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National Provider Call

CMS Quality Reporting Programs under the 2016 Medicare Physician Fee Schedule Proposed Rule

July 16, 2015

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Agenda

- 2016 Medicare Physician Fee Schedule (MPFS) Proposed Rule
  - Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Merit-based Incentive Payment System (MIPS) & Alternative Payment Models (APMs)
  - Physician Quality Reporting Program (PQRS)
  - EHR Incentive Program
  - Aligned Reporting
  - Value-Based Payment Modifier (Value Modifier)
  - Medicare Shared Savings Program (Shared Savings Program)
- Resources & Who to Call for Help
- Question & Answer Session
- Special Announcement: July 2015 IACS to EIDM Transition
- Appendices

Medicare Access and CHIP Reauthorization (MACRA) Act of 2015

New Mandates Enacted by Medicare Access and CHIP Reauthorization Act (MACRA) of 2015

MACRA amends section 1848(a)(8)(A) of the Social Security Act affecting the quality reporting programs

- PQRS ends in 2018, certain aspects of the program may be incorporated under the new incentive program
- EHR Meaningful Use Incentive payments will be made under MIPS as below
- Value-based payment modifier adjustments will be combined under MIPS as below
  - Payment Modifier will not be applied for items and services furnished on or after January 1, 2019

MACRA created the Merit-Based Incentive Payment System (MIPS) and incentive payments for participation in eligible alternative payment models beginning in 2019

MIPS replaces the sustainable growth rate

Components of the MIPS include:

- MIPS Adjustment Factor/Scoring
  - Composite Performance Score
  - Performance Threshold

Merit-Based Incentive Payment System (MIPS)

MIPS adjustment factor

- MIPS adjustment factor is for each MIPS EP/year in the form of a percentage
- Determined by comparing the composite performance score to the performance threshold
- Scoring is either positive, negative , or zero
- Aggregate Application of MIPS Adjustment for additional performance threshold for exceptional performance
  - Scaling Factor will apply to ensure budget neutrality requirement is met
- In addition to the MIPS Adjustment Factor, EPs can earn an additional positive percent (EPs composite performance score has to be ≥ to the performance threshold)
  - 2019 - 4%
  - 2020 - 5%
  - 2021 - 7%
  - 2022 and beyond 9%

CMS Seeks Comments & RFI Related to MACRA

CMS seeks comments on the following:

- Low Volume Threshold
- Clinical Practice Improvement

Incentive payments for participation in eligible alternative payment models – a new framework to promote alternative payment models

- Incentive payments for participation in eligible alternative payment models will have payment implications for providers beginning 2019; seeking questions for comment through a forthcoming Request for Information (RFI)

MIPS Provisions

Low-volume threshold:

- The minimum number of individuals enrolled under Medicare who are treated by the EP for the performance period
- The minimum number of items and services furnished to individuals enrolled under Medicare by the EP for the performance period
- The minimum amount of allowed charges billed by the EP under Medicare for the performance period

Clinical practice improvement activities:

- Expanded practice access, such as same day appointments for urgent needs and after hours access to clinician advice
- Population management, such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry
- Care coordination, such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth
- Beneficiary engagement, such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms
- Patient safety and practice assessment, such as through use of clinical or surgical checklists and practice assessments related to maintaining certification
- Participation in an alternative payment model

Promoting Alternative Payment Models (APMs)

Provisions include:

- Increasing transparency of physician-focused payment models
- Criteria and process for submission and review of physician-focused payment models
- Incentive payments for participation in eligible APMs
- Encouraging development and testing of certain models
- Integrating Medicare Advantage alternative payment models
- Study and report on fraud related to APMs under the Medicare program

Incentive payments for participation in eligible alternative payment models:

- Types of APMs include: medical homes under 1115A, shared savings program under section 1899, a demonstration under section 1866C and a demonstration required by Federal law.
  - Some demonstrations and models are excluded (health care innovation award)
- "Eligible APM entities" participate in eligible APMs that:
  - Require the use of certified EHR technology
  - Provide for payment for covered professional services based on quality measures comparable to measures under the MIPS performance category, and
  - Bear financial risk for monetary losses under the APM that are in excess of a nominal amount or are medical homes expanded under 1115A(c)

Alternative Payment Models

Under MACRA, qualifying APM participants are eligible for incentive payments

- 2019 to 2024, providers qualifying for the APM track will receive a 5% annual lump-sum bonus on MPFS payments

Qualifying APM participant

- Providers must meet increasing thresholds for the percentage of their revenue they receive through eligible APMs
- 2019-2020: 25% of Medicare revenue must be received through eligible APMs
- 2021-2022: 50% of Medicare revenue or 50% of all-payer revenue along with 25% of Medicare revenue must be received through eligible APMs
- 2023 and beyond: 75% of Medicare revenue or 75% of all-payer revenue along with 25% of Medicare revenue must be received through eligible APMs

Exclusions to MIPS

Exclusions to MIPS include the following:

