Mountain-Pacific Quality Health

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Health Technology Services

QRUR – An Important Tool for PQRS
An Interactive Session
5 August 2015

Hosted by: Sarah Leake MBA, CPEHR
QR/PR Specialist

HTS a Department of Mountain Pacific Quality Health Foundation

Welcome

- The goal of this session hosted by Health Technology Services and Mountain-Pacific Quality Health is to provide you with timely and accurate information and engage in discussion on these topics.

- We are here to help you stay focused on what you need and when you need it, so you can stay on track with Meaningful Use, Quality Reporting and other healthcare compliance programs.

Health Technology Services
Regional Extension Center
A division of Mountain-Pacific Quality Health

Health Technology Services

Regional Extension Center

A division of Mountain-Pacific Quality Health

- Mountain-Pacific holds the Centers for Medicare & Medicaid Services (CMS) Quality Innovation Network-Quality Improvement Organization (QIN-QIO) contract for the states of Montana, Wyoming, Alaska and Hawaii providing quality improvement assistance.

- HTS, a department of MPQHF, has assisted over 1200 providers and 48 Critical Access Hospitals to reach Meaningful Use. We also assist healthcare facilities with utilizing Health Information Technology (HIT) to improve health care, quality, efficiency and outcomes.

Health Technology Services
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A division of Mountain-Pacific Quality Health

- Mountain-Pacific/Health Technology Services offers services to support the following:
  - Meaningful Use EHR Program assistance
  - PQRS and other quality reporting assistance
  - HIPAA Security Risk Assessments and support
  - PCMH Certification assistance
  - HIT utilization for Healthcare quality improvement projects
  - HIT Project Management
  - HIT Misc Consulting

If you are interested in any of these services, please contact your HTS Account Manager

Disclaimer

- *This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.*

- *This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.*

Any form of organizational references contained in the following material should not be assumed as an endorsement by Mountain Pacific Quality Health Foundation.

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- These slides and a presentation recording will be emailed to you following the presentation.
- We would greatly appreciate you providing us feedback by completing the survey at the end of the webinar today.

Session Presenter

- Sarah Leake

Sarah Leake, MBA, CPEHR
QR/PR Specialist, MU, PQRS, PM

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Agenda

- What is the QRUR and Importance
- Relation to PQRS/VBM
- How to Access the QRUR
- A Look At Mid-Year QRUR
- Your Experiences with QRUR
- Resources for Reference and Education

A Check on the QRUR Landscape!

- Have you already accessed and viewed your QRUR?
- What issues did you have accessing your QRUR?
- How are you using the QRUR in your Organization?

What is QRUR and Why is it Helpful?

What are Quality Resource and Use Reports (QRURs) ?

- The Quality Resource Use Reports (QRURs) are a tool for analysis as part of the CMS Physician Quality and Value Based Program
- Contains information on Quality of Care provided to Medicare FFS Beneficiaries treated by an Organization over a period of time as well as the Resources Used.

Why Look at the QRUR?

- Provides comparative information about the quality and cost of the care delivered to Physicians Medicare Fee-for-Service Patients
- CMS will use QRURs to preview the performance scores used in calculating the value-based payment modifier (VBM),
- The Value-Based Modifier provides for differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule (PFS).

Quality Tiering

PQRS-reported quality information, along with CMS-calculated outcomes and cost measures are analyzed.

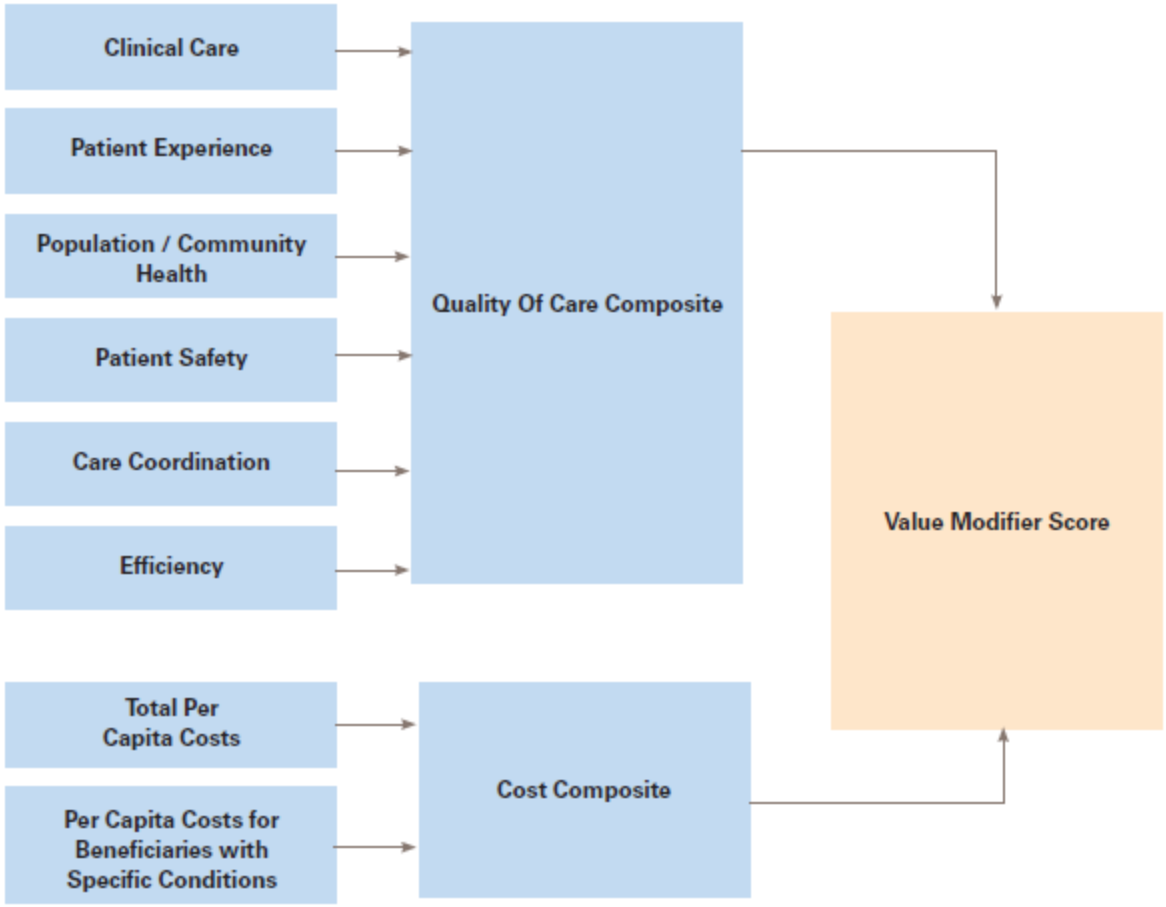
Each group practice recieves two composite scores; a quality and cost composite.

