Questions and Comments for the Centers for Medicare and Medicaid Services (CMS) Quality and Resource Use Report (QRUR) Webinar

CMS and ACS hosted a webinar on April 9, 2015 to provide an overview of the 2013 QRUR reports. QRURs are confidential feedback reports offered under CMS’ Physician Feedback Program, which provide information about the resources used (cost) and the quality of care provided by physicians and group practices to Medicare fee-for-service patients. The reports are intended to provide comparative performance data that physicians can use to improve the care provided to Medicare beneficiaries.

This document summarizes the answers to the questions and comments that were asked by participants during the webinar.

Q1: Most measures are primary-care focused and are not relevant to specialists, such as vascular surgery.

The value-based payment modifier program (VM) hinges on Physician Quality Reporting System (PQRS) participation. There are two components to the VM program: quality and cost. PQRS reporting satisfies part of the quality component of the VM. In order to calculate the quality component, the VM assesses the measures that a provider or a group chooses to report for the PQRS program. CMS uses PQRS measures for the quality component of the VM in order to align CMS incentive programs and minimize reporting burden on providers. This is achieved by allowing providers to participate in the VM using the same data they report to CMS for PQRS.

In addition to the PQRS measures, the VM quality component also includes three claims-based outcome measures:

- **All-cause readmissions**
- **Acute preventive quality indicator composite** (bacterial pneumonia, UTI, dehydration)
- **Chronic preventive quality indicator composite** (COPD, HF, DM)

CMS attributes beneficiaries to the practice that provided the plurality of primary care services to that beneficiary. There is a two-step attribution process that is used for attributing beneficiaries to provider and groups to assess the claims-based outcomes measures as well as the cost measures under the VM:

- **Step 1**: Attribute beneficiaries on outcome measures to primary care provider type
- **Step 2**: Attribute beneficiaries to specialist group

These measures would only get attributed to an individual specialist in the event that the beneficiary did not see a primary care provider or service during the performance year.

For the 2013 QRUR, if no beneficiaries are assigned to the group, the group would not receive a penalty or bonus and would automatically be deemed “average.”
Q2: I have a question about attribution: Let's suppose a surgeon operates on a patient with COPD and a history of heart failure. Is the patient attributed to the surgeon, the primary care, the pulmonologist or cardiologist? To one or all? Let's assume the medical specialists are in a large group practice, but the surgeon and primary care bill under a single tax identification number.

The beneficiary would only be attributed to one physician. There is no multiple attribution construct under the VM. Beneficiaries would get attributed under step 1 (as mentioned in Q1) if they received a primary care service. For the 2015 VM, and the 2016 VM, the same two-step process mentioned in Q1 is used. If the patient did not receive primary care services from a primary care physician, they would get attributed to the outcome and costs measures for the group from which a specialist provided the plurality of the primary care services.

It is important to note that there will be a slight change to the attribution process in the future: non-physician practitioners will also be included in step 1. The providers or group (nurses, PAs, etc.) who provided the service(s) would be included as primary care provider type.

Starting in 2017, the VM will be applicable to all groups and solo practitioners. Providers will have the option to report from any of the available 2015 PQRS reporting options and this will be calculated for the 2015 VM.

Q3: Why does CMS not rely on an episode-based approach to value reimbursement for surgery based on primary procedure?

There are several reasons why CMS chose the current VM approach rather than an episode-based approach:

- The VM is required by law to be applied to all physicians by no later than the 2017 payment adjustment period.
- PQRS is aligned with both the VM and Physician Compare to reduce administrative burden on providers and because many providers are already participating in PQRS which increases program engagement.
- The claims-based outcome measures, which CMS calculates, are included in the VM to emphasize importance of outcomes measures without the need for additional burden on doctors.
- CMS has supplemental QRURs available which provide information on additional measures, including episode-based cost measures. CMS is in the process of working with stakeholders to develop more specific episode-based cost measures and thinking about how these episode-based cost measures may be useful in a value-based payment arena in the future.
- CMS is interested in public feedback on how to improve upon this program.

Q4: How does an individual provider with insufficient quality data provide meaningful feedback to CMS on QRURs?
CMS is eager for feedback on how to better engage diverse practice types. Comments on the QRUR can be submitted in the annual Medicare Physician Fee Schedule rule, or surgeons can call number the help desk number: 888-734-6433.

Q5. Are registered group practices allowed to use measure groups to report or must they report on individual measures?

For the PQRS program, groups registered under the "Group Practice Reporting Option" or "GPRO" cannot report on PQRS measure groups. Group practices can only report on individual measures via the following reporting option: traditional qualified registry, Electronic Health Record, a CMS web interface, or a CMS certified survey vendor.

Q6. I have a hardship exemption this year for the Electronic Health Record Incentive Program. I practice part time, under twenty hours. I am also exempt from the QRUR program penalties/reward, since I have under ten Medicare hospitalized overnight patients.

To clarify, there are absolutely no exemptions currently under the PQRS program. If you see Medicare Part B fee-for-service patients, you are required to report quality measures on this patient population to avoid penalties under the PQRS program. Note that hospital payments fall under Medicare part A. Depending on your group size, you may also be subject to additional penalties under the VM. For more information on the PQRS program, view: http://bulletin.facs.org/2015/04/surgeons-can-avoid-pqrs-and-value-based-modifier-payment-penalties.

Q7. What are the PQRS reporting types?

There are several different ways that you can report for the PQRS program. Please view this article for more information: http://bulletin.facs.org/2015/04/surgeons-can-avoid-pqrs-and-value-based-modifier-payment-penalties/