- A qualifying APM participant
- A partial qualifying APM participant
  - Partial qualifying APM participant is an EP who has not met the minimum payment percentage(s) for a qualifying APM participant that year but has met a reduced threshold:
    - 2019-2020 – 20%; 2021-2022 – 40%; 2023 and subsequent years – 50%
    - If a partial qualifying APM participant reports to MIPS they will be included in MIPS, not excluded
- Low-volume threshold measurement that has not been satisfied (a minimum payment percentage)
  - The minimum number of items and services furnished (allowed charges) to individuals enrolled by an EP during the performance period

Proposed Changes to 2016 PQRS

CY 2018 Payment Adjustments

Program	Applicable to	Adjustment Amount	Based on PY
PQRS	All eligible professionals (EPs) (Medicare physicians, practitioners, therapists)	-2.0 % of MPFS	2016
Medicare EHR Incentive Program	Medicare EPs under the HITECH Act (if not a meaningful user)	-3.0 % of MPFS	2016
Value-Based Payment Modifier (VM)	All physicians, physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs) in groups with 2+ EPs and physicians, PAs, NPs, and CNSs who are solo practitioners	**Mandatory Quality-Tiering for PQRS reporters (Category 1):** **Groups with 2-9 EPs and physician solo practitioners:** Upward, neutral, or downward VM adjustment based on quality-tiering (-2.0% to +2.0x of MPFS) **Groups with 10+ EPs:** Upward, neutral, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x of MPFS) **Groups Consisting of Non-physician EPs and PA, NP, or CNS, or CRNA solo practitioners:** Upward or neutral VM adjustment only based on quality-tiering (+0.0% to +2.0x of MPFS) **All groups and solo practitioners receiving an upward adjustment under quality-tiering are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25 percent of all beneficiary risk scores nationwide.** **Non-PQRS reporters (Category 2):** **Groups with 2-9 EPs and physician solo practitioners:** automatic -2.0% of MPFS downward adjustment **Groups with 10+ EPs: A**utomatic -4.0% of MPFS downward adjustment **Groups Consisting of Non-physician EPs and PA, NP, or CNS, or CRNA solo practitioners:** automatic -2.0% of MPFS downward adjustment	2016

Proposed Changes to PQRS

- Definition of eligible professional (EP) for purposes of participating in PQRS
- Proposed changes to the requirements for the qualified clinical data registry (QCDR) and qualified registries
- QCDRs and qualified registries have more time in which to self-nominate

Proposed Changes to PQRS Reporting Criteria

Group Practice Participating in GPRO	Qualified Clinical Data Registry (QCDR) Entities	Qualified Registry Entities	Data Submission Vendor and EHR Direct Entities	Claims/ Registry (including measures groups)
• Report via QCDR • Group practices with 25+ EPs required to report on CAHPS for PQRS survey measures	• Support TIN-level reporting • New process for self-nomination and attestation	• New process for self-nomination and attestation	• No changes	• No new proposals for reporting EHR reporting for individual EPs

PQRS Criteria: Claims and Registry-Based Reporting for Individual EPs

- No proposed changes for claims and registry-based reporting for individual EPs

2016 performance year and 2018 payment adjustment

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

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

- Measure-Applicability Validation (MAV) (same process as in 2015) will apply to those who report on <9 measures or covers <3 NQS domains
- If the EP sees 1 Medicare patient in a face-to-face encounter they must report on at least 1 cross-cutting measure (included in the 9 measures)
- Measures with 0% performance rate will not count

PQRS Criteria: Measures Groups via Registry for Individual EPs

- No proposed changes for measures groups via registry reporting for individual EPs

2016 performance year and 2018 payment adjustment

1 measures group for 20 applicable patients of each EP

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

PQRS Criteria: Individual EP EHR (Direct or DSV) Reporting

2016 performance year and 2018 payment adjustment

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

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

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

- Providers must use technology that is CEHRT
- Providers must create an electronic file using CEHRT that can be accepted by CMS for reporting

PQRS Criteria: Satisfactory Participation in a QCDR by Individual EPs

Proposed to revise and use the same criterion for the 2018 payment adjustment

9 measures available for reporting under a QCDR covering at least 3 NQS domains, **AND** each measure for at least 50% of the EP's patients

- of these measures EP would report on at least 2 outcome measures

OR

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

PQRS Criteria: GPRO Reporting via the Web Interface (WI)

Proposed for group practices of 25+ EPs if CAHPS for PQRS does not apply:

- Report on all measures included in the WI; **AND**
- Populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure
    - If the pool of eligible beneficiaries is < 248, then the group practice would report on 100% of assigned beneficiaries
- Report on at least 1 measure for which there is Medicare patient data*

Proposed for **groups of 25+ EPs if CAHPS for PQRS applies:**

- Have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor, **AND**
- Report on all measures included in the WI; **AND**
- Populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear
    - If the pool of eligible assigned beneficiaries is < 248 then the group would report on 100%
- Report on at least 1 measure for which there is Medicare patient data*

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

PQRS Criteria: GPRO via Registry

Proposed for group practices of 2+ EPs:

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

If a group practice chooses instead to use a qualified registry in conjunction with CAHPS for PQRS survey measure, the group practice would:

- Report ALL CAHPS for PQRS survey measures via a certified survey vendor, AND report ≥ 6 additional measures, outside of the CAHPS for PQRS survey, covering ≥ 2 NQS domains using the qualified registry
- If < 6 measures covering < 2 NQS domains apply to the group, the group practice must report each measure that is applicable to the group practice
- Of the non-CAHPS for PQRS measures, if any EP in the group practice sees at least 1 Medicare patient in a face-to-face encounter, must report on 1 PQRS cross cutting measure (included in the 6 additional measures). If a group practice does not report on at least 1 cross-cutting measure and has 1 EP who sees at least 1 Medicare patient in a face-to-face encounter will be subject to MAV. The MAV process will now allow us to determine whether a group practice should have reported on at least 1 cross-cutting measure.