CMS classifies each score into "high," "average" or "low" based on standard deviation above/below or at the national mean score. This identifies statistically significant outliers.

CMS assigns groups to their respective quality and cost "tiers" to determine a positive, neutral or negative payment adjustment to their payment based on performance. This is known as "quality tiering" analysis.

Analysis of the **quality of care** furnished compared to the **cost of care** during a performance period – referred to as "**Quality Tiering".**

Quality Tiering Methodology



The 2013 Mid-Year Report looks at:
CMS1 Acute Conditions Composite
CMS2 Chronic Conditions Composite
CMS3 All-Cause Hospital Readmissions

VBM Payment Adjustment CY2017

Note the 2015 PQRS and Cost Performance will be Analyzed for 2017 VBM and apply to solo physicians and physician groups depending upon size.

CY 2017 VM Payment Adjustment Amounts for Groups with Two-Nine Eligible Professionals and Solo Practitioners

	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%

CY 2017 VM Payment Adjustment Amounts for Groups with Ten or More Eligible Professionals

	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%

"x" refers to a payment adjustment factor yet to be determined

VBM Calculation and Applied

Quality Tiering & VBM Calculation 2015 Data

Data is reviewed for ALL PQRS Eligible Professionals under the Group TIN – Physicians, Practitioners and Therapists

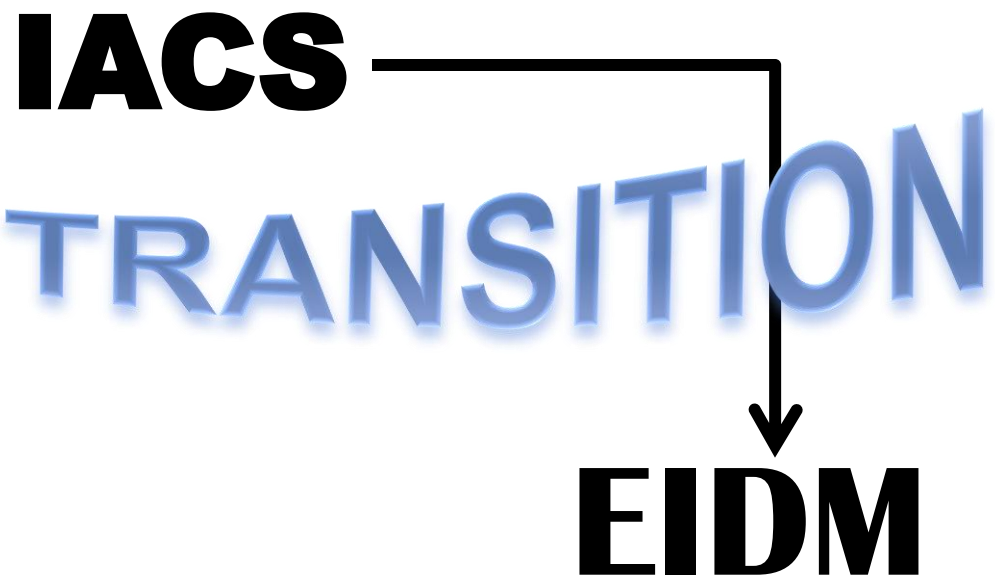
VBM Adjustments in 2017

The Value-Based Modifier will apply to physician payments under the Medicare PFS for physician solo practitioners and physicians in groups of 2 or more EPs.

How do I find the QRUR?

A Key Note..

As of July 13, 2015, users could no longer access QRURs through IACS; an EIDM account is required.



Access in EIDM for QRURs

- Individuals Must be registered and have Authorized Access with the correct roles.
  - For TINs with two or more eligible professionals:
    - PV-PQRS Group Security Official (primary or back-up)
    - PV-PQRS Group Representative
  - For solo practitioners (TINs with one eligible professional):
    - PV-PQRS Individual (primary or back-up)
    - PV-PQRS Individual Representative
- If your TIN is not Registered then you will need to Register for Physician Quality and Value Programs
- Instructions for setting up an EIDM account are available on the CMS Web page, "How to Obtain a QRUR." http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html

Login to Enterprise Portal

Note: The CMS Enterprise Portal supports the following internet browsers: There have been some issues seeing screen and Compatibility view so just be aware.

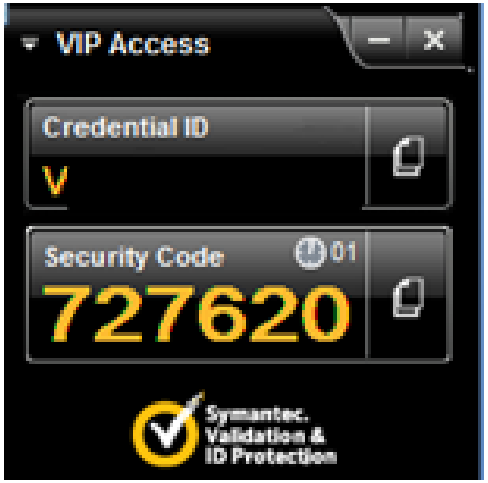
- *Internet Explorer 8*
- *Internet Explorer 9*
- *Mozilla-Firefox*
- *Chrome*
- *Safari*

CMS Enterprise Portal
https//portal.coms.gov

Multi-Factor Authentication (MFA)

