Reading & Evaluating QRUR Reports for MACRA

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Florida Society of Clinical Oncology

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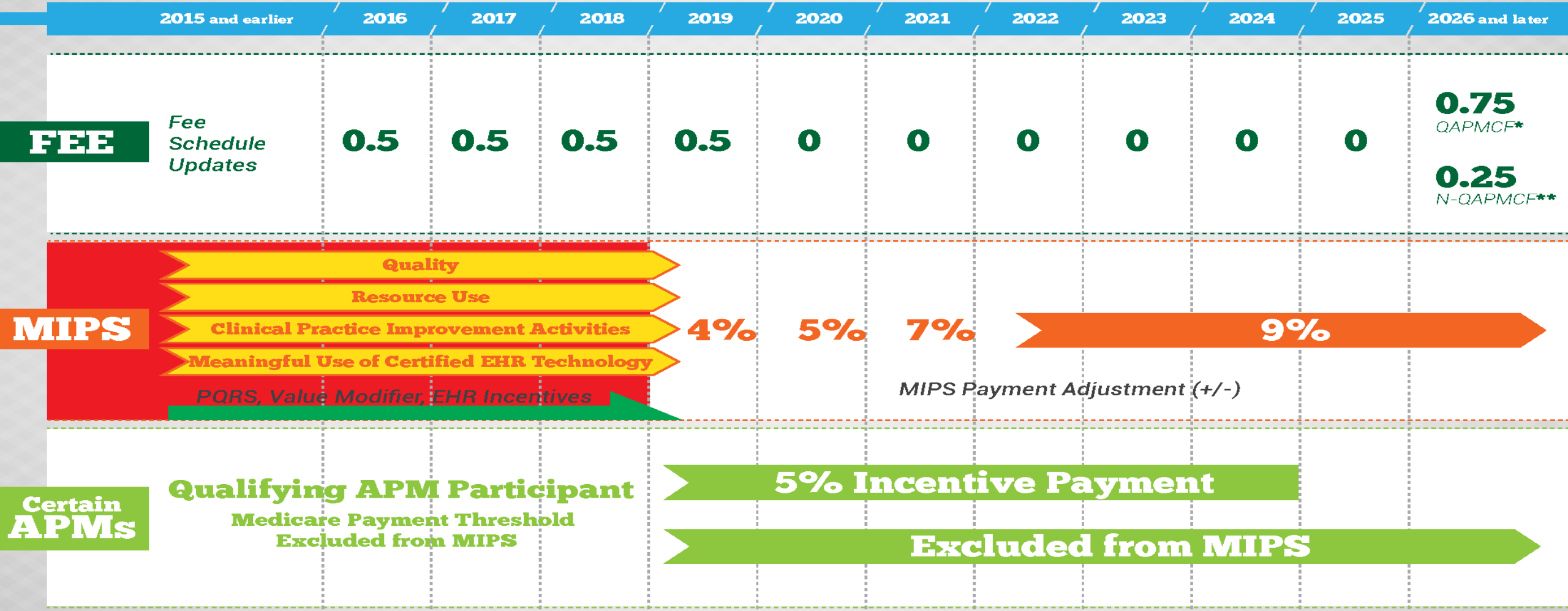
Learning Objectives

- Read through of 2015 QRUR Report
- Patient Attribution
- Focus on Financial Measures
- Payment Standardization, Risk Adjustment & Specialty Adjustment
- Use of Supplementary Exhibits
- QRUR, Value-Based Modifier & MIPS

Timeline



*Qualifying APM conversion factor

**Non-qualifying APM conversion factor

Source: CMS

Existing Programs

	2016	2017	2018
Meaningful Use	-2% Penalty	-3% Penalty	-3% Penalty
PQRS	-2% Penalty + VBM Penalty	-2% Penalty + VBM Penalty	-2% Penalty + VBM Penalty
Value-Based Modifier	2014 Performance PQRS Reporters: 100+: -2% to 2x* 10-99: -0% to 2x* Non-Reporters: 100+: -2% 10-99: -2%	2015 Performance PQRS Reporters: 10+: -4% to 4x* 10-99: -4% to 4x* 1-9: -0% to 2x* Non-Reporters: 10+: -4% 1-9: -2%	2016 Performance PQRS Reporters: 10+: -4% to 4x* 10-99: -4% to 4x* 1-9: -2% to 2x* Non-Reporters: 100: -4% 1-9: -2%

* Additional 1x available for groups with average risk score in top 25%

2015 QRUR

2015 ANNUAL QUALITY AND RESOURCE USE REPORT

AND THE 2017 VALUE-BASED PAYMENT MODIFIER

Sample Medical Practice A

LAST FOUR DIGITS OF YOUR MEDICARE-ENROLLED TAXPAYER IDENTIFICATION NUMBER (TIN): 0000

PERFORMANCE PERIOD: 01/01/2015 – 12/31/2015

ABOUT THIS REPORT FROM MEDICARE

The 2015 Annual Quality and Resource Use Report (QRUR) shows how your group or solo practice, as identified by its Medicare-enrolled Taxpayer Identification Number (TIN), performed in calendar year 2015 on the quality and cost measures used to calculate the Value-Based Payment Modifier (Value Modifier) for 2017.

In 2017, the Value Modifier will apply to all physicians in groups with two or more eligible professionals and to physicians who are solo practitioners who bill under the Medicare Physician Fee Schedule. It will not apply to eligible professionals who are not physicians.

The information contained in this report is believed to be accurate at the time of production. The information may be subject to change at the discretion of the Centers for Medicare & Medicaid Services (CMS), including, but not limited to, circumstances in which an error is discovered.

