Primary Care Development Corporation

Medicare's Quality Resource Use Reports (QRUR)

Presented by

Fernando Mclean, Jr.

Objectives

- Define the components of the Quality Resource Use Reporting (QRUR) program from CMS
- Describe the related mechanisms from MACRA
- Identify how the Merit-Based Incentive Program and the Alternative Payment Models configure with your QRUR results
- Convey how to interpret your QRUR and plan Value-Based Improvement strategies

Today's Agenda

- Overview of QRUR
  - PQRS
  - VBP
- Overview on MACRA
  - MIPS/APMs
- MIPS, VBP and Your QRUR
- Case Study
- Resources

QRUR Overview

What is a QRUR?

- QRUR is a tool
  - A Medicare feedback and benchmarking report
  - Utilized as a resource to ease the transition toward a payment model focused on value
  - Targets areas of improvement, to avoid penalties and potentially receive a bonus
  - Requires physicians to complete **P**hysician **Q**uality **R**eporting **S**ystem (PQRS) application

How is a QRUR Created?

- The report compares data on costs and quality of care provided by physicians and provider groups
  1. PQRS quality measures
  2. Claims data (outcome and cost measures)
  3. Compares similar sized peer groups

When is a QRUR Sent to You?

- Two types of reports
  - Mid year (Disseminated in Spring) – an informal preview allowing for time to address strategic adjustments on quality and cost performance
  - Annual (Disseminated in Fall) – used to calculate payment adjustments
    - Optional supplemental reporting (upon provider request)

What is PQRS?

- PQRS defines value with data
  - Mandatory to report on at least 9 measures that covers 3 National Quality Forum (NQF) domains for at least 50% of denominator eligible Medicare Fee-for-Service (FFS) patients… 0% does not count
  - Assess quality of care physicians provide to patients
  - Quantify how often they are meeting a particular quality metric

Why is PQRS Important?

- View your published quality metrics alongside peers on the Physician Compare website
- **Avoid PQRS negative payment adjustments**
- Avoid **automatic downward** Value Modifier payment adjustment and be eligible for upward, neutral or downward payment adjustment based on performance

How to Apply for PQRS

- You can determine eligibility, choose the **reporting mechanism** (type of reporting), select and report your **measures**
- PQRS How to Get Started website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How_To_Get_Started.html

QRUR

2015 ANNUAL QUALITY AND RESOURCE USE REPORT

AND THE 2017 VALUE-BASED PAYMENT MODIFIER

[redacted]

LAST FOUR DIGITS OF YOUR MEDICARE-ENROLLED TAXPAYER IDENTIFICATION NUMBER (TIN): [redacted]

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.

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-2.0% Adjustment

YOUR TIN'S 2017 VALUE MODIFIER

Did Not Meet Physician Quality Reporting System (PQRS) Reporting Criteria = Automatic Downward Adjustment (-2.0%)

Your TIN did not meet the criteria to avoid the 2017 PQRS payment adjustment by reporting quality data to the PQRS through the Group Practice Reporting Option (GPRO) and less than 50 percent of the eligible professionals in your TIN met the criteria to avoid the 2017 PQRS payment adjustment as individuals.

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 an automatic downward adjustment of two percent (-2.0%).

Information on PQRS reporting mechanisms and reporting criteria can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html.

QUESTIONS?

- Contact the Physician Value Help Desk at 1-888-734-6433 (select option 3) or at pvhelpdesk@cms.hhs.gov with questions or feedback about this report.
- If your TIN is subject to the Value Modifier in 2017 and you disagree with the Value Modifier calculation indicated above in the "Your TIN's 2017 Value Modifier" section and in Exhibit 1 of this report, then an authorized representative of your TIN can submit a request for an Informal Review through the CMS Enterprise Portal. The informal review period lasts for 60 days.

Reporting Available on QRUR

2015 Supplemental QRUR

2015 Supplemental QRURs

2015 Supplemental QRURs Drill Down Table 1

2015 Supplemental QRURs Drill Down Table 2

2015 Supplemental QRURs Drill Down Table 3

2015 Annual QRUR

2015 Annual Quality and Resource Use Report (QRUR)

Table 1. Physicians and Non-Physician Eligible Professionals Identified in Your Medicare-Enrolled Taxpayer Identification Number (TIN), Selected Characteristics

Table 2. Patients and Hospital Admissions (except Medicare Spending per Beneficiary)

Table 3. Per Capita Costs for All Beneficiaries

Table 4. Per Capita Costs for Selected Conditions

Table 5. Medicare Spending Per Beneficiary (MSPB)

