

GUIDE TO NAVIGATING CMS QUALITY INITIATIVES AND AVOIDING PENALTIES FOR CY 2016

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North American Spine Society

Information Compiled by the NASS Performance Measurement Committee

Impact of SGR Reform on current quality reporting programs

Under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), several current Medicare quality reporting programs, including the Physician Quality Reporting System (PQRS), Value-Based Modifier (VM), and the Electronic Health Record (EHR) Incentive/Meaningful Use Program will be consolidated into one new system called the Merit-Based Incentive Payment System (MIPS), which will begin in 2019 based on reporting year 2017. Penalties associated with current quality reporting programs will sunset in 2018, before MIPS begins. MIPS will contain 4 performance assessment categories, including quality measures, resource use, meaningful use of electronic health records, and clinical practice improvement activities. Under MIPS, weights will be assigned to each category to create a composite score for eligible providers based on their performance in these categories. Reporting requirements for the MIPS program are expected to be finalized in Fall 2016. Eligible providers are still required to successfully participate in the current Medicare quality reporting programs in order to avoid downward payment adjustments. Successful implementation and participation in current programs will also aid eligible providers in their transition to the new MIPS system.

NASS will continue to monitor rule-making for MIPS implementation and provide updates to membership via the NASS website, newsletters and SpineLine.

How do I participate in PQRS?

Step 1: Determine Eligibility

The following are considered “eligible professionals” and are eligible to participate in PQRS:

- *Medicare Physicians:* MD, DO, DPM, DDS, OD, DC
- *Medicare Practitioners and Therapists:* Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist, Certified Nurse Midwife, Advanced Practice Registered Nurse, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Nutrition Professional, Audiologists Physical Therapist, Occupational Therapist, Qualified Speech-Language Therapist

An overview of eligibility requirements can be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016_PQRS_List_of_EPs.pdf.

Step 2: Determine Participation as Individual or in a Group

Individual

Individuals can participate in the 2016 PQRS by reporting via Claims (paper), Qualified Registry, Qualified Clinical Data Registry (QCDR) or Electronic Health Records (EHRs). **No sign-up or pre-registration is required.**

It is common for individual eligible professionals to bill fee-for-service Medicare under more than one TIN. Because these claims are submitted and paid at the group/TIN level, individuals need to make sure that they participate in PQRS through each group/TIN under which they submit claims and receive payment from CMS.

Group Practice

For purposes of PQRS, group practice is defined as a single tax identification number (TIN) with 2 or more eligible healthcare professionals.

Your program administrator should decide which PQRS measures to submit on behalf of your group practice. If you are in a multi-specialty group practice, it is likely that some measures will not be applicable to everyone in your practice. There may be times when some members will not participate in the collection of all measures that the group will report. However, if the group (TIN) successfully reports PQRS measures, all members of the group practice will receive PQRS credit regardless of who provided the service.

Group Practice Reporting Option (GPRO)

To be considered as a 2016 PQRS GPRO, group practices must:

- Have billed Medicare Part B PFS on or after January 1, 2016 and prior to December 31, 2016.
- Agree to have PQRS performance results publicly posted on the Physician Compare website.
- **Register** to participate in a group practice through the PV-PQRS Registration System by June 30, 2016 via <https://portal.cms.gov>.

For additional information on the 2016 GPRO, go to: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html.

Step 3: Determine How You Will Report PQRS Measures

Eligible professionals may choose from the following methods to submit data to CMS:

- [Medicare Part B claims](#),
- [Qualified Registry](#),
- [Qualified Clinical Data Registry \(QCDR\)](#),
- [Direct Electronic Health Record \(EHR\) using certified EHR technology \(CEHRT\)](#),
- [CEHRT via Data Submission Vendor](#),
- [or the Group Practice Reporting Option \(GPRO\)](#).

See PQRS requirements for submission methods for individuals and group practices for meeting program requirements and avoiding payment adjustments on pages 4-5.

Can PQRS reporting requirements be aligned with other reporting programs?

Yes, eligible professionals can submit clinical quality measures (CQMs) once and have it count toward meeting PQRS and EHR Meaningful Use reporting requirements. For more information go to: https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/ecqm_library.html.

Step 4: Determine Applicable Measures

A list of PQRS measures most applicable to spine care providers can be found on pages 7-11.

For a full list and specifications of 2016 individual quality measures and measures groups, go to: http://www.cms.gov/apps/ama/license.asp?file=/PQRS/Downloads/PQRS_2016_Measure_List_01072016.xlsx.

