Value-Based Payment Modifier

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Presented by

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ALLIANT QUALITY

Learning Objectives

- Describe the role of the Quality Improvement Organization (QIO)
- Define Value-Based Payment Modifier and PQRS programs
- Describe how to participate in the program
- Understand the PQRS penalties and how to avoid them

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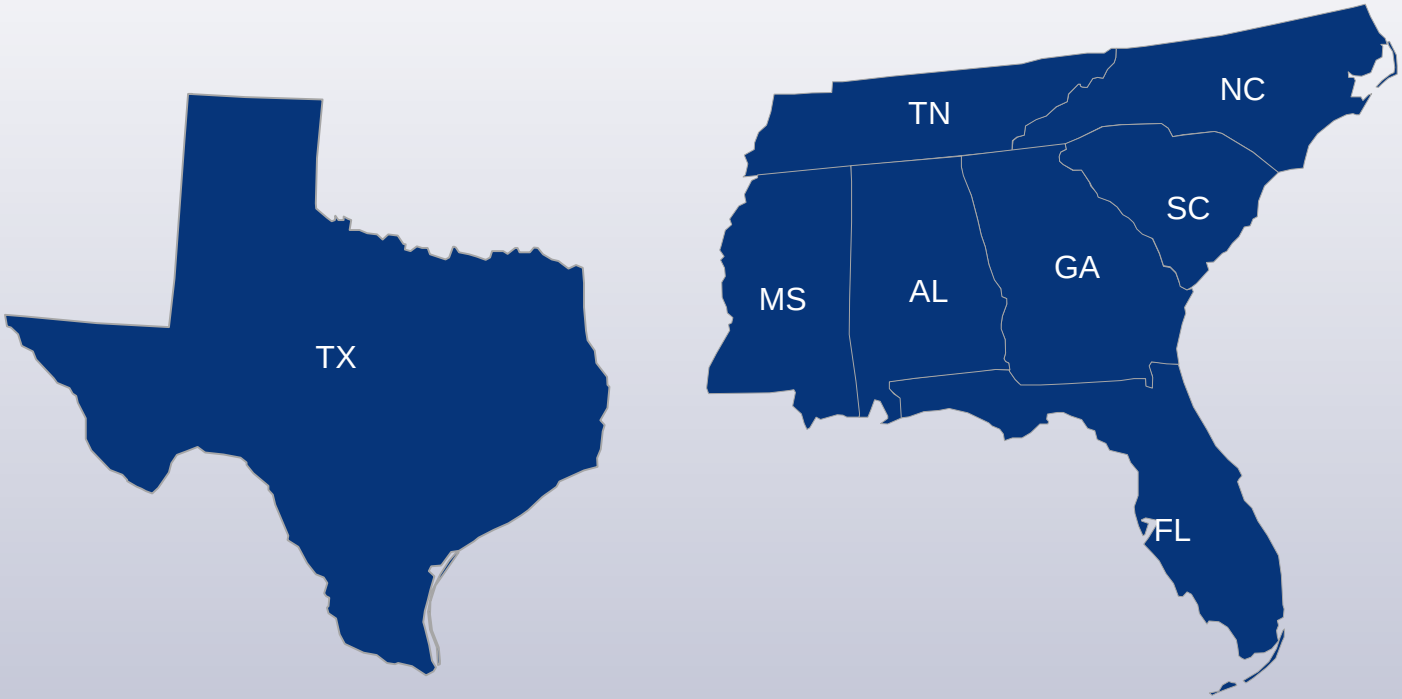
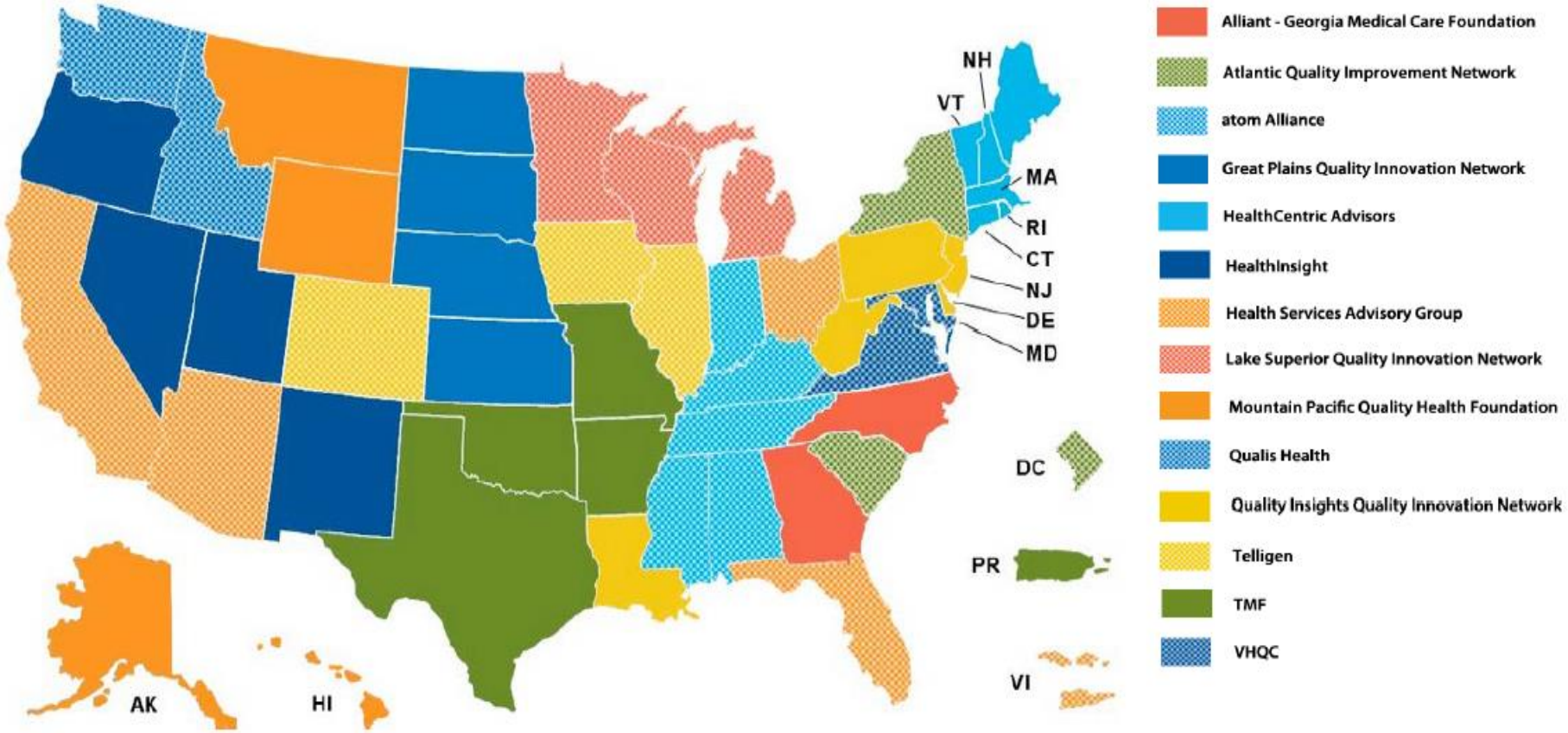


11 SOW QIN-QIO Map



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QIN NCC Quality Innovation Network National Coordinating Center

11 SOW QIN-QIO
August 2014 – July 2019
Key Roles

1. **Results Oriented**
   A Multi-state & Local Change-agent Champion
2. **Learning & Action Networks**
   A Facilitator of Learning & Action
3. **Technical Assistance**
   A Teacher & Advisor
4. **Communication**
   A Highly-effective Communicator and Trusted Partner

Support Quality Reporting with an Emphasis on Improvement

Develop expertise in and support physician reporting through PQRS and participation in Value Modifier/Physician Feedback program

Technical assistance to inpatient psychiatric facilities to *improve* on incentive measures

Support physicians in quality improvement initiatives based upon Value Modifier/ Physician Feedback performance

Collaborate with REC to identify and characterize physicians not reporting data electronically

Better Care, Smarter Spending, Healthier People

- In three words, our vision for improving health delivery is about **better, smarter, healthier.**
- If we find better ways to **deliver care, pay providers, and distribute information**, we can receive better care, spend our dollars more wisely, and have healthier communities, a healthier economy, and a healthier country.
- We understand that it's **our role and responsibility to lead … and we will.**
- What we won't do – and can't do – is go it alone. Patients, providers, government, and business all stand to benefit if we get this right, and this **shared purpose calls out for deeper partnership**.
- So we will continue to work across sectors for the goals we share: **better care, smarter spending, and healthier people**.

