2016 Physician Quality Reporting System (PQRS) Reporting

American Academy of Physical Medicine and Rehabilitation (AAPM&R)

Sophia Autrey
Division of Electronic and Clinician Quality (DECQ)
Quality Measurement and Value-Based Incentives Group (QMVIG)

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Agenda

- Quality Measurement
- Overview of Physician Quality Reporting System
- PQRS Individual EP Reporting Options
- Overview of Measure-Applicability Validation (MAV)
- PQRS Measures
- Resources and Where to Call for Help
- Appendices

CMS Initiatives

Quality Measurement

Transformation of Health Care at the Front Line

- The Affordable Care Act (ACA) requires the Secretary of the Department of Health and Human Services (HHS) to establish a *national* strategy that will improve:
  - The delivery of health care services
  - Patient health outcomes
  - Population health
- The Secretary established a National Strategy for Quality Improvement in Health Care (the National Quality Strategy or NQS) that sets priorities to guide this effort and includes a strategic plan for how to achieve it

Three Categories of CMS Programs

1. **Pay-for-Reporting**
   - Provider incentives to report information
2. **Pay-for-Performance**
   - Provider incentives to achieve targeted threshold or clinical performance
3. **Pay-for-Value**
   - Incentives linked to both quality and efficiency improvements

CMS' Vision for Quality Measurement

- Align measures with the National Quality Strategy (NQS) and Six Measure Domains/Priorities
- Implement measures that fill critical gaps within the 6 domains
- Align measures across CMS programs whenever possible
- Core sets of measures
- Removal of measures that are no longer appropriate (e.g., topped out)
- Align measures with external stakeholders, including private payers and boards and specialty societies
- Major aim of measurement is improvement over time

6 NQS Domains

- HHS' NQS priorities for health care quality improvement

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

Physician Quality Reporting Programs

Overview of Physician Quality Reporting System

What is PQRS?

The Physician Quality Reporting System (PQRS) is a reporting program that uses potential negative payment adjustments to promote reporting of quality information by individual EPs and group practices.

What is PQRS?

- The 2016 PQRS is a reporting program that promotes reporting of quality information by eligible professionals (EPs)
- Individual EPs and group practices that do not participate or satisfactorily report in PQRS will be subject to a payment adjustment

PQRS Program Year	PQRS Payment Adjustment Period	Negative Adjustment Rate
2014	2016	-2.0%*
2015	2017	-2.0%*
2016	2018	-2.0%*

**Applies to all of the EP's or group practice's Medicare Part B PFS covered professional services under MPFS during the payment adjustment period*

Who Can Participate?

- A list of eligible medical care professionals is available on the How to Get Started page of the CMS PQRS website.

Medicare physicians	Practitioners	Therapists
• Doctor of Medicine • Doctor of Osteopathy • Doctor of Podiatric Medicine • Doctor of Optometry • Doctor of Oral Surgery • Doctor of Dental Medicine • Doctor of Chiropractic	• Physician Assistant • Nurse Practitioner* • Clinical Nurse Specialist* • Certified Registered Nurse Anesthetist* (and Anesthesiologist Assistant) • Certified Nurse Midwife* • Clinical Social Worker • Clinical Psychologist • Registered Dietician • Nutrition Professional • Audiologists	• Physical Therapist • Occupational Therapist • Qualified Speech-Language Therapist

**** Includes Advanced Practice Registered Nurse (APRN)***

Why PQRS?

- EPs are provided the opportunity to assess the quality of care provided to patients, helping ensure patients get the right care at the right time
- EPs are able to quantify how often particular care metrics are met
- EPs receive feedback reports comparing their performance on a given measure with other participating EPs

PQRS Measure Selection

The following factors should be considered when deciding which measures to select for PQRS reporting:

- Clinical condition usually treated
  - Review diagnosis coding in the measure's denominator, if applicable
- Settings where care is usually delivered (e.g., office, emergency department [ED], surgical suite)
  - Review CPT coding in the measure's denominator
- Quality action (Numerator) intended to be captured by the measure
  - Clinical care typically provided to patients (e.g. preventive, chronic, acute) harmonize with the eligible professionals (EPs) clinical practice and the numerator of the measure

PQRS Measure Selection (cont.)

