AMERICAN SOCIETY OF PLASTIC SURGEONS

How do I read my QRUR?

Understanding Your Annual Quality and Resource Use Report

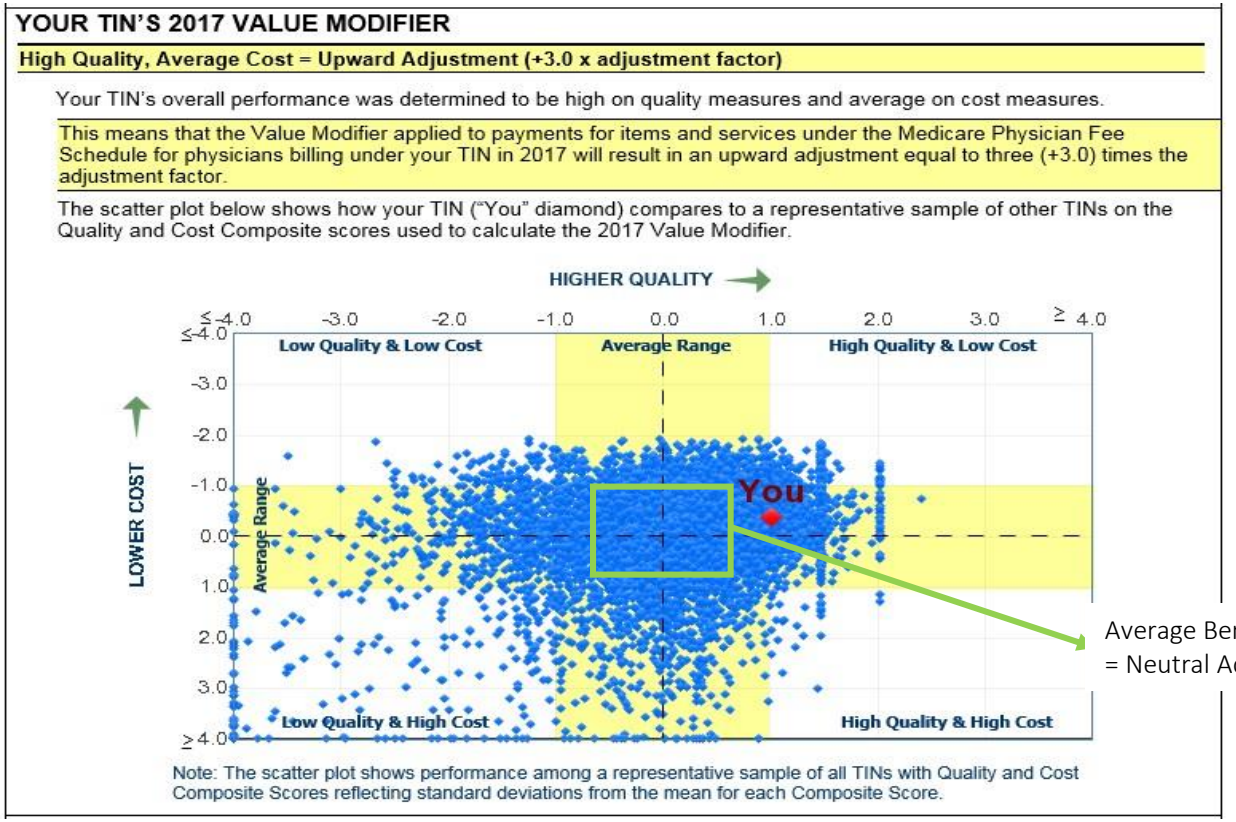
AMERICAN SOCIETY OF PLASTIC SURGEONS

★ What is in the report?