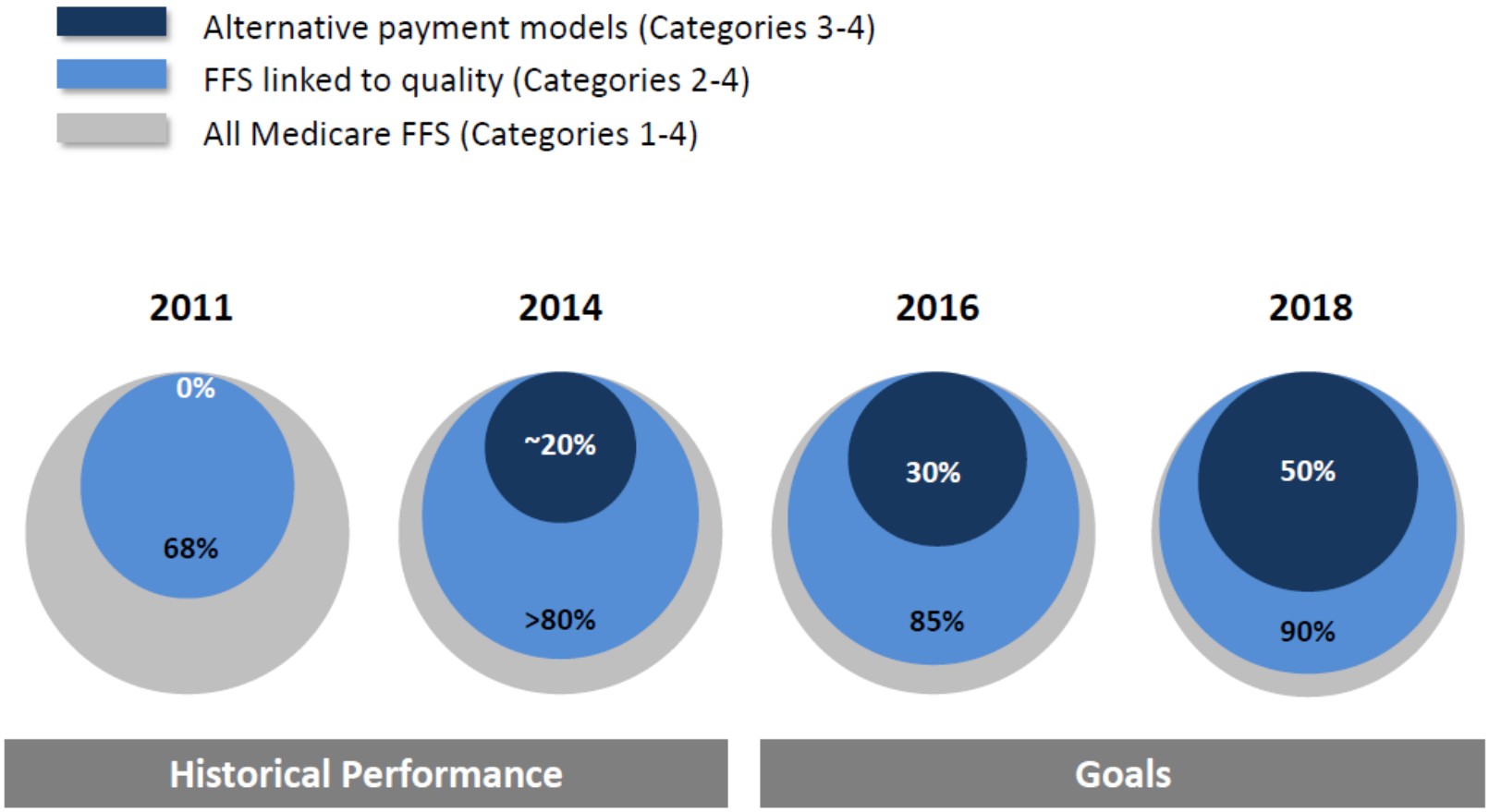
Dr. Patrick Conway, M.D., MSc
CMS Chief Medical Officer and Deputy Administrator for Innovation and Quality Director,
Center for Medicare and Medicaid innovation, Director, Center for Clinical Standards and Quality

CMS has adopted a framework that categorizes payments to providers

	Category 1: Fee for Service – No Link to Value	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models Built on Fee-for-Service Architecture	Category 4: Population-Based Payment
Description	▪ Payments are based on volume of services and not linked to quality or efficiency	▪ At least a portion of payments vary based on the quality or efficiency of health care delivery	▪ Some payment is linked to the effective management of a population or an episode of care ▪ Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk	▪ Payment is not directly triggered by service delivery so volume is not linked to payment ▪ Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)
Medicare Fee-for-Service examples	▪ Limited in Medicare fee-for-service ▪ Majority of Medicare payments now are linked to quality PQRS	▪ Hospital value-based purchasing ▪ Physician Value Modifier ▪ Readmissions / Hospital Acquired Condition Reduction Program	▪ Accountable Care Organizations ▪ Medical homes ▪ Bundled payments ▪ Comprehensive Primary Care initiative ▪ Comprehensive ESRD ▪ Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	▪ Eligible Pioneer Accountable Care Organizations in years 3-5 ▪ Maryland hospitals

Source: Rajkumar R, Conway PH, Tavenner M. CMS – engaging multiple payers in payment reform. JAMA 2014; 311: 1967-8.

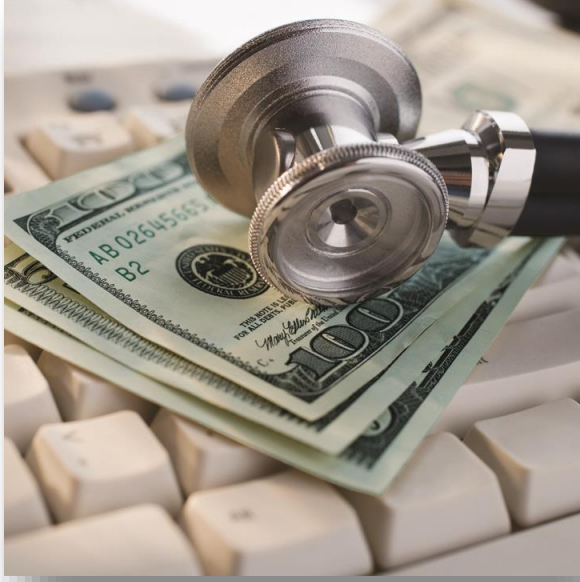
Target percentage of payments in 'FFS linked to quality' and 'alternative payment models' by 2016 and 2018