Additional considerations should include researching measures applicable to the individual EP's/group practice's *scope of practice* that are based on the following:

- Reporting mechanism of the measure
- Domain associated with the measure
- Individual clinical quality improvement goals for 2016
- Other quality reporting programs in use or being considered

2016 PQRS Measures Resources

- **2016 PQRS Implementation Guide**
  - Provides guidance about how to select measures for reporting, how to read and understand a measure specification, and outlines the various reporting methods available for 2016 PQRS.
  - The Implementation Guide also details how to implement claims-based reporting of measures to facilitate satisfactory reporting of quality-data codes by eligible professionals.
- **2016 PQRS Measures List**
  - Identifies and describes the measures used in PQRS, including all available reporting methods/options, corresponding PQRS number and NQF number, NQS domains, plus measure developers and their contact information.

2018 Payment Adjustments

Program	Applicable to	Adjustment Amount	Based on PY
PQRS	All EPs	-2.0% of Medicare Physician Fee Schedule (MPFS)	2016
Medicare EHR Incentive Program	Medicare physicians (if not a meaningful user)	-4.0% of MPFS	2016
Value-based Payment Modifier	All physicians in groups with 2+ EPs and physicians who are solo practitioners	**Mandatory Quality-Tiering for PQRS reporters:** • **Groups with 2-9 EPs and solo practitioners:** Upward or neutral, or download VM adjustment only based on quality-tiering (-2.0% to +2.0x of MPFS) • **Groups with 10+ EPs:** Upward, neutral, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x of MPFS) Groups and solo practitioners receiving an upward adjustment are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25% of all beneficiary risk scores nationwide. **Non-PQRS reporters:** • **Groups with 2-9 EPs and solo practitioners:** automatic -2.0% of MPFS downward adjustment • **Groups with 10+ EPs: A**utomatic -4.0% of MPFS downward adjustment	2016

2016 PQRS

PQRS INDIVIDUAL EP REPORTING OPTIONS

Individual Measure Reporting

- Report on at least 9 individual measures covering 3 NQS domains for at least 50% of the EP's Medicare Part B FFS patients
- If the EP sees at least 1 Medicare patient in a face-to-face encounter, the EP will report on at least 1 measure contained in the proposed cross-cutting measure set
- If less than 9 measures apply to the EP, the EP would report up to 8 measure(s), **OR** 9 or more PQRS measures across less than 3 domains for at least 50% of the EP's Medicare Part B FFS patients eligible for each measure AND report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period
- Measures with a 0% performance rate would not be counted with the exception of inverse measures.

Reporting via Claims

- Claims-based reporting is readily accessible to EPs as it is a part of routine professional and institutional billing processes
- Only EPs participating at the individual level may report via claims
  - Not available to group practices participating via the group practice reporting option (GPRO)
- Benefits of reporting via claims
  - No need to contact a vendor
  - Simple to select measures and begin reporting

Reporting via Registry

- A qualified registry is an entity that collects clinical data from EPs and submits it to CMS on behalf of the participants
- EPs should work directly with their chosen registry in order to submit data satisfactorily on the selected measures or measures groups
  - A list of qualified registries will be posted on the CMS website soon.
- The qualified registry must submit this data to CMS via defined .xml specifications, which is posted.

