



## 2016 Annual QRURs Webcast

**Moderated by: Leah Nguyen**  
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Operator: Hello and welcome to today's Medicare Learning Network® Event. My name is Jen, and I'll be your web event specialist today.

All lines have been placed on mute to prevent any background noise. Please note that today's event is being recorded. During the presentation, we'll have a question-and-answer session. You can ask text questions at any time. Click the green Q&A icon on the lower left-hand corner of your screen, type your question in the open area, and click Submit. We will also be taking questions via the phone lines, and instructions on how to do so will be given at the appropriate time.

If you would like to view the presentation in a full screen view, click the full-screen button in the lower right-hand corner of your screen. Press the Escape key on your keyboard to return to your original view. For optimal viewing and participation, please disable your popup blockers.

And finally, should you need technical assistance, as a best practice, we suggest you first refresh your browser. If that does not resolve the issue, please click on the Support option in the upper right-hand corner of your screen for online troubleshooting.

It is now my pleasure to turn today's program over to Leah Nguyen. Leah, the floor is yours.

## Announcements & Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this Medicare Learning Network webcast on the 2016 Annual Quality and Resource Use Report, or QRUR. In mid-September, CMS made these reports available to all group practices and solo practitioners nationwide. This webcast provides an overview of the report and explains how to interpret and use the information.

Before we get started, there are a few items I would like to quickly cover. Today's event uses webcast technology. We recommend streaming the audio live through your computer speakers. Those of you participating via webcast may download a copy of today's slide presentation by clicking the blue Files button at the bottom left side of your screen. And please note that this event is being recorded and transcribed.

Also this webcast is being evaluated by CMS for CME and CEU continuing education credit. For additional information, please refer to the CE Activity Information & Instructions document on slide 54 of the presentation.

At this time, I would like to turn the call over to Sabrina Ahmed from the Division of Value-Based Payment at CMS.

## Presentation

Sabrina Ahmed: Thank you, Leah. Thank you, everyone, for joining us on this webcast this afternoon. My name is Sabrina Ahmed, and I'm in the Division of Value-Based Payment in the Center for Medicare. The agenda for today's presentation is on slide 3.



So in this presentation, we will discuss the 2016 Annual Quality and Resource Use Reports, also referred to as the QRURs. We'll go over the basic content of the 2016 QRURs, the tables that accompany the 2016 QRURs. We'll provide an overview of the 2018 Value Modifier policy as well as how you can download your QRUR and also request an Informal Review of your Value Modifier. And then at the end of our presentation, we'll have a question-and-answer session.

## Overview of the 2018 Annual Quality and Resource Use Report

Slide 5, please. The 2016 Annual QRUR shows how a group or a solo practitioner, as identified by Medicare-enrolled Taxpayer Identification Number, or TIN, performed in 2016 on the quality and cost measures used to calculate the 2018 Value Modifier. So, your practice is identified in the QRUR by TIN.

For TINs subject to the 2018 Value Modifier, the QRUR shows how the Value Modifier will apply to Medicare Physician Fee Schedule payments for services provided by physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists in 2018. For TINs that are not subject to the 2018 Value Modifier, the Annual QRURs are provided for informational purposes only.

The quality and cost measures in the QRURs are based on care provided from January 1, 2016, through December 31<sup>st</sup>, 2016.

All TINs nationwide that had at least one eligible professional bill Medicare under the TIN in 2016 received a full QRUR, including TINs that are not subject to the 2018 Value Modifier.

## Overview of the 2018 Value Modifier

Slide 7, please. So before reviewing the content of the QRURs in the next few slides, I'll provide an overview of the Value Modifier policies in 2018. So in 2018, the Value Modifier will apply to all physicians, and also for the first time, to all physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists who bill under the Medicare Physician Fee Schedule. In this presentation, I'll refer to these clinician types that the 2018 Value Modifier applies to as clinicians subject to the Value Modifier.

The Value Modifier is applied at the practice level as identified by its Medicare-enrolled TIN. This means that each TIN receives the 2018 Value Modifier based on its quality and cost performance in 2016. Clinicians subject to the Value Modifier that bill under that TIN in 2018 will have their payments adjusted accordingly regardless of whether they were in the TIN during the 2016 performance period. As was the policy last year, CMS will continue to apply the 2018 Value Modifier to Physician Fee Schedule payments made to TINs that participated in a Shared Savings Program Accountable Care Organization in 2016.

The 2018 Value Modifier will be waived for a TIN that had at least one eligible professional who billed for Medicare Physician Fee Schedule items and services under the TIN in 2016 that participated in the Pioneer ACO Model, the Comprehensive Primary Care Initiative, the Next Generation ACO Model, the Oncology Care Model, or the Comprehensive ESRD Care Initiative in 2016.

Please note that 2018 is the last payment adjustment year under the Value Modifier Program. The Value Modifier Program is being replaced by the Merit-Based Incentive Payment System, or MIPS, which is



under the new Quality Payment Program. The first performance period for the Quality Payment Program is calendar year 2017, and the first payment adjustment year under the Quality Payment Program will be 2019.

To prepare for success in the Quality Payment Program, we encourage eligible professionals to review their Annual QRUR and their PQRS Feedback Report and also learn more about the Quality Payment Program by visiting the Quality Payment Program website.

Slide 8, please. The 2018 Value Modifier payment adjustments shown in the 2016 Annual QRURs are based on proposals that were included in the 2018 Medicare Physician Fee Schedule Proposed Rule. This proposed rule was published in the *Federal Register* on July 1<sup>st</sup>, 2017.

In the proposed rule for the 2018 Value Modifier, we proposed to reduce by half the automatic downward Value Modifier payment adjustment for TINs that did not meet the minimum quality reporting requirements. So these are the Category 2 TINs that I'll review later. We also proposed to hold TINs that met the minimum reporting requirements harmless from downward payment adjustments based on their performance. So, this means that the Category 1 TINs would be held harmless from downward adjustments under quality tiering. And the third Value Modifier proposal was to reduce the maximum upward payment adjustment based on performance for TINs with at least 10 eligible professionals to align with the maximum upward Value Modifier payment adjustment for TINs with 1 to 9 eligible professionals. I'll highlight which slides are impacted by these proposals as I go through the next few slides.

The 2018 Medicare Physician Fee Schedule Final Rule is targeted for display on or around November 1<sup>st</sup>. If these Value Modifier policies are not finalized as proposed, then we will provide an update to report recipients.

Slide 9, please. So the term eligible professional, or EP, is used in the QRUR to refer to the set of clinicians that determine group size for applying the Value Modifier and to the TIN's PQRS reporting status. So, different types of physicians, practitioners, and therapists are shown in this slide, and they are all considered to be eligible professionals. However, only the physician and practitioner types shown in bold on slide 9 are subject to the Value Modifier in 2018. So, the EPs that are not in bold on this slide will not – they will not be subject to the 2018 Value Modifier; however, they will count toward your TIN's 2016 group size and your TIN's quality performance.