Four *Distinct* National Programs

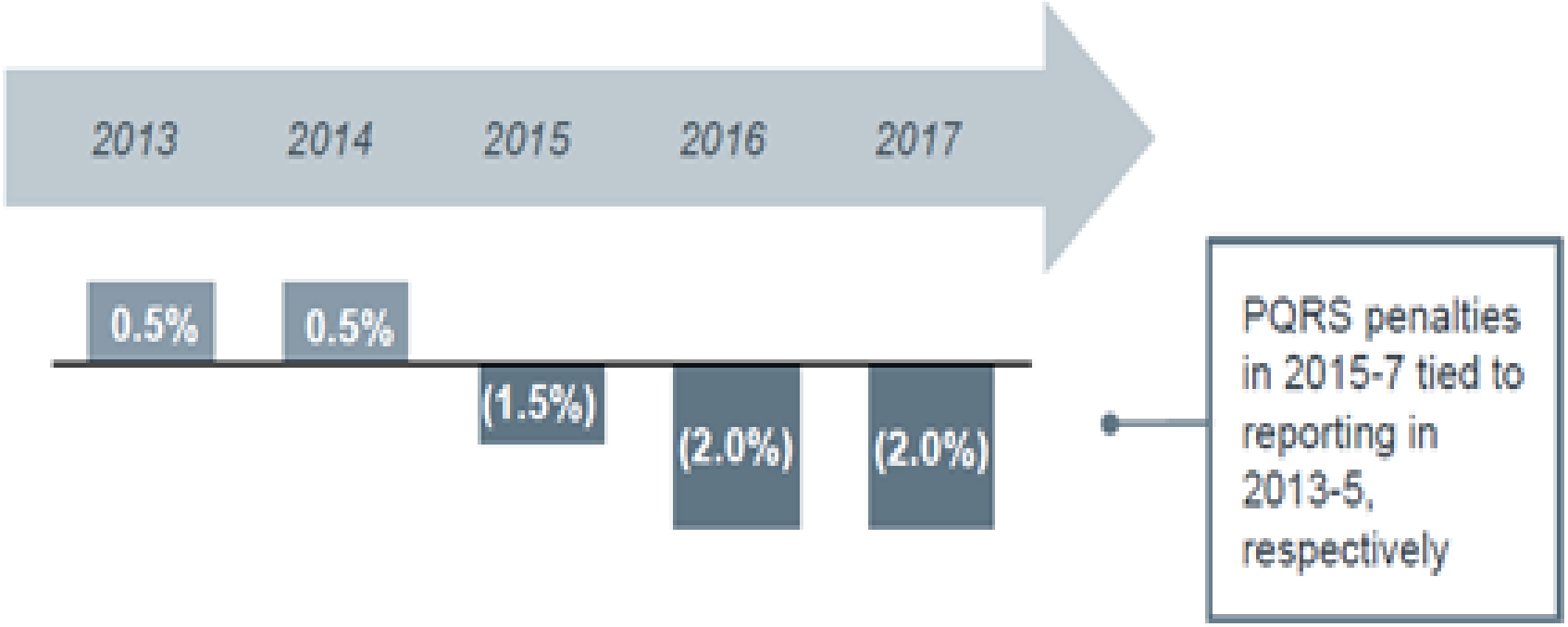
- **Meaningful Use**
  - Incentives/penalties to fund installation and use of electronic health records through the American Recovery and Reinvestment Act (ARRA)
- **Physician Quality Reporting System (PQRS)**
  - Authorized under the Tax Relief and Healthcare Act of 2006
- **ePrescribing Program (eRx)**
  - Authorized under Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (incentive ended *in 2014*)
- **Value-based Payment Modifier (VM)**
  - Authorized under the Patient Protection and Affordable Care Act of 2010

What is PQRS?



- PQRS stands for “Physician Quality Reporting System” formerly PQRI
- Established in 2007 required by the 2006 Tax Relief and Health Care Act (TRHCA)
- Voluntary program until 2013

Financial penalties for PQRS non-participation began in 2013 and will increase up to 2% in 2017



Source: CMS, "CY 2015 Physician Fee Schedule Final Rule," October 31, 2014, available at: www.federalregister.gov ; Advisory Board Company interviews and analysis.

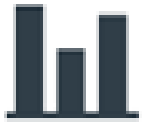
What is the Value-Based Payment Modifier (Value Modifier -VM)

VM provides for differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule (PFS) based upon the quality of care furnished compared to the cost of care during a performance period. The VM is an adjustment made on a per claim basis to Medicare payments for items and services under the Medicare PFS. It is applied at the Taxpayer Identification Number (TIN) level to physicians.

Implementation of the VM is based on participation in Physician Quality Reporting System

How does the VM work?

1. CMS Collects Cost, Quality Data



- Providers report performance on PQRS[1], CG-CAHPs[2] measures
- CMS track per capita costs for Medicare parts A and B

2. CMS Groups Providers into Quality Tiers

- Provider, group performance risk-adjusted, compared to national averages
- Final scores tiered, assigned modifiers

3. Medicare Payment Adjusted Based on Tiering

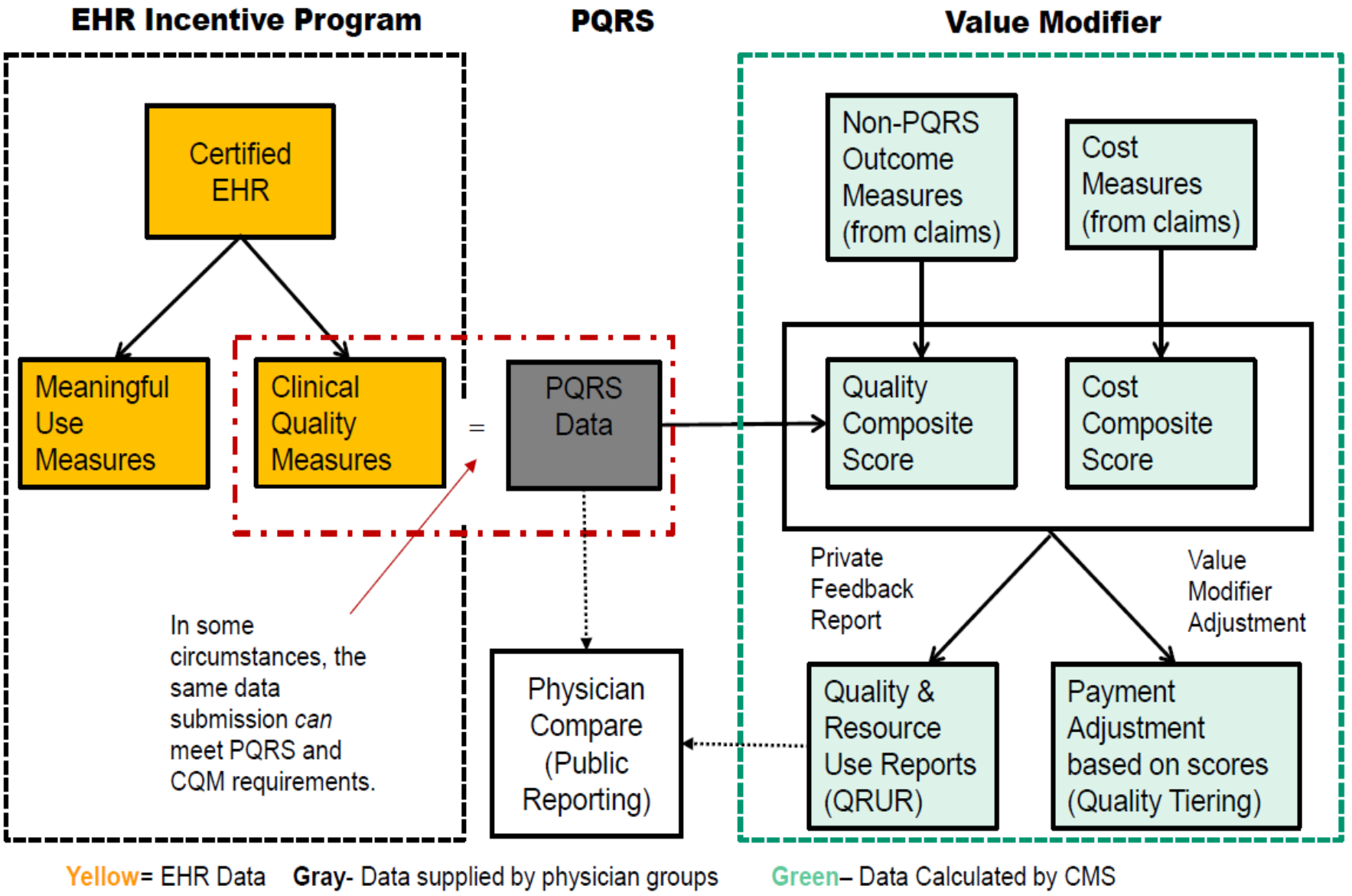
- High performing groups will receive payment boosts, low performers will see payment reduction
- Failure to participate in PQRS results in maximum penalty