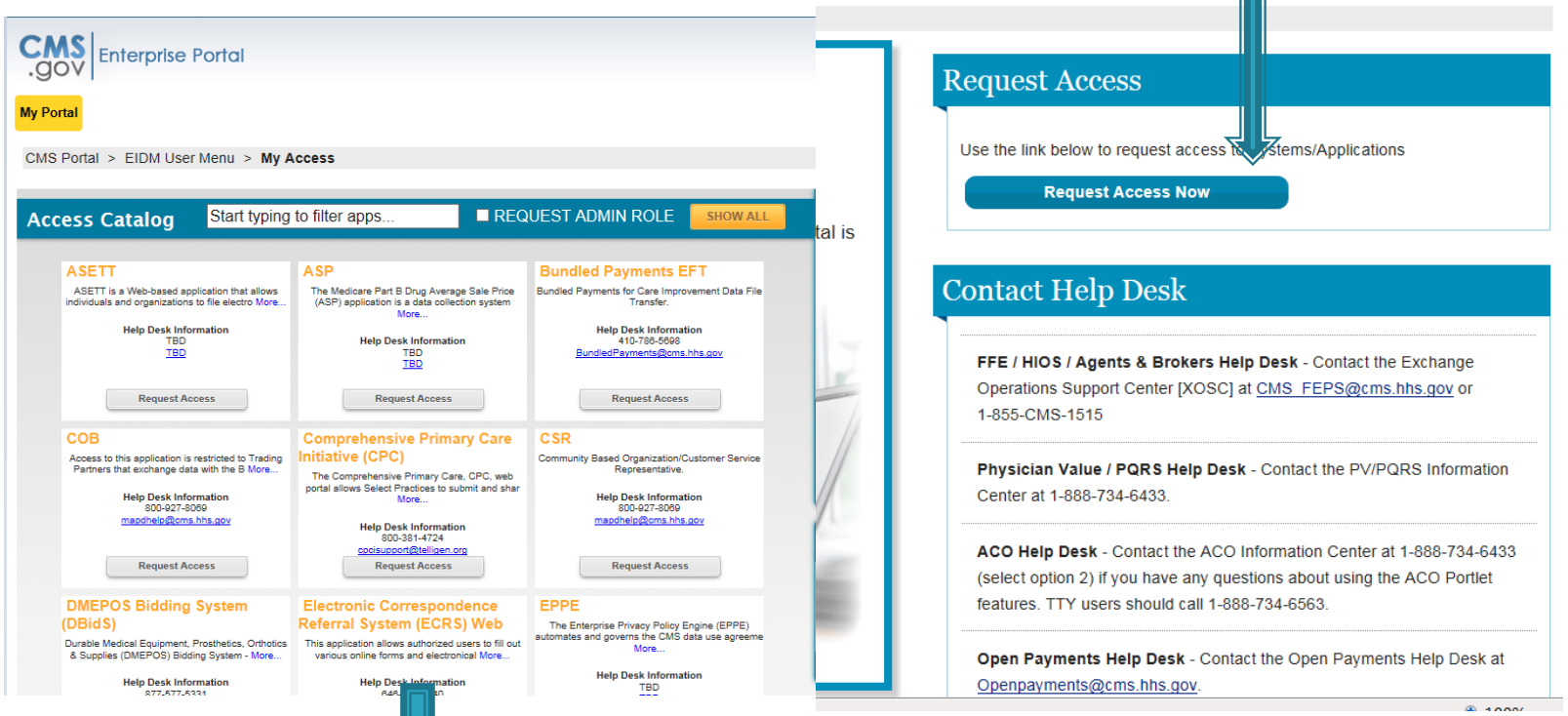
- If you have/had an existing IACS Account you will need to update account information and add a secondary level of validation. (Multi-Factor Authentication(MFA)

Phone/Tablet/PC/Laptop is an option if you will be accessing often. You will need to download Symantec Validation & ID Protection Software



EIDM System

1. Request Access

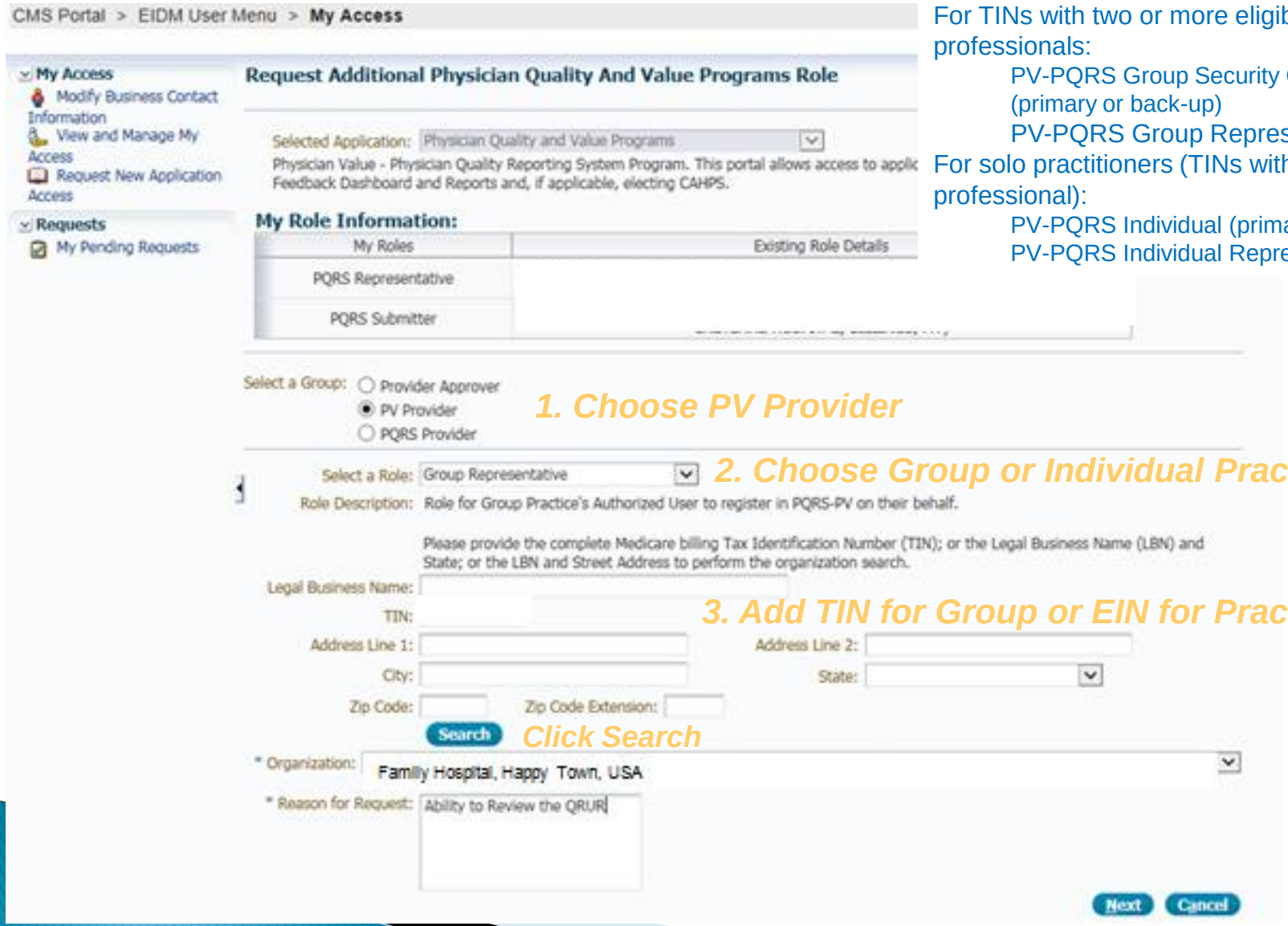


2. Choose Physician Quality box..

Physician Quality and Value Programs

Health Technology Services

Request Role (1)



