QUESTIONS & ANSWERS ABOUT THE 2013 QUALITY AND RESOURCE USE REPORTS

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QUESTIONS & ANSWERS ABOUT THE 2013 QUALITY AND RESOURCE USE REPORTS

A. About the Physician Feedback/Value-Based Payment Modifier Program

1. What is the Medicare Physician Feedback Program?

The Medicare Physician Feedback/Value-Based Payment Modifier Program is part of a larger effort by the Centers for Medicare & Medicaid Services (CMS) to improve the quality and efficiency of medical care by developing meaningful, actionable, and fair ways to measure physician performance. The program's main goal is to give physicians and groups of physicians information through confidential feedback reports—called Quality and Resource Use Reports (QRURs)—about the resources used by and the quality of care furnished to their Medicare fee-for-service (FFS) patients. Physicians and groups of physicians can use these QRURs to see how they compare with other physicians and groups of physicians caring for Medicare patients. This program began under the Medicare Improvements for Patients and Providers Act of 2008 (formerly called the Physician Resource Use Measurement and Reporting Program), and later extended and enhanced it under the 2010 Affordable Care Act. See section "B. Overview of the 2013 QRURs" for more information about these reports, which were disseminated in the fall of 2014.

The Physician Feedback/Value-Based Payment Modifier Program also supports Section 3007 of the 2010 ACA, which directs the secretary of the U.S. Department of Health and Human Services is to develop and implement a budget-neutral, value-based payment modifier (VM). The payment modifier will be used to adjust Medicare Physician Fee Schedule payments based on the quality and cost of care physicians deliver to Medicare beneficiaries. For physicians and groups of physicians subject to the VM, the QRURs will report their value-based payment modifier. See section "C. Overview of the Value-Based Payment Modifier (VM)" for further details on the VM program.

2. Who has already received feedback reports?

CMS has been using a phased approach to create and disseminate Physician Feedback reports to gain experience and to obtain stakeholder feedback:

- In 2008–2009, CMS tested resource use measures and prototype feedback reports with approximately 300 randomly selected physicians in 12 metropolitan areas.
- In 2009–2010, CMS developed and tested feedback reports (that included both quality and resource use measures) with approximately 1,600 medical professionals and 36 groups with which they were affiliated.
- In 2010–2011, CMS distributed group-level QRURs, based on 2010 data, to 35 groups participating in the Group Practice Reporting Option (Group Practice Reporting Option (GPRO)) I program of the Physician Quality Reporting System (PQRS), and individual-level QRURs to more than 20,000 primary care and specialist physicians practicing in Iowa, Kansas, Missouri, and Nebraska.
- In December 2012, QRURs based on care provided in 2011 were produced for 54 groups participating in the CMS PQRS Group Practice Reporting Option (GPRO) I with at least 200 eligible professionals. Additionally, CMS produced QRURs for nearly 95,000

individual primary care and specialist physicians practicing in groups of 25 or more eligible providers in California, Illinois, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, and Wisconsin. In May 2013, CMS also provided Supplemental QRURs to the 54 groups that provided episode costs for cardiac and pneumonia conditions.

- In September 2013, CMS made QRURs based on care provided in 2012 available to groups that had at least 25 eligible professionals who billed under the group's taxpayer identification number (TIN) in 2012 and who had at least 20 Medicare FFS beneficiaries attributed to the group. This nationwide dissemination effort included groups participating in the Medicare Shared Savings Program, the Pioneer Accountable Care Organization (ACO) Model, and the Comprehensive Primary Care Initiative. CMS did not produce QRURs for individual physicians in 2013.
- Most recently, in October 2014, CMS made available QRURs, based on care provided in 2013, to physicians and groups of physicians that had at least one physician who billed under a TIN in 2013. This nationwide dissemination effort excluded those participating in the Medicare Shared Savings Program, the Pioneer ACO Model, and the Comprehensive Primary Care Initiative, as well as those lacking at least one physician or for whom no quality or cost data could be computed.

Throughout this process, CMS collaborated with stakeholders inside and outside of the government, reached out to physician and medical specialty groups, and held public listening sessions to get feedback for future changes to the reports.

B. Overview of the 2013 QRURS (disseminated in fall 2014)

1. What are the Quality and Resource Use Reports?

Quality and Resource Use Reports (QRURs) are confidential feedback reports provided to physicians and groups of physicians under the Medicare Physician Feedback Program. The reports provide information about the resources used and the quality of care furnished to their Medicare fee-for-service (FFS) patients. Physicians and groups of physicians can use these QRURs to see how they compare with other groups of physicians caring for Medicare patients.

Some of the information contained in the QRURs is used to calculate the physician value-based payment modifier (VM). The VM will be used to adjust Medicare Physician Fee Schedule payments to physicians, based on the quality and cost of care delivered to Medicare beneficiaries. For physicians and groups of physicians who may be subject to the VM starting in 2015 (groups of 100 or more eligible professionals (EPs)), the QRURs will provide information on how the group's quality and cost performance affect their Medicare payments in 2015 through the application of the VM. Calendar year (CY) 2013 is the performance period for the VM in 2015. See section "C. Overview of the Value-Based Payment Modifier (VM)" for further details on the VM program.

2. Who received a 2013 QRUR?

In the fall of 2014, CMS provided QRURs, based on care provided in 2013, to physicians and groups of physicians nationwide that met two criteria: (1) they had at least one physician who billed for Medicare-covered services under the TIN in 2013 and (2) they had at least one quality or cost measure with at least one Medicare FFS case. This group includes TINs that participated in the PQRS Group Practice Reporting Option (GPRO). TINs with one or more eligible professionals that participated in the Medicare Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care Initiative will not receive QRURs.

3. How are groups of physicians defined in the QRURs?

CMS defines a group of physicians as a single TIN with two or more individual eligible professionals (identified by their individual National Provider Identifier (NPI)) who have reassigned their Medicare billing rights to the TIN.

4. What information is in the 2013 QRURs?

The 2013 QRURs contain information on both quality of care and resource use in 2013, and they provide information on the VM that will go into effect in 2015 based on performance in 2013. For certain groups of physicians, information about the 2015 VM included in the 2013 QRURs aims to help report recipients understand how their payments will be affected if they elected the quality-tiering option in 2013. For TINs that participated in the Group Practice Reporting Option (GPRO) program, the 2013 QRURs report the 2013 PQRS incentive payment earned. More information about TIN VM eligibility is available in Section C, "Overview of the Value-Based Payment Modifier (VM)."

a. VM methodology

The 2013 QRURs display each report recipient's Quality and Cost Composite Scores, their scores within each of the domains that make up the composites, and performance on individual

measures that contribute to each domain. You can find additional information about the 2015 VM at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html.