2015 QRUR

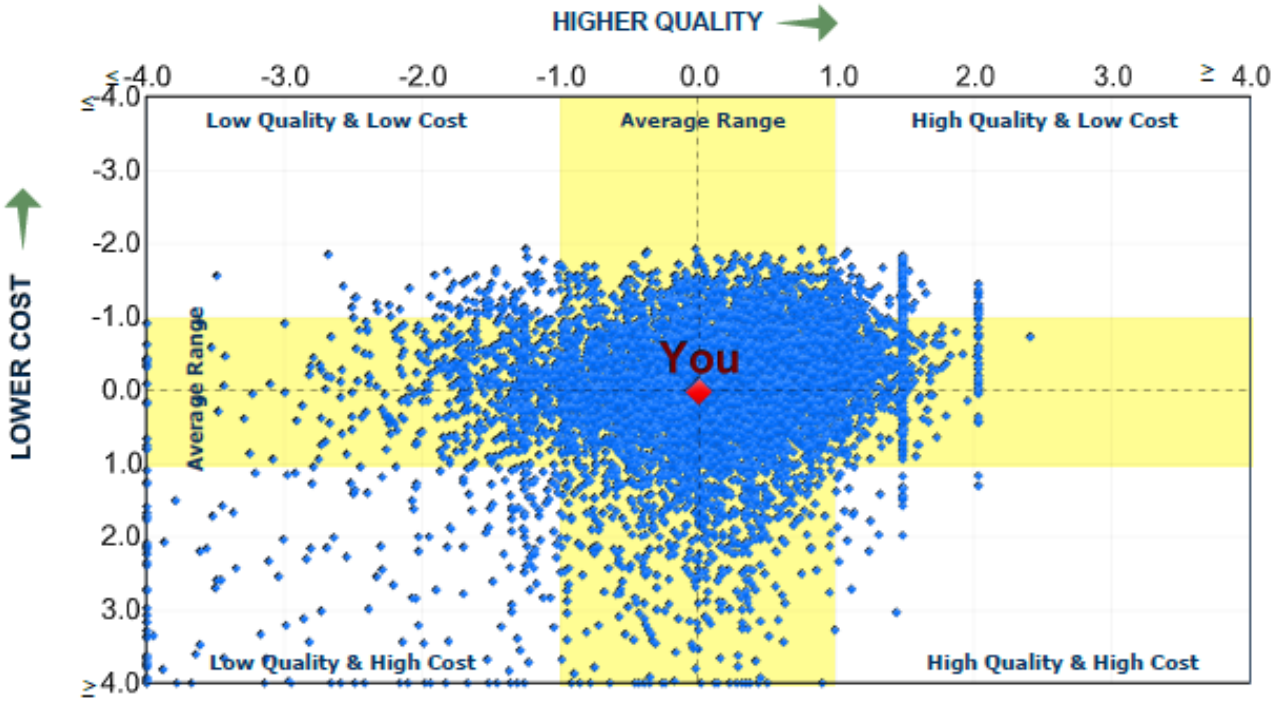
YOUR TIN'S 2017 VALUE MODIFIER

Average Quality, Average Cost = Neutral Adjustment (0.0%)

Your TIN's overall performance was determined to be average on quality measures and average on cost measures.

This means that the Value Modifier applied to payments for items and services under the Medicare Physician Fee Schedule for physicians billing under your TIN in 2017 will result in a neutral adjustment, meaning no adjustment (0.0%).

The scatter plot below shows how your TIN ("You" diamond) compares to a representative sample of other TINs on the Quality and Cost Composite scores used to calculate the 2017 Value Modifier.



Note: The scatter plot shows performance among a representative sample of all TINs with Quality and Cost Composite Scores reflecting standard deviations from the mean for each Composite Score.

2015 QRUR

The Value Modifier calculated for your TIN is shown in the highlighted cell in Exhibit 1. The Value Modifier applied to payments for items and services under the Medicare Physician Fee Schedule for physicians billing under your TIN in 2017 will result in a neutral adjustment, meaning no adjustment (0.0%).

Exhibit 1. 2017 Value Modifier Payment Adjustments under Quality-Tiering
(TINs with 10 or More Eligible Professionals)

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

Note: An adjustment factor (AF) derived from actuarial estimates of projected billings will determine the precise size of the reward for higher performing TINs in a given year. The AF for the 2017 Value Modifier will be posted at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html. If an asterisk (*) appears in the highlighted cell, it indicates that an additional upward adjustment of 1.0 x AF was applied to your TIN for serving a disproportionate share of high-risk beneficiaries.

2017 Value Modifier Results

CY 2015 Performance

	Low Quality	Average Quality	High Quality	
Low Cost	155	2,963	129	3,247
Average Cost	22,784	542,071	9,084	573,939
High Cost	4,492	11,252	348	16,092
	27,431	556,286	9,561	

+15.5% 1X
+77.4% 5X

291,830 did not report PQRS!

-2 -4%

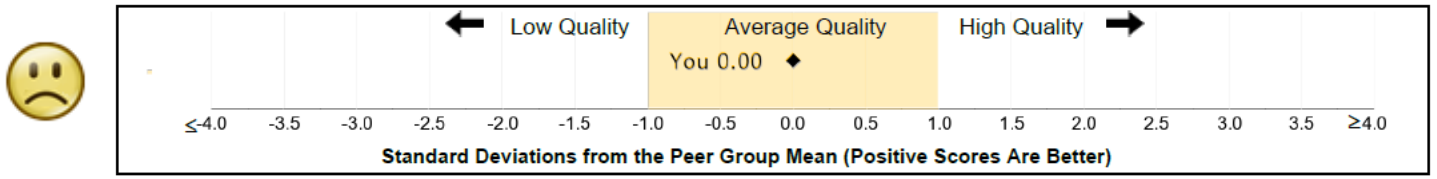
Groups with 10 or more eligible professionals

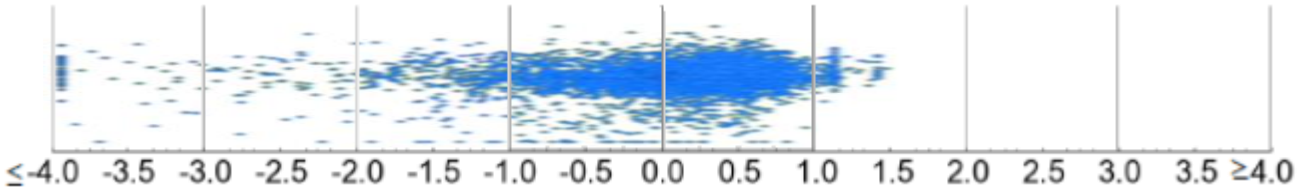
2015 QRUR

PERFORMANCE ON QUALITY MEASURES

Your TIN's Quality Tier: Average

Exhibit 2. Your TIN's Quality Composite Score





Scores

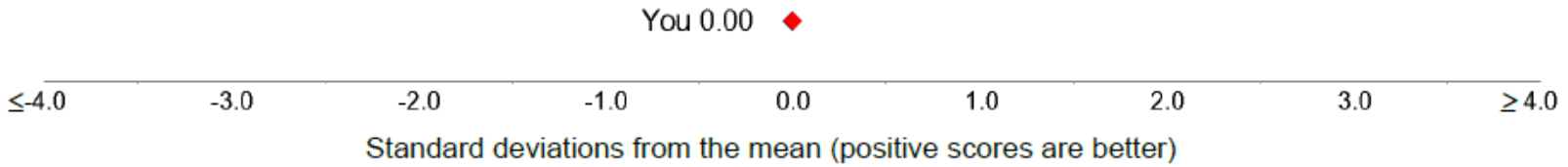
Low 4.6 % **Average 94%** **High 1.6%**

Rating ≥10 EP

2015 QRUR

Exhibit 3-ECC. Effective Clinical Care Domain Quality Indicator Performance

Domain Score



		Your TIN				All TINs in Peer Group	
Measure Identification Number(s)	**Measure Name**	Number of Eligible Cases	**Performance Rate**	Standardized Performance Score	Included in Domain Score?	**Benchmark (National Mean)**	Standard Deviation
1* (GPRO DM-2, CMS122v3)	Diabetes: Hemoglobin A1c Poor Control	0	**0.00%**	0.00	No	**0.00%**	0.00
8 (GPRO HF-6, CMS144v3)	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	0	**0.00%**	0.00	No	**0.00%**	0.00
112 (GPRO Prev-5, CMS125v3)	Breast Cancer Screening	0	**0.00%**	0.00	No	**0.00%**	0.00