Table 6. Medicare Shared Savings Program

Table 7. Individual Eligible Professional Performance on the 2015 PQRS Measures

2015 PQRS Feedback Reports

PQRS Payment Adjustment Feedback Report for Groups

PQRS Payment Adjustment Measure Performance Detail Report for Groups

2015 Mid-Year QRUR

2015 Mid-Year Quality and Resource Use Report

Download to Print and Save Your TIN's 2015 Mid-Year Quality and Resource Use Report (QRUR)

Table 1. Physicians and Non-Physician Eligible Professionals in Your TIN, Selected Characteristics

Table 2A. Beneficiaries Attributed to Your TIN for the Cost Measures (except MSPB) and Claims-Based Quality Outcome Measures, and the Care that Your TIN and Others Provided

Table 2B. Beneficiaries Attributed to Your TIN for the Cost Measures (except MSPB) and Claims-Based Quality Outcome Measures: Costs of Services Provided by Your TIN and Others

Table 3. Beneficiaries Attributed to Your TIN for the Cost Measures (except MSPB) and Claims-Based Quality Outcome Measures: Hospital Admissions for Any Cause

Table 4. Beneficiaries Attributed to Your TIN for the Medicare Spending per Beneficiary Measure

Tables 5-10. Per Capita or Per Episode Costs, by Categories of Service, for the Six Cost Measures

QRUR Example of Table 3A (1 of 2)

Service Category	Your TIN			All TINs in Peer Group†		How Much Higher or (Lower) Your TIN's Costs Were than TINs in Peer Group
	Number of Attributed Beneficiaries Using any Service in this Category	Percentage of Beneficiaries Using any Service in this Category	Per Capita Costs for Attributed Beneficiaries†	Benchmark (National Mean) Percentage of Beneficiaries Using Any Service in This Category	Benchmark (National Mean) Per Capita Costs	
ALL SERVICES	249	100.00%	$7,160	100.00%	$12,326	($5,167)
Outpatient Evaluation and Management Services, Procedures, and	**249**	**100.00%**	**$1,778**	**100.00%**	**$1,962**	**($185)**
Evaluation & Management Services Billed by Eligible Professionals	249	100.00%	$1,138	99.99%	$1,163	($25)
Billed by Your TIN	249	100.00%	$448	99.98%	$502	($54)
Primary Care Physicians	249	100.00%	$424	62.06%	$346	$78
Medical Specialists	35	14.06%	$24	18.02%	$54	($30)
Surgeons	0	0.00%	$0	8.06%	$21	($21)
Other Eligible Professionals	0	0.00%	$0	20.41%	$81	($81)
Billed by Other TINs	216	86.75%	$690	80.87%	$661	$29
Primary Care Physicians	51	20.48%	$46	23.75%	$56	($10)
Medical Specialists, Surgeons, and Other Eligible Professionals	210	84.34%	$644	78.93%	$606	$39
Major Procedures Billed by Eligible Professionals	27	10.84%	$171	9.66%	$183	($12)
Billed by Your TIN	0	0.00%	$0	1.56%	$22	($22)
Primary Care Physicians	0	0.00%	$0	0.24%	$1	($1)
Medical Specialists	0	0.00%	$0	0.71%	$8	($8)
Surgeons	0	0.00%	$0	0.43%	$6	($6)
Other Eligible Professionals	0	0.00%	$0	0.30%	$7	($7)
Billed by Other TINs	27	10.84%	$171	8.35%	$161	$10
Primary Care Physicians	2	0.80%	$3	0.19%	$2	$0
Medical Specialists, Surgeons, and Other Eligible Professionals	26	10.44%	$169	8.24%	$159	$10
Ambulatory/Minor Procedures Billed by Eligible Professionals	128	51.41%	$278	62.91%	$433	($154)
Billed by Your TIN	14	5.62%	$4	22.63%	$67	($62)
Primary Care Physicians	14	5.62%	$4	10.23%	$17	($13)
Medical Specialists	0	0.00%	$0	5.06%	$21	($21)
Surgeons	0	0.00%	$0	3.51%	$19	($19)
Other Eligible Professionals	0	0.00%	$0	4.93%	$10	($10)
Billed by Other TINs	124	49.80%	$274	52.11%	$366	($92)
Primary Care Physicians	9	3.61%	$7	3.58%	$6	$1
Medical Specialists, Surgeons, and Other Eligible Professionals	120	48.19%	$267	51.00%	$359	($92)
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	49	19.68%	$190	14.14%	$184	$6

