



PQRS – Finalize 2015 and A Look Ahead

Thursday, February 4, 2016 – 2–3 PM MST

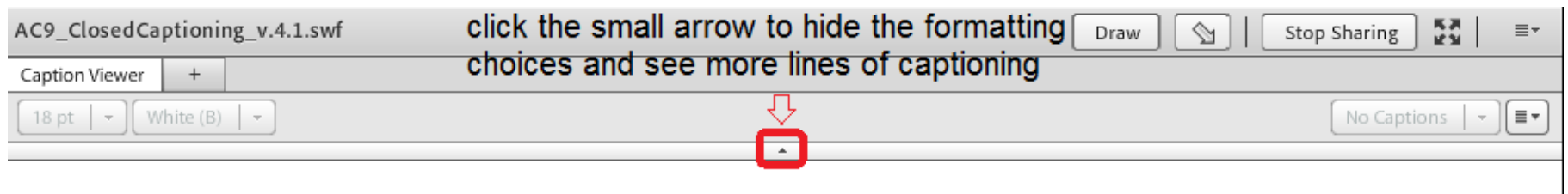
Presented by: Sarah Leake MBA, CPEHR
Health Technology and Quality Program Specialist
Co-Hosted by: Sharon Phelps
Population Health Improvement Lead

Welcome

- ▶ Thank you for spending your valuable time with us today.
- ▶ This webinar will be recorded for your convenience.
- ▶ A copy of today's webinar recording will be available on our website following the webinar. A link to the recording as well as a link to our website webinar archive will be emailed to you following the webinar.
- ▶ A copy of today's presentation slides will be available on our website in approximately a week.
- ▶ All phones will be muted during the presentation and unmuted during the Q&A session. Computer users can use the chat box to ask questions which will be answered at the end of the presentation.
- ▶ We would greatly appreciate your providing us feedback by completing the survey at the end of the webinar today.

Closed Captioning

- ▶ Closed captioning will appear under today's presentation. To see more lines of captioned text, click the small arrow below.





Mountain-Pacific
Quality Health

HEALTH TECHNOLOGY SERVICES

transforming health care through innovative technology

3404 Cooney Drive, Helena, MT 59602 • www.healthtechnologyservice.com • 406.457.5897

- ▶ 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 1480 providers and 50 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.

Legal Disclaimer

The presenter is not an attorney and the information provided is the presenter(s)' opinion and should not be taken as legal advice. The information is presented for informational purposes only.

Compliance with regulations can involve legal subject matter with serious consequences. The information contained in the webinar(s) and related materials (including, but not limited to, recordings, handouts, and presentation documents) is not intended to constitute legal advice or the rendering of legal, consulting or other professional services of any kind. Users of the webinar(s) and webinar materials should not in any manner rely upon or construe the information as legal, or other professional advice. Users should seek the services of a competent legal or other professional before acting, or failing to act, based upon the information contained in the webinar(s) in order to ascertain what is may be best for the users individual needs.

Session Presenter

- ▶ Sarah Leake



Sarah Leake, MBA, CPEHR
Health Technology and
Quality Program Specialist

Webinar Objectives

- ▶ The goal of this session is look at the process and where you should be for completing PQRS in the 2015 reporting year.
- ▶ This webinar will share some lessons learned, ideas and challenges seen in the 2015 PQRS reporting.
- ▶ Review the available PQRS Changes and Requirements for 2016 Reporting

The PQRS Process and Lessons



PQRS 2015 Data Submission Timeframes

- ▶ EHR Direct or Data Submission Vendor (QRDA I or III) – 1/1/16 – 2/29/16
- ▶ Qualified Clinical Data Registries (QCDRs) (QRDA III) – 1/1/16 – 2/29/16
- ▶ Group Practice Reporting Option (GPRO) Web Interface – 1/18/16 – 3/11/16
- ▶ Qualified Registries (Registry XML) – 1/1/16 – 3/31/16
- ▶ QCDRs (QCDR XML) – 1/1/16 – 3/31/16

Submission ends at **8:00 p.m. Eastern Time (ET)** on the end date listed.

Note Scheduled Maintenance Times



Physician Quality Reporting System (PQRS)

CMS Announces Submission Timeframes for 2015 Physician Quality Reporting System (PQRS) Data

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the 2015 PQRS data submission timeframes:

- **EHR Direct or Data Submission Vendor (QRDA I or III) - 1/1/16 - 2/29/16**
- **Qualified Clinical Data Registries (QCDRs) (QRDA III) - 1/1/16 - 2/29/16**
- **Group Practice Reporting Option (GPRO) Web Interface - 1/18/16 - 3/11/16**
- **Qualified Registries (Registry XML) - 1/1/16 - 3/31/16**
- **QCDRs (QCDR XML) - 1/1/16 - 3/31/16**

Submission ends at **8:00 p.m. Eastern Time (ET)** on the end date listed. An Enterprise Identity Management (EIDM) account with the "Submitter Role" is required for these PQRS data submission methods. Please see the [EIDM System Toolkit](#) for additional information.

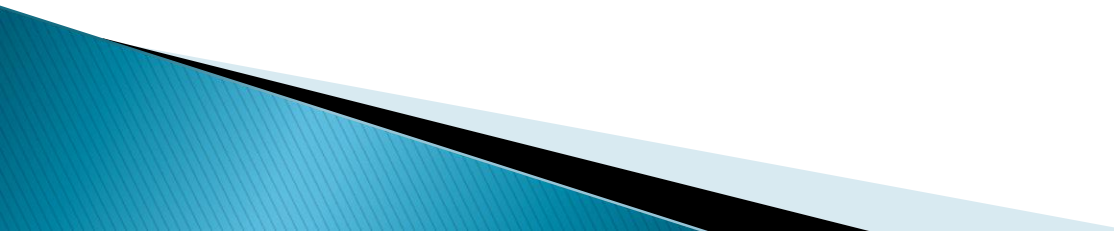
Please know that maintenance is currently scheduled for the following timeframes:

- **1/22/2016 at 8:00 p.m. ET – 1/25/2016 at 6:00 a.m. ET**
- **2/26/2016 at 8:00 p.m. ET – 2/29/2016 at 6:00 a.m. ET**
- **3/11/2016 at 8:00 p.m. ET – 3/14/2016 at 6:00 a.m. ET**
- **3/16/2016 at 8:00 p.m. ET – 3/21/2016 at 6:00 a.m. ET**

The Physician and Other Health Care Professionals Quality Reporting Portal (Portal) may be unavailable during these times.