Quality Tiering Under the Value Modifier

Quality/cost	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Medium quality	+1.0x*	+0.0%	-1.0%
Low quality	+0.0%	-1.0%	-2.0%

* Program is revenue-neutral so exact incentive will depend on number eligible for incentive

Alignment of Programs



Quality Resource and Use Reports (QRURs)

- Annual reports that determines upward, downward, or neutral adjustments
- Comparative information about the quality of care furnished, and the cost of that care, to their Medicare fee-for-service (FFS) patients
- Beneficiary-specific information to help coordinate and improve the quality and efficiency of care furnished
- Information on how the provider group would fare under the value-based payment modifier (VM)

How will the VM payment adjustments affect your organization in the future?

Group Size (Number of Providers)	2015[3]	2016	Finalized for 2017	Finalized for 2018
100+	↓↓↑	↓↓↑	↓↓↑	↓↓↑
10-99	No Adjustment	↓↑	↓↓↑	↓↓↑
1-9	No Adjustment	No Adjustment	↓↑	↓↓↑
Non-Physician EPs[4], Any Group Size	No Adjustment	No Adjustment	No Adjustment	↓↓↑

↓ Penalties for PQRS non-reporting

↓ Negative adjustment based on performance

↑ Positive adjustment based on performance

3) 2015 performance-based adjustments only apply to groups that chose to participate in quality tiering in 2013.
4) Non-physician eligible providers include all non-physician providers who bill Medicare under a group's tax ID number.

Medicare Payment Adjustment Calculator

If you participate in any of the following incentive programs offered by the Centers for Medicare & Medicaid Services (CMS), use this worksheet to calculate the various payment adjustments that affect your practice: Meaningful Use (MU); Physician Quality Reporting System (PQRS); Value-Based Payment Modifier (VBM).

http://www.hsag.com/contentassets/061ff241ceb542769e4102c0fb79b125/medicare-payment-adjustment-calculator.xlsx.

Reporting Year:	**2013**	**2014**	**2015**	**2016**	**2017**
Payment Year:	**2015**	**2016**	**2017**	**2018**	**2019**
Payment adjustments for:					
MU	2.00%	2.00%	3.00%	4.00%	5.00%
PQRS	1.50%	2.00%	2.00%	2.00%	2.00%
VBM	1.00%	2.00%	2.00%	2.00%	2.00%

Calculating estimated payment adjustments:

Select reporting year from drop-down menu:	2015
Payment year is automatically entered:	**2017**
Enter estimated Medicare Part B allowable charges for payment year:	$ 150,000.00

Estimated payment adjustments:

MU	3.0%	**MU Payment Lost:**	$	4,500.00
PQRS	2.0%	**PQRS Payment Los**	$	3,000.00
VBM	2.0%	**VBM Payment Lost**	$	3,000.00
Total payment adjustment	7.0%	**Total Payment Los**	$	10,500.00

Value-based payment adjustment calendar

Reporting Year 2013: Payment Year 2015	For groups of 100 or more eligible providers billing under a single (TIN)
Reporting Year 2014: Payment Year 2016	For groups of 10 or more eligible providers billing under a single TIN
Reporting Year 2015: Payment Year 2017	For all eligible providers

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5 Steps to PQRS Participation

1. Determine if you are an eligible professional (EP)
2. Review the list of PQRS Measures/pick all measures specific to your specialty
3. Select your chosen reporting method based on those measures
4. Register for an IACS account before fall of each year and keep it current
5. Periodically review your feedback report that details your reporting outcomes

Who is Eligible to Participate?

	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			
Doctor of Osteopathy	X	X	X	X			
Doctor of Podiatric Medicine	X	X	X	X			
Doctor of Optometry	X	X	X	X			
Doctor of Oral Surgery	X	X	X	X			
Doctor of Dental Medicine	X	X	X	X			
Doctor of Chiropractic	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				
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				

VM implemented in 2015 for groups of 100+ EPs (based on 2013 PQRS performance; for groups of 10+ EPs in 2016 (based on 2014 PQRS performance)

For 2016 VM (based on 2014 PQRS performance), physicians in groups of 10-99 EPs will be subject to upward or neutral adjustment; physicians in groups of 100+ EPs will be subject to upward, neutral, or downward adjustment (based on tiering structure)

What is a measure?

Measures consist of two major components: denominators and numerators.

PQRS Denominators and Numerators

Numerator

- The upper portion of a fraction used to calculate a rate, proportion, or ratio. The numerator must detail the quality clinical action expected that satisfies the condition(s) and is the focus of the measurement for each patient, procedure, or other unit of measurement established by the denominator (that is, patients who received a particular service or providers that completed a specific outcome/process).

Denominator

- The lower portion of a fraction used to calculate a rate, proportion, or ratio. The denominator must describe the population eligible (or episodes of care) to be evaluated by the measure. This should indicate age, condition, setting, and timeframe (when applicable). For example, "Patients aged 18 through 75 years with a diagnosis of diabetes."

Each component is defined by specific codes described in the respective measure's specification along with the reporting instructions and use of modifiers.

Measure Specification Construct
(example)

NUMERATOR

CPT II 4004F

CPT II 1036F

CPT II 4004F *with* 1P

CPT II 4004F *with* 8P

(**Clinical action** required for performance)

DENOMINATOR

90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90815, 90845, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

(Describes **eligible cases** for which a **clinical action** was performed: the eligible patient population as defined by denominator specification)

The National Quality Strategy (NQS)

In 2015, measures are classified according to the 6 NQS domains based on the NQS's priorities. PQRS reporting mechanisms typically require an EP or PQRS group practice to report 9 or more measures covering at least 3 NQS domains, and cross-cutting measures for EPs with billable face-to-face encounters for satisfactory reporting or participation to avoid the 2017 negative payment adjustment.

The Six NQS Domains

Patient Safety	Person and Caregiver-Centered Experience and Outcomes	Communication and Care Coordination
Effective Clinical Care	Community/ Population Health	Efficiency and Cost Reduction

What are the Reporting Methods?

Individual EPs	PQRS Group Practices
EHR direct product that is Certified Electronic Health Record Technology (CEHRT)	GPRO Web Interface (25+ providers)
EHR data submission vendor (DSV) that is CEHRT	Qualified PQRS registry (2+ providers)
Qualified PQRS registry	EHR direct product that is CEHRT (2+ providers)
Qualified Clinical Data Registry (QCDR)	EHR data submission vendor that is CEHRT (2+ providers)
Medicare Part B claims submitted to CMS	CAHPS for PQRS using CMS-certified survey vendor (2+ providers) (CAHPS is supplemental to other reporting mechanisms)
	• *PQRS group practices must register for the GPRO and select their reporting mechanism by June 30, 2015. For more information about reporting PQRS measures as a group, visit the* Group Practice Reporting Option webpage.

Claims /Registry/Cross Cutting Measures

- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
- Documentation of Current Medications in the Medical Record
- Pain Assessment and Follow-Up
- Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- Medication Reconciliation
- Care Plan

▲ Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention -- National Quality Strategy Domain: Community/Population Health

DESCRIPTION:
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months **AND** who received cessation counseling intervention if identified as a tobacco user

NUMERATOR:
Patients who were screened for tobacco use at least once within 24 months **AND** who received tobacco cessation counseling intervention if identified as a tobacco user

Definitions:
Tobacco Use – Includes use of any type of tobacco.
Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy.