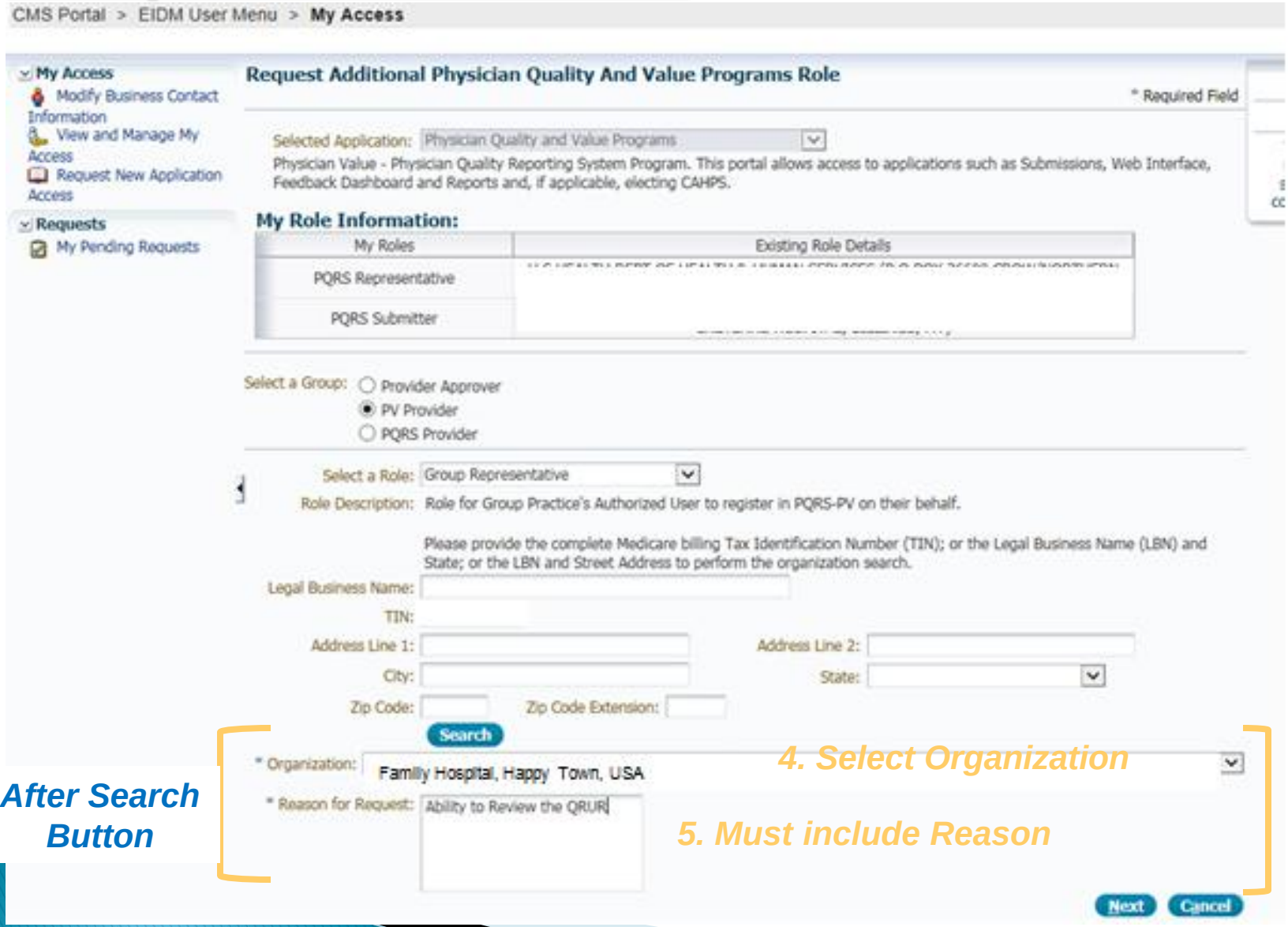
For TINs with two or more eligible professionals:

- PV-PQRS Group Security Official (primary or back-up)
- PV-PQRS Group Representative

For solo practitioners (TINs with one eligible professional):

- PV-PQRS Individual (primary or back-up)
- PV-PQRS Individual Representative

Request Role (2)