2015 QRUR

B. Communication and Care Coordination Domain CMS-Calculated Quality Outcome Measures

Exhibit 3-CCC-B provides information on the three quality outcome measures calculated from Medicare Part A and Part B claims data.

			Your TIN				All TINs in Peer Group	
Performance Category	**Measure Identification Number(s)**	**Measure Name**	Number of Eligible Cases	**Performance Rate**	Standardized Performance Score	Included in Domain Score?	**Benchmark (National Mean)**	Standard Deviation
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care-Sensitive Conditions	CMS-1	Acute Conditions Composite	0	—	—	No	**0.00**	0.00
	-	Bacterial Pneumonia	0	—	—	—	**0.00**	0.00
		Urinary Tract Infection	0	—	—	—	**0.00**	0.00
		Dehydration	0	—	—	—	**0.00**	0.00
	CMS-2	Chronic Conditions Composite	0	—	—	No	**0.00**	0.00
	-	Diabetes (composite of 4 indicators)	0	—	—	—	**0.00**	0.00
		Chronic Obstructive Pulmonary Disease (COPD) or Asthma	0	—	—	—	**0.00**	0.00
		Heart Failure	0	—	—	—	**0.00**	0.00
Hospital Readmission	CMS-3	All-Cause Hospital Readmission	0	—	—	No	**0.00%**	0.00

2015 QRUR

Quality Measurement Benchmarks

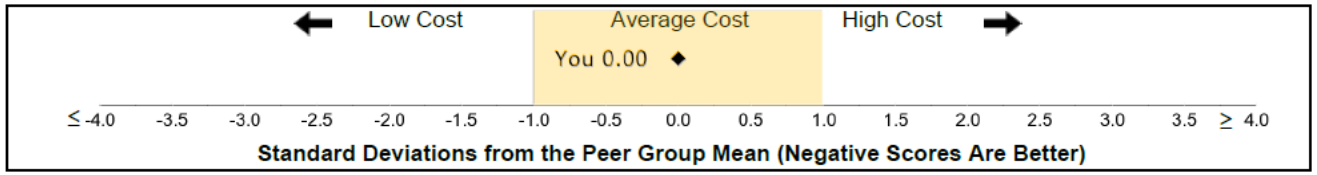
Measure Number	Measure Name	-1 StDev	Mean	+1 StDev
CMS-3	All-Cause Hospital Readmissions	13.9%	15.3%	16.7%
PQRS 39	Screening / Therapy for Osteoporosis	14.8%	40.2%	76.3%
PQRS 67	MDS & AL: Baseline Cytogenetic Testing	90.5%	97.4%	104%
PQRS 70	CLL: Baseline Flow Cytometry	87.8%	97.3%	107%
PQRS 71	Hormonal Therapy for IC-IIIC HR+ BC	60.9%	87.1%	113%