Step 5: Establish a Work Flow and Participate

Establish an office work flow to ensure that all staff members understand the measures selected for reporting and to allow for efficient and consistent data capture.

This document is provided for information and education only. It is the provider's responsibility to know and understand the parameters of the reporting programs in which they participate as well as the resulting consequences.

2016 PQRS Reporting Requirements for Individual and Group Practice Reporting

Reporting Requirements and Payment Adjustment Information

There were few changes from performance year 2015 PQRS reporting requirements to 2016 PQRS reporting requirements. For 2016 and subsequent years, the payment adjustment is 2.0%. There is a 2-year gap between the performance year and when the payment adjustment is applied under PQRS. Therefore, if eligible professionals do not successfully report PQRS measures in performance year 2015, they will be paid 2.0% less than the MPFS amount for that service in 2017. Incentives for successful participation in PQRS are no longer offered.

2016 PQRS Reporting Requirements by Mechanism

Reporting Mechanism → Type of Reporting	Claims-Based Reporting	Qualified Registry Reporting	Qualified Clinical Data Registry (QCDR) Reporting	CMS Certified (CERT) Direct Electronic Health Record (EHR) Based Reporting OR CERT EHR Data Submission Vendor	Group Practice Reporting Option (GPRO) Web-Interface
Individual Reporting	<p>9 individual measures covering at least 3 NQS domains for at least 50% of Medicare Part B FFS patients.</p> <p>At least 1 measure must be a cross cutting measure. This will count toward the 9 measure minimum.</p>	<p>9 individual measures covering at least 3 NQS domains for at least 50% of Medicare Part B FFS patients.</p> <p>At least 1 measure must be a cross cutting measure. This will count toward the 9 measure minimum.</p> <p><u>OR</u></p> <p>Report 1 measures group for at least 20 patients, a majority of which must be Medicare Part B FFS patients.</p>	<p>9 individual measures covering at least 3 NQS domains for at least 50% of Medicare Part B FFS patients.</p> <p>At least 2 measures must be an outcomes measures. This will count toward the 9 measure minimum.</p> <p>If 2 outcome measures are not available, EPs must report at least 1 outcomes measures and at least 1 resource use, patient experience, or efficiency/appropriate use measure.</p>	<p>9 measures covering at least 3 of the NQS domains</p> <p>An EP must report on at least 1 measure for which there is Medicare patient data.</p>	Not available
Group Reporting, 2-99 Eligible Professionals	Not available	9 individual measures covering at least 3 NQS domains for at least 50% of	New option for 2016: 9 individual measures covering at least 3 NQS domains for at least 50% of	9 measures covering at least 3 of the NQS domains	<p><i>Not available for Groups 2-24</i></p> <p><i>For Groups 25-99:</i></p>

		<p>Medicare Part B FFS patients.</p> <p>At least 1 measure must be a cross cutting measure. This will count toward the 9 measure minimum.</p>	<p>Medicare Part B FFS patients.</p> <p>At least 2 measures must be an outcomes measures. This will count toward the 9 measure minimum.</p> <p>If 2 outcome measures are not available, EPs must report at least 1 outcomes measures and at least 1 resource use, patient experience, or efficiency/appropriate use measure.</p>	<p>An EP must report on at least 1 measure for which there is Medicare patient data.</p> <p>OR</p> <p>Report all CAHPS Measures via a certified CMS Survey Vendor. CMS will not bear the cost of administering the CAHPS for PQRS survey measures AND 6 PQRS measures covering at least 2 NQS domains</p>	<p>Report all measures included in the Web Interface; AND</p> <p>Populate data fields for the first 248 consecutively assigned beneficiaries. If beneficiaries <248, then report on 100% of assigned beneficiaries.</p> <p><i>Optional:</i> Report all CAHPS Measures via a certified CMS Survey Vendor. CMS will not bear the cost of administering the CAHPS for PQRS survey measures.</p>
Group Reporting, 100 or more Eligible Professionals	Not available	<p>Report all CAHPS Measures via a certified CMS Survey Vendor. CMS will not bear the cost of administering the CAHPS for PQRS survey measures AND 6 PQRS measures covering at least 2 NQS domains</p> <p>At least 1 measure must be a cross cutting measure. This will count toward the 6 measure minimum.</p>	<p>New option for 2016:</p> <p>Report all CAHPS Measures via a certified CMS Survey Vendor. CMS will not bear the cost of administering the CAHPS for PQRS survey measures AND 6 PQRS measures covering at least 2 NQS domains</p> <p>At least 1 of the measures must be an outcome measure.</p>	<p>Report all CAHPS Measures via a certified CMS Survey Vendor. CMS will not bear the cost of administering the CAHPS for PQRS survey measures AND 6 PQRS measures covering at least 2 NQS domains</p>	<p>Report all measures included in the Web Interface; AND</p> <p>Populate data fields for the first 248 consecutively assigned beneficiaries. If beneficiaries <248, then report on 100% of assigned beneficiaries.</p> <p>AND</p> <p><i>Required:</i> Report all CAHPS Measures via a certified CMS Survey Vendor. CMS will not bear the cost of administering the CAHPS for PQRS survey measures.</p>