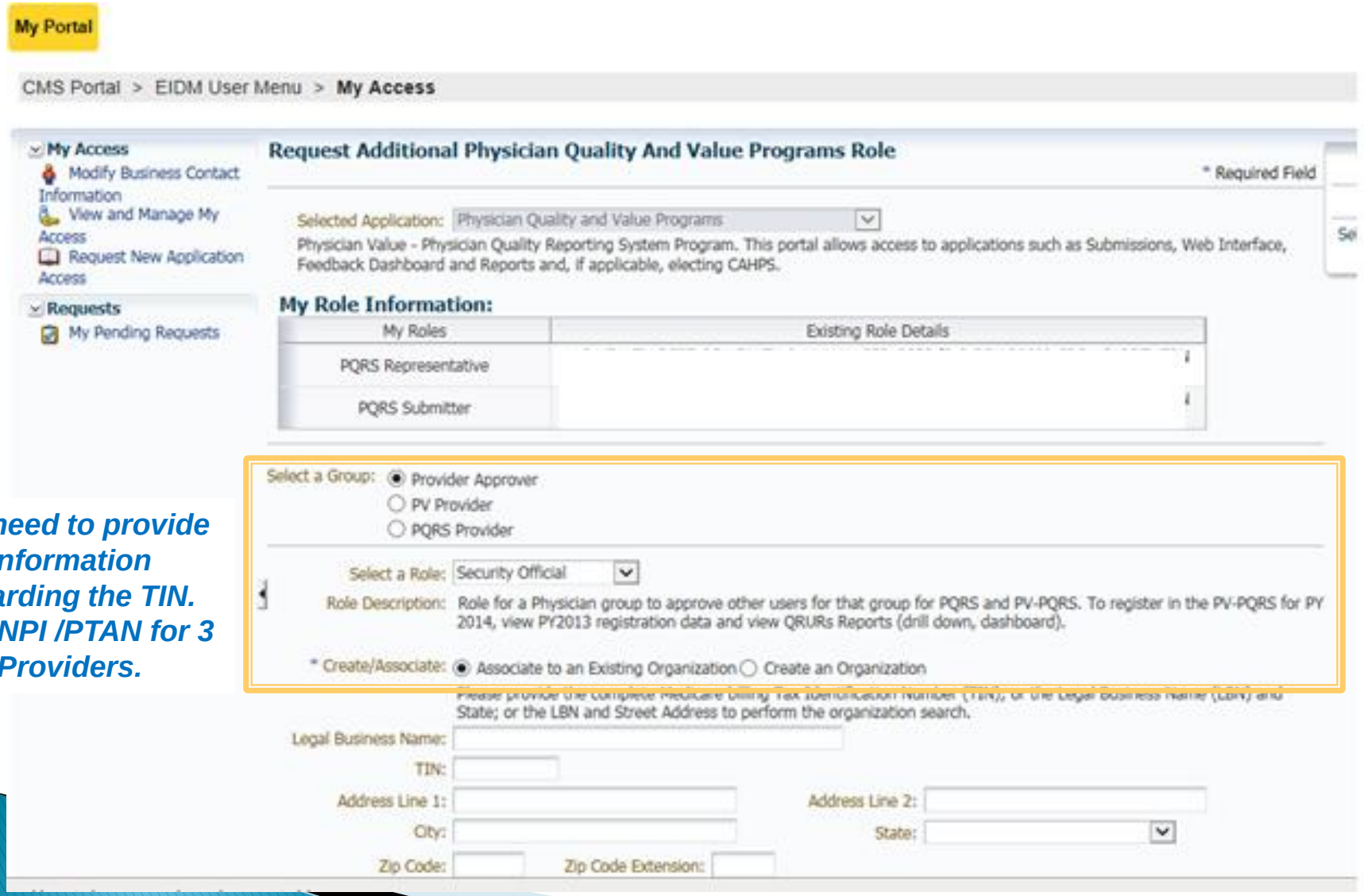


After Search Button

4. Select Organization

5. Must include Reason

If you need a Security Official



Will need to provide information regarding the TIN. Also NPI /PTAN for 3 Providers.

Accessing the QRURs

- Quick Reference Guide for Accessing the 2014 Mid-Year QRUR and Supplementary Exhibits *(How to access, download and print the QRUR reports. Shows the various reports available..)*

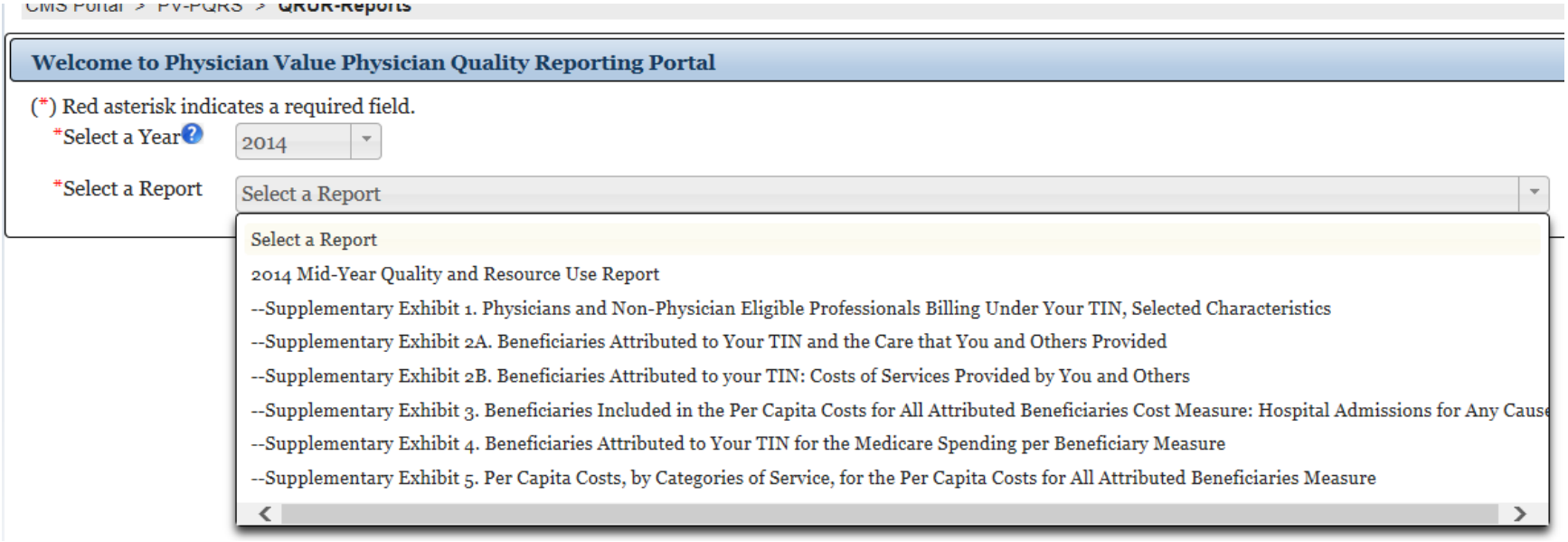
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2014-MYQRURS-Quick-Reference-Guide.pdf

Login and Choose QRUR

Steps	Screenshots
2. After accepting the **Terms and Conditions**, enter your IACS User ID and Password in the **Welcome to CMS Enterprise Portal** screen. Select **Login** to continue.	
3. Click the **PV-PQRS** tab at the top of the screen, and then select the **QRUR-Reports** option from the dropdown menu.	