Performance on the Quality and Cost Composite Scores is determined using standardized scoring, which shows how many standard deviations from the mean (benchmark) a TIN's performance on a given measure falls. Quality benchmarks (peer group means) are based on prior performance year (2012) data. Cost benchmarks are based on current performance year (2013) data.

b. Quality data

The quality data reported in the 2013 QRURs and used to calculate the Quality Composite Score varies, depending on the PQRS reporting option that the TIN elected in 2013:

- For TINs that satisfactorily reported data to the PQRS via the Group Practice Reporting Option (GPRO) web-based interface or a qualified registry in 2013, the Quality Composite Score is based, in part, on performance on the quality indicators reported.
- For TINs that requested to have CMS compute quality performance to avoid the 2015 PQRS payment adjustment, the Quality Composite Scores reported in the 2013 QRURs is calculated, in part, from 14 administrative claims-based quality indicators reflecting aspects of the following treatment areas: bone, joint, and muscle disorders; chronic obstructive pulmonary disease; diabetes mellitus; ischemic vascular disease; mental health; medication management; and preventive care.
- For all TINs, CMS also calculated three outcome measures that will be included in the Quality Composite Score based on FFS claims submitted for Medicare beneficiaries attributed to the TIN in 2013. They include two composite measures of hospital admissions for ambulatory care-sensitive conditions (one for acute conditions and one for chronic conditions) and one measure of all-cause hospital readmissions.

c. Cost data

As in previous years, cost data reported in the 2013 QRURs reflect payments for all Medicare Part A and Part B claims submitted by all providers who treated beneficiaries attributed to a physician or group of physicians and non-physician practitioners, including providers not affiliated with the TIN. Outpatient prescription drug (Part D) costs are not included. The Cost Composite Score reflects total per capita costs for all attributed beneficiaries and for subgroups with specific chronic conditions: diabetes, coronary artery disease, chronic obstructive pulmonary disease, and heart failure.

d. New measures for the 2016 VM

The 2013 QRURs provide additional information on cost and quality measures that will be used to calculate the VM in 2016 (based on 2014 performance data). For informational purposes only, the 2013 QRUR reports the group's performance on these measures, based on 2013 data. This data includes a new cost measure, Spending per Hospital Patient with Medicare (also known as Medicare Spending per Beneficiary (MSPB)), that will be used to calculate the Cost Composite Score for the 2016 VM. This measure and other per capita cost assessments will be adjusted for the specialty composition of the TIN. In addition, for calculation of the Quality

Composite Score that will be used for the 2016 VM, groups of physicians that do not participate in Group Practice Reporting Option (GPRO) will be able to have PQRS data reported by individuals within the TIN aggregated to the group level.

5. How were beneficiaries attributed to physicians and groups of physicians and non-physician practitioners in the QRURs?

Beneficiaries are attributed using the same two-step approach to attribution used to attribute beneficiaries to ACOs in the Medicare Shared Savings Program. For all cost and quality measures included in the Quality or Cost Composites that are calculated from Medicare administrative claims data, beneficiaries are attributed to physicians, groups of physicians, and other entities identified by CMS Certification Number (Federally Qualified Health Centers, Rural Health Clinics, Critical Access Hospitals Billing Under Method II, and Electing Teaching Amendment Hospitals). Under this rule, a beneficiary receiving primary care services (Table 1) from one or more primary care physicians is attributed to the physician or group of physicians whose primary care physicians provided the plurality of allowable Medicare charges for the beneficiary's primary care services. Otherwise, the beneficiary is attributed to the physician or group of physicians whose other physicians, clinical nurse specialists, nurse practitioners, and physician assistants provided the plurality of allowable Medicare charges for the beneficiary's primary care services, as long as at least one physician in the TIN, regardless of specialty, provided primary care services to the beneficiary.

For PQRS Group Practice Reporting Option (GPRO) web interface measures, beneficiaries are attributed according to the same two-step attribution rule described above. For PQRS Group Practice Reporting Option (GPRO) registry measures, beneficiaries are attributed based on measure specifications, which vary individually.

For the Spending per Hospital Patient with Medicare (or Medicare Spending per Beneficiary) measure, which is not included in the Quality or Cost Composites for the 2013 QRUR but is reported for informational purposes, beneficiaries are attributed in a separate process. For this measure, a Medicare Spending per Beneficiary episode is attributed to a TIN if the TIN provided more Part B-covered services (as measured by Medicare allowed charges) during the index hospitalization than did any other TIN.

Table 1. Healthcare Common Procedure Coding System (HCPCS) primary care service codes criteria

HCPCS Codes	Brief Description
99201–99205	New patient, office or other outpatient visit
99211–99215	Established patient, office or other outpatient visit
99304–99306	New patient, nursing facility care
99307–99310	Established patient, nursing facility care
99315–99316	Established patient, discharge day management service
99318	Established patient, other nursing facility service
99324–99328	New patient, domiciliary or rest home visit

HCPCS Codes	Brief Description
99334–99337	Established patient, domiciliary or rest home visit
99339–99340	Established patient, physician supervision of patient (patient not present) in home, domiciliary or rest home
99341–99345	New patient, home visit
99347–99350	Established patient, home visit
G0402	Initial Medicare visit
G0438	Annual wellness visit, initial
G0439	Annual wellness visit, subsequent

Note: Labels are approximate. See the American Medical Association's Current Procedural Terminology and the CMS website (http://www.cms.gov) for detailed definitions.

6. Were beneficiaries who received the plurality of their primary care services from a Federally Qualified Health Center or Rural Health Clinic attributed to me?

No. Beneficiaries who received the plurality of their primary care services from a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) will be attributed to that entity, and not to a physician or group of physicians billing under a TIN. While FQHCs and RHCs will be attributed beneficiaries, they and other entities not reimbursed under the Medicare Physician Fee Schedule did not receive 2013 QRURs, nor will they be subject to the 2015 VM.

7. How do the populations of Medicare beneficiaries represented in the resource use/cost data and the quality data differ?

The populations used to calculate the resource use/cost data and the quality data differ, as follows:

- The per capita cost data derived from Medicare claims represent all FFS Medicare beneficiaries attributed to the TIN, using the attribution rules described in Question 5 ("How were beneficiaries attributed to physicians and groups of physicians in the QRURs?") of this section. Medicare used the same attribution rule to define the population for all of the administrative claims-based quality measures used in the QRURs.
- Performance on Group Practice Reporting Option (GPRO) web interface measures is based on beneficiaries attributed according to the same two-step attribution rule used for the administrative claims-based quality measures. For PQRS registry measures, beneficiaries are attributed based on measure specifications, which vary from measure to measure.
- For the Spending per Hospital Patient with Medicare (or Medicare Spending per Beneficiary) measure, a hospitalization episode is attributed to a TIN if during the hospitalization the TIN provided more Part B-covered services (as measured by Medicare allowed charges) than any other TIN.

You can find additional information in Section II of the Detailed Methodology for the 2013 Quality and Resource Use Reports on the QRUR website at

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2013-QRUR.html.

8. Why are there blank cells in some exhibits of my report?

Cells are intentionally left blank if it is not possible to calculate a particular statistic or performance measure because there are zero eligible cases.

9. Does CMS display performance on all reported PQRS measures in the QRUR?

For Group Practice Reporting Option (GPRO) registry and individually reported PQRS measures, performance rates of 0 percent (or 100 percent, in the case of measures for which lower performance rates indicate better performance) are not reported in the QRUR. For these measures, records with zero eligible cases are also not displayed. See Question 22 ("How were the TIN-level performance rates in Exhibit 14 calculated?") in this section for additional information.

10. The list of hospitals admitting my patients, as shown in QRUR Exhibit 6, does not appear to be complete. How did CMS identify the hospitals that account for my Medicare beneficiaries' inpatient stays?