QRUR Example of Table 3A (2 of 2)

Service Category	Your TIN			All TINs in Peer Group†		How Much Higher or (Lower) Your TIN's Costs Were than TINs in Peer Group
	Number of Attributed Beneficiaries Using any Service in this Category	Percentage of Beneficiaries Using any Service in this Category	Per Capita Costs for Attributed Beneficiaries†	Benchmark (National Mean) Percentage of Beneficiaries Using Any Service in This Category	Benchmark (National Mean) Per Capita Costs	
Ancillary Services	240	96.39%	$1,497	93.15%	$1,407	$90
Laboratory, Pathology, and Other Tests	237	95.18%	$651	88.21%	$483	$168
Imaging Services	199	79.92%	$746	70.17%	$610	$136
Durable Medical Equipment and Supplies	58	23.29%	$101	25.92%	$315	($214)
Hospital Inpatient Services	47	18.88%	$1,655	21.82%	$3,577	($1,922)
Inpatient Hospital Facility Services	39	15.66%	$1,429	18.36%	$3,067	($1,638)
Eligible Professional Services During Hospitalization	46	18.47%	$227	21.60%	$511	($284)
Billed by Your TIN	0	0.00%	$0	4.74%	$80	($80)
Primary Care Physicians	0	0.00%	$0	3.16%	$36	($36)
Medical Specialists	0	0.00%	$0	1.32%	$20	($20)
Surgeons	0	0.00%	$0	0.45%	$18	($18)
Other Eligible Professionals	0	0.00%	$0	0.47%	$6	($6)
Billed by Other TINs	46	18.47%	$227	21.24%	$431	($204)
Primary Care Physicians	28	11.24%	$41	14.45%	$104	($63)
Medical Specialists, Surgeons, and Other Eligible Professionals	43	17.27%	$186	20.48%	$326	($141)
Emergency Services Not Included in a Hospital Admission	65	26.10%	$122	33.14%	$350	($228)
Emergency Evaluation & Management Services	64	25.70%	$106	32.72%	$302	($196)
Procedures	11	4.42%	$10	10.95%	$26	($16)
Laboratory, Pathology, and Other Tests	13	5.22%	$1	13.03%	$2	($2)
Imaging Services	33	13.25%	$6	22.26%	$20	($14)
Post-Acute Services	15	6.02%	$499	15.50%	$1,953	($1,454)
Home Health	11	4.42%	$141	10.90%	$591	($450)
Skilled Nursing Facility	6	2.41%	$359	7.28%	$1,027	($669)
Inpatient Rehabilitation or Long-Term Care Hospital	0	0.00%	$0	1.44%	$336	($336)
Hospice	0	0.00%	$0	2.85%	$281	($281)
All Other Services	161	64.66%	$1,608	77.74%	$2,795	($1,187)
Ambulance Services	25	10.04%	$66	15.33%	$187	($121)
Anesthesia Services	52	20.88%	$68	22.57%	$91	($24)
Chemotherapy and Other Part B-Covered Drugs	49	19.68%	$181	28.61%	$818	($637)
Dialysis	5	2.01%	$647	1.79%	$354	$293
Other Facility-Billed Evaluation & Management Expenses	54	21.69%	$78	17.86%	$141	($63)
Other Facility-Billed Expenses for Major Procedures	16	6.43%	$292	6.70%	$499	($207)
Other Facility-Billed Expenses for Ambulatory/Minor Procedures*	42	16.87%	$233	27.70%	$543	($310)
All Other Services Not Otherwise Classified	91	36.55%	$43	54.05%	$162	($119)