Multi-Factor Authentication Required

Choose Year and Report



QRUR Content

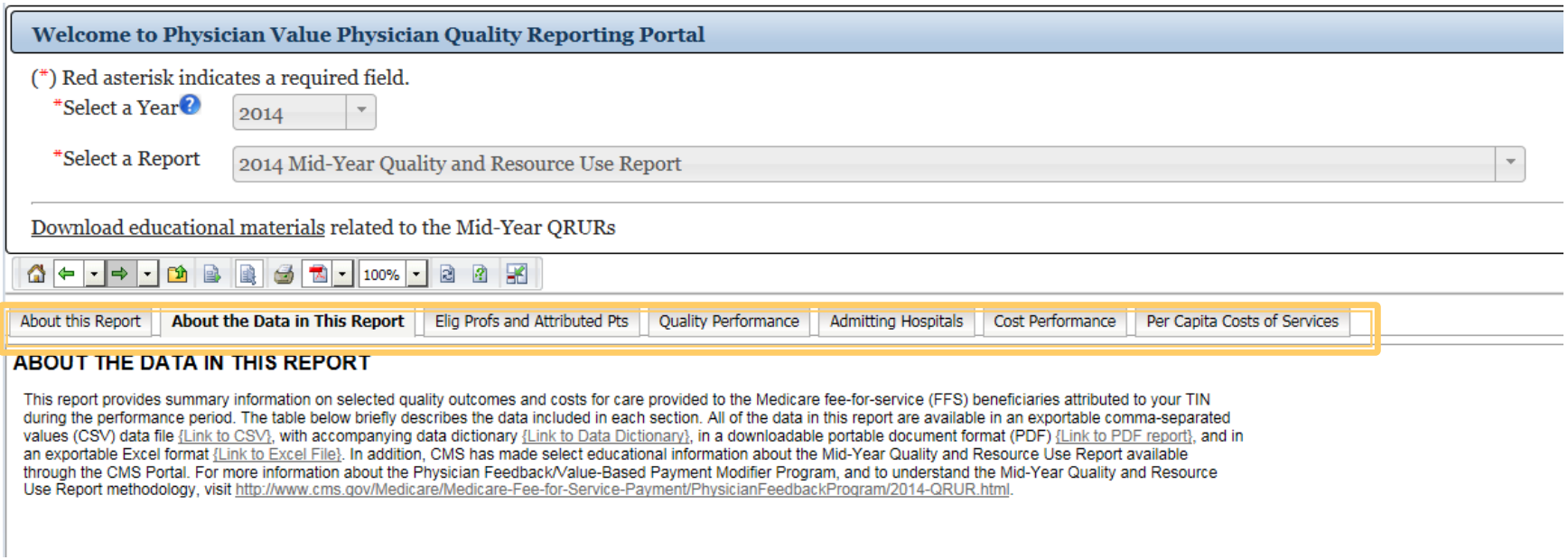
QRURs Report Available

- 2013 QRUR was available late September 2014
  - Based on Care in 2013, at least 1 Physician Billed to TIN
  - First Report with Data showing Adjustments for VBM

- 2014 Mid-Year QRUR available as of 4/30/2015
  - Performance period July 1, 2013 – June 30, 2014

- 2014 QRUR available **late summer**
  - Performance 2014 year
  - Available for Sole Practitioners and Groups

The 2014 Mid Year QRUR



A look at the 2014 Mid-Year QRUR?

- Disseminated in April 2015, provides **interim** information to TINs for Performance on: **three quality outcome** and **six cost measures** that CMS **calculates directly from Medicare claims**,
- Claims billed from July 1, 2013 through June 30, 2014.
- The following data are not included;
  - Information about the 2016 VBM payment adjustment,
  - Quality and cost composite scores for the 2016 VBM, and
  - Quality measures data reported under the PQRS.
- •The report is for informational purposes only and it will not affect your TIN's payments under the Medicare PFS

2014 Mid-Year QRUR Sections

- **Key information on Mid-Year QRUR**
  - QRUR General Information
  - Attributed Beneficiaries
  - MSPB Episodes of Hospital Care
  - Quality Performance Section
  - Hospitals Admitting
  - Cost Performance Section Page
  - Supplementary Information Pages

What Information is Contained in the 2014 Mid-Year QRUR?

Mid-Year QRUR Report Section	Exhibit	Use the Information in the Report to:
Cover Page	-	Understand why you received a 2014 Mid-Year QRUR
About the Data in this Report	-	Read a summary of the report methodology and retrieve links to supplementary exhibits and glossary items (if viewing the report dashboard)
Eligible Professionals Billing to Your Taxpayer Identification Number (TIN)	1	Understand how many eligible professionals billed under your TIN during the performance period
Attribution of Medicare Beneficiaries and Episodes to Your TIN	2-4	Understand how Medicare FFS beneficiaries and episodes of hospital care were attributed to your TIN
Performance on Quality	5	Review your performance on the three, CMS-calculated outcome measures
Hospitals Admitting Your Patients	6	Identify the hospitals that accounted for at least five percent of your attributed beneficiaries' inpatient stays during the performance period
Performance on Costs	7-8	Review your performance on costs across two performance categories, and understand the dollar difference between your attributed beneficiaries' payment-standardized and risk-adjusted per capita costs, by category, and the corresponding costs for your peer group for the Per Capita Costs for All Attributed Beneficiaries measure

Note: All references to "episodes" in this presentation indicate episodes of hospital care for the Medicare Spending per Beneficiary measure.

*Note: The charts on this and following page were extracted from CMS Presentation "***Review of the 2014 Mid-Year Quality and Resource Use Reports***",* June 3, 2015

Additional Supporting Information in the Supplementary Exhibits

Report Section	Supplementary Exhibit	Use the Information in the Supplementary Exhibit to:
Physicians and Non-Physician Eligible Professionals Billing Under Your TIN, Selected Characteristics	1	Understand how many eligible professionals billed under your TIN during the performance period
Beneficiaries Attributed to Your TIN and the Care that You and Others Provided and Costs of Services Provided by You and Others	2A, 2B	Understand which attributed beneficiaries are driving your TIN's cost measures and identify those beneficiaries that are in need of greater care coordination
Beneficiaries Included in the Per Capita Costs for All Attributed Beneficiaries Cost Measure: Hospital Admissions for Any Cause	3	Understand which beneficiaries are driving your TIN's performance on the three hospital-related, claims-based quality outcome measures
Beneficiaries Attributed to Your TIN for the Medicare Spending per Beneficiary Measure	4	Understand which attributed beneficiaries were attributed to your TIN for the Medicare Spending per Beneficiary (MSPB) measure
Per Capita Costs, by Categories of Service, for the Per Capita Costs for All Attributed Beneficiaries Measure	5	Review a categories of service breakdown for the beneficiaries attributed to your TIN for the Per Capita Costs for All Attributed Beneficiaries measure

Note: All references to "episodes" in this presentation indicate episodes of hospital care for the Medicare Spending per Beneficiary measure.

Quick Look at Mid-Year QRUR Exhibits

2014 Mid-Year QRUR
Exhibit 1: Eligible Professionals Billings to Your TIN

- Exhibit 1 shows the number and percentage of physicians and non-physician eligible professionals billing to your TIN. This number is determined by claims submitted to Medicare under your TIN during the performance period.

Review the eligible professional composition of your TIN

Supplementary Exhibit 1 Lists the Physicians and Non-Physicians Eligible and billing under your TIN.

*Note: 2014 Mid-Year QRUR Sample Exhibit s on the following 4 pages were extracted from CMS Presentation "***Review of the 2014 Mid-Year Quality and Resource Use Reports***",* June 3, 2015

2014 Mid-Year QRUR
Performance on Quality Component

- CMS-1, CMS-2, and CMS-3 are risk-adjusted quality outcome measures calculated by CMS using administrative claims data.
- Lower performance rates on these measures indicate better performance.
- The peer group for the quality measures is all TINs nationwide with at least 20 eligible cases for each quality measure.