In order to provide the most actionable data, Exhibit 6 of the 2013 QRUR lists the hospitals where at least 5 percent of all inpatient stays occurred in 2013 for Medicare beneficiaries attributed to you. CMS used a hierarchical methodology to identify which hospital is associated with each provider number on Medicare Part A claims for services provided in 2013. First, CMS used the Provider of Services file (http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/NonIdentifiableDataFiles/ProviderofServicesFile.html), which is updated quarterly using data collected through the CMS regional offices. If the provider number, name, and location were found there, CMS displayed this name and location in QRUR Exhibit 6. If the name or location was not in the Provider of Services file, CMS consulted the Provider Enrollment, Chain, and Ownership System (PECOS) and displayed the name and location identified there. If the full name or location of the hospital was not found in either source, the QRUR exhibit displays "NAME NOT FOUND" in the hospital name column and "CITY NOT FOUND" and "STATE NOT FOUND" in the location column.

11. What services and costs are included in the QRURs' per capita cost measures?

The total per capita cost measures in the QRURs include all 2013 Medicare fee-for-service Part A (hospital insurance) and Part B (medical insurance) payments to all providers who treated beneficiaries attributed to a given TIN, whether or not those providers themselves were associated with the TIN. These Medicare costs include those associated with inpatient, outpatient, skilled nursing facility, home health, hospice, durable medical equipment, and non-institutional provider/supplier services. Payments for Part D outpatient prescription drugs are not included. To the extent that Medicare claims include such information, the total per capita cost measures include payments to providers from Medicare, beneficiaries (copayments and deductibles), and third-party private payers.

The QRURs also include condition-specific per capita cost measures for Medicare beneficiaries who had at least one of the following four chronic health conditions: diabetes, coronary artery disease, chronic obstructive pulmonary disease, or heart failure. The four

conditions are not mutually exclusive—we counted beneficiaries with more than one of these conditions within each relevant condition. Also, the condition-specific total per capita cost measures include all costs of care, not just those associated with treating the condition.

12. Why are hospital-based costs included in QRURs about TINs' performance?

CMS is seeking to align incentives and encourage care coordination across settings, as requested by our stakeholders. We believe that the TIN providing the plurality of primary care services to beneficiaries over the course of the year is well positioned to influence the overall care of the patients attributed to it. For this reason, in calculating per capita cost measures, we included costs for all Medicare Part A (hospital insurance) and Part B (medical insurance) services for the year (2013) for each patient attributed to the TIN.

13. If a TIN is affiliated with a hospital, but some patients attributed to the TIN were admitted to an unaffiliated hospital, are those unaffiliated hospital costs included in the calculation of the TIN's costs?

Yes. All Medicare Part A and B claims paid for Medicare beneficiaries attributed to a TIN are included in that TIN's per capita costs for 2013.

14. Could "split billing" affect how costs are distributed among various types of services?

Yes. "Split billing," or "provider-based billing," could affect reported categories of service in the QRUR, as well as per capita costs. There are several reasons why two separate bills (that is, split billing) may be generated for a single service. One common instance is when two bills are generated separately for the professional and technical components of a service provided by a physician in a hospital facility. The professional component of the service might include physician consultation or physician interpretation of an X-ray, CT scan, MRI, or laboratory test done in the hospital. Professional component reimbursements are made to the physician or group of physicians. The technical component of the service might include laboratory, X-rays, or any other nonprofessional aspect of the service. Technical component payments are made to the hospital. The site-of-service coding on Medicare claims determines how costs with split bills were categorized. Medicare payment accounts for higher overhead costs at hospitals than at free-standing sites, so the site-of-service coding also determined how those costs were standardized.

15. How did CMS account for differences in Medicare payment rates for medical services in calculating cost measures (payment standardization)?

Before calculating any cost measures for the QRURs, CMS standardized the unit costs (payments) for the 2013 Medicare claims. This process equalized the Medicare payments associated with a specific service, so that a given service is priced at the same level across all providers in the same type of health care setting regardless of geographic location or differences in Medicare payment rates (such as from payments to hospitals for graduate medical education, for indirect medical education, and for serving a disproportionate number of poor and uninsured patients).

Medicare payments for the same services can vary depending on local input prices (such as wage index and geographic practice costs) and on payment rates for different classes of providers in a given category. Without payment standardization, a provider with higher Medicare payments could appear to have higher costs than other providers in the peer group when, in fact,

differences in geographic location or facility-specific payments (rather than resource use) might be responsible.

16. How did CMS account for differences in patients' medical histories (risk-adjustment) when calculating quality or cost measures?

Risk-adjustment accounts for differences in quality or cost measures caused by physiologic differences in patients (such as age or complex disease histories) that could be expected to make costs higher or lower than average, regardless of the efficiency of the care.

For the total per capita cost measure reported in the 2013 QRURs, CMS used the Hierarchical Condition Categories (CMS-HCC) risk-adjustment model, which predicts patients' resource use for the coming year, based on diagnoses from Medicare claims for the patient from the previous year. The CMS-HCC model assigns International Statistical Classification of Diseases and Related Health Problems–9th Revision (ICD-9) codes to 70 clinical conditions. For each beneficiary enrolled in Medicare FFS the previous year, the CMS-HCC model generates a risk score based on the presence of these 70 conditions and on the beneficiary's age, gender, original reason for Medicare entitlement (age or disability), and Medicaid entitlement. Risk adjustment of 2013 costs also takes into account the presence of end-stage renal disease (ESRD) in 2012.

For the Medicare Spending per Beneficiary measure, the condition codes used in the CMS-HCC model are also used, but they are gathered from claims submitted in the 90 days preceding a Medicare Spending per Beneficiary episode's start date. This method captures those conditions most relevant to the shorter episodes, surrounding inpatient hospitalizations that are used in this measure. The Medicare Spending per Beneficiary measure risk adjustment methodology also includes beneficiary age and institutional status.

The two composite measures of hospital admissions for ambulatory care-sensitive conditions that Medicare calculated for the 2013 QRURs also are risk-adjusted to account for differences in the age and gender of beneficiaries attributed to different TINs. For measures in the acute conditions composite (bacterial pneumonia, urinary tract infection, and dehydration), the denominator includes all Medicare patients attributed to the TIN. However, the denominator for measures in the chronic conditions composite (diabetes, chronic obstructive pulmonary disease, and heart failure) is restricted to patients diagnosed with the specific condition.

Similarly, the all-cause hospital readmissions measure is risk-adjusted to account for differences in beneficiary case mix based on patient age and clinical characteristics. Moreover, service mix is accounted for by assigning the index admission to one of five mutually exclusive specialty cohort groups consisting of related conditions or procedures—groupings that presume that admissions treated by similar teams of clinicians are likely to have similar risks of readmission. The specialty cohort-specific readmissions are then combined in constructing the all-cause hospital readmissions measure.

17. How will CMS account for specialty mix when making peer group comparisons for cost measures in the future?

All cost measures contributing to the 2016 VM (based on performance in 2014) will be adjusted to reflect the mix of physician specialties within a TIN. Note that CMS did not account

for specialty mix in 2013. The specialty-adjustment methodology, applied separately for each cost measure, is as follows:

a. **Compute "national, specialty-specific expected costs" for each specialty.** This component of the measure will be computed as the weighted average of all TINs' payment-standardized and risk-adjusted costs, where the weight for each TIN is the number of eligible cases multiplied by that specialty's share of the TIN's eligible professionals, multiplied by the number of eligible professionals of that specialty in the TIN.

b. **Compute the "specialty-adjusted expected cost" for each TIN.** This component of the measure will be computed as the weighted average of the national, specialty-specific expected cost of all the specialties in the TIN, where the weights are each specialty's proportion of the TIN's Part B payments.

c. **Compute the "specialty-adjusted cost" for each TIN.** Divide the TIN's payment-standardized and risk-adjusted cost by the TIN's specialty-adjusted expected cost, and multiply this ratio by the national average cost.