Registry-based Reporting Criteria

- EPs wanting to satisfactorily report 2016 PQRS data to avoid the 2018 negative payment adjustment can do so by meeting one of two registry-based reporting criteria:
  - Individual measures reporting
  - Measures group reporting

Measures Group Reporting

- Report at least 1 measures group for at least 20 patients,
  - The majority (11 patients) of which are required to be Medicare Part B FFS patients
- Measures groups containing a measure with a 0% performance rate will not be counted

Reporting via EHR (Direct or DSV)

- Certified EHR Technology (CEHRT) Requirement for Electronic Clinical Quality Measures (CQM) reporting
  - Providers must use technology that is CEHRT
  - Providers must create an electronic file using CEHRT that can be accepted by CMS for reporting
- 9 measures covering at least 3 of the NQS domains. **If** an EP's EHR does not contain patient data for at least 9 measures covering at least 3 domains, then the EP must report on all the measures for which there is Medicare patient data.
- Report on at least 1 measure for which there is Medicare patient data

Reporting via EHR (cont.)

EPs must report using the most recent version of the electronic specifications for the CQMs if they choose to electronically report CQMs for the Medicare EHR Incentive Program.

Medicare CY2018 payment adjustment for the failure to demonstrate meaningful use under the EHR Incentive Program is -3.0% MPFS, based on PY2016 reporting.

For a reporting period in 2016, to avoid the 2018 payment adjustment:

- Report 9 measures covering at least 3 of the NQS domains.
- Providers may report results including zeroes in numerator/denominator

Providers choosing to submit their CQMs electronically must use the CMS form and manner requirements to submit CQMs. If the provider completes a single electronic submission of CQM data that meets the requirements for both PQRS and the EHR Incentive Program, the single submission may count for both programs.

PQRS

OVERVIEW OF MEASURE-APPLICABILITY VALIDATION (MAV)

Measure-Applicability Validation (MAV)

- MAV, used with both claims and registry-based PQRS reporting, is a process used to review and validate an individual EP's or group practice's inability to report or submit at least nine measures covering at least three NQS domains.
- CMS will analyze data to validate, using the clinical relation/domain test and the minimum threshold test to confirm that additional measures and/or NQS domains were not applicable to the individual EP's or group practice's scope of practice.
- If it is determined that at least one cross-cutting measure was not reported, the individual EPs or group practices with face-to-face encounters will be automatically subject to the 2018 PQRS payment adjustment and MAV will not be utilized for that individual EP or group practice.
  - CMS will analyze claims data to determine if at least 15 cross-cutting measure denominator eligible encounters can be associated with the individual EP.
  - For those individual EPs or group practices with no face-to-face encounters, MAV will be utilized for those that report less than nine measures and/or less than three NQS domains.

If additional measures or NQS domains are found to be applicable through MAV, the individual EP or group practice would be subject to the 2018 PQRS payment adjustment.

MAV

MAV also applies when:

For measures reported, there must be *at least one* patient or procedure reported in the numerator that is counted as meeting performance.

- For measures that move toward 100 percent (100%), to indicate higher quality outcome, the performance rate must be greater than zero percent (0%).
- For inverse measures where higher quality moves the rate toward zero percent (0%), the performance rate must be less than 100%.

MAV and Cross-Cutting Measures

- **Cross-cutting measures** are defined as any measure that is broadly applicable across multiple clinical settings and individual EPs and group practices within a variety of specialties.
- At least 1 cross-cutting measure must be satisfactorily reported for those individual EPs or group practices with face-to-face encounters.
  - CMS will analyze claims data to determine if at least 15 cross-cutting measure denominator eligible patients or encounters can be associated with the individual EP or group practice.
    - If it is determined that at least 1 cross-cutting measure was ***not*** reported, the individual EP or group practice with face-to-face encounters will be automatically subject to the 2017 PQRS payment adjustment and MAV will not be utilized for that individual EP or group practice.
    - For those individual EP or group practices with no face-to-face encounters, MAV will be utilized for those that report less than 9 measures and/or less than 3 domains.

MAV and Clusters

- **Claims-Based:** MAV utilizes claims data to determine if those measures were applicable to you. If the claims data indicates that you had patients that met the denominator criteria for those measures, then the MAV process will evaluate the claims data to determine if you had at least 15 eligible encounters to report. If MAV determines there were greater than 15 encounters, then the CMS would anticipate that the measure was applicable for reporting and therefore the measures should have been reported and the 2018 PQRS payment adjustment would apply.
- **Registry-Based:** Measures in a Cluster, is if one measure in a cluster is reported by the individual EP or group practice, CMS anticipates that other measures in the cluster would be applicable and should be reported.