NUMERATOR NOTE: *In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling report* ***4004F*** *with* ***8P****.*

Numerator Options:
Performance Met: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user **(4004F)**
OR
Performance Met: Current tobacco non-user **(1036F)**

OR

Medical Performance Exclusion: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reasons) **(4004F *with* 1P)**

OR

Performance Not Met: Tobacco screening OR tobacco cessation intervention **not** performed, reason not otherwise specified **(4004F *with* 8P)**

Dementia Measure Group Reporting

- 280 – Staging of Dementia
- 282 – Functional Status Assessment
- 283 – Neuropsychiatric Symptom Assessment
- 284 – Management of Neuropsychiatric Symptoms
- 285 – Screening for Depressive Symptoms
- 286 – Counseling Regarding Safety Concerns
- 287 – Counseling Regarding Risks of Driving
- 288 – Caregiver Education and Support

▲ Measure #281: Dementia: Cognitive Assessment -- National Quality Strategy Domain: Effective Clinical Care

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period

NUMERATOR:
Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period

Numerator Instructions:
Cognition can be assessed by the clinician during the patient's clinical history. Cognition can also be assessed by direct examination of the patient using one of a number of instruments, including several originally developed and validated for screening purposes. This can also include, where appropriate, administration to a knowledgeable informant. Examples include, but are not limited to:

- Blessed Orientation-Memory-Concentration Test (BOMC)
- Montreal Cognitive Assessment (MoCA)
- St. Louis University Mental Status Examination (SLUMS)
- Mini-Mental State Examination (MMSE) *[Note: The MMSE has not been well validated for non-Alzheimer's dementias.]*
- Short Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)
- Ascertain Dementia 8 (AD8) Questionnaire
- Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) *[Note: Validated for use with nursing home patients only]*
- Formal neuropsychological evaluation

Numerator Options:
Performance Met: Cognition assessed and reviewed **(1494F)**

OR

Medical Performance Exclusion: Documentation of medical reason(s) for not assessing cognition (eg, patient with very advanced stage dementia, other medical reason) **(1494F *with* 1P)**
OR
Patient Performance Exclusion: Documentation of patient reason(s) for not assessing cognition **(1494F *with* 2P)**

OR

Performance Not Met: Cognition **not** assessed and reviewed, reason not otherwise specified **(1494F *with* 8P)**

Registry Reporting Only Measures

- Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Follow-up After Hospitalization for Mental Illness (FUH)
- Tobacco Use and Help with Quitting Among Adolescents
- Preventive Care and Screening: Unhealthy Alcohol Use – Screening

EHR Reporting

- Depression Utilization of the PHQ-9 Tool
- Maternal Depression Screening
- Depression Remission at Twelve Months
- Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance Use
- ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
- Anti-Depressant Medication Management
- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

I WANT TO PARTICIPATE IN 2015 PQRS TO AVOID THE 2017 NEGATIVE PAYMENT ADJUSTMENT

SELECT REPORTING METHOD

(Refer to the 2015 Physician Quality Reporting System Measures List *for a listing of all 2015 measures and associated NQS domains for a specific reporting method. Also review the appropriate measure specifications for the selected reporting method(s) 2015 for PQRS.)*

CHOOSE CLAIMS-BASED REPORTING OPTIONS TO AVOID 2017 PQRS NEGATIVE PAYMENT ADJUSTMENT

REGISTRY-BASED REPORTING

EHR-BASED REPORTING

GROUP PRACTICE REPORTING OPTION

QUALIFIED CLINICAL DATA REGISTRY-BASED REPORTING

< 9 MEASURES COVERING 3 NQS DOMAINS APPLY

[1] REPORT ON 1-8 INDIVIDUAL MEASURES

12 MONTHS
1/1/15-12/31/15

REPORT **≥ 50%** OF APPLICABLE MEDICARE PART B FFS PATIENTS

IF EP SEES AT LEAST 1 MEDICARE PATIENT IN FACE TO FACE ENCOUNTER, REPORT AT LEAST 1 CROSS-CUTTING MEASURE

Measures with a 0% performance rate will be considered in analysis but will not be considered satisfactorily reported for incentive eligibility

Subject to Claims-based Measure Applicability Validation (MAV)

≥ 9 MEASURES COVERING 1-2 NQS DOMAINS APPLY

[2] REPORT ON ≥ 9 INDIVIDUAL MEASURES COVERING APPLICABLE DOMAINS

12 MONTHS
1/1/15-12/31/15

REPORT **≥ 50%** OF APPLICABLE MEDICARE PART B FFS PATIENTS

IF EP SEES AT LEAST 1 MEDICARE PATIENT IN FACE TO FACE ENCOUNTER, REPORT AT LEAST 1 CROSS-CUTTING MEASURE

Measures with a 0% performance rate will be considered in analysis but will not be considered satisfactorily reported for incentive eligibility

Subject to Claims-based Measure Applicability Validation (MAV)

≥ 9 MEASURES COVERING 3 OR MORE NQS DOMAINS APPLY

[3] REPORT ON ≥ 9 INDIVIDUAL MEASURES

12 MONTHS
1/1/15-12/31/15

REPORT **≥ 50%** OF APPLICABLE MEDICARE PART B FFS PATIENTS

IF EP SEES AT LEAST 1 MEDICARE PATIENT IN FACE TO FACE ENCOUNTER, REPORT AT LEAST 1 CROSS-CUTTING MEASURE

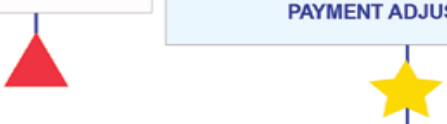
Measures with a 0% performance rate will be considered in analysis but will not be considered satisfactorily reported for incentive eligibility

I WANT TO PARTICIPATE IN 2015 PQRS
TO AVOID THE 2017 NEGATIVE PAYMENT ADJUSTMENT

SELECT REPORTING METHOD

(Refer to the 2015 Physician Quality Reporting System Measures List *for a listing of all 2015 measures and associated NQS domains for a specific reporting method. Also review the appropriate measure specifications for the selected reporting method(s) 2015 for PQRS.)*

- CLAIMS-BASED REPORTING
- **CHOOSE REGISTRY-BASED REPORTING OPTIONS TO AVOID 2017 PQRS NEGATIVE PAYMENT ADJUSTMENT**
- EHR-BASED REPORTING
- GROUP PRACTICE REPORTING OPTION
- QUALIFIED CLINICAL DATA REGISTRY-BASED REPORTING



INDIVIDUAL MEASURES

< 9 MEASURES COVERING 3 OR MORE NQS DOMAINS APPLY

[4] REPORT ON 1-8 INDIVIDUAL MEASURES

12 MONTHS
1/1/15-12/31/15

REPORT **≥ 50%** OF APPLICABLE MEDICARE PART B FFS PATIENTS

IF EP SEES AT LEAST 1 MEDICARE PATIENT IN FACE TO FACE ENCOUNTER, REPORT AT LEAST 1 CROSS-CUTTING MEASURE

Measures with a 0% performance rate will not be counted

Subject to Registry-based Measure Applicability Validation (MAV)

≥ 9 MEASURES COVERING 1-2 NQS DOMAINS APPLY

[5] REPORT ON ≥ 9 INDIVIDUAL MEASURES COVERING APPLICABLE DOMAINS

12 MONTHS
1/1/15-12/31/15

REPORT **≥ 50%** OF APPLICABLE MEDICARE PART B FFS PATIENTS

IF EP SEES AT LEAST 1 MEDICARE PATIENT IN FACE TO FACE ENCOUNTER, REPORT AT LEAST 1 CROSS-CUTTING MEASURE

Measures with a 0% performance rate will not be counted

Subject to Registry-based Measure Applicability Validation (MAV)