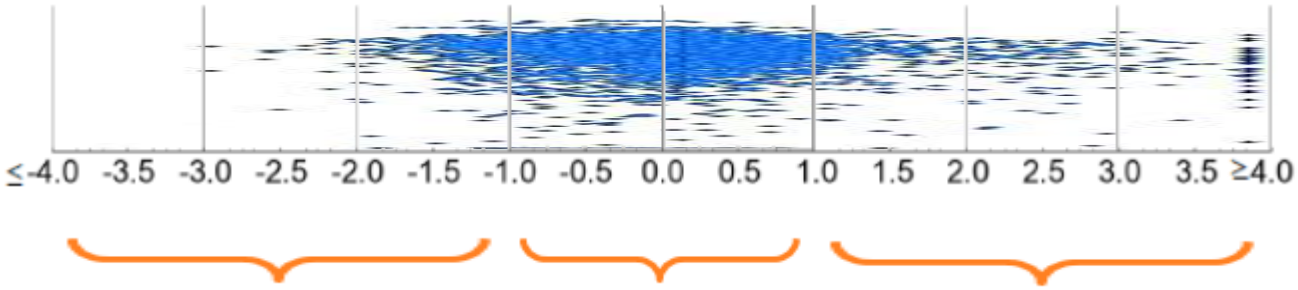
2015 QRUR

PERFORMANCE ON COST MEASURES

Your TIN's Cost Tier: Average

Exhibit 4. Your TIN's Cost Composite Score



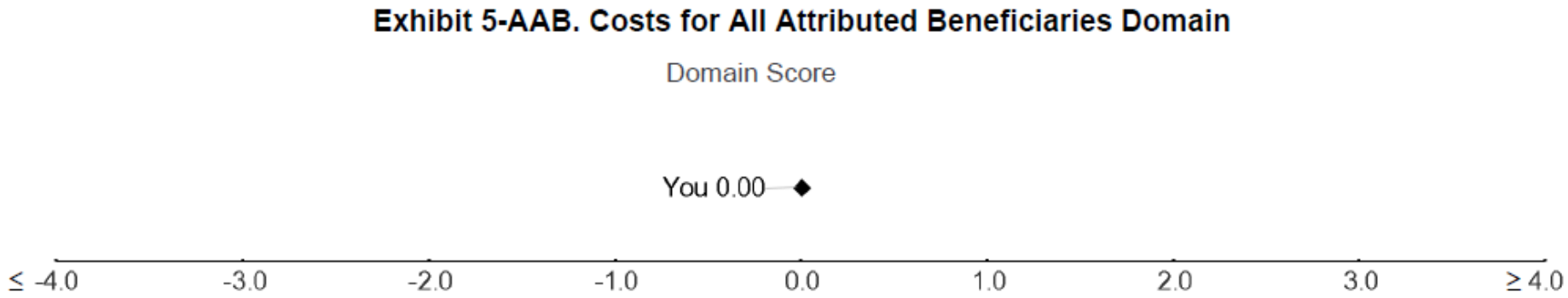


Scores

Rating ≥10 EP

2015 QRUR

Exhibit 5-AAB. Costs for All Attributed Beneficiaries Domain



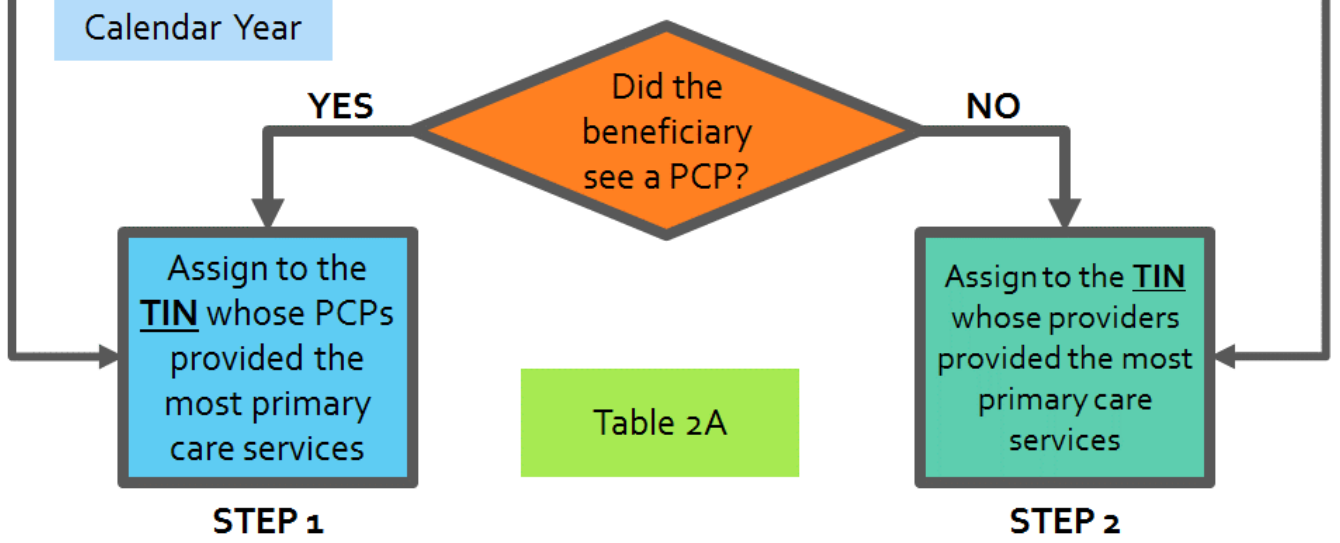
	Your TIN				All TINs in Peer Group	
Cost Measure	Number of Eligible Cases or Episodes	**Per Capita or Per Episode Costs**	Standardized Cost Score	Included in Domain Score?	**Benchmark (National Mean)**	Standard Deviation
Per Capita Costs for All Attributed Beneficiaries	0	—	—	No	**$0.00**	$0.00
Medicare Spending per Beneficiary	0	—	—	No	**$0.00**	$0.00

Per Capita Costs

Attributed Beneficiaries

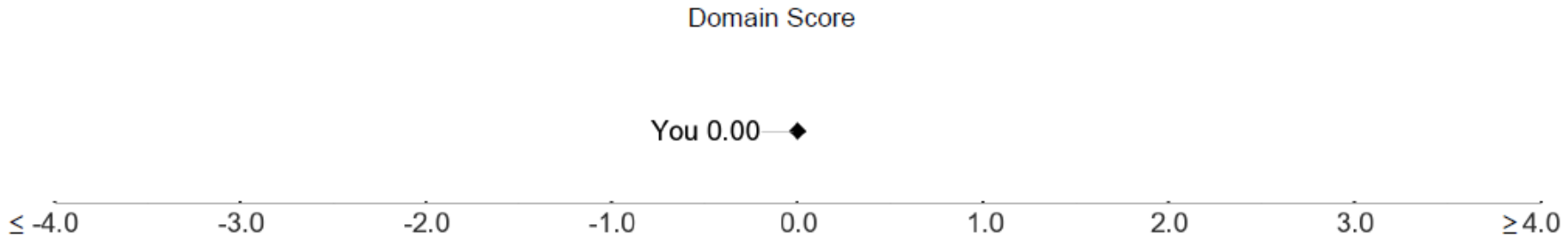
Cost Measure	Number of Eligible Cases or Episodes	Per Capita or Per Episode Costs	Standardized Cost Score	Included in Domain Score?	Benchmark (National Mean)	Standard Deviation
Per Capita Costs for All Attributed Beneficiaries	0	—	—	No	$0.00	$0.00

Summary: Basis for Attribution			
		Number	Percentage
All attributed beneficiaries		#	100%
Step 1	*Beneficiaries attributed because your TIN's primary care physicians, nurse practitioners, physician assistants, or clinical nurse specialists provided most primary care services*	#	#.##%
Step 2	*Beneficiaries attributed because your TIN's specialist physicians provided most primary care services*	#	#.##%



2015 QRUR

Exhibit 5-BSC. Costs for Beneficiaries with Specific Conditions Domain

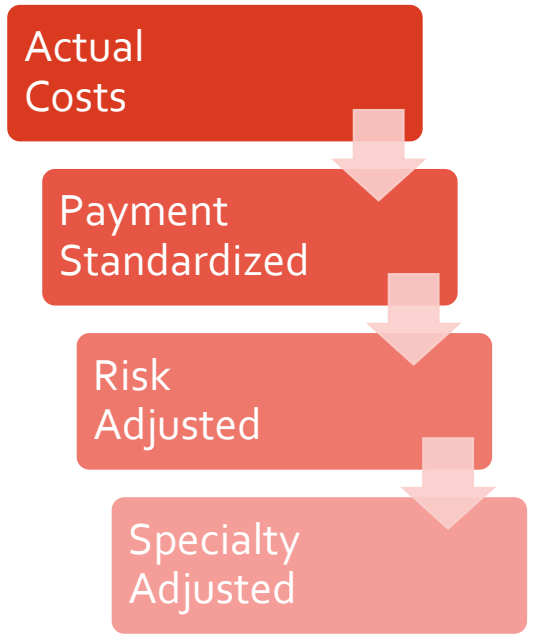


	Your TIN				All TINs in Peer Group	
Cost Measure	Number of Eligible Cases	**Per Capita Costs**	Standardized Cost Score	Included in Domain Score?	**Benchmark (National Mean)**	Standard Deviation
Per Capita Costs for Beneficiaries with Diabetes	0	—	—	No	**$0.00**	$0.00
Per Capita Costs for Beneficiaries with Chronic Obstructive Pulmonary Disease	0	—	—	No	**$0.00**	$0.00
Per Capita Costs for Beneficiaries with Coronary Artery Disease	0	—	—	No	**$0.00**	$0.00
Per Capita Costs for Beneficiaries with Heart Failure	0	—	—	No	**$0.00**	$0.00