Annual Report Section	Exhibit	Purpose
Cover Page		• Indicates whether your TIN is subject to the 2017 VM • If eligible, shows the 2017 VM payment adjustment • Explains how a TIN subject to the 2017 VM can file an informal review request
Your TIN's 2017 Value Modifier (VM)	1	• Clarifies how the VM applies to your TIN in 2017 • Details whether the high-risk bonus adjustment applies to your TIN
Your TIN's Quality Composite Score	2-3	• Includes your TIN's Quality Composite Score • Reveals how your TIN performed on quality measures
Your TIN's Cost Composite Score	4-5	• Features your TIN's Cost Composite Score • Highlights how your TIN performed on cost measures

★ Cover

- Indicates whether your TIN is subject to the 2017 VM payment adjustment



Average Benchmark
= Neutral Adjustment

★ Your TIN's 2017 Value Modifier

- Explains how the Value Modifier applies to your practice's TIN

YOUR TIN'S 2017 VALUE MODIFIER

How does the Value Modifier apply to your TIN in 2017?

The Value Modifier will apply to your TIN because at least one physician billed Medicare under your TIN in 2015, and no eligible professional billing under your TIN participated in the Pioneer ACO Model or the Comprehensive Primary Care initiative in 2015. In 2015, your TIN had 53 eligible professional(s).

At least 50 percent (77.36%) of the eligible professionals in your TIN reported quality data to the Physician Quality Reporting System (PQRS) as individuals and met the criteria to avoid the 2017 PQRS payment adjustment (or, if a solo practitioner, you met the criteria as an individual). This also qualifies your TIN to avoid an automatic Value Modifier downward payment adjustment in 2017. CMS used its quality-tiering methodology to calculate your TIN's 2017 Value Modifier based on the number of eligible professionals in your TIN and your TIN's performance on quality and cost measures during 2015.

- Exhibit 1 displays the 2017 Value Modifier calculated for your TIN

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%	+3.0* x AF	+5.0* x AF
Average Cost	-2.0%	0.0%	**+3.0* x AF**
High Cost	-4.0%	-2.0%	0.0%

Note: TINs with 10 or more EPs will receive a +2.0 x AF upward adjustment for having High Quality/Average Cost. An additional upward adjustment of +1.0 x AF was applied to this TIN, because it achieved that designation and treated a high proportion of clinically complex beneficiaries, as described in the next slide.

- Determines whether there will be a payment adjustment

How does the high-risk bonus adjustment apply to your TIN?

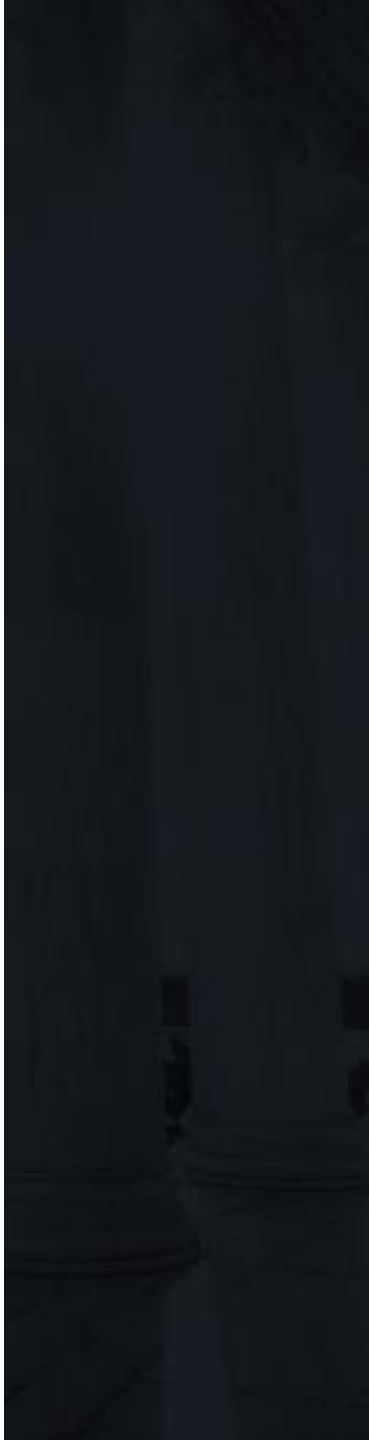
TINs that qualify for an upward adjustment under quality-tiering will receive an additional upward adjustment to their 2017 Value Modifier equal to one (1.0) times the adjustment factor, if they served a disproportionate share of high-risk beneficiaries in 2015. The average risk for all beneficiaries attributed to your TIN is at the 82nd percentile of beneficiaries nationwide.