QRUR Annual and Mid-Year Comparison

QRUR Component	2015 Mid-Year QRUR (Performance Period: July 1, 2014–June 30, 2015)		2015 Annual QRUR (Performance Period: January 1, 2015–December 31, 2015)	
	Included?	Relevant Exhibits	Included?	Relevant Exhibits
Value Modifier Calculation	No	-	Yes	Cover Page and Exhibit 1
Quality Tier Designation	No	-	Yes	Cover Page and Exhibit 1
Quality Composite Score	No	-	Yes	Exhibit 2
Quality Domain Scores	No	-	Yes	Exhibits 3
CMS-Calculated Quality Outcome Measures	Yes	Exhibit 5	Yes	Exhibit 3-CCC-B
PQRS Quality Measures	No	-	Yes	Exhibits 3, Table 7
CAHPS Survey Measures	No	-	Yes, if available	Exhibit 3-PCE
Cost Composite Score	No	-	Yes	Exhibit 4
Cost Domain Scores	No	-	Yes	Exhibits 5
Per Capita Costs for All Attributed Beneficiaries	Yes	Exhibit 8	Yes	Exhibit 5-AAB
Per Capita Costs for Beneficiaries with Specific Conditions	Yes	Exhibits 8	Yes	Exhibit 5-BSC
Medicare Spending per Beneficiary	Yes	Exhibit 8	Yes	Exhibit 5-AAB
Eligible Professionals in Your TIN	Yes	Exhibit 1; Table 1	Yes	Table 1
Medicare Beneficiaries Attributed to your TIN	Yes	Exhibit 2; Tables 2A, 2B, and 4	Yes	Tables 2A and 5B
Beneficiary-Level Cost and Utilization Data	Yes	Exhibits 3 and 4; Table 3, 4, and 5	Yes	Tables 2C, 3B, 5D, 6A, and 6B