PQRS Criteria: GPRO via EHR

Proposed for group practices of 2+ EPs:

- The group practice would report on 9 measures covering ≥ 3 domains, if the group practice's direct EHR product or EHR data submission vendor product does not contain patient data for ≥ 9 measures covering ≥ 3 domains then the group must report the measures for which there is patient data
    - The criteria proposed above applies to group practices of 25+ EPs if the CAHPS for PQRS survey does not apply to the group practices

If group practices of 25+ EPs chooses to use a direct EHR product or EHR data submission vendor product in conjunction with reporting the CAHPS for PQRS survey measures, the group practice would:

- Report ALL CAHPS for PQRS survey measures via a certified survey vendor, AND
- Report at least 6 additional measures (outside the CAHPS for PQRS), covering ≥ 2 NQS domains. If < 6 measures apply to the group practice, the group practice must report all applicable measures
- Of the non-CAHPS for PQRS measures that must be reported in conjunction with the reporting the CAHPS for PQRS survey measures, a group would be required to report on at least 1 measure for which there is Medicare patient data
- This proposed option to report 6 additional measures is consistent with the proposed criterion for satisfactory reporting for the 2018 PQRS payment adjustment via EHR without CAHPS for PQRS, since both criteria address a 3 domains

PQRS Criteria: GPRO via a QCDR

New proposal for 2016

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

Proposed Criteria for Satisfactory Participation

- The group practice would report at least 9 measures available for reporting under a QCDR covering at least 3 NQS domains, AND
- Report each measure for at least 50% of the EP's patients
  Of these measures, the group practice would report on at least 2 outcome measures, OR if 2 outcome measures are not available, report on at least 1 outcome measure, and at least 1 of the following types of measures: resource use, patient experience of care, efficiency/appropriate use, or patient safety

Requirements for the QCDR

A QCDR must perform the following functions:

- Submit quality measures data or results to CMS for purposes of demonstrating that, for a reporting period, its EPs have satisfactorily participated in PQRS. A qualified clinical data registry must have in place mechanisms for the transparency of data elements and specifications, risk models, and measures
- Submit to CMS, for purposes of demonstrating satisfactory participation, quality measures data on multiple payers, not just Medicare patients
- Provide timely feedback, at least four times a year, on the measures at the individual participant level for which the qualified clinical data registry reports on the EPs behalf for purposes of the individual EP's satisfactory participation in the quality clinical data registry
- Possess benchmarking capacity that compares the quality of care an EP provides with other EPs performing the same or similar functions

Proposed Changes for QCDR Vendors and Qualified Registries

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

- **Attestation Statements:** In lieu of submitting an attestation statement via email, beginning in 2016, we propose to allow registries to attest during the submission period that the quality measure results and any and all data including numerator and denominator data provided to CMS are accurate and complete using a web-based check box mechanism

Proposed Changes for QCDR Vendors and Qualified Registries

- **Data Validation Requirements**:
  - CMS proposes adding the following requirements for QCDRs to the existing guidance on validation strategy:
    - Organization name, program year, and vendor type
    - Methods for data collection, TIN verification, data reporting and verification, rate calculation, and PQRS measure specification confirmation
    - Process for data auditing and sampling methodology
  - Qualified registries and QCDRs must send evidence of successful results from their data validation strategy in a **Data Validation Execution Report** via e-mail to the QualityNet Help Desk at Qnetsupport@sdps.org by 5:00 PM ET on June 30, 2017

Group Practices Reporting via GPRO Web Interface, EHR and Registry

Proposed criteria for the satisfactory participation for 2018 PQRS payment adjustment:

- Requires all group practices of 25 or more EPs that register to participate in the GPRO WI for 2016 to select a CMS-certified survey vendor to report CAHPS for PQRS
- Group practices using a direct EHR product or EHR DSV or registry in conjunction with reporting the CAHPS for PQRS survey measures would report all CAHPS for PQRS survey measures via a certified survey vendor, and report at least 6 additional measures (outside the CAHPS for PQRS), covering at least 2 NQS domains; If fewer than 6 measures apply to the group practice, the group practice must report all applicable measures
- Of the non-CAHPS for PQRS measures that must be reported with the reporting of the CAHPS for PQRS survey measures, a group would be required to report at least 1 measure for which there is Medicare patient data

Proposed Quality Measures Updates

Proposed New Measures

- 46 for individual reporting
- 3 new Measures Groups (Cardiovascular Prevention, Diabetic Retinopathy, Multiple Chronic Condition)
- 1 for GPRO Web Interface
- National Quality Strategy (NQS) domains covered:
  - 2 Person and Caregiver-Centered Experience and Outcomes
  - 4 Community/Population Health
  - 20 Effective Clinical Care
  - 4 Communication and Care Coordination
  - 10 Patient Safety
  - 6 Efficiency and Cost Reduction

Proposed Measures for Removal

- 12 to be removed from Claims or Registry
- 1 measure was part of a Measures Group only

Changes to Existing Measures

- 4 measures changing NQS Domains

EHR Incentive Program

Certification Requirements for Electronic Reporting of Clinical Quality Measures

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

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

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

For any CY before 2018: providers must use electronic reporting via EHR technology certified to the 2014 Edition or the 2015 Edition certification criteria**.**

For 2018 and subsequent years: providers must use electronic reporting via EHR technology certified to the 2015 Edition certification criteria (certified to meet QRDA I and III standards).