Medicare determined your TIN's eligibility for the high-risk bonus adjustment based on whether your TIN met (✓) or did not meet (✗) both of the following criteria in 2015:

- ✓ Had strong quality and cost performance
- ✓ Average beneficiary's risk is at or above the 75th percentile of beneficiaries nationwide

Your TIN will receive the high-risk bonus adjustment to the 2017 Value Modifier because your TIN met these criteria.

This additional upward adjustment is reflected in the Value Modifier payment adjustment for your TIN (Exhibit 1).



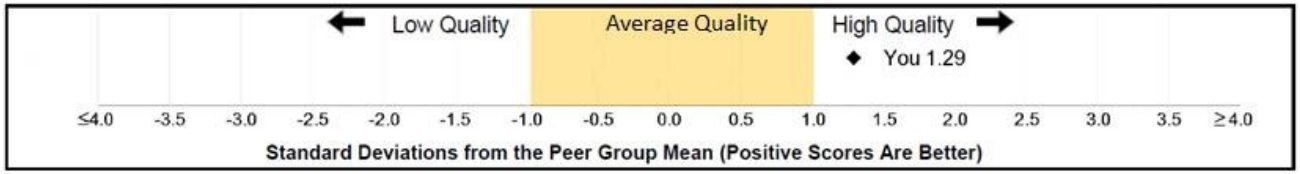
★ Your TIN's Quality Composite Score

- Details the quality measures used to calculate your TIN's Quality Composite Score
- Exhibit 3 shows your TIN's performance on those quality measures used to calculate the Quality Composite Score (by domain score)

PERFORMANCE ON QUALITY MEASURES

Your TIN's Quality Tier: High

Exhibit 2. Your TIN's Quality Composite Score



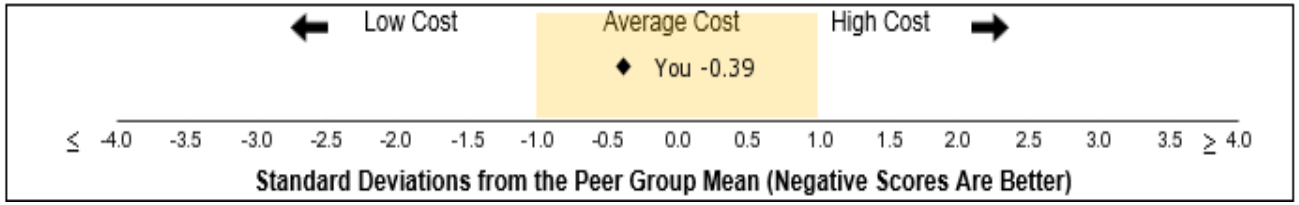
★ Your TIN's Cost Composite Score

- Exhibit 4 highlights your TIN's Cost Composite Score, which reflects the overall performance on cost measures compared to peer groups

PERFORMANCE ON COST MEASURES

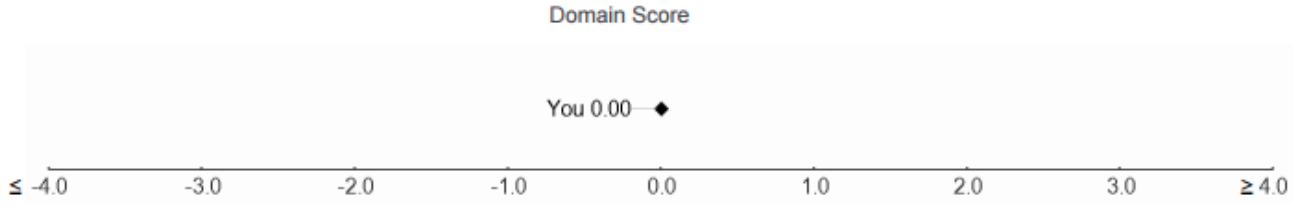
Your TIN's Cost Tier: Average

Exhibit 4. Your TIN's Cost Composite Score



- Exhibits 5-AAB and 5-BSC show your TIN's performance on those cost measures used to calculate the Cost Composite Score (by domain score)