Exhibit 5. CMS-Calculated Outcome Measure Performance

Performance Category	Measure Number	Measure Name	Your Eligible Cases	Your Performance Rate	Benchmark	Benchmark -1 Standard Deviation	Benchmark +1 Standard Deviation
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care Sensitive Conditions	CMS-1	**Acute Conditions Composite**	383	12.02	7.53	1.81	13.24
	-	Bacterial Pneumonia	383	16.89	11.20	1.76	20.63
	-	Urinary Tract Infection	383	13.35	7.25	0.00	15.08
	-	Dehydration	383	6.08	4.10	0.00	8.58
	CMS-2	**Chronic Conditions Composite**	142	0.00	50.43	26.19	74.66
	-	Diabetes (composite of 4 indicators)	56	0.00	18.07	0.00	36.07
	-	Chronic Obstructive Pulmonary Disease (COPD) or Asthma	24	0.00	70.23	25.43	115.03
	-	Heart Failure	90	0.00	99.75	48.72	150.77
Hospital Readmissions	CMS-3	**All-Cause Hospital Readmissions**	64	18.16%	15.94%	14.55%	17.34%

Compare your quality outcome performance to that of your peers nationwide

Performance on Cost Component

- Total Costs for All Attributed Beneficiaries measure
- Total Costs per Beneficiary for Chronic Conditions Composite:
  - Total Costs per Beneficiary with COPD
  - Total Costs per Beneficiary with CHF
  - Total Costs per Beneficiary with CAD
  - Total Costs per Beneficiary with Diabetes
- Attributed to:
  - Medicare Spending per Beneficiary
  - Hospitals Admitting Your Attributed Beneficiaries

2014 Mid-Year QRUR Performance on Cost

- Exhibit 7 shows the payment-standardized, risk-adjusted, and specialty-adjusted per capita or per episode costs for the beneficiaries attributed to your TIN.

Exhibit 7. Per Capita Costs for Your Attributed Medicare Beneficiaries

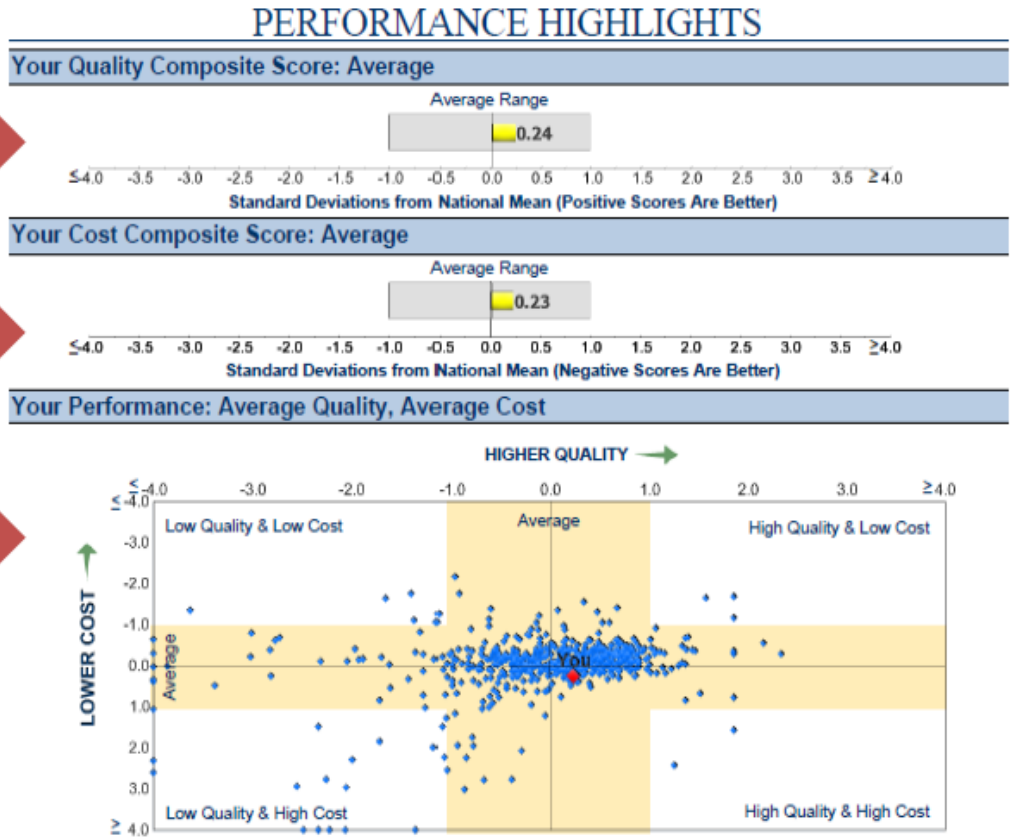
Performance Category	Cost Measure	Your Eligible Cases or Episodes	Your Per Capita or Per Episode Costs	Benchmark	Benchmark – 1 Standard Deviation	Benchmark + 1 Standard Deviation
Per Capita Costs for All Attributed Beneficiaries	All Beneficiaries	354	$11,126	$11,135	$7,962	$14,309
	Medicare Spending per Beneficiary	772	$20,232	$20,339	$18,651	$22,026
Per Capita Costs for Beneficiaries with Specific Conditions	Diabetes	54	$17,785	$16,149	$11,243	$21,055
	Chronic Obstructive Pulmonary Disease (COPD)	17	$25,805	$25,179	$17,269	$33,088
	Coronary Artery Disease (CAD)	36	$23,095	$18,357	$12,780	$23,934
	Heart Failure	82	$15,686	$28,115	$19,188	$37,041

Compare your cost performance to that of your peers

Key Exhibits in the 2014 QRUR

Performance Highlights (1) Available in the 2014 Annual QRUR

1. Your Quality Composite Score
2. Your Cost Composite Score
3. Your Quality Tiering Performance



*Note: 2014 Annual QRUR Sample Exhibit s on the following 4 pages were extracted from CMS Presentation "***Overview of the 2013 Quality and Resource Use Reports***"* , October 2014

Performance Highlight (2) Available in the Annual 2014 QRUR

4. Your Eligibility for a High-Risk Bonus Adjustment

5. Your Value-Based Payment Adjustment

High-Risk Bonus Adjustment: Not Eligible

You are eligible for an additional upward adjustment for serving high-risk beneficiaries if you met (✓) all four criteria listed below in 2013:

- ✗ Your average beneficiary's risk (74th percentile of beneficiaries nationwide) is not at or above the 75th percentile.
- ✗ You had high overall performance
- ✓ You elected quality tiering for calendar year 2015.
- ✓ You satisfactorily reported PQRS quality measures via the Group Practice Reporting Option (GPRO) web interface or a qualified GPRO registry.

Your Value-Based Payment Modifier

The highlighted payment adjustment will be applied to your Medicare Physician Fee Schedule reimbursements in 2015.

	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0 x AF	+2.0 x AF
Average Cost	-0.5%	+0.0%	+1.0 x AF
High Cost	-1.0%	-0.5%	+0.0%

Note: The displayed payment adjustment includes the high-risk bonus adjustment, if applicable. The precise size of the reward for higher-performing groups will vary from year to year, based on an adjustment factor (AF) derived from actuarial estimates of projected billings. The AF for 2015 will be posted at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.