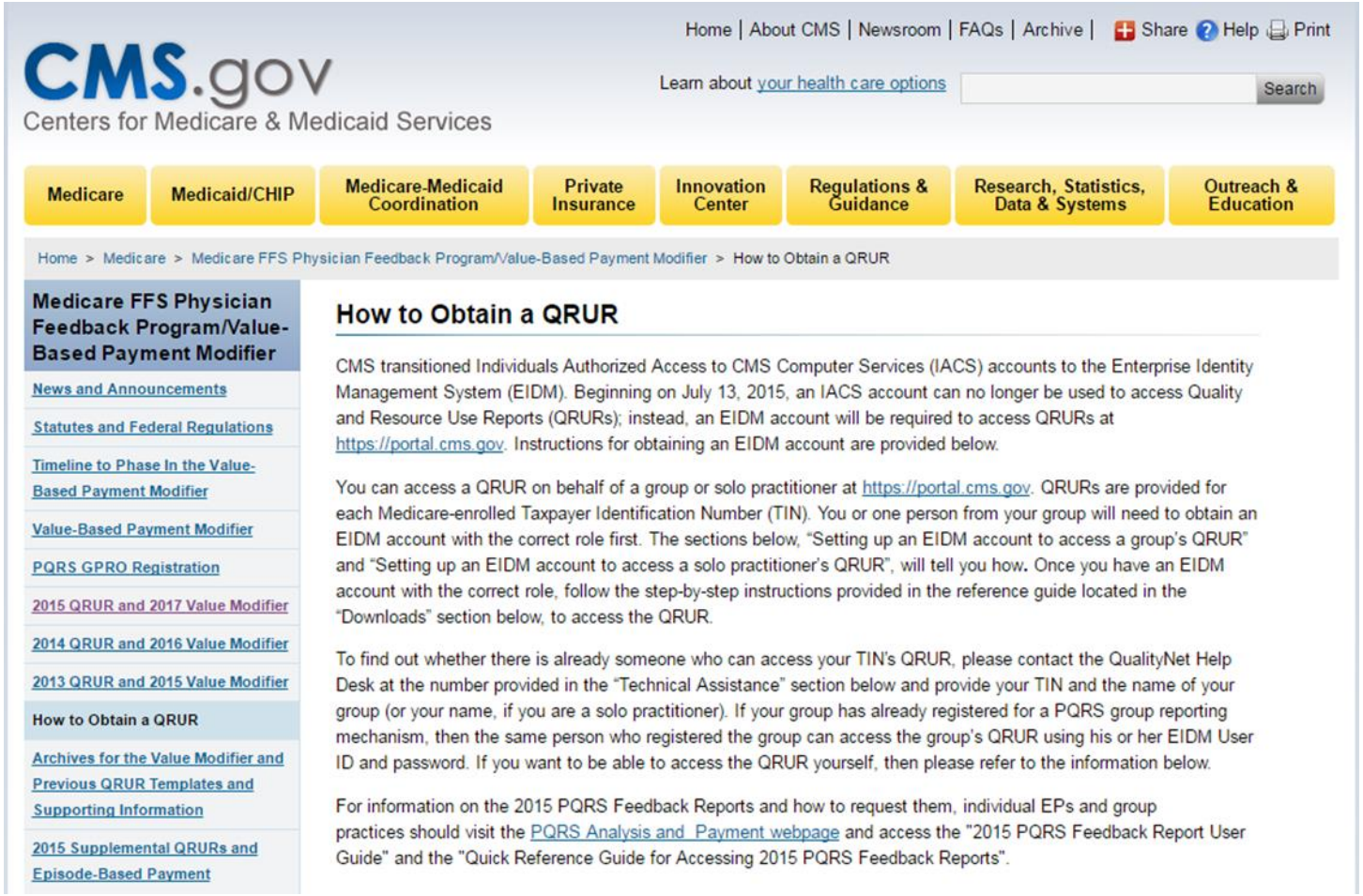
Source: CMS.gov

Importance of Utilizing QRUR

- Provides your TIN's performance highlights
- Benchmarking and risk adjustment that compare a practice's quality and cost measures to peer practices
- A quality composite score – calculated by PQRS measures
- A cost composite score – calculated by claims reporting
- The application of the Value Modifier – calculated by CMS using quality and cost measures
- **V**alue **B**ased **P**ayment (VBP) ties provider reimbursement to quality of care based on the Triple Aim (better population health, better individual health and lower cost)

How to Obtain a QRUR

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



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Home > Medicare > Medicare FFS Physician Feedback Program/Value-Based Payment Modifier > How to Obtain a QRUR

Medicare FFS Physician Feedback Program/Value-Based Payment Modifier

- News and Announcements
- Statutes and Federal Regulations
- Timeline to Phase In the Value-Based Payment Modifier
- Value-Based Payment Modifier
- PQRS GPRO Registration
- 2015 QRUR and 2017 Value Modifier
- 2014 QRUR and 2016 Value Modifier
- 2013 QRUR and 2015 Value Modifier
- How to Obtain a QRUR
- Archives for the Value Modifier and Previous QRUR Templates and Supporting Information
- 2015 Supplemental QRURs and Episode-Based Payment

How to Obtain a QRUR

CMS transitioned Individuals Authorized Access to CMS Computer Services (IACS) accounts to the Enterprise Identity Management System (EIDM). Beginning on July 13, 2015, an IACS account can no longer be used to access Quality and Resource Use Reports (QRURs); instead, an EIDM account will be required to access QRURs at https://portal.cms.gov. Instructions for obtaining an EIDM account are provided below.

You can access a QRUR on behalf of a group or solo practitioner at https://portal.cms.gov. QRURs are provided for each Medicare-enrolled Taxpayer Identification Number (TIN). You or one person from your group will need to obtain an EIDM account with the correct role first. The sections below, "Setting up an EIDM account to access a group's QRUR" and "Setting up an EIDM account to access a solo practitioner's QRUR", will tell you how. Once you have an EIDM account with the correct role, follow the step-by-step instructions provided in the reference guide located in the "Downloads" section below, to access the QRUR.

To find out whether there is already someone who can access your TIN's QRUR, please contact the QualityNet Help Desk at the number provided in the "Technical Assistance" section below and provide your TIN and the name of your group (or your name, if you are a solo practitioner). If your group has already registered for a PQRS group reporting mechanism, then the same person who registered the group can access the group's QRUR using his or her EIDM User ID and password. If you want to be able to access the QRUR yourself, then please refer to the information below.

For information on the 2015 PQRS Feedback Reports and how to request them, individual EPs and group practices should visit the PQRS Analysis and Payment webpage and access the "2015 PQRS Feedback Report User Guide" and the "Quick Reference Guide for Accessing 2015 PQRS Feedback Reports".

MACRA Overview

What is MACRA?

- The Medicare Access and CHiP Reauthorization Act (MACRA) of 2015 is a Federal Law that:
  - Impacts Fee-for-Service Medicare Part B payments
  - Replace the sustainable growth rate by giving tools, models and resources to help physicians give their patients better care
  - Modifies the method Medicare rewards clinicians for value over volume
  - Provides multiple pathways with various levels of risk and reward for clinicians to incorporate more payments to value

What is MACRA? (Continued)

- Streamlines various quality generating programs under the newly established **M**erit-Based **I**ncentive **P**ayments **S**ystem (MIPS)
- Provides financial incentives for eligible **A**dvanced Alternative **P**ayment **M**odels (APMs)
  - Minimize additional reporting burdens for participants in APMs
  - Support multi-payer initiatives (i.e., Medicaid, Medicare Advantage, etc.)
- Promotes understanding of each clinician status with respect to MIPS and/or APMs