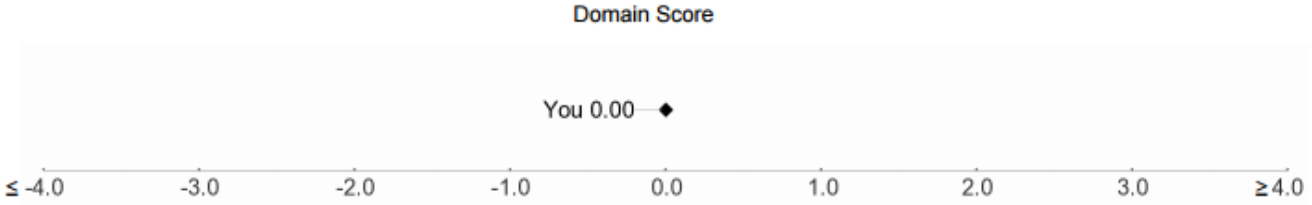
Exhibit 5-AAB. Costs for All Attributed Beneficiaries Domain



	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

Note: Only the measures for which your TIN had the minimum number of eligible cases or episodes are included in the domain score. For the Per Capita Costs for All Attributed Beneficiaries measure, the minimum number of eligible cases is 20. For the Medicare Spending per Beneficiary measure, the minimum number of eligible episodes is 125. The benchmark for a cost measure is the case-weighted national mean cost among all TINs in the measure's peer group during calendar year 2015. For the Per Capita Costs for All Attributed Beneficiaries measure, the peer group is defined as all TINs nationwide that had at least 20 eligible cases. For the Medicare Spending per Beneficiary measure, the peer group is defined as all TINs nationwide that had at least 125 eligible episodes.

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

Note: Only the measures for which your TIN had the minimum number of eligible cases are included in the domain score. For the cost measures shown in this exhibit, the minimum number of eligible cases is 20. The benchmark for a cost measure is the case-weighted national mean cost among all TINs in the measure's peer group during calendar year 2015. For the cost measures shown in this exhibit, the peer group is defined as all TINs nationwide that had at least 20 eligible cases for each measure.

★ Next Steps

Read ASPS's What if my Value Modifier is Incorrect?

- Click here to access your practice's 2015 Annual QRUR
- Visit CMS.gov for FAQs, fact sheets and more on the 2015 QRUR and 2017 Value Modifier

Technical Assistance

For QRUR and VM questions or to provide feedback on the content and format of the QRUR, contact the **Physician Value Help Desk:**

Phone: 1-888-734-6433 (select option 3)

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

Email: pvhelpdesk@cms.hhs.gov

For PQRS and EIDM questions, contact the **QualityNet Help Desk:**

Phone: 1-866-288-8912

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

Email: qnetsupport@hcqis.org

Glossary

★ Value-Based Payment Modifier (VM)

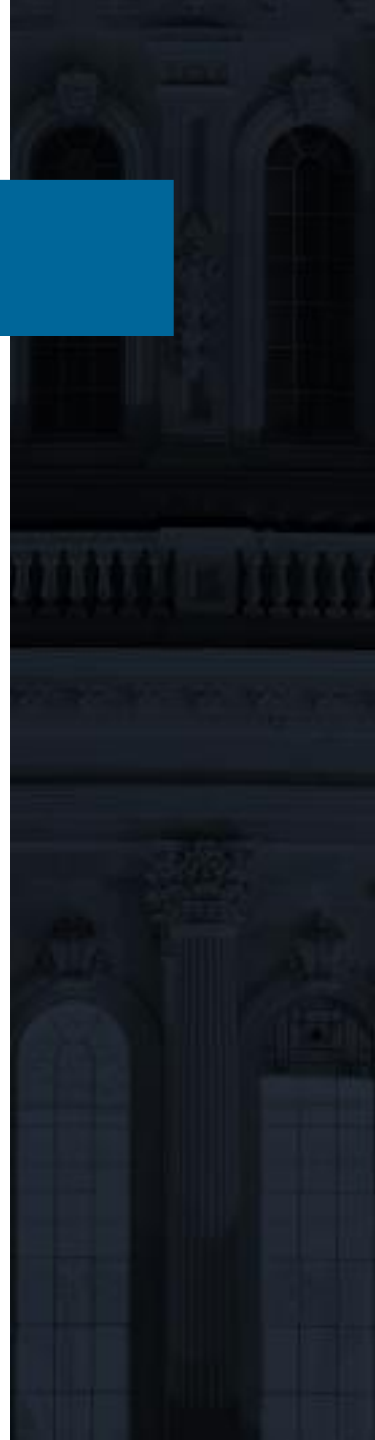
- Provides payment adjustments to a physician or group based on the quality of care provided compared to the cost of that care
- Compares your results to that of your peers
- Provides a positive, neutral or negative payment adjustment
  - Positive Adjustment: your VM is above the benchmark
  - Neutral: your VM is at the benchmark and you will not receive a payment adjustment
  - Negative Adjustment: your VM is below the benchmark