What are PQRS National Quality Strategy (NQS) Domains?

Under most PQRS reporting mechanisms in 2016, eligible professionals must select quality measures that cover at least 3 of the 6 available National Quality Strategy (NQS) domains. These 6 domains represent the Department of Health and Human Services' NQS priorities for health care quality improvement. Pages 7-11 focus on PQRS measures that may be of special interest to spine care providers and the measure's corresponding NQS domain.



What Are Cross-Cutting Measures?

In 2015, a new reporting criterion was added for the reporting of individual claims and registry measures. For performance year 2016, eligible professionals or group practices are required to report one cross-cutting measure (of the 9 required measures) if they have at least one Medicare patient with a face-to-face encounter. Below is the list of cross-cutting measures eligible providers may choose from. For more information, go to: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html>.

- Tobacco Use and Help with Quitting Among Adolescents
- Breast Cancer Screening
- Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk
- Medication Reconciliation Post Discharge
- Care Plan
- Preventive Care and Screening: Influenza Immunization
- Pneumonia Vaccination Status for Older Adults
- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
- Documentation of Current Medications in the Medical Record
- Pain Assessment and Follow-Up
- Diabetes: Hemoglobin A1c Poor Control
- Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
- Functional Outcome Assessment
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Controlling High Blood Pressure
- Childhood Immunization Status
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
- Falls: Risk Assessment
- Falls: Plan of Care
- Falls: Screening for Fall Risk
- CAHPS for PQRS Clinician/Group Survey
- Closing the Referral Loop: Receipt of Specialist Report

PQRS Measures Applicable to Spine Care

Important Note: In 2015, CMS removed over 50 measures and measures groups from the PQRS program, including the Back Pain Measures Group and the Perioperative Care Measures Group. As the measures change from year to year, be sure to refer to measure listing for the current year when selecting measures to report. For a full listing of 2016 PQRS Measures and Measures Groups, go to: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html>.

2016 PQRS Measures of Special Interest to Spine Care Providers*

* NASS has compiled these measures for information purposes only. The measures listed are neither exclusive nor all-inclusive. Providers are advised to review the measure list and specifications for those most relevant to their patient panels.

Measure	Description	Reporting Options	National Quality Strategy Domain
Functional Outcome Assessment			
#182 Functional Outcome Assessment	Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies	Claims, Registry	Communication and Care Coordination Cross Cutting Measure
#220 Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments	Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the lumbar spine in which the change in their Risk-Adjusted Functional Status is measured	Registry	Communication and Care Coordination
#223 Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairments	Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the neck, cranium, mandible, thoracic spine, ribs, or other general orthopedic impairment in which the change in their Risk-Adjusted Functional Status is measured	Registry	Communication and Care Coordination

This document is provided for information and education only. It is the provider's responsibility to know and understand the parameters of the reporting programs in which they participate as well as the resulting consequences.

Medical Management			
#130 Documentation of Current Medications in the Medical Record	Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Claims, Registry, EHR, GPRO Web Interface	Patient Safety Cross Cutting Measure
Medical Reconciliation			
#46 Medication Reconciliation	The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years and older of age seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is reported as three rates stratified by age group: • Reporting Criteria 1: 18-64 years of age • Reporting Criteria 2: 65 years and older • Total Rate: All patients 18 years of age and older	Claims, Registry	Communication and Care Coordination Cross Cutting Measure
Osteoporosis and Osteoarthritis Measures			
#24 Osteoporosis: Communication with the Physician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older	Percentage of patients aged 50 years and older treated for fracture with documentation of communication with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis	Claims, Registry	Communication and Care Coordination
#39 Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	Percentage of female patients aged 65-85 years of age who ever had a central dual-energy X-ray absorptiometry (DXA) to check for osteoporosis	Claims, Registry, Preventive Care Measures Group	Effective Clinical Care
#41 Osteoporosis: Pharmacologic Therapy for Men and Women Aged	Percentage of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months	Claims, Registry	Effective Clinical Care