Eligible professionals who do not satisfactorily report quality measure data to meet the 2015 PQRS requirements will be subject to a negative PQRS payment adjustment on all Medicare Part B Physician Fee Schedule (PFS) services rendered in 2017. For questions, please contact the QualityNet Help Desk at 1-866-288-8912 or via email at Qnetsupport@hcqis.org from 7:00 a.m. - 7:00 p.m. Central Time. Complete information about PQRS is available at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>.

Process for PQRS Participation

1. Identify Eligible Professionals
 2. Determine Group Size Billing to TIN
 3. Decide if Group or Individual Reporting
 4. Choose Reporting Mechanism
 5. Select Measures to Report
 6. Quality Measure Validation
 7. Quality Monitoring
- 

1. Identify Eligible Professionals

- ✓ Review the CMS PQRS 2015 List of Eligible Professionals [2015 PQRS List of Eligible Professionals](#)
- ✓ Review the Quality Use Resource Report (QRUR) and/or PQRS Feedback Report
- ✓ Determine Billing **Method in all Settings** for each Provider
 - ✓ CMS-1500, CMS-1450 at NPI Level
- ✓ Calls and Emails with QualityNet, Physician Value and MAC
- ▶ Reference FAQs on the Subject

CMS Programs and Eligibility 2015

	PQRS		Value Modifier		EHR Incentive Program		
	Eligible for Incentive	Subject to Payment Adjustment	Included in Definition of "Group" (1)	Subject to VM (2)	Eligible for Medicare Incentive(3)	Eligible for Medicaid Incentive (4,5)	Subject to Medicare Payment Adjustment (7,8)
Medicare Physicians							
Doctor of Medicine	X	X	X	X	X	X	X
Doctor of Osteopathy	X	X	X	X	X	X	X
Doctor of Podiatric Medicine	X	X	X	X	X		X
Doctor of Optometry	X	X	X	X	X		X
Doctor of Oral Surgery	X	X	X	X	X	X	X
Doctor of Dental Medicine	X	X	X	X	X	X	X
Doctor of Chiropractic	X	X	X	X	X		X
Practitioners							
Physician Assistant	X	X	X			X (6)	
Nurse Practitioner	X	X	X			X	
Clinical Nurse Specialist	X	X	X				
Certified Registered Nurse Anesthetist (10)	X	X	X				
Certified Nurse Midwife	X	X	X			X	
Clinical Social Worker	X	X	X				
Clinical Psychologist	X	X	X				
Registered Dietician	X	X	X				
Nutrition Professional	X	X	X				
Audiologists	X	X	X				
Therapists							
Physical Therapist	X	X	X				
Occupational Therapist	X	X	X				
Qualified Speech-Language Therapist	X	X	X				

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_PQRS_List_of_Eligible_Professionals.pdf

How Participation/Penalties are Determined

- ▶ PQRS covered professional services are those paid under or based on the Medicare Part B, Physician Fee Schedule (MPFS).
- ▶ Eligible Professionals are identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN].
- ▶ These individual eligible professionals or group practices must satisfactorily report data on quality measures.
- ▶ **Those that do not meet the 2015 PQRS reporting requirements will be subject to a negative payment adjustment on all Medicare Part B MPFS services rendered in 2017.*

Appendix D: CMS-1500 Claim PQRS Example

Example of an individual NPI reporting on a single CMS-1500 claim.

See <http://www.cms.gov/manuals/downloads/clm104c26.pdf> for more information and complete billing requirements.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY - Relate A-L to service line below (24E)										ICD-9		22. RESUBMISSION CODE		ORIGINAL REF. NO.	
A.		B.		C.		D.		E.		F.		G.		H.	
Diabetes Mellitus		Coronary Artery Disease (CAD)													
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C.		D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. RENDERING PROVIDER I.D. #	
07	05	15	07	05	15	11	99213		1,2	47.00			NPI	0123456789	
07	05						3048F		1	0.01			NPI	0123456789	
07	05						3074F		1	0.01			NPI		
07	05	15	07	05	15	11	3078F		1				NPI		
07	05	15	07	05	15	11	4011F						NPI		
07	05	15	07	05	15	11	1090F			0.01			NPI		

25. FEDERAL TAX I.D. NUMBER XX-XXXXXXX		26. PATIENT'S ACCOUNT NO. XXXXX		27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 47.00		29. AMOUNT PAID \$		30. PAY BY (DDCC-UB)	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER I.D. # XXXXXXXXXX			

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12) Version

- The patient was seen for an office visit (99213). The provider is reporting several measures related to diabetes, coronary artery disease (CAD), and urinary incontinence:
- Measure #2 (LDL-C) with QDC 3048F + diabetes line-item diagnosis (24E points to DX 250.00 in Item 21);
- Measure #3 (BP in Diabetes) with QDCs 3074F + 3078F + diabetes line-item diagnosis (24E points to Dx 250.00 in Item 21);
- Measure #6 (CAD) with QDC 4011F + CAD line-item diagnosis (24E points to Dx 414.00 in Item 21); and
- Measure #48 (Assessment - Urinary Incontinence) with QDC 1090F. For PQRS, there is no specific diagnosis associated with this measure. Point to the appropriate diagnosis for the encounter.
- Note: All diagnoses listed in Item 21 will be used for PQRS analysis. Measures that require the reporting of two or more diagnoses on a claim will be analyzed as submitted in Item 21.
- NPI placement: Item 24J must contain the NPI of the individual provider that rendered the service when a group is billing.
- If billing software limits the line items on a claim, you may add a nominal line-item charge of a penny to one of the QDC line items on that second claim. PQRS analysis will subsequently join both claims based on the same beneficiary, for the same date-of-service, for the same TIN/NPI and analyze as one claim.