2016 PQRS

PQRS MEASURES

2016 PQRS Measures

NQF	PQRS	NQS Domain	Measure Title	Reporting Mechanism
0045	024	Communication and Care Coordination	Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for Men and Women Aged 50 Years and Older	Claims, Registry
0325	032	Effective Clinical Care	Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy	Claims, Registry
0046	039	Effective Clinical Care	Screening for Osteoporosis for Women Aged 65-85 Years of Age	Claims, Registry, Measures Groups
N/A	041	Effective Clinical Care	Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older	Claims, Registry

2016 PQRS Measures (cont.)

NQF	PQRS	NQS Domain	Measure Title	Reporting Mechanism
0054	108	Effective Clinical Care	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	Measures Groups only
N/A	109	Person and Caregiver-Centered Experience and Outcomes	Osteoarthritis (OA): Function and Pain Assessment	Claims, Registry
N/A	145	Patient Safety	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy	Claims, Registry
N/A	176	Effective Clinical Care	Rheumatoid Arthritis (RA): Tuberculosis Screening	Measures Groups only

2016 PQRS Measures (cont.)

NQF	PQRS	NQS Domain	Measure Title	Reporting Mechanism
N/A	177	Effective Clinical Care	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	Measures Groups only
N/A	178	Effective Clinical Care	Rheumatoid Arthritis (RA): Functional Status Assessment	Registry, Measures Groups
N/A	179	Effective Clinical Care	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	Measures Groups
N/A	180	Effective Clinical Care	Rheumatoid Arthritis (RA): Glucocorticoid Management	Measures Groups

2016 PQRS Measures (cont.)

NQF	PQRS	NQS Domain	Measure Title	Reporting Mechanism
2624	182	Communication and Care Coordination	Functional Outcome Assessment	Claims, Registry
0022	238	Patient Safety	Use of High-Risk Medications in the Elderly	EHR, Registry, Measures Groups
N/A	342	Person and Caregiver-Centered Experience and Outcomes	Pain Brought Under Control Within 48 Hours	Registry only
N/A	408	Effective Clinical Care	Opioid Therapy Follow-up Evaluation	Registry only

2016 PQRS Measures (cont.)

NQF	PQRS	NQS Domain	Measure Title	Reporting Mechanism
N/A	409	Effective Clinical Care	Clinical Outcome Post-Endovascular Stroke Treatment	Registry only
N/A	412	Effective Clinical Care	Documentation of Signed Opioid Treatment Agreement	Registry only
N/A	414	Effective Clinical Care	Evaluation or Interview for Risk of Opioid Misuse	Registry only
0053	418	Effective Clinical Care	Osteoporosis Management in Women Who Had a Fracture	Claims, Registry

2016 PQRS Measures (cont.)

NQF	PQRS	NQS Domain	Measure Title	Reporting Mechanism
N/A	419	Efficiency and Cost Reduction	Overuse Of Neuroimaging For Patients With Primary Headache And A Normal Neurological Examination	Claims, Registry
N/A	435	Effective Clinical Care	Quality Of Life Assessment For Patients With Primary Headache Disorders	Claims, Registry

2016 Updates

RESOURCES AND WHERE TO CALL FOR HELP

Resources

- **2016 MPFS Final Rule**
  https://www.federalregister.gov/articles/2015/11/16/2015-28005/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions
- **PQRS Website**
  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS
- **PQRS Payment Adjustment Information**
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html
- **Medicare Electronic Health Record (EHR) Incentive Program**
  http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html
- **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 (cont.)

