at least 1 measure in the PQRS cross-cutting measure set.
12-month (Jan 1–Dec 31, 2016)	2—99 EPs	Individual Measures	Direct EHR Product or EHR Data Submission Vendor Product	Report 9 measures covering at least 3 domains. If the group practice's direct EHR product or EHR data submission vendor product 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 patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1–Dec 31, 2016)	2—99 EPs that elect CAHPS for PQRS; 100+ EPs that must report CAHPS for PQRS	Individual Measures + CAHPS for PQRS	Direct EHR Product or EHR Data Submission Vendor Product + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor, and report at least 6 additional measures, outside of CAHPS for PQRS, covering at least 2 of the NQS domains using the direct EHR product or EHR data submission vendor product. If less than 6 measures apply to the group practice, the group practice must report all of the measures for which there is Medicare patient data. Of the additional 6 measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, a group practice would be required to report on at least 1 measure for which there is Medicare patient data.

[Acronyms](#)

TABLE Q2: Summary of Finalized Requirements for the 2018 PQRS Payment Adjustment: Group Practice Reporting Criteria for Satisfactory Reporting of Quality Measures Data via the GPRO (cont.)

Reporting Period	Group Practice Size	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria
12-month (Jan 1–Dec 31, 2016)	2-99 EPs	Individual PQRS measures and/or non-PQRS measures reportable via a QCDR	Qualified Clinical Data Registry (QCDR)	Report at least 9 measures available for reporting under a QCDR covering at least 3 of the NQS domains, AND report each measure for at least 50% of the group practice's patients. Of these measures, the group practice would report on at least 2 outcome measures, OR, if 2 outcomes measures are not available, report on at least 1 outcome measures and at least 1 of the following types of measures – resource use, patient experience of care, efficiency/appropriate use, or patient safety.
12-month (Jan 1–Dec 31, 2016)	2—99 EPs that elect CAHPS for PQRS; 100+ EPs that must report CAHPS for PQRS	Individual PQRS measures and/or non-PQRS measures reportable via a QCDR + CAHPS for PQRS	QCDR + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor, and report at least 6 additional measures covering at least 2 NQS domains using the QCDR. Of the additional measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, at least 1 measure must be an outcome measure.

[Acronyms](#)

APPENDIX B: VM Reference Slides

[Acronyms](#)

VM Policies for 2016, 2017, & 2018

Value Modifier Components	2016 Finalized Policies	2017 Finalized Policies	2018 Finalized Policies
Performance Year	2014	2015	2016
Group Size	Physicians in groups with 10+ EPs	Physicians in groups with 2+ EPs and physician solo practitioners	Physicians, PAs, NPs, CNSs, and CRNAs in groups with 2+ EPs and those who are solo practitioners
Quality-Tiering	<p>Mandatory: Groups of physicians with 10-99 EPs receive only the upward or neutral VM adjustment (no downward adjustment).</p> <p>Groups of physicians with 100+ EPs can receive upward, neutral, or downward VM adjustment.</p>	<p>Mandatory: Groups of physicians with 2-9 EPs and physician solo practitioners receive only the upward or neutral VM adjustment (no downward adjustment).</p> <p>Groups of physicians with 10+ EPs can receive upward, neutral, or downward VM adjustment.</p>	<p>Mandatory: Groups consisting of non-physician EPs and PAs, NPs, CNSs, and CRNAs who are solo practitioners receive only the upward or neutral VM adjustment (no downward adjustment).</p> <p>Groups of physicians with 2+ EPs and physician solo practitioners can receive upward, neutral, or downward VM adjustment.</p>
Peer Group for Categorizing Quality and Cost Composites	Groups with 10+ EPs	Groups with 2+ EPs and solo practitioners	Groups with 2+ EPs and solo practitioners
Available Quality Reporting Mechanisms	GPRO Web Interface, Qualified PQRS Registry, EHR, or 50% of EPs report under the PQRS as individuals	Same as 2016	GPRO Web Interface, Qualified PQRS Registry, EHR, or QCDR, or 50% of EPs report under the PQRS as individuals

[Acronyms](#)

VM Policies for 2016, 2017, & 2018 (cont.)