Eligible but Not able to Participate

Some professionals may be eligible to participate per their specialty, but due to billing method may *not be able to participate*:

- ▶ Professionals who do not bill Medicare at an individual National Provider Identifier (NPI) level.
- ▶ Services payable under fee schedules or methodologies other than the Medicare Part B PFS are not included in PQRS.

This is a Voluntary Program per CMS, but failure to participate will incur penalties.

Overriding Eligibility Issue

- ▶ Finding Lack of Clarity Related to CAH
 - [PQRS-CAH Virtual Office Hour-Feb 8, 1pm MT](#)
- ▶ Letters from CMS Identifying Penalties for Providers
 - Understand your Billing Methods
 - Call QualityNet or EMAIL explaining Circumstances
 - Medicare Administrative Contractor (MAC)
 - *Be persistent in obtaining answers*
 - Finding on a Case by Case basis- Letters may not be Applicable

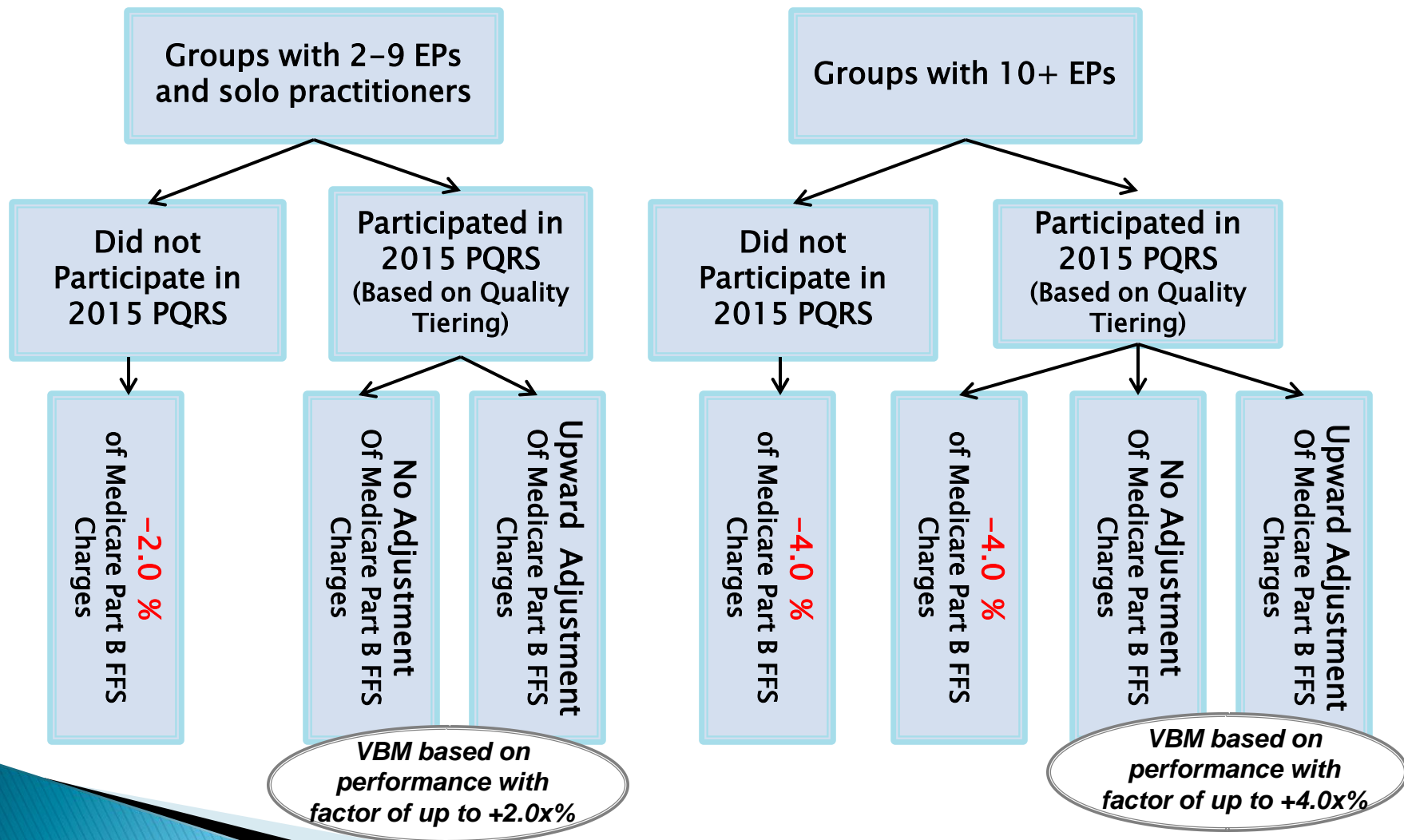
This can be a process!

2. Determine Group Size for TIN

- ✓ Review QRUR for # Professionals, the smaller of;
 - ✓ Pecos Generated List
 - ✓ Claims – Providers billing to the TIN
- ✓ Must have Registered PQRS Security Admin to Approved Roles in CMS Enterprise Portal
- ✓ Assign Representative Role for PV–PQRS
 - ✓ PV–PQRS allows review of QRUR Report and to Register for Group Reporting Options GPRO