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

PQRS Criteria: EHR Incentive Program Electronic Reporting

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

For a reporting period in 2016, to avoid the 2018 payment adjustment:
Report 9 measures covering at least 3 of the NQS domains.
Providers may report results including zeroes in numerator/denominator

Providers choosing to submit their CQMs electronically must use the CMS form and manner requirements to submit CQMs. If the provider completes a single submission of CQM data for both PQRS and the EHR Incentive Program, the provider must meet the reporting requirements for both programs to receive dual-credit.

Aligned Reporting

Clinical Quality Measures (CQMs)

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

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

Comprehensive Primary Care (CPC) Initiative Practice Sites

- CPC practice sites are required to report to CMS 9 of 13 CPC eCQMs that cover 3 NQS domains
  - eCQMs may be submitted electronically to the PQRS portal or via attestation to CPC for a full calendar year (January 1 – December 31)
  - EPs in their first year of demonstrating meaningful use may also use this group reporting option
  - CPC practice sites that intend to meet the eCQM reporting requirement for MU via their CPC reporting, **MUST meet CPC reporting** to obtain the MU eCQM reporting credit
  - Alternatively, CPC practice site EPs may also report their eCQMs for MU credit via the Medicare EHR Incentive Program in accordance with the program requirements for meaningful use

Value-Based Payment Modifier

What Is the Value-Based Payment Modifier (VM)?

- The VM assesses both the quality of care furnished and the cost of that care during a performance period
- The VM is an adjustment made on a per-claim basis to Medicare payments for items and services furnished under the Medicare Physician Fee Schedule (PFS)
- The VM is applied at the Taxpayer Identification Number (TIN) level and applies to all physicians and certain non-physician EPs billing under the TIN who are subject to the VM during the payment year

What Is an Eligible Professional (EP)?

- **Physician**

Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Dental Surgery, Doctor of Dental Medicine, and Doctor of Chiropractic

- **Practitioner**

Physician Assistant (PA), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Nutrition Professional, and Qualified Audiologist

- **Therapist**

Physical Therapist, Occupational Therapist, and Qualified Speech-Language Therapist

Proposed Policies for the 2018 VM

- Performance year is 2016
- Applies to physicians, PAs, NPs, CNSs, and CRNAs in groups with 2+ EPs and those who are solo practitioners, as identified by their TIN
- Quality-tiering is mandatory
  - TINs that consist of non-physician EPs will be held harmless from downward adjustments
  - All other TINs will be subject to upward, neutral, or downward adjustments

Proposed Policies for the 2018 VM

CY 2018 VM payment adjustment, for physicians, PAs, NPs, CNSs, and CRNAs in groups with 2+ EPs and those who are solo practitioners

PQRS Reporters – 3 types – Category 1

1a. Group reporters : Report as a group via a PQRS GPRO and meet the criteria to avoid the 2018 PQRS payment adjustment

OR

1b.Individual reporters in the group: at least 50% of EPs in the group report PQRS measures as individuals AND meet the criteria to avoid the 2018 PQRS payment adjustment

2. Solo practitioners: Report PQRS measures as individuals AND meet the criteria to avoid the 2018 PQRS payment adjustment

Mandatory Quality-Tiering Calculation

- Physicians, PAs, NPs, CNSs, & CRNAs in groups with 2-9 EPs and physician solo practitioners → **Upward, no, or downward VM** adjustment based on quality-tiering (-2.0% to +2.0x)
- Physicians, PAs, NPs, CNSs, & CRNAs in groups with 10+ EPs → **Upward, no, or downward VM** adjustment based on quality-tiering (-4.0% to +4.0x)
- Groups & solo practitioners consisting of non-physician EPs → **Upward or no VM** adjustment based on quality-tiering (0.0% to +2.0x)

Non-PQRS Reporters – Category 2

1. Groups: Do not avoid the 2018 PQRS payment adjustment as a group OR do not meet the 50% threshold option as individuals

2. Solo practitioners: Do not avoid the 2018 PQRS payment adjustment as individuals

-2.0% (for physicians, PAs, NPs, CNSs, & CRNAs in groups with 2-9 EPs, physician solo practitioners, & groups and solo practitioners consisting of non-physician EPs)

-4.0% (for physicians, PAs, NPs, CNSs, & CRNAs in groups with 10+ EPs)

(Automatic VM downward adjustment)

Note: The VM payment adjustment is separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs.

What Quality Measures Will Be Used to Calculate the 2018 VM?