18. How did CMS define peer groups for benchmarking purposes?

In calculating standardized scores for the Quality and Cost Composite Scores in the 2013 QRURs, each TIN's performance on quality and cost measures is compared with a weighted mean (benchmark) performance of its peers. Quality benchmarks are based on prior year (2012) performance, and cost benchmarks are based on current year (2013) performance. If there is no comparable prior-year measure for a quality measure, CMS did not calculate the benchmark for that measure and does not display it in the 2013 QRURs.

For the 2013 QRUR quality measures, CMS defined the peer group as all eligible TINs nationwide. For the 2013 QRUR cost measures, CMS defined peer groups based on the number of eligible professionals billing under a TIN in 2013. For TINs with one to 99 eligible professionals, the peer group is composed of all TINs nationwide that have one or more eligible professionals billing under the TIN. For TINs with 100 or more eligible professionals, the peer group is composed of all TINs with 100 or more eligible professionals billing under their TIN.

19. What would be the effect on a physician's or group's VM if the 2013 QRUR showed it had "insufficient data" to assess its performance on quality or cost?

For purposes of calculating the VM, a TIN with insufficient data for either the Quality or Cost Composite is categorized as average. There would be insufficient data to calculate a score if, for every measure included in the composite score, a TIN had fewer than 20 eligible cases or had a performance rate that was more than one standard deviation from the benchmark but not statistically significantly different from the benchmark. Quality or Cost Composite Scores are not shown in displays of VM performance in the QRUR if there were insufficient data to calculate a score.

20. Why would the QRUR indicate that a performance rate was calculated for at least one measure within a quality or cost domain (in Exhibit 5 or 8) but not show a domain score for that domain (in Exhibit 4 or 7)?

Domain performance scores for the Quality and Cost Composites may be calculated and displayed in Exhibits 4 and 7 if the TIN had at least one measure in that cost or quality domain with at least 20 eligible cases. In contrast, Exhibit 5 (quality measures) and Exhibit 8 (cost measures) show all measures in the domain for which the TIN had at least one eligible case.

Missing domain performance scores are most likely to occur with small TINs (with fewer eligible professionals billing under a single TIN), which tend to have fewer attributed beneficiaries eligible to be included for some measures. For example, several quality measures and all of the condition-specific per capita cost measures apply only to beneficiaries with the particular health condition. In addition, beneficiaries attributed to a TIN that do not have a valid HCC score, which is used in the per capita cost risk-adjustment model, are not included in any of the per capita cost measures.

The Quality or Cost Composite domain performance score is an equally weighted average of the non-missing domain performance scores. If no domain performance scores can be calculated due to too few cases for all measures included in each domain, CMS did not calculate the TIN's Quality or Cost Composite score.

21. Can you please provide an example of how Quality and Cost Composite Scores were calculated?

The Quality and Cost Composite Scores in the QRUR summarize a TIN's performance on multiple individual quality and cost measures, respectively. Only measures with at least 20 cases are eligible for inclusion in composite score calculations. The first step in computing a composite score is to standardize the scores for the individual measures by subtracting the benchmark score from the report recipient's score and dividing the result by the standard deviation. Domain performance scores are then formed for each measure domain by averaging the standardized scores of the measures within that domain. Next, these domain-level performance scores are combined into an average domain performance score. (Only domains with at least one measure eligible for inclusion in composite score calculations are included in the average domain performance score.) Finally, the average domain performance score itself is standardized by subtracting the report recipient's average domain performance score from the mean average domain performance score—computed across all TINs in the report recipient's peer group—and divided by the standard deviation of the average domain performance score. The result is a score that reflects the report recipient's performance in terms of number of standard deviations above or below the peer group mean.

Table 2 illustrates the calculation of a composite cost score. The Cost Composite consists of two equally weighted domains: (1) Per Capita Costs for All Attributed Beneficiaries and (2) Per Capita Costs for Attributed Beneficiaries with Specific Conditions. The former domain includes only one measure, the Per Capita Costs for All Beneficiaries measure. The latter domain includes four condition-specific measures for diabetes, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), and heart failure.

To compute the Cost Composite Score, first begin by computing standardized scores for each of the five measures. These are calculated by subtracting the benchmark performance rate (column C in Table 2) from the TIN's score (column B) and dividing by the standard deviation (column D). The result is the standardized score for the individual performance measure (column E). For example, in Table 2, the TIN's Per Capita Costs for All Attributed Beneficiaries (row 1) is $17,795, the benchmark is $10,370, and the standard deviation is $1,864. The standardized score is therefore ($17,795 – $10,370) / $1,864 = 3.98. This rate is also the domain performance score, because there is only one measure in the domain.

The second domain performance score for Per Capita Costs for Attributed Beneficiaries with Specific Conditions is the average of the standardized scores for the diabetes (row 3) and heart failure measures (row 6). Note that the COPD and CAD measures (rows 4 and 5, respectively) are not included (column F) because there are fewer than 20 eligible cases (column A). Therefore, the domain's score is (4.64 + 0.72) / 2 = 2.68.

With the two domain performance scores in hand (rows 2 and 7, column E), the average domain performance score may now be computed as (3.98 + 2.68) / 2 = 3.33. The final step is to standardize the average domain performance score by subtracting the mean across all peers (0.16) from the report recipient's own score (4.21) and dividing by the standard deviation (2.16), yielding a composite score of 1.47. Therefore, the TIN's composite cost score was 1.47 standard deviations higher than the mean composite score among the TIN's peers, reflecting the TIN's higher risk-adjusted costs across the individual performance measures. The asterisk next to the standardized cost composite score indicates that it is statistically significantly different from the mean at the 5 percent level. To be considered either a high or low performer relative to its peers on the cost composite measure, a qualifying TIN's score must be at least one standard deviation above or below the mean cost composite score and statistically significantly different from the mean cost composite score.

The computation of the quality composite score is analogous, differing only in the specific measures and domains that constitute the composite.

Table 2. Example cost composite score computation

.	.	TIN's number of eligible cases (A)	TIN's risk-adjusted per capita cost (B)	Benchmark (mean) (C)	Standard deviation (D)	Standardized score (E)	Included in domain score (F)
(1)	Per Capita Costs for All Attributed Beneficiaries	207	$17,795	$10,370	$1,864	3.98	Yes
(2)	Domain Score: Per Capita Costs for All Attributed Beneficiaries (from Row 1)					3.98	
(3)	Per Capita Costs for Attributed Beneficiaries with Diabetes	84	$28,153	$14,946	$2,848	4.64	Yes
(4)	Per Capita Costs for Attributed Beneficiaries with COPD	18	$26,240	$24,270	$4,934	0.40	No
(5)	Per Capita Costs for Attributed Beneficiaries with CAD	4	$22,140	$17,333	$3,384	1.42	No
(6)	Per Capita Costs for Attributed Beneficiaries with Heart Failure	54	$30,157	$26,190	$5,537	0.72	Yes
(7)	Domain Score: Per Capita Costs for Attributed Beneficiaries with Specific Conditions					2.68	
(8)	Average Domain Score			0.16	2.16	3.33	
(9)	Standardized Cost Composite Score					1.47*	
(10)	Average Cost Domain Score Mean & S.D. Across Peers (Use for TINs with 25–99 EPs)			0.16	2.16		
(11)	Average Cost Domain Score Mean & S.D. Across Peers (Use for TINs with 100+ EPs)			0.10	1.80		

* Significantly different from the benchmark at the 5 percent level.