Value Modifier Payment Adjustments for Eligible Professionals in 2017

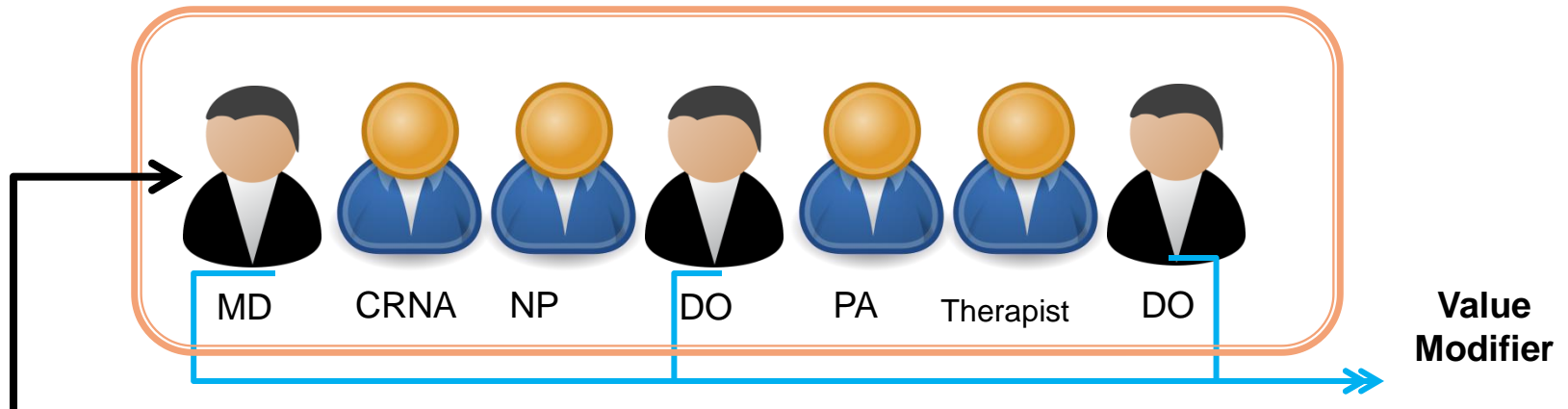
(Based on 2015 Quality and Cost data)



NOTE: In addition to PQRS 2% adjustment for not reporting successfully!

Eligible Providers – PQRS and VM

Group Size – TIN Level



PQRS – All eligible Provider, (bill Medicare Part B MPFS), must successfully report PQRS or a -2% adjustment in 2017

Value Modifier adjustment is applied to Physicians Only (for 2017)

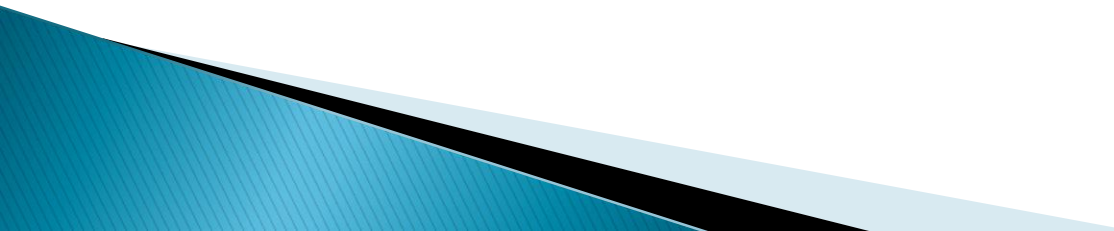
What is my Eligible Group Size?

- ▶ What is 50% to avoid the Value Modifier?
- ▶ Conflicting Information on # of Eligible Professionals – Example:
 - QRUR Report (24 claims, 33 PECOS)
 - Letters from CMS on Penalties in 2016 (92)
 - *QualityNet checked some of the NPIs and the Provider is Associated with a different TIN*

3. Decide Group or Individual Reporting

- ✓ Registration period WAS April 1 – June 30, 2015 to report as a Group
- ✓ Identify Group Size
 - ✓ CAHPS Required for Group size of 100 or more
- ✓ Identify Mechanism for Reporting based on Group Size
 - ✓ EHR eCQMs
 - ✓ Registry Individual Measure
 - ✓ GPRO Web Interface

4. Determine Reporting Mechanism

- ✓ Understand Your Reporting Options
 - ✓ General Reporting Requirements
 - ✓ CEHRT Able to Report PQRS Measures
 - ✓ Yes – engage with EHR Vendor
 - ✓ No – select a Registry Vendor, Claims Method
 - ▶ Considerations for Reporting Mechanisms
- 

Methods for Reporting

Reporting Methods in 2015					
METHOD	Individual	Group 2-9	Group 10-24	Group 25-99	Group 100+
Claims	X				
Registry Individual Measures	X	X	X	X	X
Registry Measures Group	X				
Certified EHR or Direct Submission Vendor	X	X	X	X	X
Qualified Clinical Data Registry (QCDR)	X				
GPRO Web Interface				X	X
Certified CG-CAHPS Survey Vendor		Optional	Optional	Optional	Mandatory

Individual Provider Claims Reporting

- ✓ This should have been the intended method for submitting PQRS Measures from Jan 1, 2015.
- ✓ Throughout 2015 the Quality Data Codes, QDCs, should have been included on each Claim submitted for measures chosen.

Deadline Feb 26, 2016 for
2015 Claims Processed

Qualified Clinical Data Registry Reporting

- ✓ A QCDR is a CMS–approved entity that collects medical and/or clinical data to foster improvement in the quality of care provided to patients and Submits on behalf of the EP.
- ✓ QCDR is not limited to measures within PQRS and may submit measures from one or more of the following categories;
 - ✓ CAHPS, NQF endorsed Measures, Current 2015 PQRS, Specialty Society Measures, Regional Quality Collaborations
- ✓ Participating Providers have access to Quality Resources through participation in a QCDR.
- ▶ *You should be fully engaged with the QCDR with Data collected and testing submission.*

Verify the QCDR Deadline!