Slide 10, please. The chart on slide 10 shows how PQRS reporting in 2016 determines whether a TIN is eligible to have its Value Modifier calculated based on quality tiering or whether the TIN will be subject to an automatic downward Value Modifier payment adjustment. So as I mentioned earlier, in 2018, the Value Modifier will apply to all physicians, nurse practitioners, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists in groups with two or more eligible professionals and to those who are solo practitioners. Similar to previous years, we use the two-category approach to classify groups and solo practitioners subject to that 2018 Value Modifier based on how they participated in the PQRS in 2016.

Category 1, as shown in the left-hand side of the slide, includes groups that met the criteria to avoid the 2018 PQRS payment adjustment as a group practice participating in the PQRS GPRO in 2016 or groups in which at least 50 percent of the group's eligible professionals met the criteria to avoid the 2018 PQRS payment adjustment as individuals. Category 1 also includes solo practitioners that met the criteria to avoid the 2018 PQRS payment adjustment as individuals.



All groups and solo practitioners that are in Category 1 will be subject to quality tiering. Quality tiering is the methodology that's used to evaluate a TIN's performance on quality and cost measures for the Value Modifier, and it applies to all Category 1 groups and solo practitioners that are subject to the 2018 Value Modifier.

We proposed in the 2018 Medicare Physician Fee Schedule Proposed Rule that, in 2018, Category 1 TINs would be eligible for upward or neutral payment adjustments based on their performance in 2016 and would be held harmless from downward adjustments for poor performance. And I'll talk more about the proposed payment adjustments for Category 1 TINs on slide 11.

Category 2, as shown in the right-hand side of the slide, includes all groups and solo practitioners that are subject to the 2018 Value Modifier and do not fall within Category 1.

In 2018, Category 2 TINs with less than 10 EPs and also TINs that consisted only of nonphysician eligible professionals would be subject to an automatic minus 1 percent downward Value Modifier payment adjustment. And Category 2 TINs with 10 or more eligible professionals that had at least 1 physician would be subject to an automatic minus 2 percent downward Value Modifier payment adjustment in 2018.

For Shared Savings Program TINs, if a TIN's ACO reported successfully to the PQRS via the GPRO web interface in 2016 and avoided the 2018 PQRS payment adjustment, then all TINs that participated in that ACO in 2016 are classified as Category 1. If an ACO failed to report successfully to the PQRS in 2016 but a TIN that participated in that ACO reported outside the ACO to the PQRS and avoided the 2018 PQRS payment adjustment either as a group or as individual, then that TIN will be classified as Category 1.

Slide 11, please. As mentioned on the previous slide, Category 1 TINs had their 2018 Value Modifier calculated based on their quality and cost performance in 2016 using the quality-tiering methodology. The table on slide 11 shows the 2018 Value Modifier payment adjustments that we proposed to apply to all Category 1 TINs in 2018 in the 2018 Medicare Physician Fee Schedule Proposed Rule.

Category 1 TINs with below average performance would be held harmless from downward payment adjustments in 2018. The maximum upward payment adjustment that high-performing TINs would be eligible for is three times the 2018 Value Modifier adjustment factor. And the 2018 Value Modifier adjustment factor will be available in early 2018.

### **Quality, Cost & Utilization Information Contained in the 2016 Annual QRUR**

Slide 13, please. Slide 13 lists all the sections contained in the QRUR along with the exhibits shown in each section. You can view each of these sections online on the CMS Enterprise Portal website, or once you're in the portal, you can also download a PDF document that contains the TIN's entire QRUR. Instructions for accessing your QRUR are provided on slide 41.

Slide 14, please. The cover page is the first page of the QRUR. It states whether your TIN is subject to the 2018 Value Modifier. The cover page of the report provides a brief overview of what the Value Modifier is. It tells you how the Value Modifier applies to your TIN in 2018 and also provides resources you can refer to if you have questions or would like to submit an informal review.



The scatter plot on this page displays your TIN's overall Quality and Cost Composite Scores in comparison to how a representative sample of other TINs performs on the Quality and Cost Composite Scores used to calculate the 2018 Value Modifier. The blue diamonds in the scatter plot represent other TINs. If your TIN has sufficient data to calculate a Quality and Cost Composite Score, then your TIN will be shown in red as the largest diamond, so you can see how your performance in 2016 compared to other TINs.

Throughout the rest of this presentation, we'll be reviewing the QRUR for a sample TIN to help you understand how to interpret the information presented in the report. Here we see that this sample TIN was Category 1 with both high quality and low cost. So, the eligible professionals subject to the Value Modifier that bill under this TIN in 2018 will receive an upward payment adjustment of two times the adjustment factor. More detailed information about the quality and cost performance that contributed to this TIN's composite score is shown in the exhibits and tables that will be reviewed later in this presentation.

Slide 15, please. The "How Does the Value Modifier Apply to Your TIN in 2018?" section of this QRUR describes how the Value Modifier applies to your TIN in more detail than was given on the cover page. So the first paragraph tells you why the Value Modifier applies to your TIN and also how many eligible professionals were in your TIN during the 2016 performance period. The sample TIN shown here met all the criteria for being subject to the 2018 Value Modifier and had 70 eligible professionals in 2016. Then the second paragraph here tells you whether your TIN qualified to have its Value Modifier calculated using the quality-tiering methodology, meaning that it's a Category 1 TIN, or if it will be subject to an automatic downward Value Modifier payment adjustment, meaning that it's a Category 2 TIN based on your TIN's 2016 PQRS reporting.

In the highlighted paragraph in this screenshot, you can see that the eligible professionals in this TIN reported to the PQRS as individuals, and approximately 83 percent of the eligible professionals avoided the 2018 PQRS payment adjustment. Therefore, this TIN will avoid the automatic downward Value Modifier payment adjustment and will be eligible for quality tiering in 2018.

Slide 16, please. Exhibit 1 displays your TIN's payment adjustment under the 2018 Value Modifier based on your TIN's quality and cost performance in 2016. The highlighted cell shows your TIN's quality and cost performance classified into one of nine cells that represent different combinations of quality and cost category. Your TIN's quality and cost categories are then used to determine your TIN's 2018 Value Modifier payment adjustment.

Earlier in this presentation, we reviewed the payment adjustment amount that can apply to Category 1 TINs in 2018. And Exhibit 1 of the QRUR shows which of those adjustments will apply to your TIN by highlighting the applicable adjustment in blue. So we can see here that the sample TIN we're reviewing had high quality and low cost and will receive an upward payment adjustment of two times the adjustment factor in 2018.