Payment Standardization

Cost Measure	Number of Eligible Cases or Episodes	Per Capita or Per Episode Costs
Per Capita Costs for All Attributed Beneficiaries	0	—

Per Capita Costs for All Attributed Beneficiaries	Per Capita Costs for All Attributed Beneficiaries
	Medicare Spending per Beneficiary
Per Capita Costs for Beneficiaries with Specific Conditions	Diabetes
	Chronic Obstructive Pulmonary Disease (COPD)
	Coronary Artery Disease (CAD)
	Heart Failure



- **Payment Standardization:**
  - Eliminates adjustments for GPCI and wage indexes
  - Removes costs for GME, IME, DSH payments
  - Adjusts outlier payments
- **Risk Adjustment:**
  - CMS-HCC (Hierarchical Condition Categories)
  - Prospective Model – 2014 risk factors predict 2015 costs
- **Specialty Adjustment:**
  - Supplementary Exhibit 1

Prospective Risk Adjustment

2014 Conditions → 2015 Predicted Costs

2015 Conditions → 2016 Predicted Costs

2014

- 74 y/o female
- History:
  - Smoker
  - Hypertension
  - Hysterectomy
  - Wrist surgery
- **Percentile: 11**

June 2015

- Transfer from rural hospital
- AML
- Pneumonia
- 23-day admission

2015

- 7+3 cytarabine & daunorubicin
- 17 units
- 2 ED visits
- **$123,367** (payment standardized)

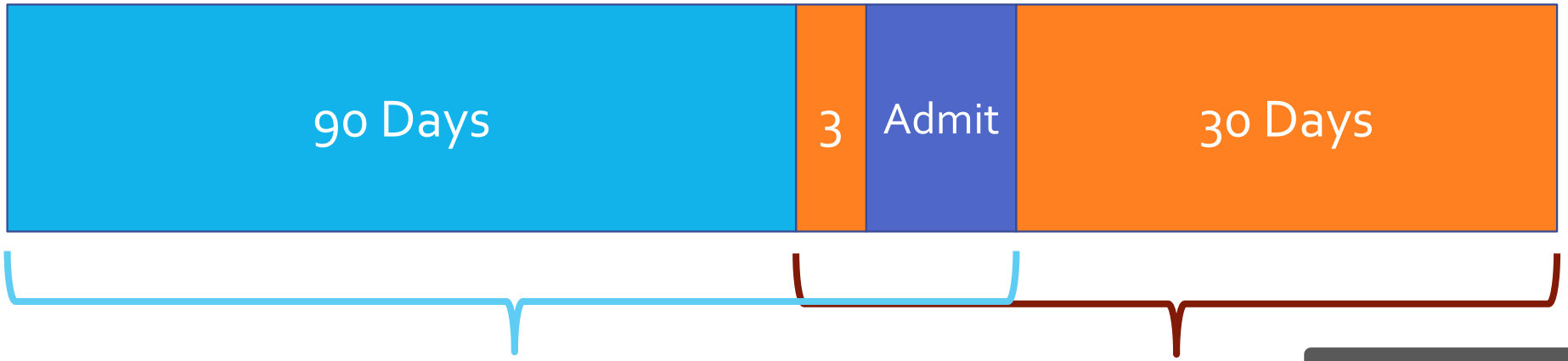
Prospective Risk Adjustment

Medicare Spending per Beneficiary

Cost Measure	Number of Eligible Cases or Episodes	Per Capita or Per Episode Costs	Standardized Cost Score	Included in Domain Score?	Benchmark (National Mean)	Standard Deviation
Medicare Spending per Beneficiary	0	—	—	No	$0.00	$0.00

Table 5B

Hospital Episode
(Medicare Spending per Beneficiary [MSPB])



Risk
HCC + MS-DRG

AML Patient: 99

Costs

Assign to the **TIN** w/ the most Part B services during **admit**

2015 QRUR

Tables

- 1: Physicians & Non-Physician Professionals
- 2A: Beneficiaries for Cost & Claims Measures
- 2B: Admitting Hospitals
- 2C: Hospital Admissions for Any Cause
- 3A: Per Capita Costs, by Category
- 3B: Cost per Beneficiary
- 4A-D: Per Capita Costs, by Category, for 4 disease types
- 5A-D: Medicare Spending per Beneficiary Costs
- 6: MSSP ACO Admissions and Readmissions
- 7: Individual Performance on PQRS

- Supplemental QRUR: Disease-based Episodes

2015 QRUR

Tables 2 & 3

Table 2A. Beneficiaries Attributed to Your TIN for the Cost Measures (except Medicare Spending per Beneficiary) and Claims-Based Quality Outcome Measures, and the Care that Your TIN and Other TINs Provided

Beneficiaries Attributed to Your TIN							Your TIN's Medicare FFS Claims			Chronic Condition Subgroup †			
HIC	Gender	DOB	Index †	HCC Percentile Ranking †	Died in 2015	Basis for Attribution (Step 1 or Step 2)†	Date of Service on Last Claim	Number of Primary Care Services†	Percent of Total Primary Care Charges†	Diabetes	Chronic Obstructive Pulmonary Disease	Coronary Artery Disease	Heart Failure
123456789A	M	01/01/1930	111111111	95	No	2	11/17/2014	15	58.80%	Yes	Yes	No	Yes
000000000A	M	06/06/1954	333333333	37	No	2	08/28/2014	1	100.00%	No	No	No	No
999999999B	F	01/23/1943	555555555	98	Yes	1	04/01/2014	5	65.27%	No	Yes	No	Yes

Table 3B. Costs of Services Provided by Your TIN and Other TINs: Beneficiaries Attributed to Your TIN for the Cost Measures (except Medicare Spending per Beneficiary) and Claims-Based Quality Outcome Measures

Beneficiaries Attributed to Your TIN			Included in Per Capita Costs for All Attributed Beneficiaries Measure†	Total Payment-Standardized† Medicare FFS Costs
HIC	Gender	DOB		
#	M	04/15/1983	Yes	$#.##
#	F	08/23/1941	Yes	$#.##
#	F	08/24/1938	Yes	$#.##