Deadlines:

QCDR (QRDA) – Feb 29, 2016

QCDR (XLM) – Mar 31, 2016

EHR Reporting

- ✓ Be Engaged with EHR Vendor.
- ✓ Identified and selected measures for providers.
- ▶ If vendor is submitting on your behalf then
 - Prepare the QDRA I or III file format for testing and final submission.
 - YOU validate the data values
 - Vendor validates the Format
- ✓ If you are the “Direct Submission Vendor”
 - ✓ Will need to be registered as PQRS Submitter in EIDM
 - ✓ Generate the Correct QDRA File Format
 - Verify File acceptance with Validation tool on the QualityNet

Deadline Feb 29, 2016

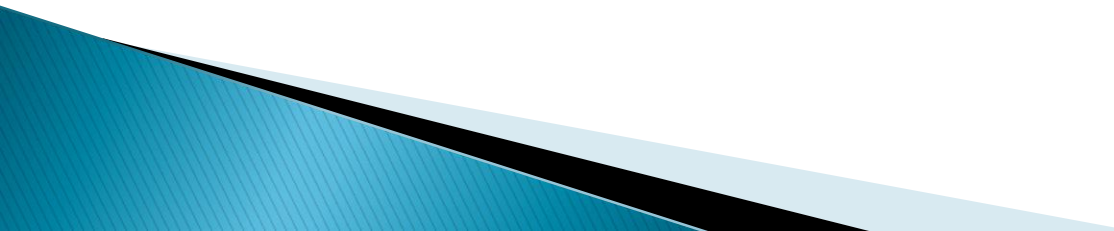
Registry Considerations

- ▶ Is the EHR Vendor also a Certified PQRS Registry Vendor?
- ▶ If No.. Choose and Engage with a Certified PQRS Registry
 - Understand the Vendors reporting capabilities
- ▶ Identified and now preparing data to submit through templates or through Format Identified by Vendor
- ▶ Capturing Data for Registry
 - Does Your EHR Vendor Report CQMs in Registry Format?
 - Are you able to run reports from EHR to capture the measure information?
 - If No, You will you need to abstract manually?

Be Aware of the Registry's Deadline!

Deadline Registry Submission –
Mar 31, 2016

5. Select Measures to Report

- ▶ Know the Reporting Requirements for the Mechanism
 - ▶ Understand the Measures Logic
 - ▶ Review Activity Contributing to the Value Modifier
 - ▶ Coordinate with EHR Vendor or Registries
 - ▶ Align with other Quality Programs
- 

2015 PQRS: General Reporting Requirements

- ▶ Requirement is to report 9 measures across 3 National Quality Strategy (NQS) domains.
 - 1.Patient Safety
 - 2.Person and Caregiver–Centered Experience and Outcomes
 - 3.Communication and Care Coordination
 - 4.Effective Clinical Care
 - 5.Community/Population Health
 - 6.Efficiency and Cost Reduction
- ▶ Same domains as the Clinical Quality Measures (CQM) domains for meaningful use.
- ▶ Required to report one “cross–cutting” measure if at least one Medicare face–to–face encounter.
(Claims and Registry Reporting)

Differences in Beneficiary Requirements

Criteria	Registry Reporting	EHR Reporting
No of Measures	9	9
No of Domains	3	3
% of Medicare Beneficiaries Required	<p>Measures must have at least 50% of Medicare Part B PFS patients.</p> <p>Each measure reported must be met at least once, no 0% reporting</p> <p>*unless an Inverse Measure</p>	<p>or Report the measures for which there is Medicare patient data. An EP must report on at least 1 measure containing Medicare patient data.</p> <p>Report on all payers.</p>

Lessons from the Field



Choosing Registry Measures – Ideas from the Field

- ▶ Individual Measure for Specific Provider type
 - Review recommended Measures on Registry or Specialty Sites
 - Some Situations:
 - Emergency Medicine– Adult Sinusitis Measure Group
 - Surgeons – General Surgery Measure Group
 - Cardiology – Coronary Artery Disease Measure Group
 - CRNA’s working in Clinic – Ambulatory measures so can use Measures Group (for example Diabetes, or Individual Measures)
 - CRNA’s Hospital based – Limited measures (#193)
 - Invoking MAV Process may be only Option
 - Investigate if Measures are in Cluster
 - Remember to report Cross–Cutting Measures

Registry Reporting Medicare Only (Option)

- ▶ You MAY report Medicare Only beneficiaries to achieve the >50% Medicare Patients reported requirement.
- ▶ Measure Example:
 - 120 beneficiaries (denominator), 50 beneficiaries are Medicare
 - Report only Medicare Beneficiaries would require you report at minimum 26 Medicare cases
 - Report whole population would require you to report a minimum of 50 cases: 50/99
- ▶ “Do not limit sample”

Inverse Measures – Example

Measure #238: Use of High-Risk Medications in the Elderly

Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported.

- 1) Percentage of patients who were ordered at least one high-risk medication.
- 2) Percentage of patients who were ordered at least two different high-risk medications.

- *Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.*

For measures reported there must be at least one patient or procedure in the numerator of the rate for the measure to be counted as meeting performance. For measures that move towards 100% to indicate higher quality outcome, the rate must be greater than 0%. For inverse measures where higher quality moves the rate towards 0% the rate must be less than 100%. Eligible professionals who fail these criteria for a reported measure will **not** proceed through MAV and will be subject to the 2017 payment adjustment.

6. Quality Measure Validation

- ▶ Analyze Data from EHR, or your Billing database
- ▶ Validate data for the Reporting Mechanism
 - Num/Den values are correct for measure
 - Data Format is correct for Submission Type
 - QualityNet Submission Engine Validation Engine Tool (SVET) Tool
 - Four Submission Types
 - Registry XML, QCDR XML, QRDA Category 1 and 3
 - EHR Direct Submissions – “File Passed Validation”

Quality Net SVET

The screenshot displays the CMS.gov QualityNet Submission Engine Validation Tool (SEVT) interface. At the top right, there is a "Log Off" button and the user name "Peter Rangelov". The main header includes the "CMS.gov" logo and "QualityNet".

Site Navigation

Welcome, qmuu884

Log Off

- PQRS Feedback Reports - Viewer
- **Submission Engine Validation Tool**
- Submission Reports
- Submissions

Submission Engine Validation Tool

This tool allows users to validate the format and/or content of a file prior to submission.
NOTE: This is not intended for GPRO/ACO web interface users.