Slide 17, please. The next section of the QRUR, titled "How Does the High-Risk Bonus Adjustment Apply to Your TIN?," explains why your TIN did or did not receive the high-risk bonus adjustment. The TIN we're looking at in this presentation did not qualify for the high-risk bonus adjustment. And on this slide, we see that the reason for that is that, although this TIN did have strong quality and cost performance as evidenced by an upward payment adjustment under quality tiering, it did not have an average beneficiary risk score above the 75<sup>th</sup> percentile for all beneficiaries nationwide. In the text in this screenshot, we see that this TIN's average beneficiary risk score was at the 38<sup>th</sup> percentile of all beneficiaries nationwide.



Slide 18, please. The next section of the QRUR explains the TIN's quality performance in greater detail. Exhibit 2 displays the TIN's Quality Cost Composite Score for all Category 1 TINs that have sufficient data to calculate the Quality Composite Score. For purposes of quality tiering, a TIN's Quality Composite Score is classified into one of three quality tiers that are high, average, or low based on how the score compares to the mean, or the TIN's peer group. To be considered either high quality or low quality, a TIN's score must be at least one standard deviation from the peer group mean and be statistically significantly different from the mean.

The Quality Composite Score for Category 2 TINs are not calculated in this exhibit. The sample TIN we see on this slide has a Quality Composite Score of positive 1.32, and it is statistically significantly higher than the mean. So this number corresponds to the quality coordinate in the scatter plot on the cover page. It also falls in the high-quality area in Exhibit 1. In the next few slides, we'll see more about how the Quality Composite Score was calculated and about the individual measures that went into the calculation.

Slide 19, please. This section of the QRUR after Exhibit 2 describes the types of quality measures that were used to calculate your TIN's Quality Composite Score and how they were reported. For all TINs, the Quality Composite Score may be based on quality measures from up to three different sources: first one being data that the TIN reported about their patient's care through the PQRS, second one is through feedback provided by patients through the CAHPS® survey, and the third type is quality outcomes calculated from Medicare fee-for-service claims submitted by all providers treating beneficiaries attributed to the TIN.

So the specific language in this section will be tailored to your TIN depending on how your TIN reported quality data to the PQRS, whether your TIN chose to report CAHPS data, and also which quality outcome measures applied to your TIN. CMS will automatically calculate claims-based quality outcome measures for every TIN. And the other measures are included in these calculations only if they were reported by your TIN.

Slide 20, please. Exhibits 3A and 3B show your TIN's domain scores. It explains how they were calculated and also how they were used to calculate your TIN's Quality Composite Score. All quality measures are classified into six quality domains. A score for each quality domain is calculated at the equally weighted average of measure scores within the domain for all measures that have 2015 benchmarks and the required minimum number of eligible cases. A TIN's performance is then summarized across all domains for which scores could be calculated. The summary score is standardized relative to the mean of the summary scores within the TIN's peer group to create the TIN's Quality Composite Score.

As shown in the left two columns of Exhibit 3A, the sample TIN had four quality domains that counted for the purposes of this calculation and had a summary score of 1.21. Then in the right two columns of Exhibit A, we see that the benchmark is 3.0 and the standard deviation for the peer group is 0.69. From these data, CMS derives the TIN's Quality Composite Score by determining how many standard deviations the TIN's summary score is from the peer group mean. So this yielded a Quality Composite Score of 1.32, which is more than one standard deviation from the mean. And as we saw on Exhibit 1, this Quality Composite Score is higher than 1.0 and statistically significantly different from the mean, which is why this TIN's quality performance was classified as high quality under quality tiering.

Exhibit 3B provides more details about the domain scores used to calculate your TIN's summary performance. You can see, in this example, domain scores were calculated for four of the quality domains in which there



were at least one quality measure with a required number of minimum cases and a prior year benchmark. The average of these four domain scores is 1.21, which is the summary score shown in Exhibit 3A. No scores were calculated for the two domains with no measures. And these domains were not included in the summary calculations for the Quality Composite Score.

Slide 21, please. Exhibit 4 for the sample TIN is shown in slides 21 and 22. In a series of tables for each quality domain, Exhibit 4 presents your TIN's quality domain scores and also the measure level performance rates for each quality measure in each domain, provided that there were at least one measure in the domain with at least one eligible case. The screenshot on slide 21 shows the sample TIN's individual measures for Exhibit 4-ECC. This exhibit provides information on the PQRS measures. The TIN reported in the Effective Clinical Care Domain. And as we saw on the previous slide, this TIN had only one measure in this domain, and that measure is shown here. It's the – it was the Colorectal Cancer Screening measure. PQRS measures need to have at least 20 eligible cases and a prior year benchmark to be included in a domain score. You can see that this TIN had 258 eligible cases for this measure and also had a prior year benchmark. As a result, this measure was included in the Effective Clinical Care Domain.

Slide 22, please. The screenshots on slide 22 show the sample TIN's domain score for the Communication and Care Coordination Domain based on the claims-based measures shown in Exhibit 4-CCC-B. Because CMS calculates claims-based quality outcome measures for all TINs, this exhibit shows each TIN's results for all of the measures, including those for which there were zero eligible cases.

Slide 23, please. In the next three Exhibits—5, 6, and 7—these are the cost analogs of the three quality exhibits that we reviewed, which were Exhibits 2, 3, and 4. Exhibit 5 displays your TIN's standardized Cost Composite Score that was used to calculate the Value Modifier. This score shows how far your overall performance on cost measures was from the mean for your peer group. CMS uses the same criteria to classify the Cost Composite Score as high or low cost as it does for the Quality Composite Score. That is, the Cost Composite Score must be at least one standard deviation away from the mean and statistically significantly different from the mean to be considered either high cost or low cost.

For the Quality Composite Score, a higher score is better, but for the Cost Composite Score, a lower score is better. The TIN in this example had a score of negative 1.10, which was statistically significantly lower than the mean. This score corresponds to the low cost classification shown as Exhibit 1 on slide 16.

Slide 24, please. So before going into more detail on your TIN's cost measure performance, the QRUR describes the cost measures that were used to calculate your TIN's Cost Composite Score. All six cost measures included in this report as shown in this slide are calculated using administrative claims data and do not require any separate reporting by the TIN. All cost measures included in the Cost Composite Score are both risk adjusted and specialty adjusted to account for factors that could affect the beneficiary's cost. Risk adjustment accounts for differences in the relative clinical complexity of each TIN's attributed beneficiaries, And specialty adjustment accounts for the specialty mix among the eligible professionals in the different TINs.

Slide 25, please. Exhibits 6A and 6B show your TIN's cost domain scores as well as some of the data used to calculate your TIN's Cost Composite Score.