50 Years and Older			
#109 Osteoarthritis (OA): Function and Pain Assessment	Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain	Claims, Registry	Person and Caregiver-Centered Experience and Outcomes
Pain Management			
#131 Pain Assessment and Follow-Up	Percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present	Claims, Registry, Multiple Chronic Conditions Measures Group	Community/Population Health Cross Cutting Measure
#408 Opioid Therapy Follow-up Evaluation	All patients 18 and older prescribed opiates for longer than six weeks duration who had a follow-up evaluation conducted at least every three months during Opioid Therapy documented in the medical record.	Registry	Effective Clinical Care
#412 Documentation of Signed Opioid Treatment Agreement	All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record.	Registry	Effective Clinical Care
#414 Evaluation or Interview for Risk of Opioid Misuse	All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, SOAAP-R) or patient interview documented at least once during Opioid Therapy in the medical record.	Registry	Effective Clinical Care
Perioperative Care *See Antithrombotic Therapies in Spine Surgery for NASS' evidence-based guideline recommendations on VTE prophylaxis and Antibiotic Prophylaxis in Spine Surgery for NASS' evidence-based guideline recommendations on antibiotic prophylaxis in spine surgery patients.			
#21 Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin	Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis	Claims, Registry	Patient Safety
#22 Perioperative Care: Discontinuation	Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral	Claims, Registry	Patient Safety

of Prophylactic Antibiotics (Non-Cardiac Procedures)	antibiotic, who have an order for discontinuation of prophylactic parenteral antibiotics within 24 hours of surgical end time		
#23 Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	Percentage of patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time	Claims, Registry	Patient Safety
Preventive Care			
#128 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30 kg/m ² ; Age 18 – 64 years BMI ≥ 18.5 and < 25 kg/m ²	Claims, Registry, EHR, GPRO Web Interface/ACO, Preventive Care Measures Group	Community/Population Health Cross Cutting Measure
#134 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Claims, EHR, Registry, GPRO Web Interface/ACO, Preventive Care Measures Group, Multiple Chronic Conditions Measures Group	Community/Population Health Cross Cutting Measure
#226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	Claims, Registry, EHR, GPRO Web Interface/ACO, Preventive Care Measures Group	Community/Population Health Cross Cutting Measure
# 317 Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented	Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated	Claims, Registry, EHR, GPRO Web Interface/ACO	Community/Population Health Cross Cutting Measure

#431 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user.	Registry, Preventive Care Measures Group	Community/Population Health
Radiology			
#145 Radiology: Exposure Time Reported for Procedures Using Fluoroscopy	Final reports for procedures using fluoroscopy that document radiation exposure indices, or exposure time and number of fluorographic images (if radiation exposure indices are not available).	Claims, Registry	Patient Safety
#312 Use of Imaging Studies for Low Back Pain	Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis	EHR	Efficiency and Cost Reduction
Referral			
#374 Closing the Referral Loop: Receipt of Specialist Report	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	EHR	Communication and Care Coordination Cross Cutting Measure

2016 PQRS Deadlines

For additional timeline information, go to: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015-17_CMS_PQRS_Timeline.pdf

Reporting Mechanism	Deadline	Notes
GPRO Registration	June 30, 2016	Last day to register through the PV-PQRS Registration System to participate in 2015 PQRS via GPRO
Claims	February 24, 2017	Last day that 2016 claims will be processed to be counted for PQRS reporting to determine the 2018 payment adjustment
Dual PQRS/EHR Incentive Program Participation Data	February 28, 2017	Last day to submit 2016 CQMs for dual participation in PQRS and the Medicare EHR Incentive Program
Qualified Clinical Data Registry (QCDR)—using QRDA Format		Last day for QCDRs (QRDA) and EHRs to submit 2016 PQRS data
Electronic Health Record (EHR)		
Qualified Clinical Data Registry (QCDR)—using XML format and Registries	March 31, 2017	Last day for QCDRs (QCDR XML only) and registries to submit 2016 data

What is the Value-Based Payment Modifier?