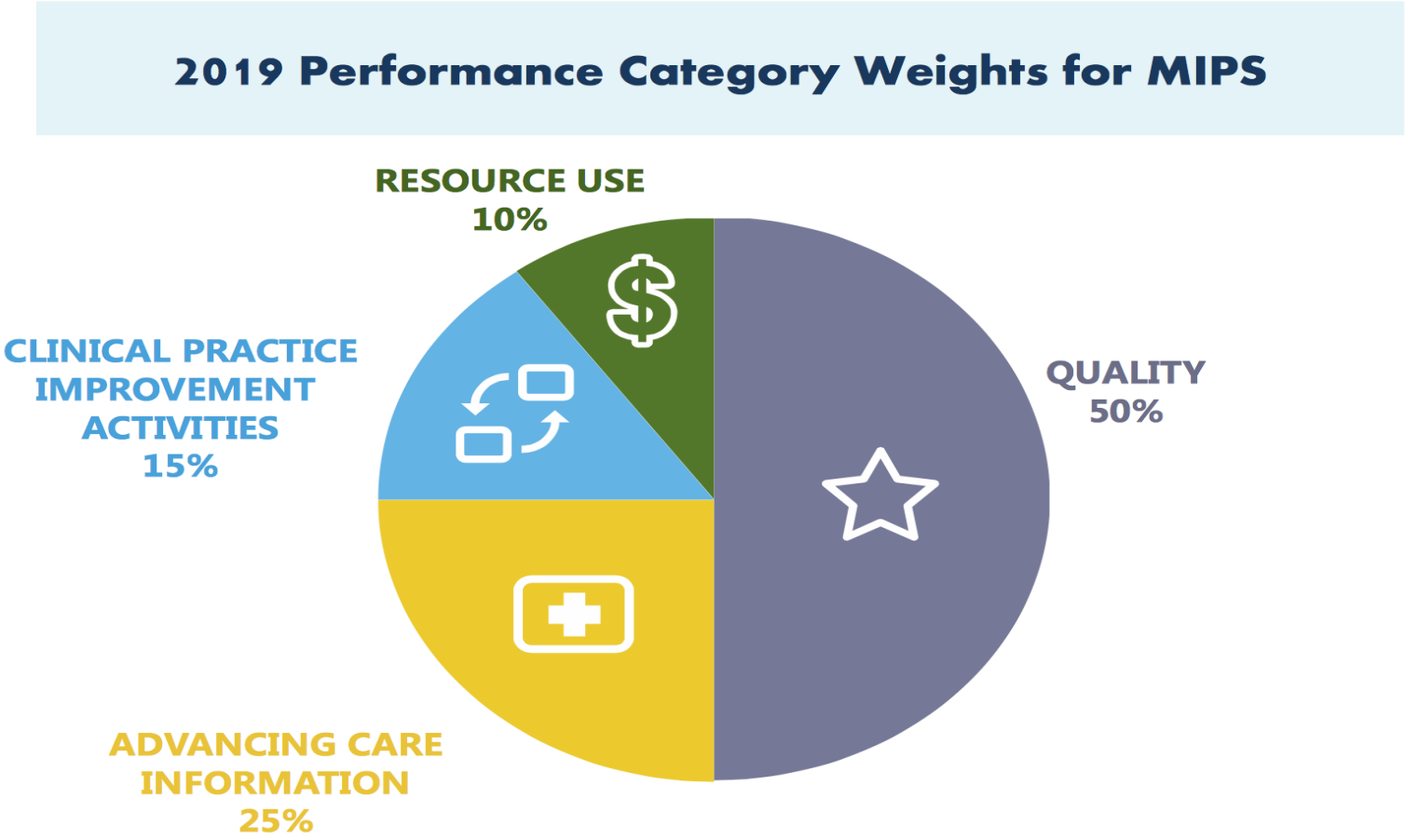
Definition of “Eligible Clinician”

- Clinicians defined as “Eligible Clinicians” under MACRA must report MIPS. In the Final Rule, CMS expanded the exemption categories for payment years 2019-2021
  - **Who’s Included:** Clinicians (MD, DO, PA, NP, Clinical nurse specialist, Certified registered nurse anesthetist or a group with such practitioners, FQHCs if they meet all other definitions) who **bill $30,000+/year *and* care for 100+ Medicare patients/year**
  - **Who’s Excluded:** New Medicare-enrolled eligible clinicians and clinicians with low patient volume of Medicare revenue < $30,000/year *or* < 100 Medicare patients/year

What is MIPS?