Exhibit 5-BSC. Costs for Beneficiaries with Specific Conditions Domain

	Your TIN				All TINs in Peer Group	
Cost Measure	Number of Eligible Cases	**Per Capita Costs**	Standardized Cost Score	Included in Domain Score?	**Benchmark (National Mean)**	Standard Deviation
Per Capita Costs for Beneficiaries with Diabetes	0	—	—	No	**$0.00**	$0.00
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Per Capita Costs for Beneficiaries with Coronary Artery Disease	0	—	—	No	**$0.00**	$0.00
Per Capita Costs for Beneficiaries with Heart Failure	0	—	—	No	**$0.00**	$0.00

2015 QRUR

Table 5

Table 5B. Beneficiaries and Episodes Attributed to Your TIN for the Medicare Spending per Beneficiary (MSPB) Measure

Beneficiaries and Episodes Attributed to Your TIN for the MSPB Measure					Apparent Lead Eligible Professional†			Total Payment-Standardized Episode Cost†	Characteristics of Hospital Admission				
HIC	Gender	DOB	Index†	HCC Percentile Ranking†	NPI	Name	Specialty		Date of Admission	Admitting Hospital (Name, CCN, City, State)			
#	M	12/13/1931	#	#	#	Name A	Orthopedic Surgery	$#,##	06/24/2015	SAMPLE HOSPITAL A	#	CITY	STATE
#	M	12/13/1931	#	#	#	Name B	Orthopedic Surgery	$#,##	09/16/2015	SAMPLE HOSPITAL B	#	CITY	STATE
#	M	12/13/1931	#	#	#	Name C	Orthopedic Surgery	$#,##	05/01/2015	SAMPLE HOSPITAL C	#	CITY	STATE

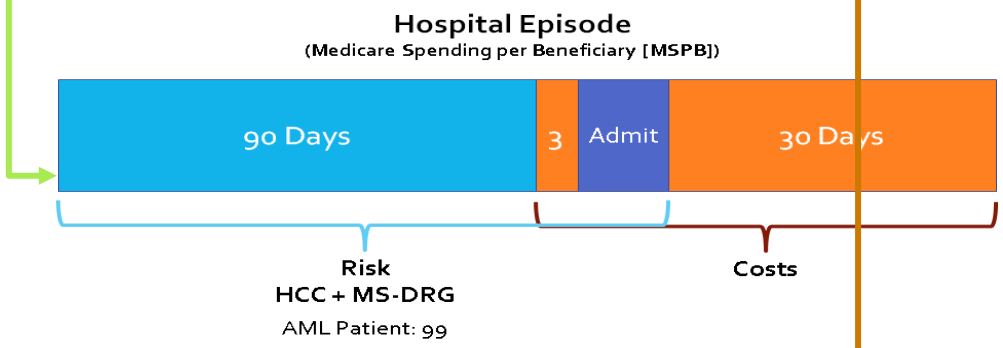

Exhibit 5-AAB. Costs for All Attributed Beneficiaries Domain

	Your TIN			
Cost Measure	Number of Eligible Cases or Episodes	**Per Capita or Per Episode Costs**	Standardized Cost Score	Included in Domain Score?
Per Capita Costs for All Attributed Beneficiaries	0	—	—	No
Medicare Spending per Beneficiary	0	—	—	No

Table 5D. Medicare Spending per Beneficiary (MSPB) Costs, by Episode and Service Category

Beneficiaries and Episodes Attributed to Your TIN for the MSPB Measure						Medicare Spending per Beneficiary, by Category of Service, Furnished by All Providers				
HIC	Gender	DOB	Index†	HCC Percentile Ranking†	Total Payment-Standardized Episode Cost†	Acute Inpatient Hospital: Index Admission†	Acute Inpatient Hospital: Readmission	Eligible Professional Services Billed by Your TIN During Index Hospitalization†	Eligible Professional Services Billed by Other TINs During Index Hospitalization†	Other Physician or Supplier Part B Services Billed During Any Hospitalization
#	M	12/13/31	#	#	$#.##	$#.##	$#.##	$#.##	$#.##	$#.##
#	M	12/13/31	#	#	$#.##	$#.##	$#.##	$#.##	$#.##	$#.##

Assign to the **TIN** w/ the most Part B services during **admit**

2015 QRUR

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- Supplemental QRUR: Disease-based Episodes

Existing Programs

	2016	2017	2018
Meaningful Use	-2% Penalty	-3% Penalty	-3% Penalty
PQRS	-2% Penalty + VBM Penalty	-2% Penalty + VBM Penalty	-2% Penalty + VBM Penalty
Value-Based Modifier	2014 Performance PQRS Reporters: 100+: -2% to 2x* 10-99: -0% to 2x* Non-Reporters: 100+: -2% 10-99: -2%	2015 Performance PQRS Reporters: 10+: -4% to 4x* 10-99: -4% to 4x* 1-9: -0% to 2x* Non-Reporters: 10+: -4% 1-9: -2%	2016 Performance PQRS Reporters: 10+: -4% to 4x* 10-99: -4% to 4x* 1-9: -2% to 2x* Non-Reporters: 100: -4% 1-9: -2%

* Additional 1x available for groups with average risk score in top 25%

MIPS

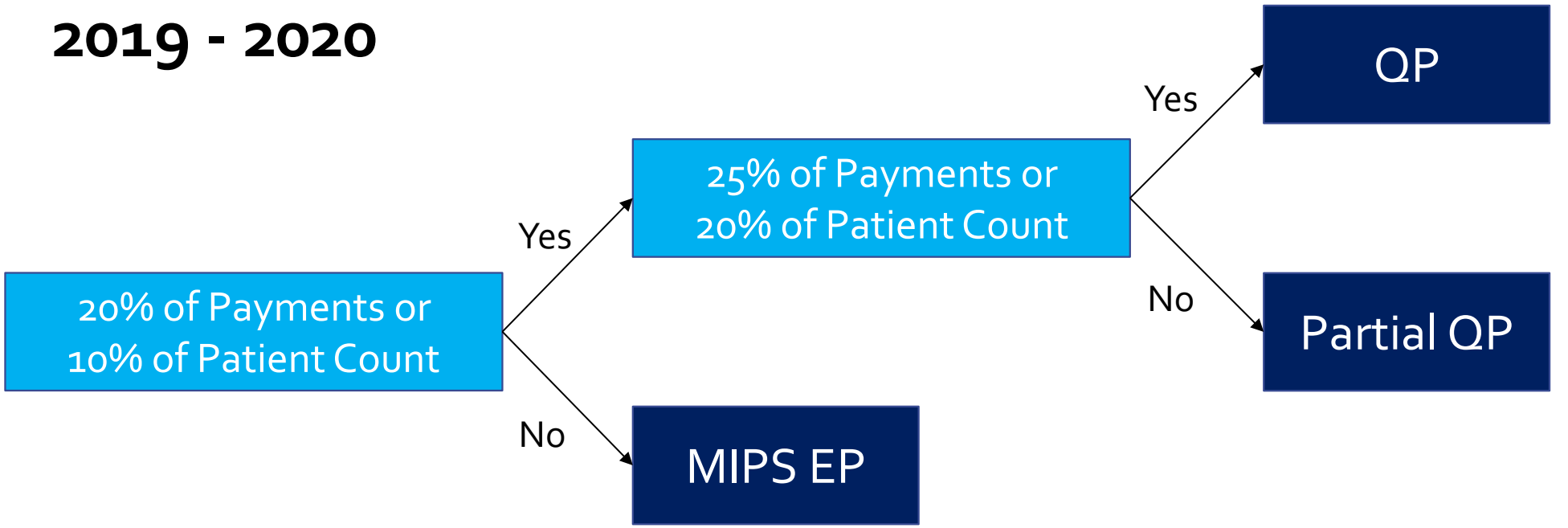
Merit-Based Incentive Payment System: Category Weights