22. How were the TIN-level performance rates in Exhibit 14 calculated?

TIN-level performance rates are calculated for each measure from the performance rates presented in Supplementary Exhibit 5 by aggregating performance numerators and performance denominators across all eligible professionals who were both incentive-eligible under the TIN and reported at least one eligible case for the measure. (For measures, for which a higher performance rate indicates better quality, records with a 0 percent performance rate are excluded from Supplementary Exhibit 5 and Exhibit 14; for measures for which a lower performance rate indicates better quality, records with a 100 percent performance rate are excluded from these exhibits.) The ratio of the aggregated performance numerator to the aggregated performance denominator provides the performance rate for the TIN. If an individual eligible professional submitted a measure through more than one reporting mechanism, only the record with the most favorable performance rate (highest performance rate for measures for which higher performance rates indicate better quality and lowest performance rate for measures for which lower performance rates indicate better quality) is counted in calculating the TIN-level performance results. Ties for most favorable performance rate are settled by selecting the record with the highest performance denominator. See Section B, Question 9 ("Does CMS display performance on all reported PQRS measures in the QRUR?") for additional information.

23. Does CMS provide patient-level data (with beneficiary identifiers) to TINs, so that the TINs can see which patients have been attributed to them and what services the patients used?

Yes. Supplementary Exhibits 2, 3, and 4 include information on the beneficiaries attributed to the TIN, including gender, date of birth, risk status, Medicare FFS claims filed and services provided, chronic conditions, and hospital admissions.

24. How can I give CMS feedback about the QRURs?

You can submit comments about the content and format of the QRUR by calling the QRUR Help Desk at 1-888-734-6433 (select option 3). Normal business hours are Monday–Friday, 8 a.m. to 8 p.m. EST.

C. Overview of the value-based payment modifier (VM)

1. What is the VM?

The value-based payment modifier (VM) is a differential payment to physicians under the Medicare Physician Fee Schedule, based on the quality of care furnished compared with costs during a specified performance period. The VM is completely separate from the payment adjustment and payment incentives under the PQRS.

Section 3007 of the Affordable Care Act requires the secretary of the U.S. Department of Health and Human Services to establish a payment modifier that provides for differential payment to physicians based upon the quality of care furnished compared with the cost of that care.

2. When will the VM be applied to physician fees?

By statute, the VM will be applied to specific TINs for services furnished beginning January 1, 2015. Implementation began in 2013 through the rulemaking process for the Medicare Physician Fee Schedule. In this first phase of implementation, CMS finalized policies to phase in the VM by applying it, starting January 1, 2015, to physician payments under the Medicare Physician Fee Schedule for groups of physicians with 100 or more eligible professionals. The performance period for the VM that will be applied to payments beginning January 1, 2015 is 2013.

Section 1848(k) (3) (B) of the Social Security Act specifies the definition of an eligible professional.

Eligible professionals consist of:

- **Physicians**—doctor of medicine, doctor of osteopathy, doctor of podiatric medicine, doctor of optometry, doctor of dental surgery, doctor of dental medicine, doctor of chiropractic
- **Practitioners**—physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical social worker, clinical psychologist, registered dietician, nutrition professional, audiologists
- **Therapists**—physical therapist, occupational therapist, qualified speech-language therapist

CMS defines a group of physicians as a single TIN with two or more individual eligible professionals (identified by their individual NPI) who have reassigned their Medicare billing rights to the TIN.

The Affordable Care Act stipulates that the VM be applied to all physicians and groups of physicians paid under the Medicare Physician Fee Schedule for services furnished beginning no later than January 1, 2017.

3. Will the VM apply to all eligible professionals treating Medicare beneficiaries?

No. The 2015 VM will apply only to payments to physicians participating in the Medicare FFS program paid under the Medicare Physician Fee Schedule. Also, it will not apply to

physicians that are not paid under the Medicare Physician Fee Schedule, including those providing services in Rural Health Clinics, Federally Qualified Health Centers, and Critical Access Hospitals Billing Under Method II.

Physicians are defined as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors.

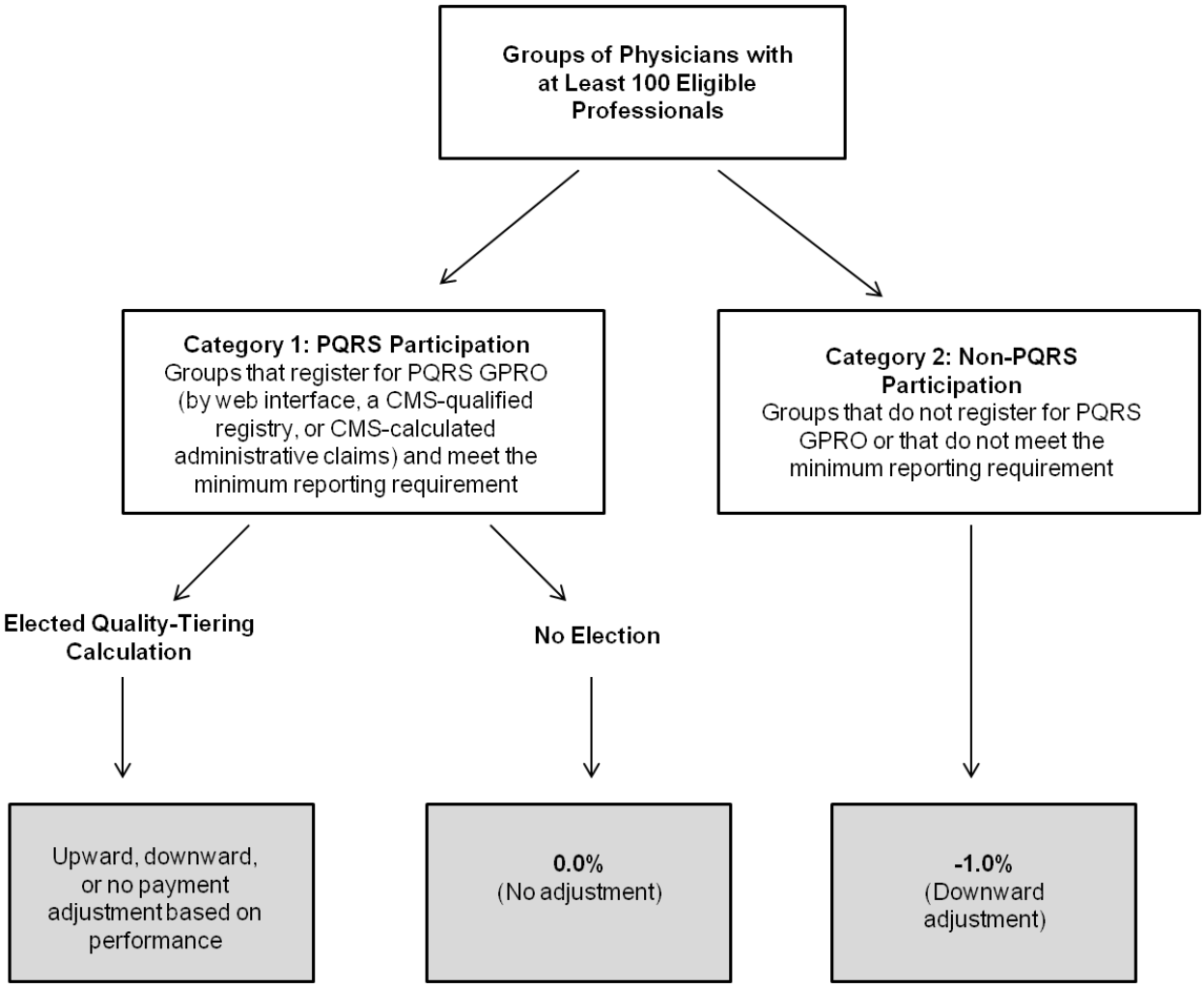
4. How will the VM be applied during the initial implementation phase?