★ Quality Composite Score

- CMS calculates this score based on:
  - Effective clinical care
  - Person- and caregiver-centered experience and outcomes
  - Community/population health
  - Patient safety
  - Communication and care coordination
  - Efficiency and cost reduction

★ Cost Composite Score

- CMS calculates this score based on:
  - Per capita costs for all attributed beneficiaries
  - Per capita costs for beneficiaries with
    - diabetes
    - COPD
    - coronary artery disease
    - heart failure
  - Medicare spending per beneficiary



Supplemental Documents

★ Understanding Your QRUR

How to understand your 2015 Annual QRUR

Provides tips on how solo practitioners and groups can use the 2015 Annual QRUR. Includes accompanying tables to understand performance and to improve quality of care, streamline resource use, and identify care coordination opportunities for beneficiaries.

Questions and Answers about the 2015 QRUR and the 2017 Value Modifier (VM)

Presents frequently asked questions (FAQs) and answers that groups and solo practitioners may have about the 2015 Mid-Year and Annual QRURs, as well as the 2017 Value Modifier.

Sample 2015 Annual QRUR (Medical Practice A)

Represents a sample 2015 Annual QRUR for a group with 10 or more EPs subject to the 2017 Value Modifier and for which CMS was able to calculate quality and cost composite scores. This group received a neutral payment adjustment under quality-tiering and did not participate in the Shared Savings Program in 2015.

Sample 2015 Annual QRUR (Medical Practice B)

Represents a sample 2015 Annual QRUR for a group with 10 or more EPs subject to the 2017 Value Modifier and for which CMS was able to calculate quality and cost composite scores. This group received an upward payment adjustment under quality-tiering and participated in the Shared Savings Program in 2015.

★ Value Modifier (VM)

[Computation of the 2017 Value Modifier (VM)]
Provides an overview of how the 2017 Value Modifier is calculated.

[FAQs: Medicare Shared Savings Program interaction with the 2017 Value Modifier (VM)]
Describes the interactions between the Medicare Shared Savings Program and the 2017 Value Modifier.

[Fact Sheet for Attribution in the 2017 Value Modifier]
Provides an overview of the two-step attribution methodology for the claims-based quality outcome measures and per capita cost measures included in the 2017 Value Modifier.

[Fact Sheet for Specialty Adjustment in the 2017 Value Modifier]
Provides an overview of the specialty adjustment methodology used in the 2017 Value Modifier.

[Fact Sheet for Risk Adjustment in the 2017 Value Modifier]
Provides an overview of the risk adjustment methodology used in the 2017 Value Modifier.

[Measure Information Form: Ambulatory Care-Sensitive Condition (ACSC) Composite Measures used in the 2017 Value Modifier]
Details an overview of the Hospital Admissions for Acute and Chronic ACSC Composite measures, calculated for the 2017 Value Modifier.

[Measure Information Form: Overall Total Per Capita Cost Measure used in the 2017 Value Modifier]
Highlights the Per Capita Costs for All Attributed Beneficiaries measure, calculated for the 2017 Value Modifier.