Slide 26, please. So in a separate table for each cost domain, Exhibit 7 provides information on a TIN's cost performance at the individual measure level. This screenshot shows Exhibit 7-AAB for the sample TIN, which contains information on the measures in the Cost for All Beneficiaries Domain. In this case, the Medicare Spending per Beneficiary measure with only 35 eligible episodes is not included in the domain score because the required number of eligible episodes is 125. For all other cost measures, the required minimum is 20 cases.

I would now like to turn the presentation over to Fiona Larbi. She's also in the Division of Value-Based Payment in the Center for Medicare. And she will be presenting the remaining slides in this presentation.

## Accompanying Tables for the 2016 Annual QRUR

Fiona Larbi: Thank you, Sabrina.

Slide 28, please. So this slide shows Table 1. And Table 1 displays information about the EPs in your TIN in both a summary table and a detailed table listing all EPs in your TIN. The Table 1 summary displays the number of eligible professionals including physicians, nonphysician EPs subject to the Value Modifier, and nonphysician EPs not subject to the Value Modifier in your TIN as indicated by two separate counts: (1) the number of EPs identified in PECOS that reassigned the billing rights to your TIN identified as of July the 16<sup>th</sup>, 2016, and (2) the number of EPs submitting claims to Medicare under your TIN between January 1, 2016, and December 31<sup>st</sup>, 2016. CMS uses the lower of these two numbers to determine the size of your TIN for the purposes of the Value Modifier. You can review this summary table to understand how the number of physicians and nonphysician EPs was determined in calculating the Value Modifier for your TIN.

Additionally, Table 1 provides details about the EPs identified as part of the TIN in PECOS or Medicare claims during the performance period. These data are useful to verify information about EPs in your TIN and whether they were associated with your TIN in PECOS and/or claims.

Slide 29, please. Next we will be reviewing Table 2A, and the screenshots for Table 2A are displayed on slides 29 and 30. This section of Table 2A provides additional details about the Medicare beneficiaries attributed to your TIN via two-step attribution. This attribution method is used for the Per Capita Costs for All Attributed Beneficiaries measure, the four Per Capita Costs for Beneficiaries with Specific Conditions measures, and the three claims-based quality outcome measures included in the Annual QRUR. Additionally, the table shows beneficiary characteristics and specific Medicare claims data for each beneficiary.

The index number shown in column 4 of the table is a unique beneficiary identification number that can be used in place of personally identifiable information to track individual beneficiaries across tables. This can help you dig deeper into individual beneficiary patterns of care. Additionally, the health insurance claim, or HIC, number will allow you to match the listed beneficiary with your TIN's practice management system record.

Slide 30, please. This section of Table 2A provides information on the EP who billed the most services of the – for the beneficiary, the date of the last hospital admission, and whether the beneficiary had one or more of four chronic conditions identified in quality outcome and cost measures. The data in this table can be used to look at which EP, both inside and outside of your TIN, provided the greatest share of primary care and nonprimary care services to each beneficiary. This may help you better coordinate care with EPs outside of



your TIN. This table also shows which beneficiaries have the four chronic conditions—diabetes, coronary artery disease, chronic obstructive pulmonary disease, and heart failure—that correspond to the four conditions included in the Per Capita Costs for Beneficiaries with Specific Conditions measures.

Using the index number shown on the previous slide, you can track beneficiaries across the other tables accompanying the QRUR to learn more about their costs and utilization. For example, you could look at their hospital admissions in Table 2C to identify patterns in admissions or diagnoses that might be driving disproportionately high costs. Or by linking to the beneficiary-level data in Table 3B, you can see if there are any particular service categories or settings of high – of care associated with these beneficiaries' costs or patterns of utilization. For example, high costs in post-acute care settings may suggest the opportunity to review care transition plan. As noted on the slide, Table 5B contains similar information for the Medicare Spending per Beneficiary measure, which we will not be reviewing as part of this presentation.

Slide 31. This is Table 2B, which lists the hospitals that provided at least 5 percent of your TIN's attributed beneficiaries' inpatient stays during the performance period. This exhibit includes only the beneficiaries attributed to your TIN's three claims-based quality outcome measures and for the five of the six cost measures. This table can help you verify whether your beneficiaries are most often – which – where your beneficiaries are most often being hospitalized. As noted on this slide too, Table 5A contains similar information for the episodes of care attributed to your TIN for the Medicare Spending per Beneficiary measure.

Slide 32, please. Table 2C provides details about hospitalizations the beneficiaries attributed to your TIN by a two-step attribution. This includes information about the beneficiary, the admitting hospital, the primary diagnosis associated with the admission, the date of discharge, and the discharge disposition showing where the patient was discharged to. This table also shows whether the hospital admission was the result of an emergency department evaluation or if it was associated with one of the ambulatory care-sensitive conditions or all-cause hospital readmissions captured in the QRUR claims-based quality outcome measures.

Hospitalizations are the driving force behind lower performance on all three cost-based quality outcome measures in Exhibit 4 as well as higher costs on all cost measures. This table provides you with detailed data that can help you understand your TIN's performance on these measures. If, for example, you notice that your TIN had poor performance on the diabetes ACSC admission measure, then you could filter the data in the column labeled ACSC Admission—it's the first column of the lower section of the table shown in this slide—to show only hospitalizations associated with diabetes. This will be shown as DIA in the column. This would allow you to identify specific patient diagnoses or hospitals associated with these admissions.

Similarly, you could filter the data in the column labeled Followed by Unplanned All-Cause Readmission within 30 Days of Discharge, the second column in the lower section of the table, to do a similar analysis for the 30-Day All-Cause Hospital Readmission measure. The unique index number assigned to each beneficiary can also help you link to the other separate tables that accompany the QRUR. CMS is not able to display beneficiary-level information about hospitalizations with a primary diagnosis of alcohol or substance abuse. However, the costs associated with such hospitalizations are still included in your TIN's overall per capita cost and quality outcome measure calculations.

Slide 33, please. On this slide, we are showing Table 3A. And this table displays the total per capita cost for your TIN's attributed beneficiaries, broken down by category of service performed by providers both within and



outside of your TIN. You can review this table to identify patterns of care that are disproportionately contributing to your attributed beneficiaries' total per capita cost. For example, if a large share of your TIN's beneficiaries received evaluation and management services from other TINs, for example, you may find increased care coordination helpful. Alternatively, if your TIN performs major procedures or ambulatory minor procedures for a large percentage of your TIN's attributed beneficiaries over the performance period, consider reviewing clinical guidelines concerning when particular procedures are indicated.

Tables 4A through 4D mirror Table 3A, providing information on the cost by categories of service, for beneficiaries included in each of the Per Capita Costs for Beneficiaries with Specific Conditions measures. This allows you to drill down into spending patterns for beneficiaries with specific conditions. Table 5C contains similar information for the Medicare Spending per Beneficiary measure.