Performance Year	2017	2018	2019+
Payment Year	2019	2020	2021+
Quality	60%	50%	30%
Cost	0%	10%	30%
Advancing Care Information	25%	25%	25%
Improvement Activities	15%	15%	15%

Different weights for those in alternative payment models.

APM Participant

2019 - 2020



- 5% Bonus
- MIPS Excluded

- MIPS Optional

- 50% on Clinical Practice Improvement
- Modified MIPS Scoring

Strategic Choices

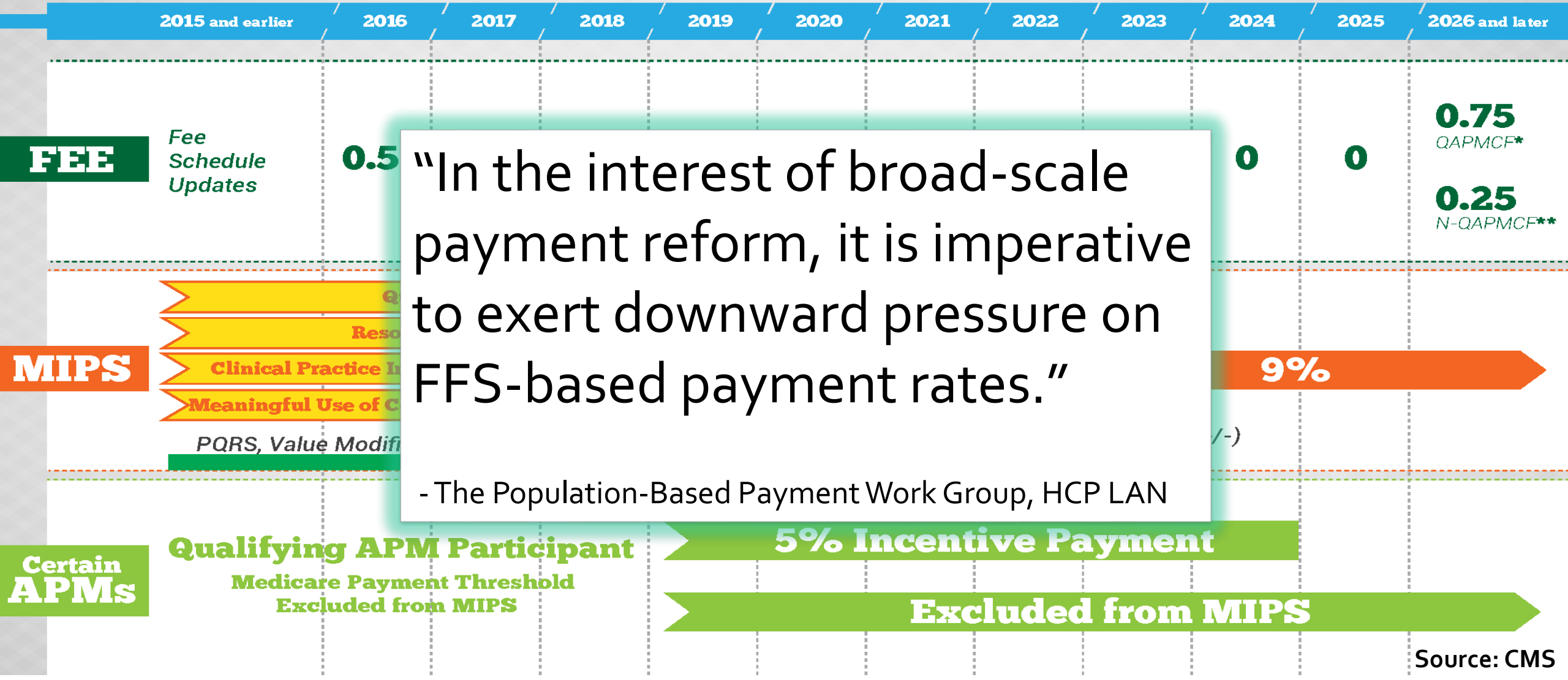
MIPS

- Scored at individual or group level
- Quality (PQRS/VBM)
- Resource Use (VBM)
- Advanced Care Information (MU)
- Clinical Practice Improvement
- 4-9% Adjustments
- 10% Exceptional Performer Bonus

APMs

- New Payment Models
- Modified MIPS Scoring
- Financial Risk
- Partial Qualifying -> MIPS Optional
- Full Qualifying -> MIPS Excluded
  - MIPS Excluded
  - 5% Bonus
  - Higher MPFS increase (2026)

Timeline



"In the interest of broad-scale payment reform, it is imperative to exert downward pressure on FFS-based payment rates."