- * Indicates required fields
- * Participation Year: 2015
- * Submission Type: (Required field-Submission Type)
 - Select One--
 - Registry XML
 - QCDR XML
 - QRDA Category 1**
 - QRDA Category 3
- * File:

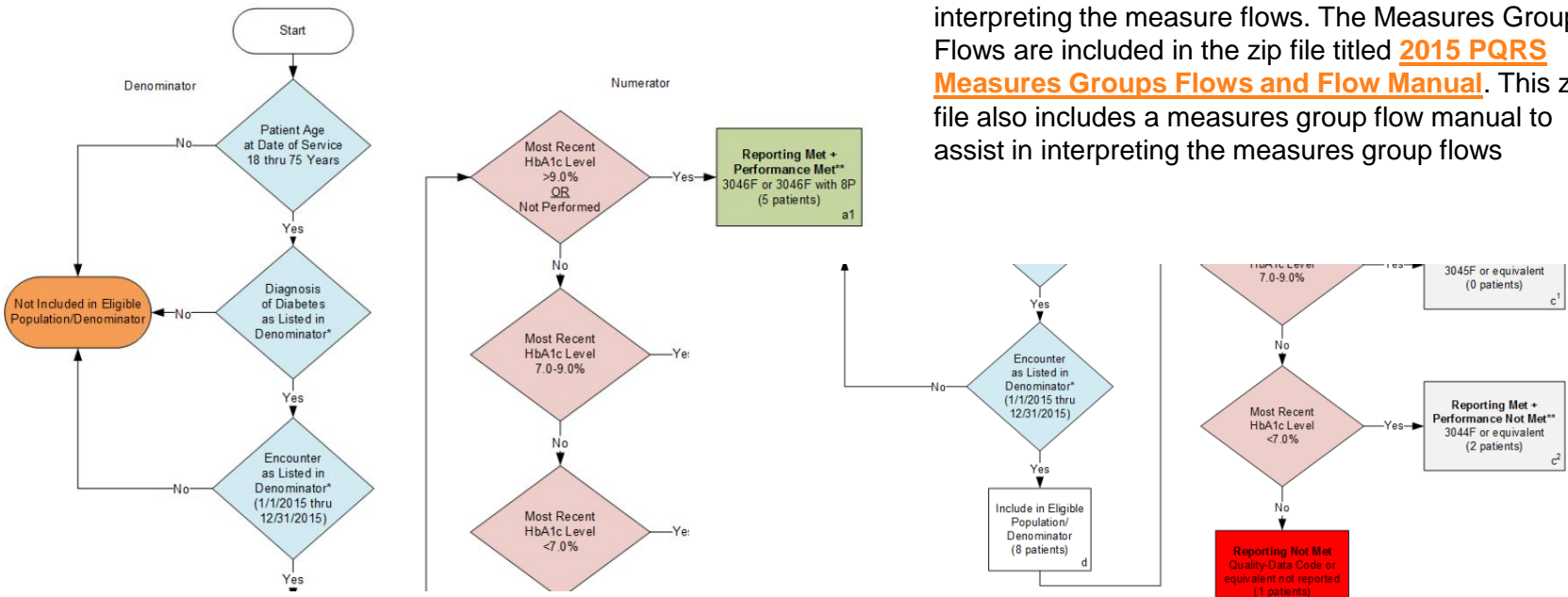
At the bottom of the page, there is a "QualityNet Home" button, the "CMS.gov" logo, and the text "QualityNet". On the right, it states: "A federal government website managed by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244" and includes the CMS logo.

[Submission Engine Validation Tool \(SEVT\) User Guide](#)

Workflows and Sample Calculations of Measures – (EHR and Claims/Registry)

The Individual Measure Flows are included in the zip file titled [2015 PQRS Individual Measure Flows and Flow Manual](#). This zip file also includes an individual claims/registry measure flow manual to assist in interpreting the measure flows. The Measures Group Flows are included in the zip file titled [2015 PQRS Measures Groups Flows and Flow Manual](#). This zip file also includes a measures group flow manual to assist in interpreting the measures group flows

2015 Claims/Registry Individual Measure Flow
PQRS #1 NQF #0059: Diabetes Mellitus: Hemoglobin A1c Poor Control



SAMPLE CALCULATIONS:

Reporting Rate=

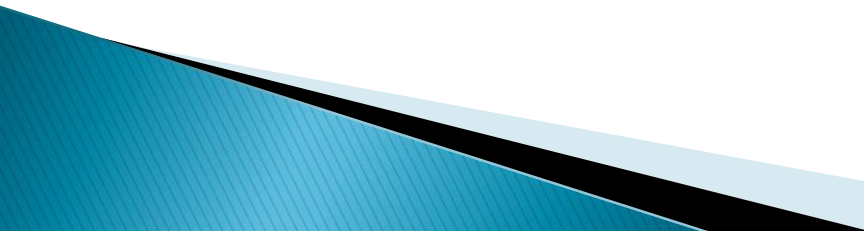
$$\frac{\text{Performance Met (a}^1=5 \text{ patients)} + \text{Performance Not Met (c}^1+c^2=2 \text{ patients)}}{\text{Eligible Population / Denominator (d=8 patients)}} = \frac{7 \text{ patients}}{8 \text{ patients}} = 87.50\%$$

Performance Rate**=

$$\frac{\text{Performance Met (a}^1=5 \text{ patients)}}{\text{Reporting Numerator (7 patients)}} = \frac{5 \text{ patients}}{7 \text{ patients}} = 71.43\%$$

*See the posted Measure Specification for specific coding and instructions to report this measure.
A low calculated performance rate for this measure indicates better clinical control and care.
NOTE: Reporting Frequency – Patient-intermediate

7. Quality Monitoring

- ▶ Periodically Run Measure Reports for monitoring
 - ▶ Validate Data from EHR
 - Ensure EHR is Configured Properly for Measures
 - Identify and verify workflow to improve measures
 - ▶ Review past performance on Cost/Quality from QRUR Report
 - ▶ Align with your other Quality Improvement Programs
- 

Key Points and Steps

- ▶ Finalize Measures for Reporting
- ▶ Work with EHR or Registry to Confirm
 - Data requirements, THEIR DEADLINES
- ▶ Create PQRS reports for Testing
 - Report or enter data into Registry Forms
 - Test submission to QualityNet
- ▶ Select final measures from 2015 to report
- ▶ Generate, Verify and Submit Data
 - Registry Form or QualityNet
- ▶ Verify data was submitted successfully

EHR Reporting Deadline: Feb 29, 2016

Registry Reporting Deadline: Mar 31, 2016

Not Started? Options?