Quality Component (Available for 2014 QRUR)

Exhibit 4. Your Performance in 2013, by Quality Domain

Quality Domain	Number of Quality Measures Included in Composite Score	Standardized Score
Standardized Quality Composite Score	**9**	**0.24* (Average)**
Average Quality Composite Score	9	0.33
Clinical Process/Effectiveness	4	0.22
Patient and Family Engagement	0	--
Population/Public Health	2	0.85
Patient Safety	0	--
Care Coordination	3	-0.08
Efficient Use of Health Care Resources	0	--

Note: The standardized quality composite score is a standardized average of equally-weighted domain scores indicating within how many standard deviations of the national mean a group practice's performance rate falls; positive scores reflect performance better than the mean, and negative scores reflect performance worse than the mean. Each domain level performance score is an equally weighted average of the standardized scores for all measures in the domain with at least 20 cases; the standardized score is the difference between the raw score and the peer group benchmark, divided by the peer group standard deviation. "Insufficient Data to Determine" for the standardized quality composite score indicates that, although the score was at least one standard deviation from the mean standardized quality composite score, it was not statistically significantly different from that mean at the 5 percent level. Domain scores are not computed for domains with no measure with at least 20 cases. See the glossary (Link to Glossary of Terms) for more detail on how this score is computed.

* Significantly different from the mean standardized quality composite score at the 5 percent level.

Cost Component (2014 Annual QRUR)

Exhibit 8. Per Capita Costs for Your Attributed Medicare Beneficiaries in 2013

Cost Categories	Your Performance		Peer Group Performance			Contribution to Your Domain Score	
	Eligible Cases	Per Capita Costs	Benchmark Per Capita Costs	Average Range: Benchmark –1 Standard Deviation	Average Range: Benchmark +1 Standard Deviation	Standardized Score	Included in Domain Score
Per Capita Costs for All Attributed Beneficiaries							
All Beneficiaries	1,882	$11,118	$10,086	$8,525	$11,647	0.66	Yes
Per Capita Costs for Beneficiaries with Specific Conditions							
Diabetes	644	$16,118	$14,441	$11,944	$16,938	0.67	Yes
Chronic Obstructive Pulmonary Disease (COPD)	420	$23,735	$23,717	$19,242	$28,191	0.00	Yes
Coronary Artery Disease	727	$18,922	$17,183	$14,193	$20,173	0.58	Yes
Heart Failure	332	$27,666	$25,993	$20,943	$31,043	0.33	Yes

Note: Per capita costs are based on payments for Medicare Parts A and B claims submitted by all providers (including medical professionals, hospitals, and post-acute care facilities) for Medicare beneficiaries attributed to a physician group. Outpatient prescription drug costs are not included.

Details Total Per Capita Costs

Details Condition-Specific Per Capita Costs

Note that risk adjusted, payment standardized costs are compared

Identify those measures contributing to your domain score

Recommended Resources

Resource Name	Link	Notes
Review of the 2014 Mid-Year Quality and Resource Use Reports (CMS)	https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2015-06-03-QRUR-Presentation.pdf	Transcript https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2015-06-03-QRUR-Transcript.pdf
2013 QRUR Interpretation and Quality Improvement Guide (TMF QIN/QIO)	Link to QRUR Guide prepared by TMF QIO/QIN	Excellent explanation of 2013 QRUR content. Improvement Ideas. *Note it is for 2013 QRUR*
Understanding Your 2014 Mid-Year QRUR (CMS)	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2014-Understanding-Your-QRUR.pdf	Excellent explanation of the Mid-Year QRUR Exhibits, Supplementary Exhibits and FAQs of content/actions to take based on data
Overview of the 2013 Quality and Resource Use Reports (CMS)	https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2014-10-23-QRUR-Presentation.pdf	Explanation of the 2013 QRUR Annual Report from CMS.

Other QRUR Events

QualityNet Hosted Webinars

https://qualitynet.webex.com/

Hosted by TMF Health Quality Institute (a QIO/QIN Partner)

- Open Forum: QRUR – Understanding the Methodology to Read and Interpret the Findings

  Aug. 11, 2015, from 11:30 – 12:30 p.m. MT

- Open Forum: QRUR – Action Steps to Help Improve Scores on Cost and Quality Measures

  Sept. 15, 2015, from 11:30 – 12:30 p.m. MT

Visit www.tmfqin.org for more information.

Upcoming Webinars

Register for our upcoming webinars and check out the resources used today: www.healthtechnologyservice.com

HTS Upcoming public webinars

- **Tuesday, Sept 1 11am-12 pm**
  *MU Audits – Why should I stay up to date?
- **To be Scheduled when Rule Released**
  *CMS Meaningful Use Changes

HTS Upcoming Webinars (soon to be scheduled)

* Quality Reporting – Open Forums

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Your Experiences with QRUR

- How are you using the QRUR in your Organization?
- Do you find it beneficial?
- Any issues with accessing or interpreting the QRUR?
- Other items to share?

How HTS can help in 2015

- **Quality Reporting Program Assistance**
  *PQRS & Value-Based Modifier for Providers, HIQR for Hospitals
- **Meaningful Use**
  *Avoiding payment adjustments
  *Stage 1 and Stage 2 assistance for EH or EPs
- *2015 Meaningful Use Requirements
- **Security Risk Assessments**
  *Basic or Comprehensive SRAs
- **HIT Consulting and Project Management**
  *Assistance with interfaces, HIE, etc.
- **Combined Services**
  *Year long assistance with Meaningful Use, PQRS/IQR and ICD-10

HTS services and pricing can be fo

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www.healthtechnologyservice.com

Questions?

Please include Further Topics or Areas you would like to explore or have interactive sessions regarding QRUR, PQRS, VBM !

Please complete our survey after the webinar!

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Resources

- A Quick Reference guide regarding the 2014 mid-year QRUR report and how to access it is at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2014-MYQRURS-Quick-Reference-Guide.pdf
- QRUR Guide http://www.tmfqin.org/Portals/0/Resource%20Center/Health%20Information%20Technology/QRUR%20Guide_508.pdf
- The site to view the Feedback Reports will be www.qualitynet.org/pqrs and login with her EIDM user id and password.
- **MLN Connects Webinar 2014 Mid-Year QRURs** https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2015-06-03-QRUR-Presentation.pdf
- **"How to Obtain a QRUR."** http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html
- **Tips to Understand and Use the QRUR** https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2013-QRUR-Tips.pdf
- **CMS Value-based Payment Modifier (VBM) Website**
- http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html
- **Physician Compare**
- http://www.medicare.gov/physiciancompare/search.html
- **QualityNet Help Desk:**

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

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