- **M**erit-Based **I**ncentive **P**ayment **S**ystem (MIPS) consists of PQRS, Value-Based Modifier and Medicare EHR incentive programs
- Clinicians will receive a **MIPS composite score** through four weighted performance categories:
  1. **Quality** – derived from Value Modifier and PQRS
  2. **Resource use** – QRUR derived from Value Modifier and PQRS
  3. **Clinical practice improvement activities** – derived from PQRS and PCMH (care coordination, shared decision making, expanding access)
  4. **Meaningful use of certified EHR technology** – renamed and now known as Advancing Care Information

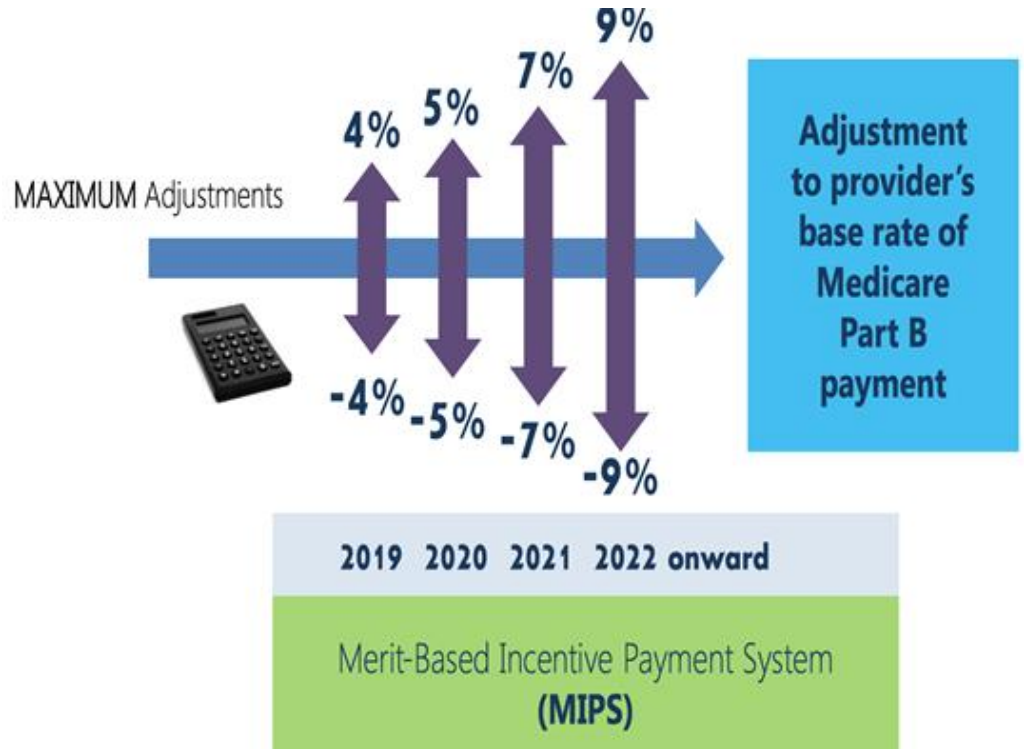
MIPS Weighted Components



CMS.Gov

MIPS Incentive Adjustments

- MIPS composite performance score determines incentive adjustments



What are APMs?

- Advanced Alternative Payment Models (APMs) who have the following:
  - Requires use of certified EHRs
  - Payment is based on comparable quality measures
  - Enhanced medical home (i.e., PCMH) or more than normal risk bearing if there are downward adjustments
- An example in New York state is CMS's Comprehensive Primary Care Plus (CPC+)
- Provides financial incentives for eligible professionals