- Groups with 2+ EPs: Measures reported through the PQRS Group Practice Reporting Option (GPRO) **OR** individual PQRS measures reported by at least 50% of the EPs in the group (50% threshold option)
- Solo practitioners: Individual PQRS measures reported by the solo practitioner
- Three claims-based outcome measures: All-Cause Hospital Readmissions, Composite of Preventable Hospitalizations for Acute Conditions, and Composite of Preventable Hospitalizations for Chronic Conditions
- CAHPS for PQRS survey measures (applicable only for groups that elect to use their 2016 CAHPS for PQRS survey results in the calculation of their 2018 VM)
- Beginning with the 2016 VM, proposed to assign "average" quality under quality-tiering if there is not at least one quality measure that meets the minimum number of cases required for the measure to be included in the quality composite
- Beginning with the 2018 VM, proposed to create separate eCQM benchmarks, based on the CMS eMeasure ID and exclude eCQM measures from the overall benchmark for a given measure

What Cost Measures Will Be Used to Calculate the 2018 VM?

- Total per capita costs measure (Parts A & B)
- Total per capita costs for beneficiaries with 4 chronic conditions (COPD, HF, CAD, and DM)
- Medicare Spending Per Beneficiary (MSPB) measure (3 days before and 30 days after an inpatient hospitalization):
  - Beginning with the 2017 VM, proposed to increase the minimum MSPB episodes for inclusion in the cost composite from 20 to 100 episodes
  - For the 2018 VM, proposed to include hospitalizations at Maryland hospitals as an index for the MSPB measure
- All cost measures are payment-standardized, risk-adjusted, and adjusted for the specialty mix of the EPs in the group

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

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

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

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

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

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

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

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

2018 VM Proposed Policies for PAs, NPs, CNSs, & CRNAs in Groups Consisting of Non-Physician EPs and those who are Solo Practitioners

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

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

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

Finality of the VM Upward Adjustment Factor

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

Determining Group Size for Applying the VM

- Beginning with the 2016 VM, proposed that the TIN's size would be based on the lower of the number of EPs indicated by the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)-generated list or our analysis of the claims data for purposes of determining the payment adjustment amount under the VM
- For the 2018 VM:
  - Proposed to identify TINs that consist of non-physician EPs if either the PECOS-generated list or our analysis of the claims data shows that the TIN consists of non-physician EPs and no physicians
  - Proposed to not apply the VM to TINs if either the PECOS-generated list or claims analysis shows that the TIN consists only of non-physician EPs who are not PAs, NPs, CNSs, or CRNAs

2017 VM Proposed Policies for Shared Savings Program Participants

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

2018 VM Policies for Shared Savings Program Participants

- Groups and solo practitioners participating in an ACO under the Shared Savings Program in the 2016 performance period will have their Value Modifier calculated as follows for the 2018 VM:
  - Cost Composite: Average
  - Quality Composite: Based on ACO's quality data submitted through the GPRO web interface and the ACO all-cause hospital readmissions measure as calculated under the Shared Savings Program
    - Proposed to include the CAHPS for ACOs Survey in the quality composite of the 2018 VM for TINs participating in ACOs in the Shared Shaving Program in 2016
- Proposed that if the ACO does not successfully report quality data as required by the Shared Savings Program, all groups and solo practitioners participating in the ACO will fall in Category 2 for the VM and be subject to the automatic downward adjustment as described on slide 39

Proposal for Applying the VM to TINs participating in the Pioneer ACO Model, CPC Initiative, or Other Similar Innovation Center Models