The Value Modifier (VM) is a budget neutral pay-for-performance program mandated by the Affordable Care Act. Through this program, CMS evaluates the performance of solo practitioners and group practices, as identified by their Taxpayer Identification Number (TIN), on the quality and cost of care they provide to their Medicare Fee-for-Service beneficiaries. Starting with payment year 2015, the VM was applied to physician groups of 100 or more based on their performance in 2013. The 2016 VM was applied to physician groups of 10 or more based on performance in 2014. All solo practitioners and physician groups of 2 or more will be subject to the VM in 2017 based on 2015 data. In 2018, based on 2016 performance data, the VM 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. Payment year 2018 will be the final year of the VM, before MIPS begins. For more information on the VM timeline, go to: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>.

Who does it impact and how?

In 2018, ALL eligible physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs) who are solo or in group practices will be subject to the VM. Quality and cost composite scores used to determine the 2018 VM will be based on performance year 2016. In this program, upward payment incentives are awarded to high performing providers and are equally balanced with downward payments adjustments for poor performance. CMS believes that this approach will identify statistically significant outliers, both high and low, in the areas of cost and quality.

In 2018, PAs, NPs, CNSs, and CRNAs who are solo practitioners or in groups consisting of only non-physician EPs will be held harmless from downward VM adjustments as long as they successfully participate in PQRS. Solo physicians and small group practices of 2-9, who do not successfully participate in PQRS in 2016, will receive an automatic 2% VM deduction in addition to the 2% PQRS deduction. Solo physicians and small group practices, who successfully report to PQRS in 2016, are subject to a neutral adjustment, downward payment adjustment up to 2% or incentive of up to 2.0x. Group practices of 10 or more are subject to a neutral adjustment, upward incentive of up to 4.0x or a reduction in payment of up to 4%, depending on their 2016 cost and quality data. See the tables below for more information on quality tiering adjustment based on TIN size.

2018 VM Tiering for Group Practices of 10 or More

2017 Value-Based Payment Modifier Quality Tiering (based on PY 2016)			
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%

*"x" refers to the upward payment adjustment factor

2018 VM Tiering for Solo Physicians and Group Practices 2-9

2018 Value-Based Payment Modifier Quality Tiering (based on PY 2016)			
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%

*"x" refers to the upward payment adjustment factor

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

2017 Value-Based Payment Modifier Quality Tiering (based on PY 2015)

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%

*"x" refers to the upward payment adjustment factor

How is the VM calculated?

The VM is calculated based on quality and cost composite scores. The quality composite score is calculated based on measures reported through PQRS compared to benchmarks. **Successful participation in PQRS is necessary in order to be eligible for VM incentives and avoid automatic downward adjustments.** The cost composite score is based on claims data and calculated using the CMS Total per Capita Cost Measure and Medicare Spending per Beneficiary Measure. CMS uses a two-step attribution process to associate Medicare beneficiaries to TIN numbers. This attribution methodology determines which beneficiaries are included in the calculation of each TIN's quality and cost adjustment under the VM. For comparison purposes, certain quality and cost measures will be risk-adjusted and cost measures will be adjusted for specialty composition of the group.

For information on attribution of beneficiaries, go to: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Attribution-Fact-Sheet.pdf>.

For information on risk adjustment of measures, go to: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Risk-Adjustment-Fact-Sheet.pdf>.

For information on specialty adjustment of cost measures, go to: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Specialty-Adjustment-Fact-Sheet.pdf>.

What is the Physician Feedback Program?

The Physician Feedback Program provides comparative performance information to solo practitioners and group practices groups about the quality and cost of care provided to their Medicare FFS patients. The Program contains two primary components, including (1) Quality and Resource Use Reports (QRURs) and (2) the implementation of the VM. QRURs are intended to provide feedback to help Medicare enrolled physicians understand the quality and efficiency of care provided to Medicare beneficiaries and to inform physicians about their performance on a subset of measures that will be included in the VM.