- ▶ Still Time to report for 2015 Measures
- ▶ If Eligible to participate, you must report to Avoid penalties
- ▶ Identify Providers Eligible for 2015 – will report individual (unless registered GPRO)
- ▶ Talk to your EHR Vendor – Are you able to report eCQM and through them?
- ▶ If not, find a Registry and use this Resource
 - Vendor will be Requesting Your Information PRIOR to the Deadline – Guaranteed!
- ▶ Determine Measures to Report
- ▶ Collect the Data
- ▶ Prepare and submit ahead of Deadline

Changes in 2016

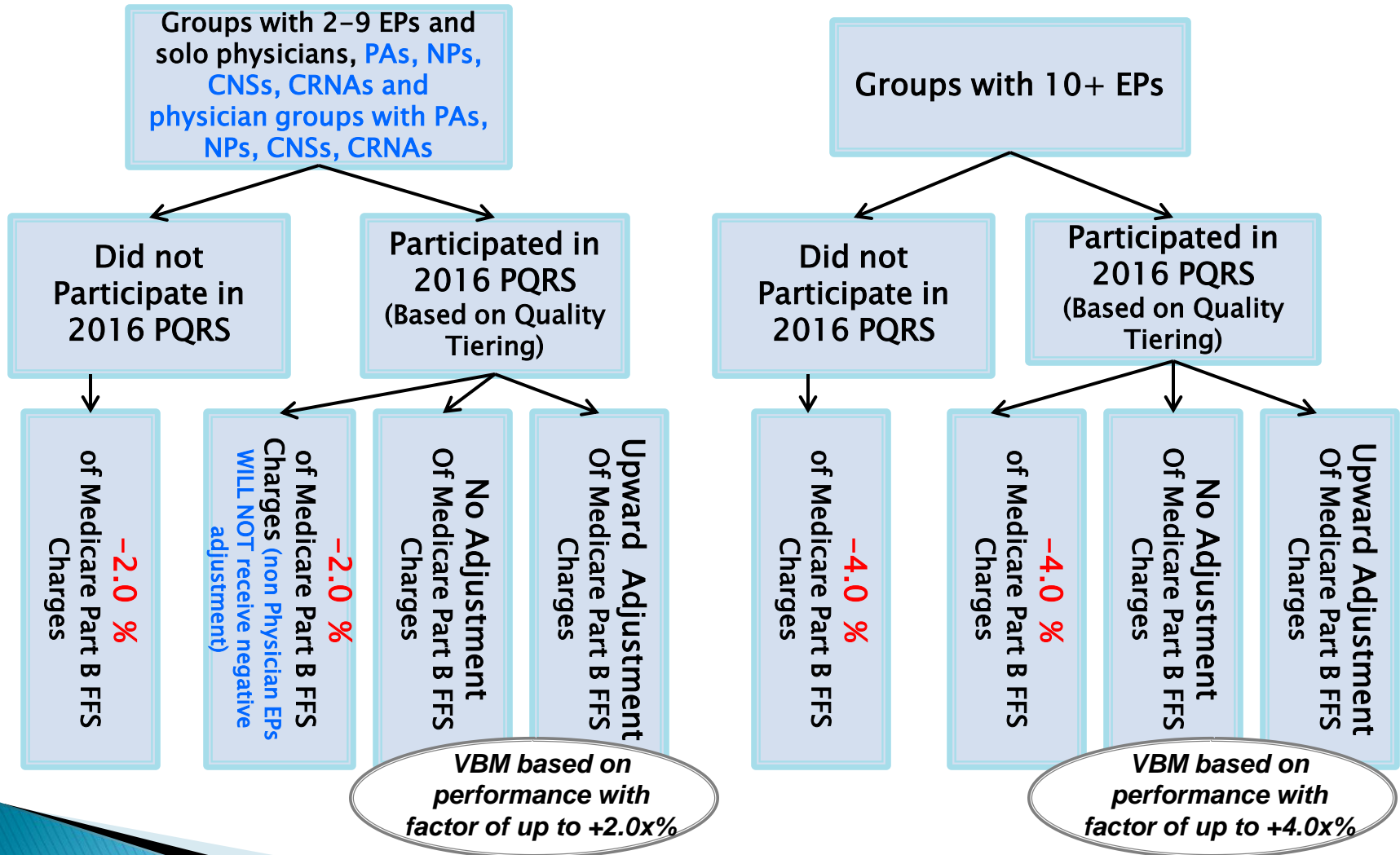
<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-30-2.html>

Value Modifier

- ▶ Groups and solo practitioners would be subject to upward, neutral, or downward adjustments derived under the quality-tiering methodology, with the exception that:
 - *groups consisting only of nonphysical EPs and solo practitioners who are nonphysical EPs will be held harmless from downward adjustments under the quality-tiering methodology in CY 2018*
- ▶ VM waived if at least one EP billed for PFS items and services under the TIN during the 2016 year in Pioneer ACO Model, Comprehensive Primary care Initiative CPCI or other similar Innovation center Models

Value Modifier Payment Adjustments for Eligible Professionals in 2018

(Based on 2016 Quality and Cost data)

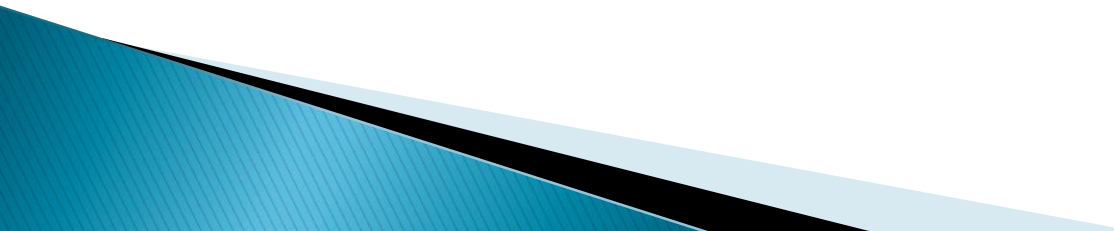


NOTE: In addition to PQRs 2% adjustment for not reporting successfully!