- The Population-Based Payment Work Group, HCP LAN

Source: CMS

APM Framework

Category 1

Fee for Service – No Link to Quality & Value

Category 2

Fee for Service – Link to Quality & Value

Category 3

APMs Built on Fee-for-Service Architecture

Category 4

Population-Based Payment

Fee-for-Service

A	B	C	D
Foundational Payments for Infrastructure & Operations	Pay for Reporting	Rewards for Performance	Rewards and Penalties for Performance

A	B
APMs with Upside Gainsharing	APMs with Upside Gainsharing/ Downside Risk

A	B
Condition-Specific Population-Based Payment	Comprehensive Population-Based Payment

PQRS

eRX

MU

VBM

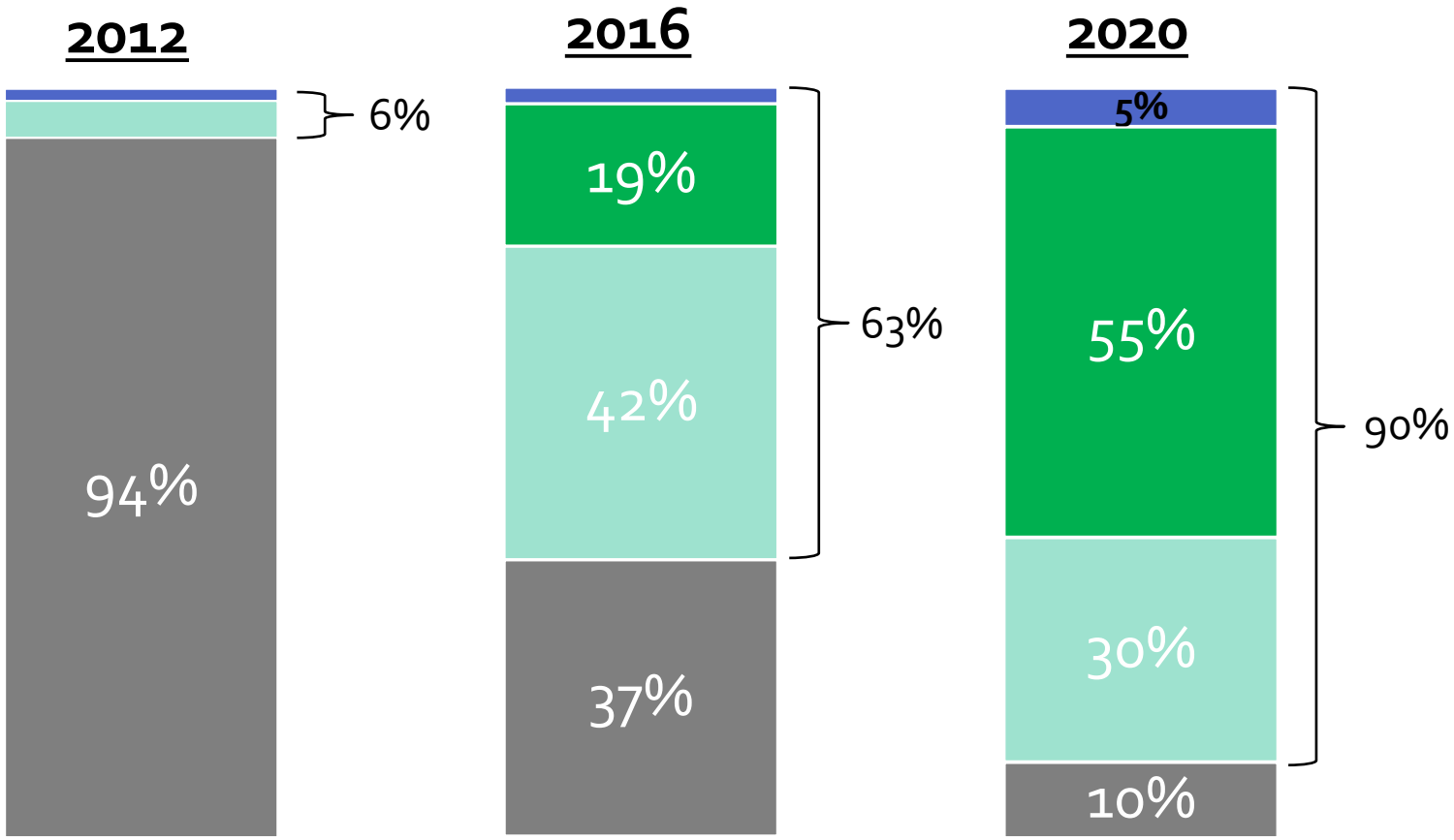
MIPS

MIPS APM (Quality, Value)

Advanced APM (Quality, Value, Risk)

Goals for Quality & Value

Population Payments	4
Shared Savings/Risk	3
Payment for Performance	2 (C&D)
Fee-for-Service	1

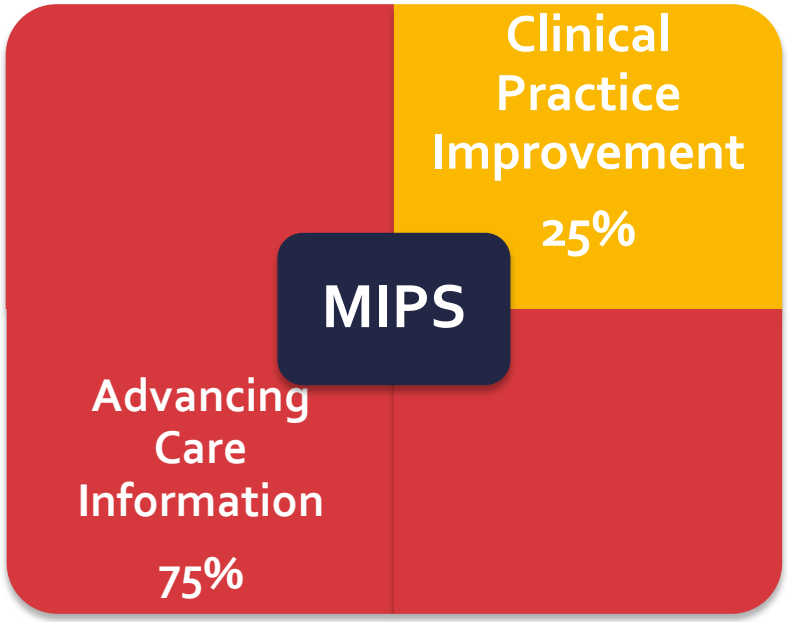


Available APMs

Medicare Model	MIPS APM	Medical Home	Advanced ACM
MSSP ACO – Track 1	YES	NO	NO
MSSP ACO – Track 2	YES	NO	**YES**
MSSP ACO – Track 3	YES	NO	**YES**
Next Generation ACO Model	YES	NO	**YES**
Oncology Care Model – one-sided	YES	NO	NO
Oncology Care Model – two-sided	YES	NO	**YES**

Oncology Care Model

- MIPS APM
  - Not assessed on Quality
  - Not assessed on Resource Use
  - 25% Clinical Practice Improvement
    - Minimum half-score due to APM
  - 75% Advancing Care Information
- Advanced APM only in two-sided risk
  - No 5% bonus in 2019; 2020?



Learning Objectives

- Read through of 2015 QRUR Report
- Patient Attribution
- Focus on Financial Measures
- Payment Standardization, Risk Adjustment & Specialty Adjustment
- Use of Supplementary Exhibits
- QRUR, Value-Based Modifier & MIPS