≥ 9 MEASURES COVERING 3 NQS DOMAINS APPLY

[6] REPORT ON ≥ 9 INDIVIDUAL MEASURES COVERING 3 NQS DOMAINS

12 MONTHS
1/1/15-12/31/15

REPORT **≥ 50%** OF APPLICABLE MEDICARE PART B FFS PATIENTS

IF EP SEES AT LEAST 1 MEDICARE PATIENT IN FACE TO FACE ENCOUNTER, REPORT AT LEAST 1 CROSS-CUTTING MEASURE

Measures with a 0% performance rate will not be counted

MEASURES GROUP(S)

SUBMIT ≥ 1 MEASURES GROUP FOR

12 MONTHS
1/1/15-12/31/15

[7] FOR ≥ 20 APPLICABLE PATIENTS FOR A MEASURES GROUP

(Only a majority [11] must be Medicare Part B FFS patients)

Measures Groups containing a measure with a 0% performance rate will not be counted

I WANT TO PARTICIPATE IN 2015 PQRS TO AVOID THE 2017 NEGATIVE PAYMENT ADJUSTMENT

SELECT REPORTING METHOD

(Refer to the 2015 Physician Quality Reporting System Measures List *for a listing of all 2015 measures and associated NQS domains for a specific reporting method. Also review the appropriate measure specifications for the selected reporting method(s) 2015 for PQRS.)*

CLAIMS-BASED REPORTING

REGISTRY-BASED REPORTING

CHOOSE EHR-BASED REPORTING OPTIONS TO AVOID 2017 PQRS NEGATIVE PAYMENT ADJUSTMENT

GROUP PRACTICE REPORTING OPTION

QUALIFIED CLINICAL DATA REGISTRY-BASED REPORTING

PHYSICIAN QUALITY REPORTING SYSTEM – MEDICARE EHR INCENTIVE PROGRAM

DIRECT EHR-BASED PRODUCT THAT IS CEHRT
OR
EHR DATA SUBMISSION VENDOR THAT IS CEHRT

[8,9]

REPORT ON ≥ 9 MEASURES COVERING 3 NQS DOMAINS DOMAINS

If an EP's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the EP must report the measures for which there is Medicare patient data. An EP must report on at least 1 measure for which there is Medicare patient data.

12 MONTHS
1/1/15-12/31/15

Note: Successful submission of CQM data will qualify EP for the PQRS incentive and meet the CQM component of the Medicare EHR Incentive Program

Refer to the EHR Incentive Program website documents for a listing of 2015 CQMs for EPs and supporting documentation

I WANT TO PARTICIPATE IN 2015 PQRS TO AVOID THE 2017 NEGATIVE PAYMENT ADJUSTMENT

SELECT REPORTING METHOD

(Refer to the 2015 Physician Quality Reporting System Measures List *for a listing of all 2015 measures and associated NQS domains for a specific reporting method. Also review the appropriate measure specifications for the selected reporting method(s) 2015 for PQRS.)*

- CLAIMS-BASED REPORTING
- REGISTRY-BASED REPORTING
- EHR-BASED REPORTING
- **GROUP PRACTICE REPORTING OPTION TO AVOID 2017 PQRS NEGATIVE PAYMENT ADJUSTMENT**
  (A group practice must register to participate in PQRS under GPRO via the web by June 30, 2015. Group practices participating in GPRO must maintain the same TIN throughout the program year.)
- QUALIFIED CLINICAL DATA REGISTRY-BASED REPORTING

2+ ELIGIBLE PROFESSIONALS

REGISTRY-BASED REPORTING

< 9 MEASURES COVERING 3 NQS DOMAINS APPLY

[10] REPORT ON 1-8 INDIVIDUAL MEASURES AS A GROUP
OR
Have all CAHPS for PQRS summary survey modules (12) reported on the group's behalf via a CMS-certified survey vendor
AND
Report at least 6 additional measures covering 2 NQS domains using a qualified registry

Of these 6 measures, if any EP in the group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice is required to report on at least 1 measure in the cross-cutting measure set.

Note: A group practice wishing to utilize this option must indicate its intent to have the CAHPS for PQRS survey reported when registering to participate in the PQRS via GPRO.

12 MONTHS
1/1/15-12/31/15

REPORT **≥ 50%** OF APPLICABLE MEDICARE PART B FFS PATIENTS; IF EP SEES AT LEAST 1 MEDICARE PATIENT IN FACE-TO-FACE ENCOUNTER, REPORT AT LEAST 1 CROSS-CUTTING MEASURE

Measures with a 0% performance rate will not be counted

Subject to Registry Measure Applicability Validation (MAV)

≥ 9 MEASURES COVERING 1-2 NQS DOMAINS APPLY

[11] REPORT ON ≥ 9 INDIVIDUAL MEASURES COVERING APPLICABLE DOMAINS AS A GROUP
OR
Have all CAHPS for PQRS summary survey modules (12) reported on the group's behalf via a CMS-certified survey vendor
AND
Report at least 6 additional measures covering 2 NQS domains using a qualified registry

Of these 6 measures, if any EP in the group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice is required to report on at least 1 measure in the cross-cutting measure set.

Note: A group practice wishing to utilize this option must indicate its intent to have the CAHPS for PQRS survey reported when registering to participate in the PQRS via GPRO.

12 MONTHS
1/1/15-12/31/15

REPORT **≥ 50%** OF APPLICABLE MEDICARE PART B FFS PATIENTS; IF EP SEES AT LEAST 1 MEDICARE PATIENT IN FACE-TO-FACE ENCOUNTER, REPORT AT LEAST 1 CROSS-CUTTING MEASURE

Measures with a 0% performance rate will not be counted

Subject to Registry Measure Applicability Validation (MAV)

≥ 9 MEASURES COVERING 3 NQS DOMAINS APPLY

[12] REPORT ON ≥ 9 INDIVIDUAL MEASURES COVERING 3 OR MORE NQS DOMAINS AS A GROUP
OR
Have all Clinician and Group CAHPS for PQRS summary survey modules (12) reported on the group's behalf via a CMS-certified survey vendor
AND
Report at least 6 additional measures covering 2 NQS domains using a qualified registry

Of these 6 measures, if any EP in the group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice is required to report on at least 1 measure in the cross-cutting measure set.

Note: A group practice wishing to utilize this option must indicate its intent to have the CAHPS for PQRS survey reported when registering to participate in the PQRS via GPRO.

12 MONTHS
1/1/15-12/31/15

REPORT **≥ 50%** OF APPLICABLE MEDICARE PART B FFS PATIENTS; IF EP SEES AT LEAST 1 MEDICARE PATIENT IN FACE-TO-FACE ENCOUNTER, REPORT AT LEAST 1 CROSS-CUTTING MEASURE

Measures with a 0% performance rate will not be counted

PHYSICIAN QUALITY REPORTING SYSTEM – MEDICARE EHR INCENTIVE PROGRAM

DIRECT EHR-BASED PRODUCT THAT IS CEHRT
OR
EHR DATA SUBMISSION VENDOR THAT IS CEHRT

[13,14] REPORT ON ≥ 9 MEASURES COVERING 3 OR MORE NQS DOMAINS

If a group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data
OR
Have all CAHPS for PQRS summary survey modules (12) reported on the group's behalf via a CMS-certified survey vendor
AND
Report at least 6 additional measures covering 2 NQS domains using an EHR Direct or EHR DSV

Of these 6 measures, if any EP in the group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice is required to report on at least 1 measure in the cross-cutting measure set.

Note: A group practice wishing to utilize this option must indicate its intent to have the CAHPS for PQRS survey reported when registering to participate in the PQRS via GPRO.

12 MONTHS
1/1/15-12/31/15

Note: Successful submission of CQM data will qualify EP for the PQRS Incentive and meet the CQM component of Medicare EHR Incentive Program

Refer to the EHR Incentive Program website documents for a listing of 2015 CQMs for EPs and supporting documentation.