In the first phase of implementation (starting on January 1, 2015), CMS will apply the VM to groups of physicians with 100 or more eligible professionals (with exceptions for groups already participating in the Medicare Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care Initiative).

CMS will separate these groups of physicians with 100 or more eligible professionals into two categories (see Diagram 1).

- **Groups of physicians reporting under the PQRS Group Practice Reporting Option (GPRO) and meeting the minimum reporting requirement.** Category 1 includes groups of physicians that have self-nominated as a group for the PQRS and reported at least one Group Practice Reporting Option (GPRO) measure, or that elected the PQRS administrative claims option as a group. Groups within Category 1 will receive no adjustment for 2015. Alternatively, they may elect to have their VM for 2015 (based on performance in 2013) calculated using the quality-tiering methodology, which could result in an upward, neutral, or downward adjustment amount. (Before the deadline for electing the quality-tiering approach, CMS provided Physician Feedback Reports in 2013 that give groups in this category a preview of what their VM would be based on 2012 performance data.)
- **Groups of physicians not participating in the PQRS Group Practice Reporting Option (GPRO) or meeting the minimum reporting criteria.** Category 2 includes those groups of physicians with 100 or more eligible professionals that did not participate in a PQRS Group Practice Reporting Option (GPRO) reporting mechanism or that did not meet the minimum PQRS Group Practice Reporting Option (GPRO) reporting criteria identified earlier. Because CMS does not have quality measure performance rates on which to assess the quality of care these groups furnish, CMS will set their VM for 2015 at -1.0 percent. This downward payment adjustment will be in addition to the -1.5 percent payment adjustment for failing to meet satisfactory reporting criteria under the PQRS program.

Diagram 1. Overview of how the value modifier will be assessed in 2015



5. How will CMS determine whether a group of physicians has 100 or more eligible professionals?

We use a two step process:

1. We query Medicare's Provider Enrollment, Chain, and Ownership System (PECOS) to identify groups of physicians with 100 or more eligible professionals as of October 15, 2013. This inquiry generates a list of potential groups that could be subject to the Value Modifier for CY 2015.

2. To ensure that the group actually had 100 or more eligible professionals during 2013, we analyze claims for services furnished during the CY 2013 performance year. We remove any groups from the October 15 PECOS list that did not have 100 or more eligible professionals that billed under the group's TIN during 2013. We will not add groups to the October 15 PECOS list.

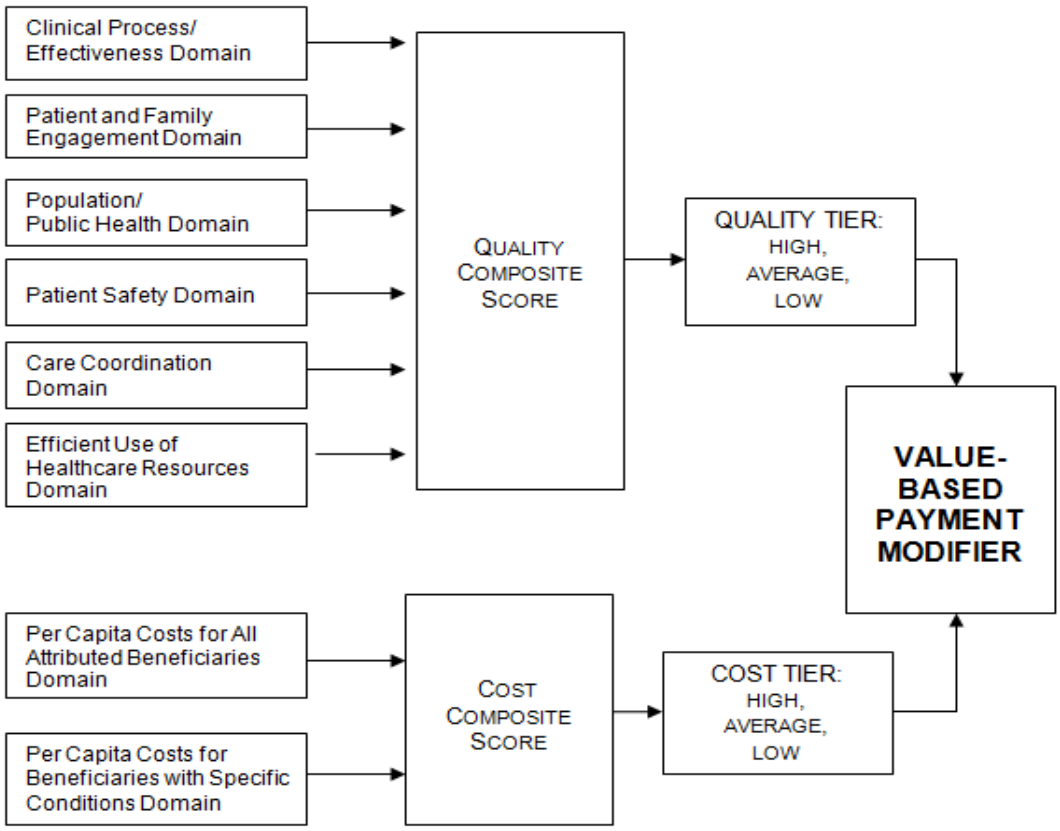
See Section B, Question 3 ("How are groups of physicians defined in the QRURs?") for additional information.

6. How will CMS calculate the VM for TINs electing the quality-tiering approach for 2015?

Groups of physicians electing the quality-tiering approach will have an opportunity to earn an upward payment adjustment for performance in the higher quality and lower cost tiers but will also be at risk for a downward payment adjustment for lower quality and higher cost performance. To be considered either a high or a low performer for quality or cost, a qualifying TIN's score must be at least one standard deviation above or below the mean performance score for quality or cost, respectively.

Under the quality-tiering approach, the VM will be determined from the Quality Composite Score and Cost Composite Score, each containing domains that will be weighted equally (see Diagram 2). CMS will use a standardized scoring approach that focuses on how much the TIN's performance differs from a peer group mean on a measure-by-measure basis. For each quality and cost measure included in the Quality or Cost Composite of the 2013 QRUR, a score expressed in standardized units is calculated based on the number of standard deviations that TIN's performance rate is away from the peer group mean.

Diagram 2. Relationship between quality and cost composites and the value-based payment modifier



The VM under quality-tiering can be inferred from a TIN's Quality and Cost Composite according to Table 3. For purposes of calculating the VM, a TIN with insufficient data for either the Quality or Cost Composite is categorized as average.