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

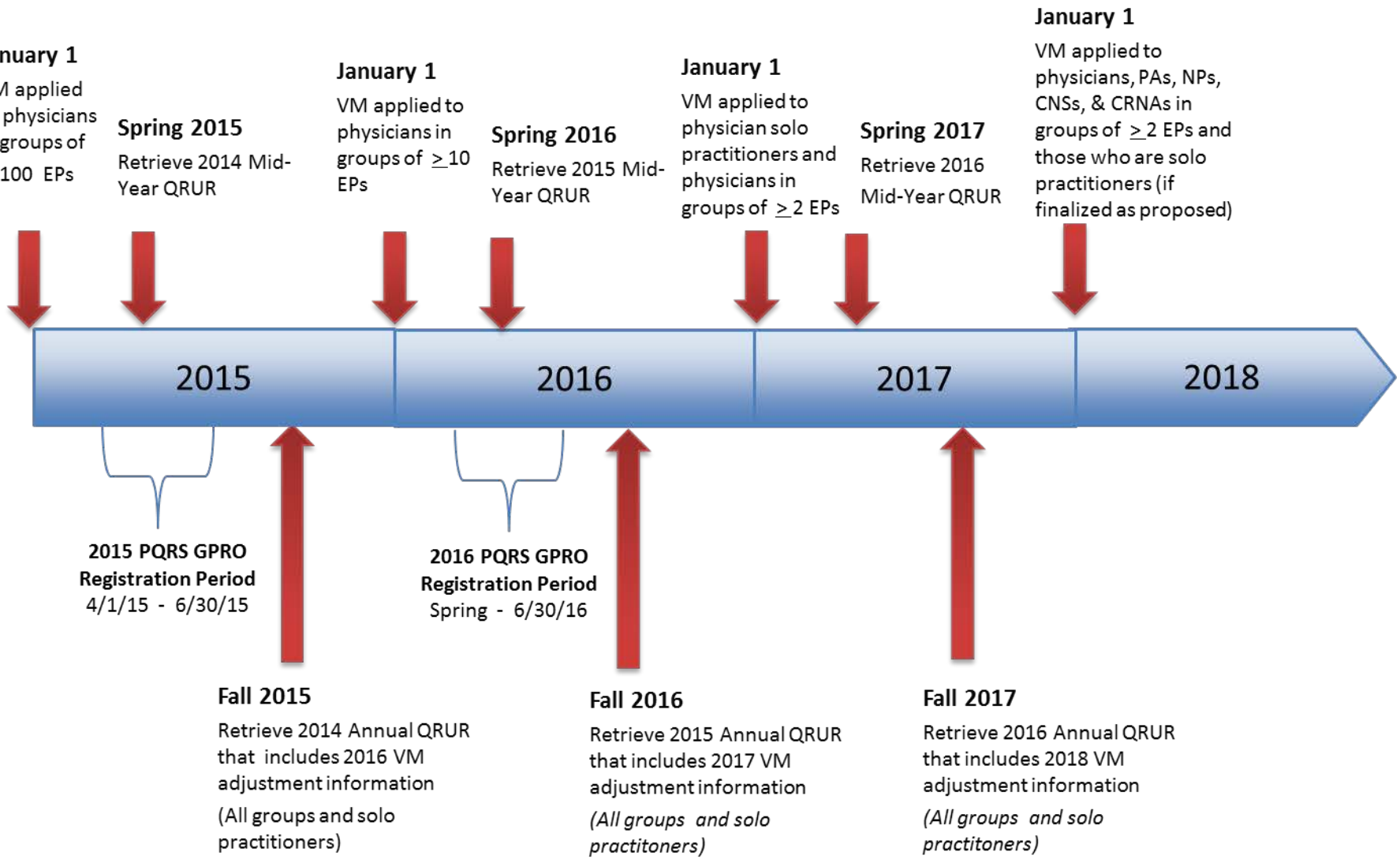
VM Informal Review

- The Informal Review submission period will occur during the 60 days following the release of the QRURs for the 2016 VM and subsequent years. We note that there is no administrative or judicial review of the determinations resulting from this expanded informal inquiry process under section 1848(p)(10) of the Act
- Proposed to reclassify a TIN as Category 1 when PQRS determines on informal review that at least 50 percent of the TIN's EPs meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the relevant CY PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS QCDR for the relevant CY PQRS payment adjustment
- We note that if the group was initially classified as Category 2, then we do not expect to have data for calculating their quality composite, in which case they'd be classified as "average quality", however, if the data is available in a timely manner, then CMS would recalculate the quality composite

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

- Choose a PQRS reporting mechanism and become familiar with the measures AND data submission timeframes
  - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html
- Decide whether and how to participate in the PQRS in 2016
  - Group reporting - Register for the 2016 PQRS GPRO between **Spring 2016 and June 30, 2016**
    - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html
  - Individual reporting – No registration necessary
- Download your 2013 Quality and Resource Use Report (QRUR) and 2014 Mid-Year QRUR now, and 2014 Annual QRUR (Fall 2015) at: https://portal.cms.gov
  - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html
- Review quality measure benchmarks under the VM
  - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

Timeline for Phasing In the VM



Medicare Shared Savings Program

Overview of Medicare Shared Savings Program

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

Medicare Shared Savings Program 2016 Physician Fee Schedule Proposals

- The CY 2016 PFS NPRM includes proposals specific to certain sections of the Shared Savings Program regulations and solicits feedback from stakeholders on the following:
  - Adding a measure of Statin Therapy for the Prevention and Treatment of Cardiovascular Disease in the Preventive Health domain of the Shared Savings Program to align with PQRS.
  - Preserving flexibility to maintain or revert measures to pay for reporting if a measure owner determines the measure no longer aligns with updated clinical practice or causes patient harm.
  - Clarifying how PQRS-eligible professionals participating within an ACO meet their PQRS reporting requirements when their ACO satisfactorily reports quality.
  - Amending the definition of primary care services used in the beneficiary assignment methodology to include claims submitted by ETA hospitals and exclude claims submitted by SNFs when the claim contains the place-of-service (POS) 31 modifier.

Public Reporting

Physician Compare Proposed Rule

Date of Publication	Rule	PQRS GPROs	ACOs	Patient Experience of Care Measures	Individual Eligible Professionals (EPs)
Late 2017	2016 Physician Fee Schedule (PFS) Proposed Rule	All 2016 PQRS GPRO measures collected via the Web Interface, registry, and EHR • Minimum sample size of 20 patients • 2016 QCDR measures • PQRS and non-PQRS measures. • No first year measures Publicly report an item-level benchmark, as appropriate	All 2016 measures reported by ACOs, including CAHPS for ACOs • Minimum sample size of 20 patients	2016 CAHPS for PQRS, in addition to CAHPS for ACOs • Group practices of 2 or more EPs and ACOs who meet the specified sample size requirements and collect data via a CMS-specified certified CAHPS vendor	All 2016 PQRS measures collected via an EHR, registry, or claims 2016 Cardiovascular Prevention measures group in support of Million Hearts 2016 QCDR measures • PQRS and non-PQRS measures • No first year measures Publicly report an item-level benchmark, as appropriate

Special Announcement: July 2015 Transition from IACS to EIDM

An important system update occurred on July 13, 2015. The Individuals Authorized Access to CMS Computer Services (IACS) system was retired, and current IACS user accounts were transitioned to an existing CMS system called Enterprise Identity Management (EIDM).The EIDM system provides a way for business partners to apply for, obtain approval for, and receive a single user ID for accessing multiple CMS applications.