2016 Final Rule

- ▶ Consistent with the requirements for the 2017 PQRS payment adjustment
- ▶ Same criteria for satisfactory reporting as 2015 (9 measures over 3 domains).
- ▶ -2.0% adjustment for not satisfactorily reporting or participating

Measure Changes

- ▶ Add measures where gaps exist
 - ▶ “Eliminate measures that are topped out, duplicative, or being replaced with a more robust measure.”
 - ▶ 281 measures in the PQRS measure set
 - ▶ 18 measures in the GPRO web interface
 - ▶ Adding group reporting via QCDR
- 

Group Reporting

If you Register to report as a GPRO and decide to cancel, you must do so by the deadline.

- ▶ **ASSUME** Group practices will be able to register for the PQRS GPRO between **April 1, 2016 and June 30, 2016** as they did in 2015.
- ▶ Size of the group will determine the GPRO options
 - GPRO Web Interface available for groups of 25+ EPs
- ▶ The Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS is
 - Mandatory for groups of 100+ EPs
 - Optional for groups of 2–99 EPs

Reporting GPRO in 2016?

▶ Strongly Consider Reporting GPRO in 2016

◦ Pros

- Successfully Reporting will cover **ALL** providers in the Group TIN from PQRS and VM Penalties
- Registry: Report 9 measures/3 domains and not all Providers need to be represented in the Measures

◦ Cons:

- Group practices required to contract with a CMS certified vendor and bear administrative costs for the CAHPS survey if 25+ group size
- Must Register to report as Group by June 30, 2016, including the Method (If date is same as 2015)
- Measures may not be applicable to all Providers – May impact Physician Compare or other Public Reporting

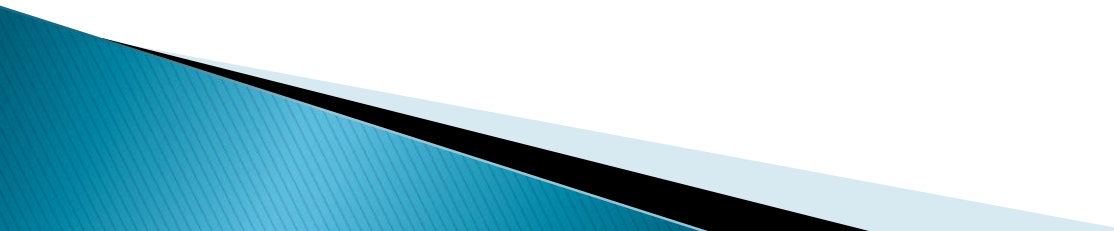
2016 PQRS: CAHPS for PQRS Survey

- ▶ In 2016, CAHPS is still mandatory for groups of 100+ EPs (in addition to other reporting methods)
 - Optional for groups of 2–99 EPs
- ▶ Group practices required to contract with a CMS certified vendor and bear administrative costs for the CAHPS survey
- ▶ Minimum Sample Size for CAHPS with (was 248 or 100% of assigned beneficiaries)
 - 100+ EPs minimum sample is 416
 - 25–99 EPs minimum sample is 255
 - 2–24 EPs minimum sample is 125
- ▶ 18 individual Measures (previously 17 in 2015)
- ▶ The CMS–certified survey vendor will administer and collect 12 summary survey modules on behalf of the group practice’s patients (previously 12 in 2015)

Performance/Payment Year Adjustments

- ▶ 2016 performance year → 2018 payment year
 - Last adjustment under PQRS.
- ▶ Starting 2017 performance year → 2019 payment year,
 - Adjustments to payment for quality reporting and other factors will be made under MIPS as required by MACRA.

Physician Compare

- All 2016 individual EP and group practice PQRS measures will be made available for public reporting.
 - All CAHPS for PQRS measures for groups of 2 or more EPs who meet the sample size requirements will be reported.
 - ACO measures, including CAHPS for ACOs are available for public reporting.
- 

Physician Compare Public Reporting Information Sessions

Medicare.gov | **Physician Compare**
The Official U.S. Government Site for Medicare

What:

Public Reporting Sessions

Session Dates and Times:

February 23, 2016 at 12:00 pm ET

February 24, 2016 at 4:00 pm ET

February 25, 2016 at 11:00 am ET

Where:

Virtual Event via WebEx

[Register Now!](#)

Physician Compare Public Reporting Information Sessions

Thank you for your interest in the upcoming Physician Compare webinars. The Centers for Medicare and Medicaid Services (CMS) will host public reporting information sessions about recent updates to the [Physician Compare](#) website and future plans for public reporting on Physician Compare, including a publicly reported benchmark and star ratings ([80 FR 71128-71129](#)).

Each one-hour webinar will offer participants the opportunity to ask questions about public reporting and quality measures on Physician Compare. Webinars will be conducted via WebEx.

All sessions will present the same information. Multiple times are offered to help best accommodate your busy schedules. During each webinar, the Physician Compare Support Team will present information and then address participant questions.

Thank you,

The Physician Compare Support Team

Upcoming Webinars

[Register](#) for our upcoming webinars –

HTS HOSTED PUBLIC WEBINAR:

- ▶ **Wednesday, Feb 24 1–2pm MST**
*2016 MU Modified Stage 2 program Requirements Review

OTHERS WEBINARS OF INTEREST:

- ▶ **Monday, Feb 8, 2016 1–2:00 pm MST**
*PQRS–CAH Virtual Office Hours (QIN NCC and PQRS Team))
<https://qualitynet.webex.com/mw3000/mywebex/default.do?siteurl=qualitynet>
- ▶ **Wednesday Feb 10 or 17, 2016 9:30–11am MDT**
*2016 Medicare Quality Reporting Programs (CMS)

Questions?



**Please complete our survey
after the webinar!**