MID-YEAR QUALITY AND RESOURCE USE REPORT	
Sample Medical Practice Last Four Digits of Your Taxpayer Identification Number (TIN): 0000	
PERFORMANCE PERIOD: 07/01/2013 - 06/30/2014	
ABOUT THIS REPORT <ul style="list-style-type: none"> This Mid-Year Quality and Resource Use Report shows how your group or solo practice, as identified by your Medicare-enrolled Taxpayer Identification Number (TIN), performed during the performance period on selected quality outcomes and cost measures that Medicare calculates from fee-for-service claims data. Quality data reported as part of the Physician Quality Reporting System (PQRS) are not included in this report. This report is provided for informational purposes only. It will not affect your Medicare Physician Fee Schedule payments and is not intended to predict future value-based performance. The information contained in this report is believed to be accurate at the time of production. The information may be subject to change at CMS' discretion, including but not limited to circumstances in which an error is discovered. 	
WHAT'S NEXT <ul style="list-style-type: none"> The Centers for Medicare & Medicaid Services (CMS) will continue to phase in the Value Modifier for Medicare Physician Fee Schedule payments. The Annual Quality and Resource Use Report, which will be disseminated in late summer 2015, will provide full information about your TIN's value-based performance in 2014, as applicable. However, the Annual Quality and Resource Use Report will be based on a different performance period, note that the metrics and performance rates compared for each exhibit in this report may change. In 2016, TINs with 10 or more eligible professionals that submit claims to Medicare and that have been identified through the Provider Enrollment, Chain and Ownership System, will be subject to the Value Modifier. The value modifier will be based on their TIN's participation in the Physician Quality Reporting System (PQRS) and on their quality and cost performance in 2014. The 2016 Value Modifier will not apply to those TINs in which at least one physician participated in the Medicare Shared Savings Program (MSSP), the Pioneer ACO Model, or the Comprehensive Primary Care (CPC) Initiative in 2014. 	
QUESTIONS? <ul style="list-style-type: none"> Contact the QRUR Help Desk at 1-888-734-6433 (press option 3) with questions or feedback about this report. For more information about the program governing the 2016 Value Modifier, please see http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram. 	

Authorized representatives can access QRURs at <https://portal.cms.gov> using an Individuals Authorized Access to the CMS Computer Services (IACS) IACS account. For instructions on how to obtain a QRUR, go to: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html>.

This document is provided for information and education only. It is the provider's responsibility to know and understand the parameters of the reporting programs in which they participate as well as the resulting consequences.

What is Physician Compare?

In accordance with provisions of the *Affordable Care Act*, CMS created a publicly accessible website that allows consumers to search for physicians and other healthcare professionals enrolled in the Medicare program. As required by the 2008 *Medicare Improvement for Patients and Providers Act*, CMS is required to publicly report the names of eligible professionals and group practices who have successfully reported PQRS measures or measures groups.

In 2016, the following will be available on Physician Compare:

- 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
- An item-level benchmark for group practice and individual EP PQRS measures using the Achievable Benchmark of Care (ABC) methodology. CMS will use the ABC methodology to assign quality rating stars to group practices and individual EPs.

For more information on public reporting policies, go to: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/index.html>.

Is your information correct?

Providers are encouraged to verify that the information listed is correct by visiting the PECOS website at: <https://pecos.cms.hhs.gov/pecos/login.do>. Providers can also update information not found in PECOS by contacting the Physician Compare Team at physiciancompare@westat.com.



Resources/Links

NASS Comment Letters

[NASS Comments on 2016 Medicare Physician Fee Schedule Proposed Rule](#)

[NASS Comments on 2016 Medicare Physician Fee Schedule Final Rule](#)

Informational Teleconferences

CMS periodically hosts events such as national provider teleconferences, listening sessions and meetings on PQRS, the Physician Feedback Program and the Value-Based Modifier. Registration is free and information for these events will be posted on the CMS website as it is available. To obtain registration information for an upcoming event, or to obtain the presentation materials, written transcripts and audio recordings from a previous event, go to:

<http://www.eventsvc.com/blhtechnologies>.

CMS Educational Videos

CMS MLN Connects

<http://www.cms.gov/Outreach-and-Education/Outreach/NPC/NPC-Video-Presentations.html>

PQRS

Centers for Medicare & Medicaid Services

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

Value Based Payment Modifier

Centers for Medicare & Medicaid Services

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

Physician Compare

Centers for Medicare & Medicaid Services

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/index.html>

Physician Compare Website

<http://www.medicare.gov/find-a-doctor/provider-search.aspx>

Physician Fee Schedule Rule-Making

Centers for Medicare & Medicaid Services- CY 2016 Physician Fee Schedule Final Rule

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html>

EHR Meaningful Use

Health IT.gov

<http://www.healthit.gov/policy-researchers-implementers/meaningful-use>

Who to contact at CMS for questions

QualityNet Help Desk (PQRS):

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

EHR Incentive Program Information Center (Meaningful Use):

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

Physician Value Help Desk (Value-Modifier)

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