MIPS and Your QRUR

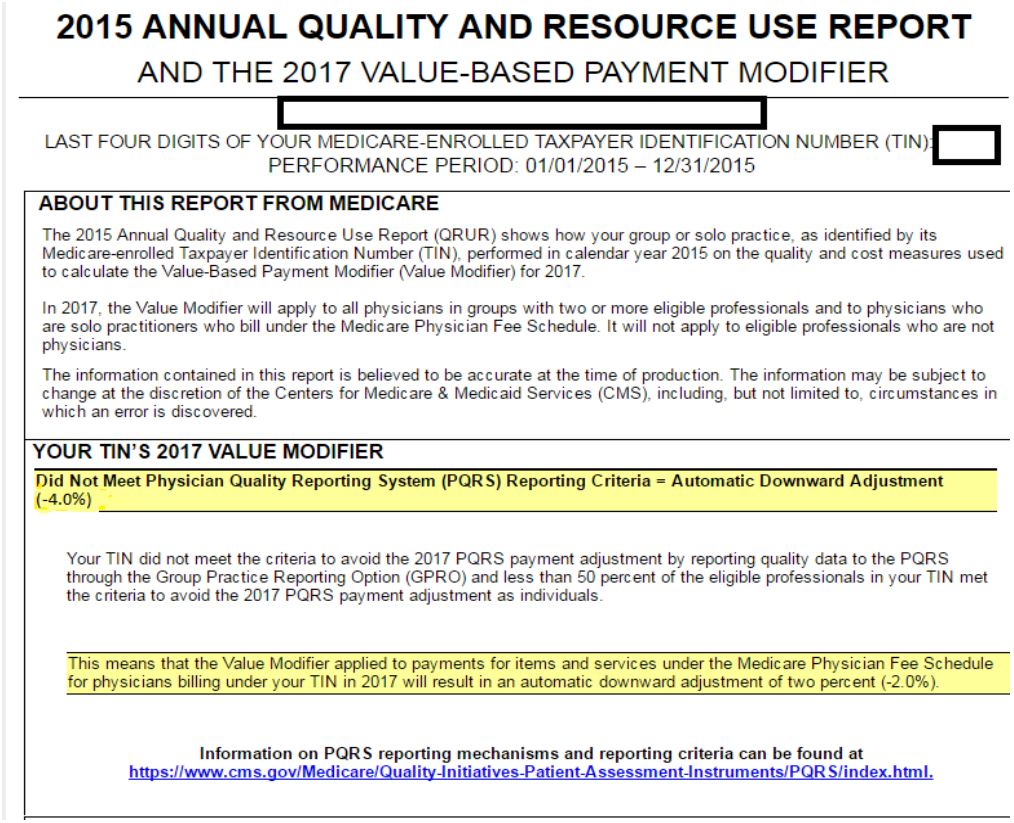
Relationship between QRUR and MIPS

- MIPS combines the PQRS, Medicare EHR incentive program, and Value Modifier, into one single program
- PCMH practices can leverage their management of chronic care patients and care coordination activities to improve their quality indicators

Relationship between QRUR and VBP

- Value-Based Payment is payment based on quality of services and outcomes
- QRUR is a Medicare Tool that informs clinicians about:
  1. Where they are in relation to other providers on spending for services and areas where they have no control of cost that impacts them (i.e. specialty services)
  2. Information on cost, quality of care and outcome measures related to patient services and care provided

Case Study



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- A hospital-based multi-provider practice
- Participants in the NYS Delivery System Reform Incentive Payment program
- 7 Primary Care Clinics
- Located in 4 counties in Central New York
- Extracted QRUR for the first time in Dec. 2016
  - Less than 50% of EP's reported PQRS data for 2015 which resulted in 4% penalty towards billable services on their TIN for the 2017 calendar year

Case Study: Activities Towards Improving 2016 Results

- Confirm registration for "Group Registry" reporting
  - ✓ Referenced the Qualified Registry vendor list [1]
- Identified at least 9 PQRS measures on at least 50% of the group's applicable Medicare Part B FFS patients
- Submit 2016 PQRS data by March 31, 2017
- Potential outcomes:
  - ✓ Reduction or removal of penalty for the 2018 calendar year

1. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016QualifiedRegistries.pdf

Next Steps…

- Apply for PQRS, so that you can obtain QRUR
- Use the QRUR to review the practice's quality and cost of care against peer groups
- Remember the QRUR is one component of MIPS
- Consider becoming a patient-centered medical home (PCMH)
- There is a financial impact to not having PQRS and QRUR

Resources

- **PQRS:**
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How_To_Get_Started.html
- **MACRA:**
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html
  - https://qpp.cms.gov
  - **CMS**
    - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf
    - https://www.healthfusion.com/blog/2016/value-based-payment/things-you-need-to-know-macra/
  - **AAFP**
    - http://www.aafp.org/practice-management/payment/medicare-payment.html
    - http://www.aafp.org/practice-management/payment/medicare-payment/apm-mips.html
    - http://www.aafp.org/practice-management/payment/medicare-payment/faq.html#macraimpact
- **QRUR:**
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-FAQs-QRUR.pdf
  - https://healthinsight.org/tools-and-resources/send/53-webinars/152-qrur-report-webinar-slides-aug-27-2015
  - http://www.aafp.org/news/government-medicine/20151125qrur.html
  - **AAFP**
    - http://www.aafp.org/practice-management/regulatory/qrur.html

Thank you!

Presenter Contact Information

212.437.3952

Fmclean@pcdc.org