25+ ELIGIBLE PROFESSIONALS

GPRO WEB INTERFACE

Please refer to the next page for GPRO Web Interface reporting requirements

I WANT TO PARTICIPATE IN 2015 PQRS TO AVOID THE 2017 NEGATIVE PAYMENT ADJUSTMENT

SELECT REPORTING METHOD

(Refer to the 2015 Physician Quality Reporting System Measures List *for a listing of all 2015 measures and associated NQS domains for a specific reporting method. Also review the appropriate measure specifications for the selected reporting method(s) 2015 for PQRS.)*

- CLAIMS-BASED REPORTING
- REGISTRY-BASED REPORTING
- EHR-BASED REPORTING
- **GROUP PRACTICE REPORTING OPTION TO AVOID 2017 PQRS NEGATIVE PAYMENT ADJUSTMENT**
  (A group practice must register to participate in PQRS under GPRO via the web by June 30, 2015. Group practices participating in GPRO must maintain the same TIN throughout the program year.)
- QUALIFIED CLINICAL DATA REGISTRY-BASED REPORTING

2+ ELIGIBLE PROFESSIONALS

- **REGISTRY-BASED REPORTING**
  - Please refer to the previous page for reporting requirements
- **PHYSICIAN QUALITY REPORTING SYSTEM – MEDICARE EHR INCENTIVE PROGRAM**
  - **DIRECT EHR-BASED PRODUCT THAT IS CEHRT**
    OR
    EHR DATA SUBMISSION VENDOR THAT IS CEHRT
    - Please refer to the previous page for reporting requirements

25-99 ELIGIBLE PROFESSIONALS

- **GPRO WEB INTERFACE**
  - REPORT ON ALL MEASURES INCLUDED IN WEB INTERFACE FOR PRE-POPULATED BENEFICIARY SAMPLE (248 – or report on 100% of beneficiaries if pool is less than 248)

    *Must report on at least 1 measure for which there is Medicare patient data
    - [15] REPORT CONSECUTIVE, CONFIRMED, AND COMPLETED BENEFICIARIES FOR EACH DISEASE MODULE
      +
      PATIENT CARE MEASURES

      Optional: In addition to completing all GPRO Web Interface measures, have all CAHPS for PQRS summary survey modules (12) reported on the group's behalf via a CMS-certified survey vendor

      Note: A group practice wishing to utilize this option must indicate its intent to have the CAHPS for PQRS survey reported when registering to participate in PQRS via GPRO

      12 MONTHS
      1/1/15-12/31/15

100+ ELIGIBLE PROFESSIONALS

- **GPRO WEB INTERFACE**
  - REPORT ON ALL MEASURES INCLUDED IN WEB INTERFACE FOR PRE-POPULATED BENEFICIARY SAMPLE (248 – or report on 100% of beneficiaries if pool is less than 248)

    *Must report on at least 1 measure for which there is Medicare patient data
    - [16] REPORT CONSECUTIVE, CONFIRMED, AND COMPLETED BENEFICIARIES FOR EACH DISEASE MODULE
      +
      PATIENT CARE MEASURES

      (Complete all measures with the GPRO Web Interface)
      +
      REPORT ALL CAHPS FOR PQRS SURVEY MEASURES VIA CMS-CERTIFIED SURVEY VENDOR

      Note: A group practice wishing to utilize this option must indicate its intent to have the CAHPS for PQRS survey reported when registering to participate in PQRS via GPRO

      12 MONTHS
      1/1/15-12/31/15

I WANT TO PARTICIPATE IN 2015 PQRS
TO AVOID THE 2017 NEGATIVE PAYMENT ADJUSTMENT

SELECT REPORTING METHOD

(Refer to the 2015 Physician Quality Reporting System Measures List *for a listing of all 2015 measures and associated NQS domains for a specific reporting method. Also review the appropriate measure specifications for the selected reporting method(s) 2015 for PQRS.)*

- CLAIMS-BASED REPORTING
- REGISTRY-BASED REPORTING
- EHR-BASED REPORTING
- GROUP PRACTICE REPORTING OPTION
- **CHOOSE TO PARTICIPATE IN QUALIFIED CLINICAL DATA REGISTRY-BASED OPTION TO AVOID 2017 NEGATIVE PAYMENT ADJUSTMENT**

≥ 9 MEASURES COVERING 3 NQS DOMAINS APPLY

[17] REPORT ON ≥ 9 INDIVIDUAL MEASURES COVERING 3 NQS DOMAINS AND REPORT
≥ 50% OF APPLICABLE MEDICARE PART B FFS PATIENTS
+
OF THESE MEASURES, REPORT AT LEAST 2 OUTCOME MEASURES, OR IF 2 OUTCOME MEASURES ARE NOT AVAILABLE, REPORT ON AT LEAST 1 OUTCOME MEASURE AND AT LEAST 1 ADDITIONAL RESOURCE USE, PATIENT EXPERIENCE OF CARE, PATIENT SAFETY, OR EFFICIENCY/ APPROPRIATE USE MEASURE

12 MONTHS
1/1/15-12/31/15

EPs participating via qualified clinical data registry are not limited to PQRS measures (maximum 30 non-PQRS – all payers)

What should a solo or group practice do in 2015?

Actively participate in PQRS

- Group reporting
  - If group reporting, be prepared to register between Spring 2015 – June 30, 2015 (proposed)
- Individual Reporting – No registration necessary

Decide which PQRS measures to report and understand the measure specifications.

Obtain your Quality and Resource Use Report – available late summer of 2015.

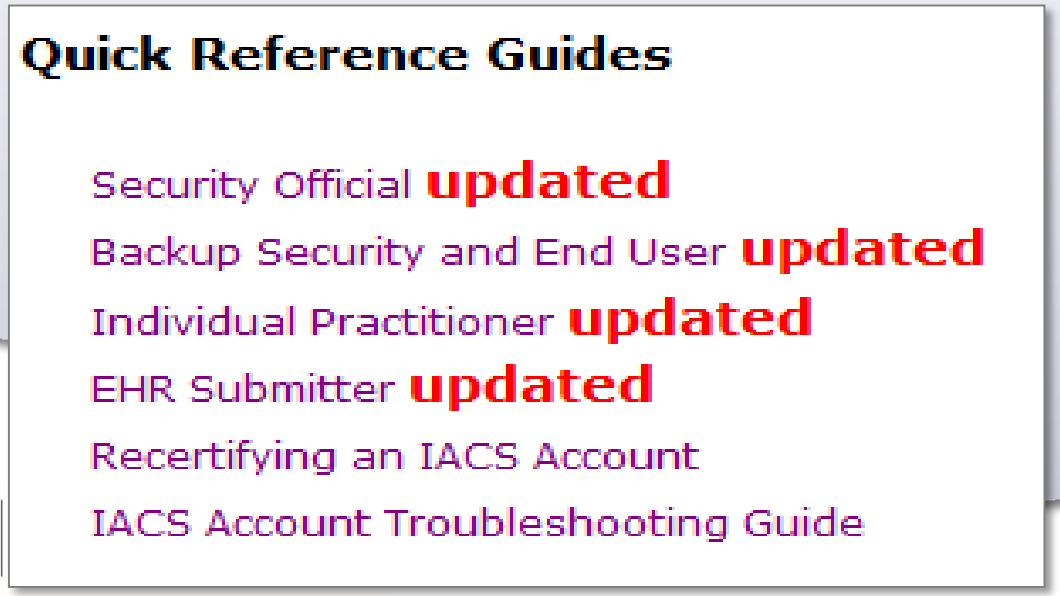
Registering for an IACS Account

- Individuals Authorized Access to the CMS Computer Services (IACS) allows the user to apply a single User ID to access many CMS applications
  - Users are limited to one IACS account per person
  - An existing IACS account cannot be transferred to another individual
  - An account can be associated to multiple Tax Identification Numbers (TINs)

IACS Quick Reference Guides

- All quick reference guides related to obtaining an IACS account are located here:

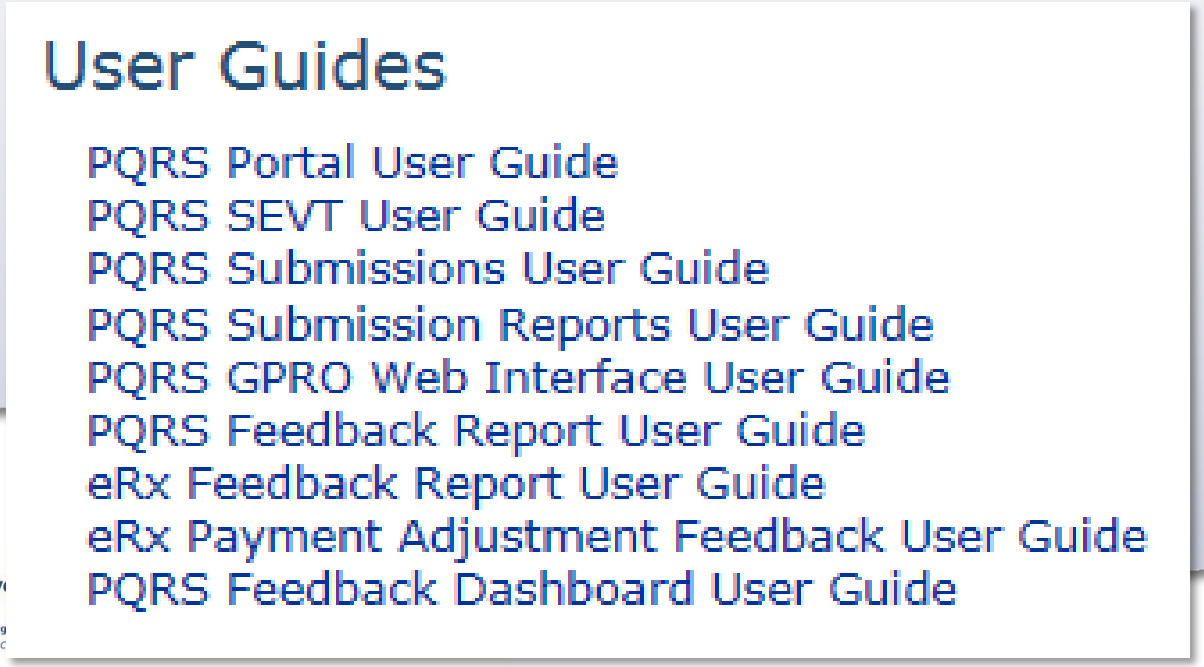
  https://www.qualitynet.org/portal/server.pt/gateway/PTARGS_0_207_374_212_229_43/http;/pdpqap42-app.sdps.org;7087/publishedcontent/publish/pqri_content/pqri_guest_community/userrefguide.html



How to Access PQRS Feedback Reports

- To request access to your PQRS Feedback Reports visit this link and review the user guides:

  https://www.qualitynet.org/portal/server.pt/community/pqri_home/212



What can you do to help our system achieve the goals of Better Care, Smarter Spending, and Healthier People?

- **Eliminate** patient harm
- **Focus** on better care, smarter spending, and healthier people within the population you serve
- **Engage** in accountable care and other alternative payment contracts that move away from fee-for-service to model based on achieving better outcomes at lower cost
- **Invest** in the quality infrastructure necessary to improve
- **Focus** on data and performance transparency
- **Test** new innovations and scale successes rapidly
- **Relentlessly pursue** improved health outcomes

Helpdesk

- **Questions about PQRS, your feedback report, or IACS can be directed to:**

  QualityNet Help Desk: Mon – Fri (7 am – 7 pm (CST)

  Phone: 1-866-288-8912 (TTY: 1-877-715-6222)

  Email: Qnetsupport@hcqis.org

- **Questions about the Value Modifier can be directed to:**

  Physician Value (PV) Help Desk: Mon – Fri: 8 am – 8 pm (EST)

  Phone: 1-888-734-6433, *press option 3* (TTY 1-888-734-6563)

  Fax: 469-372-8023

Alliant Quality Free Technical Assistance

- Selection of PQRS clinical quality measures
- Discuss various reporting methods and best method for you!
- Registration assistance with IACS and PQRS portals
- Resources on real time PQRS updates
- Network with other eligible professionals participating
- Education on the PQRS/VBPM program and QRUR reports

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

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Ready to Enroll in our Free Services?

Sign up for PQRS and VM Technical Assistance *Today*!

Complete the form to get started !

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

ALLIANT QUALITY

How to Stay Informed

- Frequently Asked Questions (FAQs)
  https://questions.cms.gov/
- MLN Connects™ Provider eNews
  http://cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Index.html
- PQRS Listserv
  https://public-dc2.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_520

Resources

2015 MPFS Final Rule - https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-26183.pdf

CMS PQRS Website - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS

Measure Codes - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/ MeasuresCodes.html

PQRS Program Timeline - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015-17_CMS_PQRS_Timeline.pdf

Medicare and Medicaid EHR Incentive Programs - http://www.cms.gov/ Regulations-and-Guidance/Legislation/EHRIncentivePrograms

Medicare Shared Savings Program - http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ sharedsavingsprogram/ Quality_Measures_Standards.html

CMS Value-based Payment Modifier (VM) Website - http://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/PhysicianFeedback Program/ValueBasedPaymentModifier.html

Physician Compare - http://www.medicare.gov/physiciancompare/search.html

Contact Information

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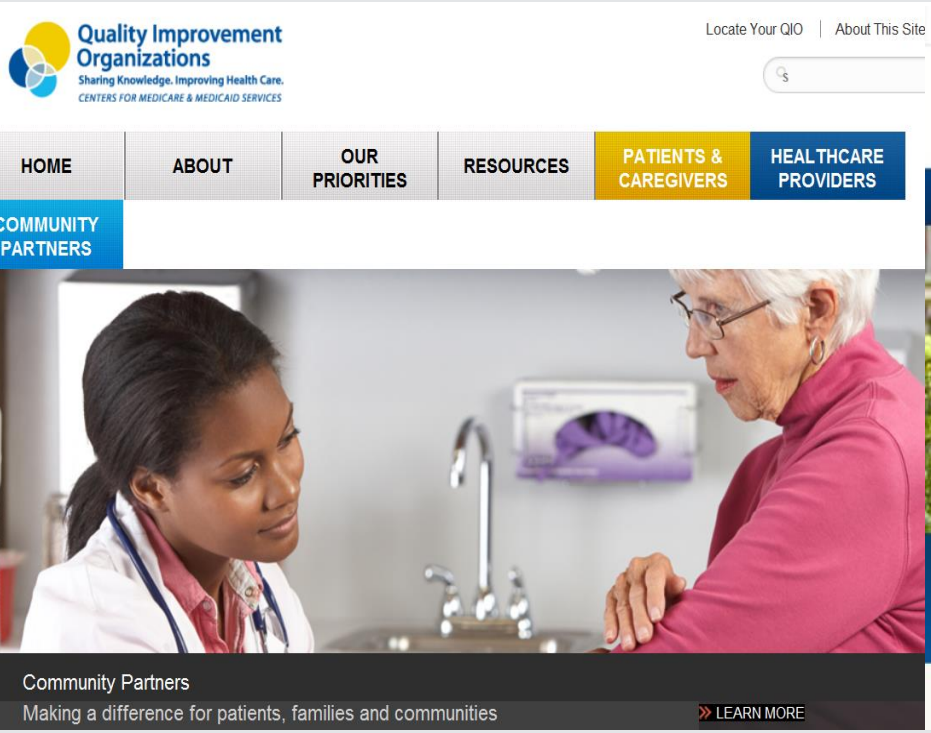
Websites to save to favorites!

http://qioprogram.org

http://www.alliantquality.org



Making Health Care Better

This material was prepared by GMCF, for Alliant Quality, the Medicare Quality Innovation Network – Quality Improvement Organization for Georgia and North Carolina, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. 11SOW-GMCFQIN-D1-15-06