Table 3. Calculation of the value-based payment modifier using the quality-tiering approach

	Low quality	Average quality	High quality
Low cost	+0.0%	+1.0* x AF	+2.0* x AF
Average cost	–0.5%	+0.0%	+1.0* x AF
High cost	–1.0%	–0.5%	+0.0%

Note: AF refers to a payment adjustment factor yet to be determined that will ensure budget neutrality.

* Eligible for an additional +1.0 x AF if satisfactorily reported PQRS quality measures via the Group Practice Reporting Option (GPRO) web interface or qualified registry and the average beneficiary risk score is in the top 25 percent of all beneficiary risk scores.

Because the VM must be budget-neutral, positive payment adjustments will depend on an adjustment factor (AF) that will vary from year to year with differences in actuarial estimates and in the number and relative performance of TINs subject to quality-tiering. TINs receiving a positive payment adjustment and who successfully participated in the PQRS Group Practice Reporting Option (GPRO) web interface or registry and who had average beneficiary risk scores above the 75th percentile of all beneficiary risk scores nationwide will be eligible for an additional upward 1 percent applied to the payment adjustment factor.

7. What quality measures will be included in the 2015 VM?

The VM will include quality measures reported by TINs using one of three PQRS Group Practice Reporting Option (GPRO) reporting mechanisms: (1) Group Practice Reporting Option (GPRO) web interface, (2) CMS-qualified registry, or (3) PQRS administrative claims-based option (a set of 14 CMS-calculated administrative claims-based measures). Additionally, three administrative claims-based outcome measures will be used to evaluate quality performance—two composite measures of potentially preventable hospital admissions for ambulatory care-sensitive conditions (one for acute conditions and one for chronic conditions) and one measure of all-cause hospital readmissions.

8. What cost measures will be included in the 2015 VM?

The cost component of the VM will include (1) total per capita costs (the Per Capita Costs for All Attributed Beneficiaries cost domain) and (2) total per capita costs for Medicare beneficiaries with one or more of the following chronic conditions: diabetes, heart failure, chronic obstructive pulmonary disease, and coronary artery disease (the Per Capita Costs for Beneficiaries with Specific Conditions cost domain).

9. How will beneficiaries be attributed to TINs for the VM?

There is no separate attribution rule for the VM. See Section B, Question 5 ("How were beneficiaries attributed to physicians and groups of physicians in the QRURs?") for additional information on how attribution is done at the measure-level.

10. How will CMS ensure that cost comparisons are fair, given geographic and institutional variations in Medicare payment rates and demographic differences in patient populations served?

When calculating per capita costs attributed to TINs, CMS will use standardized payments to account for local, regional, and institutional price differences. For example, the payment standardization methodology removes adjustments in Medicare payments that reflect practice expense and regional labor cost differences, as well as supplemental payments to hospitals that treat a high share of poor and uninsured patients or those that receive indirect graduate medical education payments.

CMS will also use the CMS-HCC risk-adjustment methodology to account for patient demographic characteristics such as age and gender; clinically-based factors, such as Medicaid dual-eligible status; and prior health conditions (including the beneficiary's CMS-HCC risk score and an indicator for the presence of ESRD) that can affect a beneficiary's costs, regardless of the efficiency of care provided. You can find more information on the risk-adjustment of the cost measures in Appendix C of the Detailed Methodology for the 2013 Quality and Resource Use Report http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2013-QRUR.html.

11. What if a TIN's performance cannot be measured for some domains of the Quality or Cost Composites?

The Quality or Cost Composite score is a simple average of the domain performance scores. If a score cannot be calculated for a TIN within a particular domain (because for all measures in the domain, the TIN has fewer than 20 eligible cases), then the composite calculation will be based only on those domains for which scores can be calculated. This situation is most likely to occur in the case of small TINs (with fewer eligible professionals billing under a single TIN), which tend to have fewer attributed beneficiaries eligible for inclusion in specific quality or cost measures. For example, several quality measures and all of the condition-specific per capita cost measures apply only to beneficiaries with the particular health condition. Beneficiaries attributed to a TIN that does not have a valid CMS-HCC score (which is used in the per capita cost risk-adjustment model) are excluded from the per capita cost measures.

If scores cannot be calculated for any cost or quality domain, then the corresponding composite score will not be calculated for that TIN.

12. How would the VM be affected for a TIN that elected the quality-tiering option but had insufficient data to assess its performance on quality or cost?

For purposes of calculating the VM, a TIN with insufficient data for either the Quality or Cost Composite will be categorized as average. Quality or Cost Composite Scores will not be shown in displays of VM performance in the QRUR if there are insufficient data to calculate a score. There would be insufficient data to calculate a score if, for every measure included in the composite score, a TIN had fewer than 20 eligible cases.

13. How much money is at risk for a given TIN under the VM in 2015?

Per legislative mandate, the VM must be budget-neutral, such that the net effect will not increase or decrease payments to physicians in the aggregate. Thus, in any given year,

application of the VM will result in positive adjustments to payments for some TINs and negative adjustments for others. Precise numbers will vary from year to year, based on performance. However, Table 3 (see page 20) shows the ratio of payment adjustments for the quality-tiering approach in 2015, as outlined in the 2013 final rule.

In addition, CMS will apply a 1 percent downward adjustment for all groups of physicians with 100 or more eligible professionals who choose not to participate in PQRS as a group. CMS will also apply an additional 1 percent upward adjustment (multiplied by the to-be-determined payment adjustment factor) for TINs reporting through the Group Practice Reporting Option (GPRO) web interface or through registries that serve a higher-risk beneficiary population (that is, a population that is less healthy than other beneficiaries). CMS will use the same 2012 HCC risk scores (that are used to risk-adjust the per capita cost measures included in the VM Cost Composite) to measure the average risk of each TIN's attributed beneficiaries. CMS will determine the 2012 HCC score distribution (from lowest to highest beneficiary risk score) and percentile thresholds for all Medicare FFS beneficiaries nationally. Next, it will compare average risk scores for beneficiaries attributed to QRUR recipients with these national percentile thresholds. TINs that participate in the PQRS Group Practice Reporting Option (GPRO) web interface or registry with average beneficiary risk scores at or above the 75th percentile of all beneficiary risk scores nationwide will be eligible for an additional upward 1 percent applied to the payment adjustment factor, if they are categorized as low cost/average quality, low cost/high quality, or average cost/high quality.

14. Our TIN did not elect quality-tiering in 2013. How can we use the information in the 2013 QRUR to determine what our VM would be under quality-tiering?

The VM under quality-tiering can be inferred from a TIN's Quality and Cost Composite according to Table 3 (see page 20). For purposes of calculating the VM, a TIN with insufficient data for either the Quality or Cost Composite will be categorized as average.

Because the VM must be budget-neutral, positive payment adjustments will depend on an adjustment factor (AF) which will vary from year to year with differences in actuarial estimates and in the number and relative performance of TINs subject to quality-tiering. TINs receiving a positive payment adjustment and who successfully participated in the PQRS Group Practice Reporting Option (GPRO) web interface or registry and who had average beneficiary risk scores above the 75th percentile of all beneficiary risk scores nationwide will be eligible for an additional upward 1 percent, applied to the payment adjustment factor.

15. Will the VM be applied to hospital-based physicians (physicians who furnish at least 90 percent of their services in either inpatient or emergency departments of a hospital)?