Slide 34, please. Next we'll review Table 3B, and screenshots for Table 3B are displayed on slides 34 and 35. Table 3B provides this aggregated beneficiary-level information about the cost of services aggregated in Table 2A. It shows both the beneficiary's total payment standardized Medicare Fee-for-Service costs and the distribution of these standardized costs across categories of service. This information can provide insight into your TIN's cost patterns or performance on any of the per capita cost measures. The chronic condition indicators used in Table 2A are also shown in this table so you can still set the display to show only beneficiaries with diabetes, for example, to better understand your TIN's performance on the Per Capita Cost of Beneficiaries with Diabetes measure.

The beneficiary level costs shown in this table are payment standardized to take into account regional differences in price. But they are not risk adjusted or specialty adjusted. So, if your performance rate on the per capita cost measures shown in QRUR Exhibit 7 seems much higher or lower than this table would indicate, then it is likely that either risk adjustments or specialty adjustments increased or decreased your costs on these measures. This might be the case, for example, either because your TIN's attributed beneficiaries were relatively lower or higher risk or because your TIN's specialty mix is associated with less expensive or more expensive care or treatment. In either case, average per capita costs for beneficiaries listed in Table 3B would not be the same as the per capita reported in the QRUR.

Slide 35, please. The image on this slide shows the rest of Table 3B showing other costs of service categories we discussed on the previous slide. Please note that Table 5D provides similar information about the cost of service associated with each Medicare Spending per Beneficiary episode of care.

Slide 36, please. On this slide, you will see Table 7. And Table 7 provides information about the performance of EPs in the TIN who participated in PQRS as individuals only. The summary table at the top of the display shows you how many EPs were in your TIN and how many avoided the PQRS payment adjustment as individuals. As we saw earlier in this presentation, 58 of the 70 EPs in the sample TIN, or 82.85 percent, avoided the PQRS payment adjustment. So this TIN was classified as Category 1. As a reminder, you can refer to Table 1 to see which EPs are counted in your TIN for the denominator of this calculation.

The rest of Table 7 displays NPI level of performance on quality measures reported to PQRS for each EP who participated in PQRS as an individual under your TIN in 2016. This information includes the measures reported, each measure's Value Modifier Quality domain, the reporting mechanism used by each eligible professional, and the number of eligible cases for each measure. It also displays whether each EP avoided the



2018 PQRS payment adjustment according to PQRS program rules. You can use this information to learn more about the individual quality measures that went into your Quality Composite Score or to better understand and improve the performance of the EPs in your TIN. For example, we saw earlier in this presentation that this TIN performs better than the benchmark on the Colorectal Cancer Screening measure. However, in this table, we see that not all EPs in the TIN had equally strong performance on the measure. While Clinician B had 100 percent performance rate, Clinician A only had 64.40 percent performance rate.

So this completes the presentation on the tables that accompany the QRUR. If you would like more information on the tables not covered in this presentation, please refer to the document entitled “How To Understand Your 2016 Quality and Resource Use Report” available on CMS’s website.

## How To Access Your QRUR

Slide 37, please. Next, we will discuss the new payment adjustment and reports lookup feature as well as how to access your QRUR.

Slide 38, please. We developed two new lookup features that are available on the CMS Enterprise Portal website. The first lookup is a payment adjustment lookup. This feature will allow a representative of TIN to look up a TIN’s current and prior years’ PQRS and Value Modifier payment adjustments. The second lookup is a report lookup. This feature will allow a representative of a TIN to find out which feedback reports are available for the TIN for a given year (i.e., the Annual QRUR, PQRS Feedback Report, Mid-year QRUR, and Supplemental QRUR).

Please note that an EIDM account is not needed to use these two lookup features. However, an EIDM account with the correct role will be needed in order to access any of the TIN’s feedback reports. To access the new lookup features, enter the URL for the CMS Enterprise Portal listed on this slide, and then select Get Started on the Physician Value widget that is displayed at the bottom of the CMS Enterprise Portal page.

Slide 39, please. So to access the new lookup function, select Lookup on the PV landing page from the left navigation menu. The lookup landing page is displayed with the following tabs.

The Payment Adjustment tab—you select this tab to see the TIN’s current and prior year’s Value Modifier and PQRS payment adjustments. From the – and then from the dropdown on the screen, select the Payment Year, and enter a TIN to check if the TIN is subject to the Value Modifier payment adjustment or enter a TIN/NPI combination to check if the TIN/NPI is subject to the PQRS and for Value Modifier payment adjustments.

The Reports tab—you would select this tab if you want to look for your feedback reports that are available for the TIN. And then, you would enter a TIN or TIN/NPI combination to search for the available reports for your organization. The payment adjustment lookup will be displayed by default. And to navigate to the report lookup, just select the Reports tab at the top of the search screen. Please note that TINs are able to access a specific report listed within the search results by selecting the report title. However, selecting the report title will prompt the user to complete the CMS Enterprise login process. Upon completion, they will then be routed to the MicroStrategy web platform.



Slide 40, please. This slide briefly discusses the EI – Enterprise Identity Management. An EIDM account with the appropriate role is required for groups and solo practitioners to obtain their 2016 Annual QRURs and PQRS Feedback reports. Both reports can be accessed on the CMS Enterprise Portal using the same EIDM account. Instructions for signing up for an EIDM account with the correct role are available on the How To Obtain a QRUR webpage.

For any questions related to your EIDM account, you can always contact the QualityNet Help Desk by calling them at the number or email on this slide. Please see the appendix at the end of this presentation for more information about signing up for an EIDM account, if you don't have one already, and requesting a correct role.

Slide 41, please. So this briefly discusses how to access your QRUR. To access your QRUR, enter the URL for the CMS Enterprise Portal. Select Login to CMS Secure Portal on the right side of the screen. Select the Terms and Conditions, and then enter your EIDM user ID and password. User guides with detailed instructions for accessing QRURs and setting up an EIDM account are available for download at the How To Obtain a QRUR page on the [CMS.gov](https://www.cms.gov) website.

Slide 42, please. This slide refers to the resource page. The Resources page is a new centralized page that provides information to inform and assist providers with the major offering at the PV-PQRS application: the Annual Quality Resource – and Resource Use Reports, PQRS Feedback Reports, and Value Modifier Informal Review request. Also, it provides the contact information for the help desk entities that support the major offerings of the application. Each section contains a brief description of the topic. And if you click on the Click for More Information tab, there are links to the quick reference guides and FAQs for each related subject. This page can actually – is actually accessed once you have logged in to your EIDM account, and it is the first option on the PV-PQRS mega-menu.

### **How To Request an Informal Review of Your TIN's 2018 VM Payment Adjustment**

Slide 43, please. This slide we're going to start discussing the Informal Review process for the 2018 Value Modifier Payment Adjustment.