- **Claims-based MAV**

  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016_PQRS_MAV_ProcessforClaimsBasedReporting_111715.pdf

- **Registry-based MAV**

  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016_PQRS_MAV_ProcessforRegistryBasedReporting_121815.pdf

- **2016 PQRS Measures List**

  http://www.cms.gov/apps/ama/license.asp?file=/PQRS/Downloads/PQRS-2016-Measure-List_01042016.xlsx

- **PQRS Web-Based Measure Search Tool for 2016 PQRS Individual Claims and Registry Measure Specification**

  https://pqrs.cms.gov/#/home

- **2016 Registry Made Simple**

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

- **2016 Claims Made Simple**

  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/downloads/2016PQRS_Claims_Made_Simple.pdf?agree=yes&next=Accept

- **2016 Measure Groups**
  https://www.cms.gov/apps/ama/license.asp?file=/PQRS/Downloads/2016_PQRS_MeasuresGroupManual_SupportingDocs_121815.zip

Where to Call for Help

- **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**
  You will be asked to provide basic information such as name, practice, address, phone, and e-mail
- **EHR Incentive Program Information Center:**
  888-734-6433 (TTY 888-734-6563)
- **Physician Compare Help Desk:**
  E-mail: PhysicianCompare@Westat.com

Time for

QUESTION & ANSWER SESSION

APPENDICES

Appendix B: Summary of Finalized Requirements for the 2018 PQRS Payment Adjustment: Individual Reporting Criteria for the Satisfactory Reporting of Quality Measures Data via Claims, Qualified Registry, and EHRs and Satisfactory Participation Criterion in QCDRs

Reporting Period	Measure Type	Reporting Mechanism	Satisfactory Reporting/Satisfactory Participation Criteria
12-month (Jan 1– Dec 31, 2016)	Individual Measures	Claims	Report at least 9 measures, covering at least 3 of the NQS domains AND report each measure for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the EP sees at least 1 Medicare patient in a face-to-face encounter, the EP will report on at least 1 measure contained in the PQRS cross-cutting measure set. If less than 9 measures apply to the EP, the EP would report on each measure that is applicable , AND report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.
12-month (Jan 1– Dec 31, 2016)	Individual Measures	Qualified Registry	Report at least 9 measures, covering at least 3 of the NQS domains AND report each measure for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the EP sees at least 1 Medicare patient in a face-to-face encounter, the EP will report on at least 1 measure contained in the PQRS cross-cutting measure set. If less than 9 measures apply to the EP, the EP would report on each measure that is applicable, AND report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.

Appendix A: Summary of Finalized Requirements for the 2018 PQRS Payment Adjustment: Individual Reporting Criteria for the Satisfactory Reporting of Quality Measures Data via Claims, Qualified Registry, and EHRs and Satisfactory Participation Criterion in QCDRs (cont.)

Reporting Period	Measure Type	Reporting Mechanism	Satisfactory Reporting/Satisfactory Participation Criteria
12-month (Jan 1– Dec 31, 2016)	Individual Measures	Direct EHR Product or EHR Data Submission Vendor Product	Report 9 measures covering at least 3 of the NQS domains. If an EP's direct EHR product or EHR data submission vendor product does not contain patient data for at least 9 measures covering at least 3 domains, then the EP would be required to report all of the measures for which there is Medicare patient data. An EP would be required to report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1– Dec 31, 2016)	Measures Groups	Qualified Registry	Report at least 1 measures group AND report each measures group for at least 20 patients, the majority (11 patients) of which are required to be Medicare Part B FFS patients. Measures groups containing a measure with a 0% performance rate will not be counted.
12-month (Jan 1– Dec 31, 2016)	Individual PQRS measures and/or non-PQRS measures reportable via a QCDR	Qualified Clinical Data Registry (QCDR)	Report at least 9 measures available for reporting under a QCDR covering at least 3 of the NQS domains, AND report each measure for at least 50% of the EP's patients. Of these measures, the EP would report on at least 2 outcome measures, OR, if 2 outcomes measures are not available, report on at least 1 outcome measures and at least 1 of the following types of measures – resource use, patient experience of care, efficiency/appropriate use, or patient safety.