Existing PQRS and PV users:

- Existing PQRS IACS users, their data, and roles were moved to EIDM and will be accessible from the "CMS Secure Portal" portion of the CMS Enterprise Portal at http://portal.cms.gov.
- Users will then access the "PQRS Portal" to submit data, retrieve submission reports, view feedback reports, or conduct various administrative and maintenance activities

New PQRS and PV users:

- To register for an EIDM account, visit the CMS Enterprise Portal at http://portal.cms.gov and click "New User Registration" under "Login to CMS Secure Portal"

For additional assistance regarding IACS or EIDMS:

- Contact the QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222) from 7:00 a.m. to 7:00 p.m. Central Time Monday through Friday, or via email at qnetsupport@hcqis.org

Question & Answer Session

Acronyms in this Presentation

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

Evaluate Your Experience

- Please help us continue to improve the MLN Connects® National Provider Call Program by providing your feedback about today's call.

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

CME and CEU

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

http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/TC-L07162015-Marketing-Materials.pdf

Thank You

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

- For more information about the Medicare Learning Network®, please visit http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html.

Who to Call for Help

- **QualityNet Help Desk:**

  866-288-8912 (TTY 877-715-6222)

  7:00 a.m.–7:00 p.m. CST M-F or **gnetsupport@hcqis.org**

  You will be asked to provide basic information such as name, practice, address, phone, and e-mail

- **Provider Contact Center:**

  Questions on status of 2013 PQRS/eRx Incentive Program incentive payment (during distribution timeframe)

  See *Contact Center Directory* at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html

- **EHR Incentive Program Information Center:**

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

- **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

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

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

  Phone: 888-734-6433, press option 3

Resources

2016 MPFS Proposed Rule

https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-16875.pdf

2015 MPFS Final Rule

https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-26183.pdf

CMS PQRS Website

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

PFS Federal Regulation Notices

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

Medicare Electronic Health Record (EHR) Incentive Program

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

Medicare Shared Savings Program

http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html

CMS Value-based Payment Modifier (VM) Website

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ PhysicianFeedback Program/ValueBasedPaymentModifier.html

Physician Compare

http://www.medicare.gov/physiciancompare/search.html

Frequently Asked Questions (FAQs)

https://questions.cms.gov/

MLN Connects™ Provider eNews

http://cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Index.html

PQRS Listserv

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

APPENDIX A: PQRS Reference Slides

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

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

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

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

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

Reporting Period	Group Practice Size	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria
12-month (Jan 1–Dec 31, 2016)	25+ EPs (if CAHPS for PQRS does not apply)	Individual GPRO Measures in the GPRO Web Interface	GPRO Web Interface	Report on all measures included in the web interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice must report on 100 % of assigned beneficiaries. In other words, we understand that, in some instances, the sampling methodology we provide will not be able to assign at least 248 patients on which a group practice may report, particularly those group practices on the smaller end of the range of 25–99 EPs. If the group practice is assigned less than 248 Medicare beneficiaries, then the group practice must report on 100% of its assigned beneficiaries. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1–Dec 31, 2016)	25+ EPs (if CAHPS for PQRS applies)	Individual GPRO Measures in the GPRO Web Interface + CAHPS for PQRS	GPRO Web Interface + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor. In addition, the group practice must report on all measures included in the GPRO web interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice must report on 100% of assigned beneficiaries. A group practice will be required to report on at least 1 measure for which there is Medicare patient data. Please note that, if the CAHPS for PQRS survey is applicable to a group practice who reports quality measures via the GPRO web interface, the group practice must administer the CAHPS for PQRS survey in addition to reporting the GPRO web interface measures.
12-month (Jan 1–Dec 31, 2016)	2+ EPs	Individual Measures	Qualified Registry	Report at least 9 measures, covering at least 3 of the NQS domains. Of these measures, if a group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice would report on at least 1 measure in the PQRS cross-cutting measure set. If less than 9 measures covering at least 3 NQS domains apply to the group practice, the group practice would report 1-8 measures covering 1–3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50% of the group's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.