Slide 44. If your TIN is subject to the VM in 2018 and you want to request a review of your Value Modifier payment determination, then a representative from your TIN can submit a request for an Informal Review through the CMS Enterprise Portal. The Informal Review period is open now through December 1<sup>st</sup>, 2017, 8 p.m. eastern standard time. The same EIDM account user ID and password can be used to access the QRURs and submit an Informal Review request.

Slide 45, please. After completing the CMS Enterprise Portal login process, you must select Value Modifier Informal Review request from the PV-PQRS mega-menu, which will display the Value Modifier Informal Review request landing page.

Slide 46, please. Here, we have displayed the Value Modifier Informal Review request landing page. And in – within this page, there will be a Value Modifier History table. You will find an action column all the way to the right within the table that contains a dropdown menu with two options: Option 1 is View QRUR—selecting this option will navigate you to the MicroStrategy web platform to continue the appropriate steps to access your



QRUR report; Option 2, Request Informal Review—selecting this option will allow you to begin the process of requesting an Informal Review request for your Value Modifier.

Slide 47, please. Now we're on the actual screen where you will request your Informal Review. We've made a couple of updates to the Informal Review request page this year. For each Informal Review question submitted, you are required to enter a reason for Informal Review and a justification explanation. However, a new field has been added—Justification for Review. The Justification for Review field is a dropdown that provides added clarity about your request for an Informal Review. The dropdown was created based on the most frequently submitted reasons for Informal Review. You also have the capability to expand on the reason for Informal Review within the free text Justification Explanation. Related Exhibits is a dynamic field that will display the applicable options based on the sections made for the Reason for Informal Review field.

After completing all applicable fields, select Add to add the question to your Value Modifier. All of the – all the fields with a red asterisk are required. So, those will need to be completed before you could actually select Add to add the question to your Value Modifier Informal Review request.

Slide 48, please. The second change to the Value Modifier Informal Review request page this year is the addition of the supporting documentation section. You are now able to attach documentation that you believe will support your request for a Value Modifier Informal Review. Examples of supporting documentation include letters of communication from third-party vendors, data submission reports, and emails. To do this, you select Add Supporting Documentation, which will display the Add Supporting Documentation popup window. Select Choose to locate and select your supporting documentation file on your system, then select Upload to add the file to the Value Modifier Informal Review request. You are able to upload the following file types: Microsoft Excel, Outlook, or Word, and PDF. There are no restrictions on the amount of files that can be attached to a Value Modifier Informal Review request. However, there is a 2-megabyte (MB) size limit for each file attached.

### Next Steps and Technical Assistance

Slide 49, please. So this ends the actual formal presentation.

Slides 50 and 51 go over next steps. Slide 51, please. So in this slide, we encourage you to download your 2016 Annual QRUR and 2016 PQRS Feedback Report. Please go to the Value Modifier webpage to review any of the QRUR supporting documents. And then if you feel that you need to submit that Informal Review, then please do so by December 1, 2017.

And on slide 51, there's technical assistance, and they have the help desk information support, the Value Modifier Help Desk and the QualityNet Help Desk. And they can help you with questions on your QRUR, Value Modifier, PQRS, and EIDM.

Now I'll turn the call back to Leah.



## Question & Answer Session

Leah Nguyen: Thank you, Fiona. We will now take your questions about QRUR. We'll begin by – this session by answering a few questions we received from webcast participants, and we'll then take questions from the phone. We are going to have a few polls that will pop up on your screen. Please disable your popup blocker so you can participate.

Operator, please prompt the telephone users and begin to compile the Q&A roster.

Operator: At this time, we would like to take any questions you might have for us today. To ask a question via the web, click the Q&A button on the lower left-hand corner of your screen, type your question in the open area, and click Submit to get your question into queue. If you would like to ask an audio question, simply press star then the number 1 on your telephone keypad. If you would like to withdraw your question, press the pound key.

Leah Nguyen: Hello. So we'll take our first question from a webcast participant. Who is our peer group for comparison? We are a dermatologist.

Dr. Wilfredo Lim: And this is Wilfredo Lim from Mathematica, and I can answer that. So there are two, I guess, areas; so one for measures and one for the composite. So for each measure, the peer group used to determine the benchmark for each measure includes all practices that meet the minimum case threshold for that measure, with the exception of the All-Cause Hospital Readmission measure, which is limited to practices with 10 or more eligible professionals that meet the case threshold. The one thing to add for the peer group for measures is that, while the benchmark includes the performance rates of all the practices that meet the case size criteria, the cost measures are specialty adjusted to account for differences and expected costs across practices of varying specialty mixes. So for the composites the peer group for practices subject to the Value Modifier is all practices including fellow practitioners that are subject to the Value Modifier for which Quality and Cost Composite Scores were used to determine the Value Modifier.

Leah Nguyen: Thank you. Our next question. I work with a group that reported GPRO web interface quality measures in 2016. Their 2016 QRUR does not include the Breast Cancer Screening measure. How can they find out if this was an error or if the measure was intentionally left off the QRUR?

Lara Converse: Hi, this is Lara Converse from Mathematica. So the Breast Cancer Screening measure, which was PQRS number 112 or GPRO measure PREV-5, was excluded from the QRURs due to possibly inconsistent performance rates related to 3D mammography. So for a full list of measures excluded from the QRUR, you can refer to Appendix C Exhibit C2 of the detailed methodology, and the link to that document is on slide 51.

Leah Nguyen: Thank you. Our next question for the Q&A session. Can you tell us if the supplemental QRUR episodes of care report will be available for practice to review as it has in past years?

Kim Spalding Bush: Thanks for that question. No, this year, we did not release the supplemental QRUR reports. Though we do have – if you're interested in cost measure performance, you may be able to access



these episode-based cost measure field test reports and give us some feedback about cost measures under consideration for potential future use by CMS. But we are not releasing supplemental QRURs this year.

Leah Nguyen: Thank you. Operator, can we take a question from the phone now?

Operator: You have a question from the line of Linda Bredl.

Linda Bredl: Hello. Hi. My question is we took a penalty for 2015 for 2017 reimbursement. Two thousand sixteen, we got by with no penalty. But my doctors want to know how do we avoid this penalty? Based on our peer group, we have 16 facilities. We are hospital based. We cannot control the patients that come to the hospital. We can't stop and not treat them based on the fact they don't have a PCP or they're – they've had poor quality treatment in the past. So how do you – how can you be proactive to avoid these penalties?

Kim Spalding Bush: Thanks for the question. So I mean, I think it's just a matter of first reporting quality. So certainly it sounds as though you avoided the automatic downward adjustment for that. And then being compared to the peer groups, we do try to account for differences in patient populations. We risk adjust our measures in the quality space. And then we specialty adjust and risk adjust the cost measures to try to account for different case mixes and also different physician group compositions. I think the other thing to note with the Value Modifier Program is that you have to be – or your performance on cost or quality would have to be at least one standard deviation from average and also statistically significantly different than average in order to be considered high or low to get the upward adjustment or downward adjustment.