Yes. For 2015, the VM will apply to groups of hospital-based physicians. CMS will determine their VM using the same methodology and measures it uses for all other groups of physicians subject to the VM in 2015. However, as it develops future proposals for the VM, CMS will continue to consider alternative performance measures specific to hospital-based physicians.

16. Will the 2015 and 2016 VM also apply to physicians participating in ACOs or the CPC initiative?

No. CMS will not apply the VM in 2015 and 2016 to any group of physicians in which a physician in the group is participating in the Medicare Shared Savings Program, the Pioneer ACO model, or the Comprehensive Primary Care initiative.

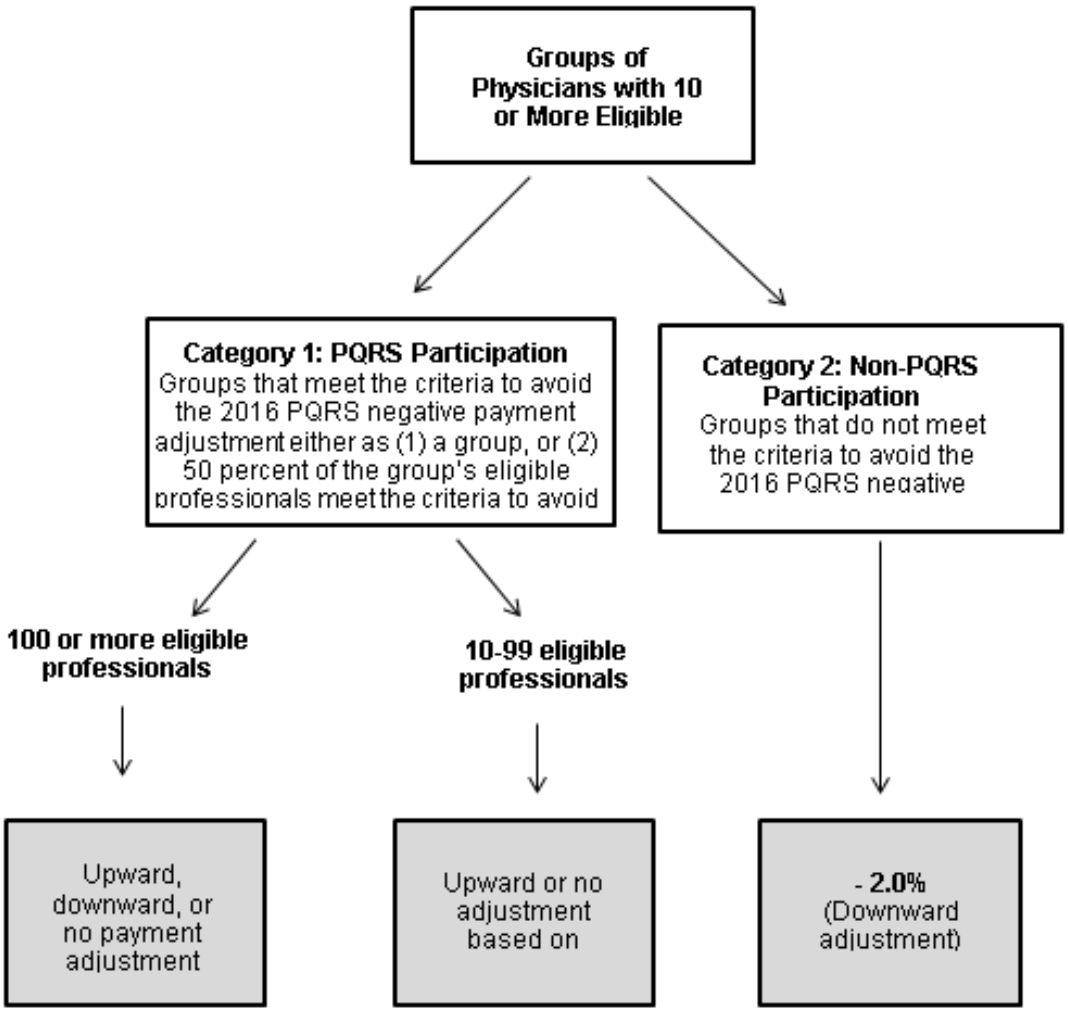
17. How will the 2016 VM differ from the 2015 VM?

The 2016 VM will reflect the following changes in policy:

- In 2016, the VM will be applied to all groups of physicians with 10 or more eligible professionals, and it will be based on 2014 performance.
- Beginning in 2016, quality-tiering will be mandatory for all groups of physicians with 10 or more eligible professionals that meet the criteria for successful reporting or participation in the PQRS (referred to in the Federal Rule as "Category 1"). However, groups of physicians with between 10 and 99 eligible professionals will be subject only to upward or neutral value-based payment modifiers, while groups of physicians with 100 or more eligible professionals will be subject to upward, neutral, or downward adjustments.
- For groups of physicians with 100 or more eligible professionals, the amount of payment at risk under quality-tiering will increase from 1.0 percent to 2.0 percent.
- Groups of physicians with 10 or more eligible professionals that do not meet the criteria for satisfactory reporting in PQRS (referred to in the Final Rule as "Category 2") will be subject to a value modifier of -2.0 percent (a downward adjustment), in addition to the 2016 PQRS payment adjustment of -2.0 percent.
- The 2016 VM will include the PQRS Group Practice Reporting Option (GPRO) reporting mechanisms available to groups of physicians and all PQRS reporting mechanisms available to individual eligible professionals for the 2014 reporting period. The PQRS Administrative Claims reporting option will no longer be available.
- Beginning in 2016, the Spending per Hospital Patient with Medicare measure (also known as the Medicare Spending per Beneficiary, or MSPB measure) will be included in the Total Per Capita Costs for All Attributed Beneficiaries domain of the Cost Composite.
- All cost measures (the five total per capita cost measures and the Spending per Hospital Patient with Medicare (or Medicare Spending per Beneficiary) measure) in the 2016 value modifier will be adjusted to account for the specialty mix of the TIN.

The following diagram provides an overview of how CMS will calculate the 2016 VM.

Diagram 3. Overview of how CMS will calculate the value modifier for 2016



18. What actions must groups of physicians with 10 or more eligible professionals take to avoid being subject to the automatic -2.0 percent (downward) value modifier payment adjustment in 2016?

CMS recommends that groups of physicians with 10 or more eligible professionals do one of the following to participate in the PQRS in 2014:

- Register with an active Individuals Authorized Access to the CMS Computer Services (IACS) account during the registration period from **April 1, 2014 to September 30, 2014** for one of three PQRS Group Practice Reporting Option (GPRO) reporting mechanisms (web interface, qualified registry, or EHR) and meet the criteria to avoid the 2016 PQRS negative payment adjustment, or

- Have at least 50 percent of the group's eligible professionals participate in PQRS as individuals or satisfactorily participate in a PQRS-qualified clinical data registry, and meet the criteria to avoid the 2016 PQRS negative payment adjustment.

Groups of physicians with 10 or more eligible professionals must take one of these actions to avoid being subject to the -2.0 percent (downward) value modifier payment adjustment in 2016, in addition to the 2016 PQRS negative payment adjustment of -2.0 percent.

19. Where can I go to find more information about PQRS reporting?

Providers can go to the PQRS web site at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/pqrs/index.html for more information. For questions or assistance with PQRS reporting, providers can also contact the QualityNet Help Desk by calling 1-866-288-8912 or emailing Qnetsupport@hcqis.org.