Value Modifier Components	2016 Finalized Policies	2017 Finalized Policies	2018 Finalized Policies
Outcome Measures NOTE: Performance on the outcome measures and measures reported through one of the PQRS reporting mechanisms will be used to calculate a quality composite score for the TIN for the VM.	<ul style="list-style-type: none"> All-Cause Hospital Readmissions Composite of Acute Prevention Quality Indicators: (bacterial pneumonia, urinary tract infection, dehydration) Composite of Chronic Prevention Quality Indicators: (chronic obstructive pulmonary disease (COPD), heart failure, diabetes) 	<p>Same as 2016, except the all-cause hospital readmissions measure will not be applied to groups with 2-9 EPs and solo practitioners</p>	<p>Same as 2017</p>
Patient Experience of Care Measures	<p>CAHPS for PQRS: Optional for groups with 25+ EPs; Required for groups with 100+ EPs reporting via Web Interface.</p> <p>Groups may elect to include their 2014 CAHPS results in the calculation of the 2016 VM.</p>	<p>CAHPS for PQRS: Optional for groups with 2-99 EPs; Required for all groups with 100+ EPs.</p> <p>Groups may elect to include their 2015 CAHPS results in the calculation of the 2017 VM.</p>	<p>Groups may elect to include their 2016 CAHPS results in the calculation of the 2018 VM.</p> <p>Include the CAHPS for ACOs Survey in the quality composite of the 2018 VM for TINs participating in ACOs in the Shared Shaving Program in 2016</p>

[Acronyms](#)

VM Policies for 2016, 2017, & 2018 (cont.)

Value Modifier Components	2016 Finalized Policies	2017 Finalized Policies	2018 Finalized Policies
Cost Measures	<ul style="list-style-type: none"> Total per capita costs measure Total per capita costs for beneficiaries with four chronic conditions: COPD, Heart Failure, Coronary Artery Disease, Diabetes Medicare Spending Per Beneficiary measure 	Same as 2016	Same as 2016
Benchmarks	No differentiation by group size (“compared to everyone”) for both cost and quality measures	No differentiation by group size (“compared to everyone”) for both cost and quality measures	No differentiation by group size (“compared to everyone”) for both cost and quality measures Create separate eCQM benchmarks, based on the CMS eMeasure ID and exclude eCQM measures from the overall benchmark for a given measure.
Maximum Payment at Risk	-2.0%	-2.0% (Groups of physicians with 2-9 EPs and solo practitioners) -4.0% (Groups of physicians with 10+ EPs)	-2.0% (Groups of physicians with 2-9 EPs and physician solo practitioners) -4.0% (Groups of physicians with 10+ EPs) -2.0% (Groups with non-physician EPs and PAs, NPs, CNSs, and CRNAs who are solo practitioners)

[Acronyms](#)

VM Policies for 2016, 2017, & 2018 (cont.)

Value Modifier Components	2015 Finalized Policy	2016, 2017 Finalized Policy	2018 Finalized Policy
Application of the VM to Participants of the Shared Savings Program, Pioneer ACO Model, and the CPC Initiative	Not Applicable	2016: Not Applicable 2017: Shared Savings Program: VM based on the ACO's quality data and average cost; Pioneer ACO Model and the CPC Initiative: average quality/average cost	Shared Savings Program: VM based on the ACO's quality and CAHPS data, and average cost; Pioneer ACO Model and the CPC Initiative: VM waived in 2017 and 2018
VM Informal Review Process: Timeline	<ul style="list-style-type: none"> Deadline of February 28, 2015 for a group to request correction of a perceived error made by CMS in the 2015 VM payment adjustment. 	Establish a 60 day period that would start after the release of the QRURs for the applicable reporting period for a group or solo practitioner (as applicable) to request correction of a perceived error made by CMS in the determination of the group or solo practitioner's VM for that payment adjustment period.	The Informal Review submission period will occur during the 60 days following the release of the QRURs for the 2016 VM and subsequent years
VM Informal Review Process: If CMS made an error	<ul style="list-style-type: none"> Classify a TIN as "average quality" in the event we determine that we have made an error in the calculation of quality composite. Recompute a TIN's cost composite if CMS made an error in its calculation. Adjust a TIN's quality tier. 	<ul style="list-style-type: none"> Recompute a TIN's quality composite in the event we determine that we or a third-party vendor have made an error in the calculation of quality composite. Otherwise, the same as 2015. 	Same as 2016, 2017 and: Reclassify a TIN as Category 1 when PQRS determines on informal review that at least 50 percent of the TIN's EPs meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the relevant CY PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS QCDR for the relevant CY PQRS payment adjustment.

[Acronyms](#)