And then the last thing to note is that the performance and the Value Modifier payment adjustments that are reflected in this year's QRUR, they reflect the proposed policies that we put forth in this year's Physician Fee Schedule rule. And under those proposed policies, which have not yet been finalized, but we would hold groups harmless from any downward adjustment based on their performance. So even if you had low quality, so long as you met the minimum quality reporting requirements and avoided that automatic downward adjustment, you will not be receiving a downward adjustment based on your quality performance if that policy is finalized. And that's what you should see reflected in your QRUR.

Linda Bredl: Okay.

Leah Nguyen: Thank you. We'll take another question from a webcast participant. Is there a CMS number or contact email if we have questions from the detailed explanation report about the methodology used or why a particular patient was attributed to a TIN?

Sabrina Ahmed: I'm Sabrina Ahmed. Yes, you can contact the Physician Value Help Desk with any questions you have about the QRUR, the methodology used to calculate the numbers shown in the QRUR, and also if you have questions on about how your Value Modifier was calculated. The Physician Value Help Desk contact information are listed on slide 51. And you can contact them by phone or by email.

Leah Nguyen: Great. Thank you. Why do some QRUR reports have a scatter plot with a red dot identifying your value relative to your peers while others don't. What is the difference in these reports?



Dr. Wilfredo Lim: Hi, this is Wilfredo Lim. So only Category 1 practices will see the scatter plots. And then among those Category 1 TINs, the You diamond will only show if we are able to compute both a Quality and Cost Composite Score unless either the score is greater than or equal to one, or less than or equal to negative one, but is not statistically significant.

Leah Nguyen: Thank you. And this is our next question. If you reported as an individual practitioner and have the same TIN as other practitioners, you would – hold on one second, the same TIN as other practitioners, you would be subject to the adjustment. What happens if one of your practitioners does well and one does poorly under the same TIN?

Kim Spalding Bush: So the Value Modifier is applied at the tax ID number level. So, all of the providers within a given TIN would receive the same adjustment. That's also true in cases where you avoid the downward adjustment by virtue of having – the automatic downward by virtue of having or had at least 50 percent of your eligible professionals avoid the PQRS payment adjustment. So in that case, every eligible professional within the TIN would not receive the automatic downward. So it does kind of work in both directions. But, yes, every professional within a given TIN is subject to the same Value Modifier payment adjustment.

Leah Nguyen: Great. Thank you. Our next question. Looking at the last slide, I don't see how you get an upward adjustment of 3X. How do you get that?

Dr. Wilfredo Lim: Hi, this is Wilfredo. You would get an upward adjustment – or a TIN could get an upward adjustment of 3X if they were Category 1, were high quality and low cost, and also were eligible for the high-risk bonus adjustment, meaning that the average CMS risk score for the beneficiaries that were attributed to their TIN was at or above the 75<sup>th</sup> percentile of beneficiaries nationally.

Leah Nguyen: Thank you. Operator, let's take a question from the phone now.

Operator: You have a question from the line of Misha Diden.

Misha Diden: Yes, I just want to get clarification of when the actual adjustment factor will be released. I believe someone mentioned the beginning of 2018. Is that correct?

Kim Spalding Bush: That's correct. We're trying to get it calculated as early as possible and implemented early in 2018. And we understand that there's some administrative burden that is associated with it if we don't do that. But the adjustment factor needs to reflect as many of our Informal Review decisions as possible. So that is, when providers believe that there's an error and they submit their Informal Review, their Value Modifier adjustment may change. So the adjustment factor is calculated by our actuaries. And we try to take into account as many of those Informal Review requests as possible and still get it finalized towards the beginning of 2018.

Misha Diden: Okay, thanks.

Leah Nguyen: Thank you. We'll take the next question from the webcast. The high-risk bonus section says you have to have strong quality and cost. Does that correlate to the high-quality/low-cost quadrant, meaning EPs have to be better than average?



Dr. Wilfredo Lim: Hi, this is Wilfredo. So for the reference to strong quality and cost in that section includes what was mentioned, so high quality and low cost. But it also includes high quality and average cost as well as average quality and low cost.

Leah Nguyen: Thank you. Here's our next question. Are transplant patients included in the Medicare Fee-for-Service cost measures beneficiary population, or do they have special status?

Dr. Wilfredo Lim: Hi, this is Wilfredo again. So the answer is, yes, there's no special treatment for a transplant patient. The one thing that would be helpful to note is that the cost measures are Winsorized to account for beneficiaries with outlier costs. So for example, for the per capita cost measures, costs for beneficiaries – under cost for beneficiaries that are above the 99<sup>th</sup> percentile are replaced with the 99<sup>th</sup> percentile value.

Leah Nguyen: Thank you. Our next question. For specialists and peer comparison, are specialist physicians compared with physicians of the same specialty or are compare – or are comparison – or are all physicians compared against all physicians regardless of specialty?

Dr. Wilfredo Lim: Hi, this is Wilfredo. So for comparison, all practices are compared to all other practices. However, for the cost measures, the underlying scores have been adjusted for the specialty mix of each practice.

Leah Nguyen: Thank you. Operator, we'll take a question from the phone now.

Operator: You have a question from the line of Tristan Long.

Tristan Long: Hi. I have a question regarding Table 3A of the supplemental files. Can you please explain, towards the bottom there is a category called Chemotherapy and Other Part B Covered Drugs. How can I find out all the drugs that are listed within that category of Other Part B?

Dr. Wilfredo Lim: This is Wilfredo. For all the drugs that are included there, I would contact the PV Help Desk for that information.

Tristan Long: Okay. Thanks.

Leah Nguyen: Thank you. We'll go back to the webcast. Our next question. We had two of our EPs that participated in the Oncology Care Model, but we also reported PQRS. Does one trump the other? Exhibit 1 was not in our PQRS report.

Dr. Wilfredo Lim: Hi, this is Wilfredo again. So in this case, the practice would be exempt for the Value Modifier due to OCM participation. So for that reason, Exhibit 1 is not shown. Note that the PQRS measures that are reported outside of the OCM model would be shown in the QRUR for informational purposes.

Leah Nguyen: Thank you. Next question. Would there only be a composite score shown if the Value Modifier applies? My Exhibit 3 does not show a composite score. It shows the list of attributed beneficiaries.