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

Reporting Period	Group Practice Size	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria
12-month (Jan 1– Dec 31, 2016)	2+ EPs that elect CAHPS for PQRS	Individual Measures + CAHPS for PQRS	Qualified Registry + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor, and report at least 6 additional measures, outside of the CAHPS for PQRS survey, covering at least 2 of the NQS domains using the qualified registry. If less than 6 measures apply to the group practice, the group practice must report 1-5 measures. Of the additional measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, if any EP in the group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice must report on at least 1 measure in the PQRS cross-cutting measure set.
12-month (Jan 1– Dec 31, 2016)	2+ EPs	Individual Measures	Direct EHR Product or EHR Data Submission Vendor Product	Report 9 measures covering at least 3 domains. If the group practice's direct EHR product or EHR data submission vendor product does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1– Dec 31, 2016)	2+ EPs that elect CAHPS for PQRS	Individual Measures + CAHPS for PQRS	Direct EHR Product or EHR Data Submission Vendor Product + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor, and report at least 6 additional measures, outside of CAHPS for PQRS, covering at least 2 of the NQS domains using the direct EHR product or EHR data submission vendor product. If less than 6 measures apply to the group practice, the group practice must report 1-5 measures. Of the additional 6 measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, a group practice would be required to report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1– Dec 31, 2016)	2+ EPs	Individual PQRS measures and/or non-PQRS measures reportable via a QCDR	Qualified Clinical Data Registry (QCDR)	Report at least 9 measures available for reporting under a QCDR covering at least 3 of the NQS domains, AND report each measure for at least 50% of the group practice's patients. Of these measures, the group practice would report on at least 2 outcome measures, OR, if 2 outcomes measures are not available, report on at least 1 outcome measures and at least 1 of the following types of measures – resource use, patient experience of care, efficiency/appropriate use, or patient safety.

APPENDIX B: VM Reference Slides

VM Policies for 2016, 2017, & 2018

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

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

Value Modifier Components	2016 Finalized Policies	2017 Finalized Policies	2018 Proposed Policies
Outcome Measures **NOTE: Performance on the outcome measures and measures reported through one of the PQRS reporting mechanisms will be used to calculate a quality composite score for the TIN for the VM.**	Same as 2015	Same as 2015	Same as 2015
Patient Experience of Care Measures	CAHPS for PQRS: Optional for groups with 25+ EPs; Required for groups with 100+ EPs reporting via Web Interface. Groups may elect to include their 2014 CAHPS results in the calculation of the 2016 VM.	CAHPS for PQRS: Optional for groups with 2-99 EPs; Required for all groups with 100+ EPs. Groups may elect to include their 2015 CAHPS results in the calculation of the 2017 VM.	Groups may elect to include their 2016 CAHPS results in the calculation of the 2018 VM. Include the CAHPS for ACOs Survey in the quality composite of the 2018 VM for TINs participating in ACOs in the Shared Shaving Program in 2016

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

Value Modifier Components	2016 Finalized Policies	2017 Finalized Policies	2018 Proposed Policies
Cost Measures	• Same as 2015, and • Medicare Spending Per Beneficiary measure (includes Part A and B costs during the 3 days before, through 30 days after discharge following an inpatient hospitalization)	Same as 2016	Same as 2016
Benchmarks	No differentiation by group size ("compared to everyone") for both cost and quality measures	No differentiation by group size ("compared to everyone") for both cost and quality measures	No differentiation by group size ("compared to everyone") for both cost and quality measures Create separate eCQM benchmarks, based on the CMS eMeasure ID and exclude eCQM measures from the overall benchmark for a given measure.
Maximum Payment at Risk	-2.0%	-2.0% (Groups with 2-9 EPs and solo practitioners) -4.0% (Groups with 10+ EPs)	-2.0% (Groups with 2-9 EPs and physician solo practitioners) -4.0% (Groups with 10+ EPs) -2.0% (Groups with non-physician EPs and PA, NP, CNS, or CRNA solo practitioners)

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

Value Modifier Components	2015 Finalized Policy	2016, 2017 Finalized Policy	2018 Proposed Policy
Application of the VM to Participants of the Shared Savings Program, Pioneer ACO Model, and the CPC Initiative	Not Applicable	2016: Not Applicable 2017: Shared Savings Program: VM based on the ACO's quality data and average cost; Pioneer ACO Model and the CPC Initiative: average quality/average cost	Shared Savings Program: VM based on the ACO's quality and CAHPS data, and average cost; Pioneer ACO Model and the CPC Initiative: VM waived in 2017 and 2018
VM Informal Review Process: Timeline	• Deadline of February 28, 2015 for a group to request correction of a perceived error made by CMS in the 2015 VM payment adjustment.	Establish a 60 day period that would start after the release of the QRURs for the applicable reporting period for a group or solo practitioner (as applicable) to request correction of a perceived error made by CMS in the determination of the group or solo practitioner's VM for that payment adjustment period.	The Informal Review submission period will occur during the 60 days following the release of the QRURs for the 2016 VM and subsequent years
VM Informal Review Process: If CMS made an error	• Classify a TIN as "average quality" in the event we determine that we have made an error in the calculation of quality composite. • Recompute a TIN's cost composite if CMS made an error in its calculation. • Adjust a TIN's quality tier.	• Recompute a TIN's quality composite in the event we determine that we or a third-party vendor have made an error in the calculation of quality composite. • Otherwise, the same as 2015.	Same as 2016, 2017 and: Reclassify a TIN as Category 1 when PQRS determines on informal review that at least 50 percent of the TIN's EPs meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the relevant CY PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS QCDR for the relevant CY PQRS payment adjustment.