Dr. Wilfredo Lim: Sure. So the composite score would be shown whether or not – if it could be calculated, whether or not the Value Modifier applies. So one thing to note, it sounds like – so Exhibit – if the question mentions that Exhibit 3 shows the list of attributed beneficiaries, I believe the inquirers may actually be referring to Table 3 or at least Table 3B, which lists the beneficiaries that have been attributed to the TIN. So that – it's possible that – yes, the inquirer would just need to look at the Exhibit 3 and the main QRUR as opposed to the tables.

Leah Nguyen: Thank you. This is our next question. How are standardized performance scores calculated?

Dr. Wilfredo Lim: Sure. So for each measure, a standardized performance score is computed by starting with the performance rate for that measure, subtracting the benchmark for that measure, and then dividing by the standard deviation for the measure.

Leah Nguyen: Thank you. Operator, let's take a question from the phone now.

Operator: You have a question from the line of Denise Lerner.

Denise Lerner: Hi. The average risk could not be calculated and the Cost Composite Score was also not calculated on our reports. Can someone explain to me why? It looks like these two may have lowered our score tremendously, but I'm not 100 percent sure. We scored pretty high on the measures that we submitted. Yet our score was calculated below 1. So it doesn't seem like we're ever going to get close to the 3 for a positive adjustment.

Kim Spalding Bush: Thank you for that question. I think because you have specific questions about the data that's reflected in your QRUR report, your – you can contact the Physician Value Help Desk at the contact information listed on slide 51. But I would also suggest that, if you believe that there's an error, that you go ahead and submit an Informal Review request. That way we can have our people take a close look at your report and make sure it's correct. And the reason I would say you may want to go ahead and do that is that the Informal Review request period will end on December 1<sup>st</sup>. So I just – I wouldn't want you to miss that if you do think something's wrong with the report.

That said, I don't know if Mathematica – if you guys could speak to why a beneficiary's, or the – I don't know if it was the practice risk score but why a risk score couldn't be calculated.

Dr. Wilfredo Lim: Sure. So – and it may be helpful to, I guess through the inquirer can provide a more specific response to your situation. So one thing to note is that you mentioned that you did well on the measures that you reported, so that – I'm assuming then that that would be the PQRS measures.

Denise Lerner: Correct.

Dr. Wilfredo Lim: The other set of measures which CMS calculates are the claims-based quality outcome and cost measures. So it's possible that there were no beneficiaries attributed to your TIN. In which case, the averages score, which is based on those beneficiaries, there would – if there were no beneficiaries attributed to the TIN, there would be no average risk score. And so that would – could possibly explain why there is no risk score computed. And it could also explain why there's no cost composite computed for your practice. But



if your practice submitted PQRS performance rates, it's possible that a Quality Composite Score could still be computed. And then it's based on the performance on quality measures and then the performance on cost measures that is then used to determine the Value Modifier. But again, I'm happy to – we'd be happy to look into your specific questions if you provide that through the help desk.

Denise Lerner: Thank you.

Leah Nguyen: Thank you. All right, we'll go back to some questions from the webcast. What comprises the Cost Composite Score, charges or allowable?

Dr. Wilfredo Lim: Hi. It's allowed charges are the basis for assessing cost.

Leah Nguyen: Thank you. Next question. How do you know what is statistically significantly different from the mean? Is there a chart for that?

Dr. Wilfredo Lim: So CMS calculates statistical significance using a chi test. First, CMS subtracts the peer group mean composite score from the TIN's composite score and then divides this difference by the standard error of the TIN's composite score. This calculation yields a chi – the chi statistic, which is used to determine statistical significance at the 5-percent level. Chi statistic values of 1.96 or higher correspond to statistical significance. To the second part of the question, this information is not reported in the QRUR, so there is no chart for this.

Leah Nguyen: Thank you. Next question. If we are dermatologists, how do – how are we included in cost composite for such acute conditions as bacterial pneumonia, diabetes, pulmonary disease, etc.?

Dr. Wilfredo Lim: Sure. So I guess going back – so for the claims-based quality and per capita cost measures, beneficiaries are attributed to a practice that – or to the practice that provided the plurality of primary care services to these beneficiaries according to the two-step attribution process. And so all of their Part A and Part B costs as well as their hospitalizations for these beneficiaries that have been attributed to the TIN are included in these measure calculations, so again, for the claims-based quality and per capita cost measures, which are being referred to in the question.

Leah Nguyen: Thank you. Operator, let's take one final question from the phone.

Operator: Your final question comes from the line of Dr. Michele Reid.

Dr. Michele Reid: I was asking a similar question. We're a community mental health center specialty. And just looking through a lot of the measures, you hear people talking about colonoscopies and other things. Do you see in the future that some of the standards will be more customized for these various specialties?

Kim Spalding Bush: Hi. Thanks for the question. So CMS is always looking to work with our stakeholders and partners to develop measures that are more reflective of the care that you're providing or the structure of your practice. So since 2018 is the last payment year for the Value Modifier and 2016 was the last performance year, I would suggest that if you have suggestions or questions—and we've had a couple other questions on the webinar here—that you could send them to the QPP Help Desk because they could be helpful as CMS



works to design and continue to develop the MIPS program that is replacing the Value Modifier. So their address is [gpp@cms.hhs.gov](mailto:gpp@cms.hhs.gov).

Leah Nguyen: Thank you. And we'll take one final question from the webcast. How do we pull up the table? It wasn't part of my QRUR report that I downloaded.

Sabrina Ahmed: This is Sabrina Ahmed. So the QRUR reports and then also the QRUR tables can both be downloaded from the CMS Enterprise Portal website. But you have to access the tables separately from the report. So if you go to the How to Obtain a QRUR website, which is listed on – I believe it's slide 51, yes, and then on that website, we have instructions for how you can access your 2016 QRUR report and the QRUR tables. So basically, it's the first instructional document that's available in the download section on that website.

Leah Nguyen: Thank you. Actually, we can do one more. Is this portion for hospitals, because I'm not seeing any of these tables in my QRUR report?

Kim Spalding Bush: So I think, actually, the answer that Sabrina just gave was probably the best one to that question as well. None of the presentation today was directed specifically for hospitals. That was all for physicians and the nonphysician practitioners who are subject to the Value Modifiers. So you should be able to go access the QRUR at the How To Access Your QRUR Report link. And then if you have continued questions, you can certainly send them to our Value Modifier Help Desk with that – either the phone number or the mailbox on slide 51.

Leah Nguyen: Thank you. Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can email it to the appropriate address listed on slide 51.

### **Additional Information**

Leah Nguyen: For information on evaluating today's event, see slide 53.

This webcast is being evaluated by CMS for CME and CEU continuing education credit. For additional information, please refer to the CE Activity Information & Instruction document on slide 54 of the presentation. Again, my name is Leah Nguyen.

I would like to thank our presenters and also thank you for participating in today's Medicare Learning Network Event on QRUR. Have a great day, everyone.

Operator: This concludes today's event. Presenters, please hold.