# *Special Open Door Forum:*

## 2011 Physician Quality Reporting System

**(Physician Quality Reporting, previously known as PQRI)**

## and

## Electronic Prescribing (eRx) Incentive Program

January 25, 2011

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# Agenda

- CMS Updates/Announcements
- Presentation
  - 2011 Physician Quality Reporting System: The Basics – Dr. Daniel Green
  - Understanding Claims-Based Reporting for eRx Incentive Program, Including Future eRx Payment Adjustments – Dr. Daniel Green
  - Reporting Requirements for the Maintenance of Certification Program Incentive – Molly MacHarris
- Question and Answer Session

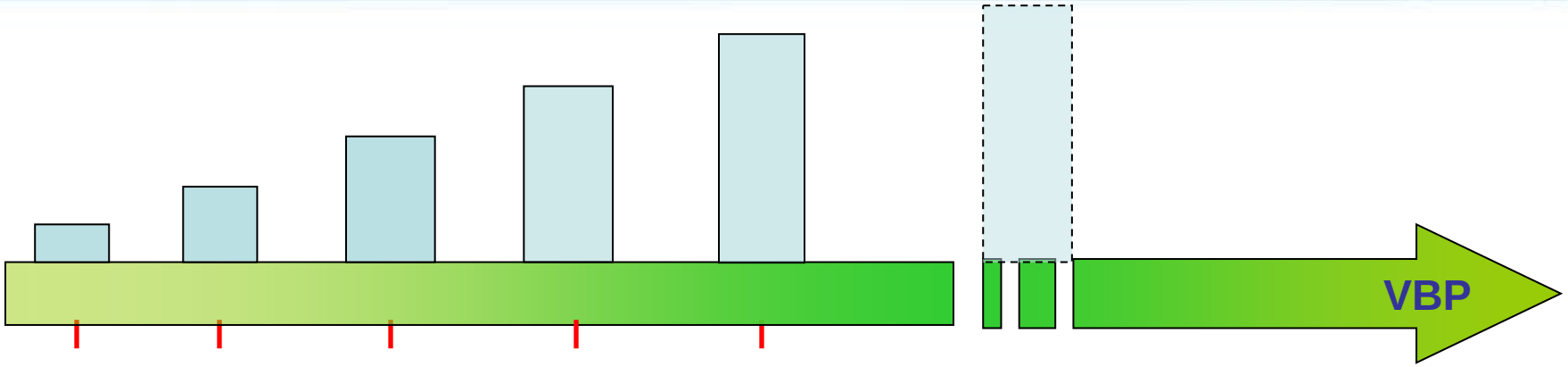
Dr. Daniel Green

# 2011 Physician Quality Reporting System: The Basics

# What is Physician Quality Reporting?

- Physician Quality Reporting is a voluntary reporting program that began in 2007 (originally called PQRI)
- Eligible professionals (or group practices) who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B beneficiaries will qualify to earn an incentive payment
  - The incentive is a percentage of the eligible professional's (or group's) estimated total Medicare Part B PFS allowed charges
- Over time, the program has expanded the number of measures and reporting options to facilitate quality reporting by a broad array of eligible professionals

# Moving Toward Value-Based Purchasing




**2007**

- TRHCA
- 74 measures
- Claims-based only

**2008**

- MMSEA
- 119 measures
- Claims
- 4 Measures Groups
- Registry

**2009**

- MIPPA
- 153 measures
- Claims
- 7 Measures Groups
- Registry
- EHR-testing
- eRx

**2010**

- MIPPA
- 175 individual measures
- Claims
- 13 Measures Groups
- Registry
- EHRs
- eRx
- GPRO

**2011**

- ACA, HITECH
- 170 individual measures
- Claims
- 14 Measures Groups
- Registry
- EHRs
- eRx
- GPRO I
- GPRO II

**2012**

**TBD through rule-making**

# Determining Eligibility

- A list of eligible professionals who are able to participate in Physician Quality Reporting and/or the eRx Incentive Program is available on both the program websites at www.cms.gov/PQRI and www.cms.gov/eRxIncentive
  - Not all entities are considered eligible as they may be reimbursed by Medicare under methods or fee schedules other than the Physician Fee Schedule (PFS)
    - e.g., Federally Qualified Health Centers are not eligible to report Physician Quality Reporting data because they are not reimbursed under the PFS
  - Eligible professionals include physicians, nurse practitioners, clinical nurse specialists, physician assistants, physical therapists, and many other health care professionals

# Measure Specification Construct

## NUMERATOR

(**Clinical action** required for performance)

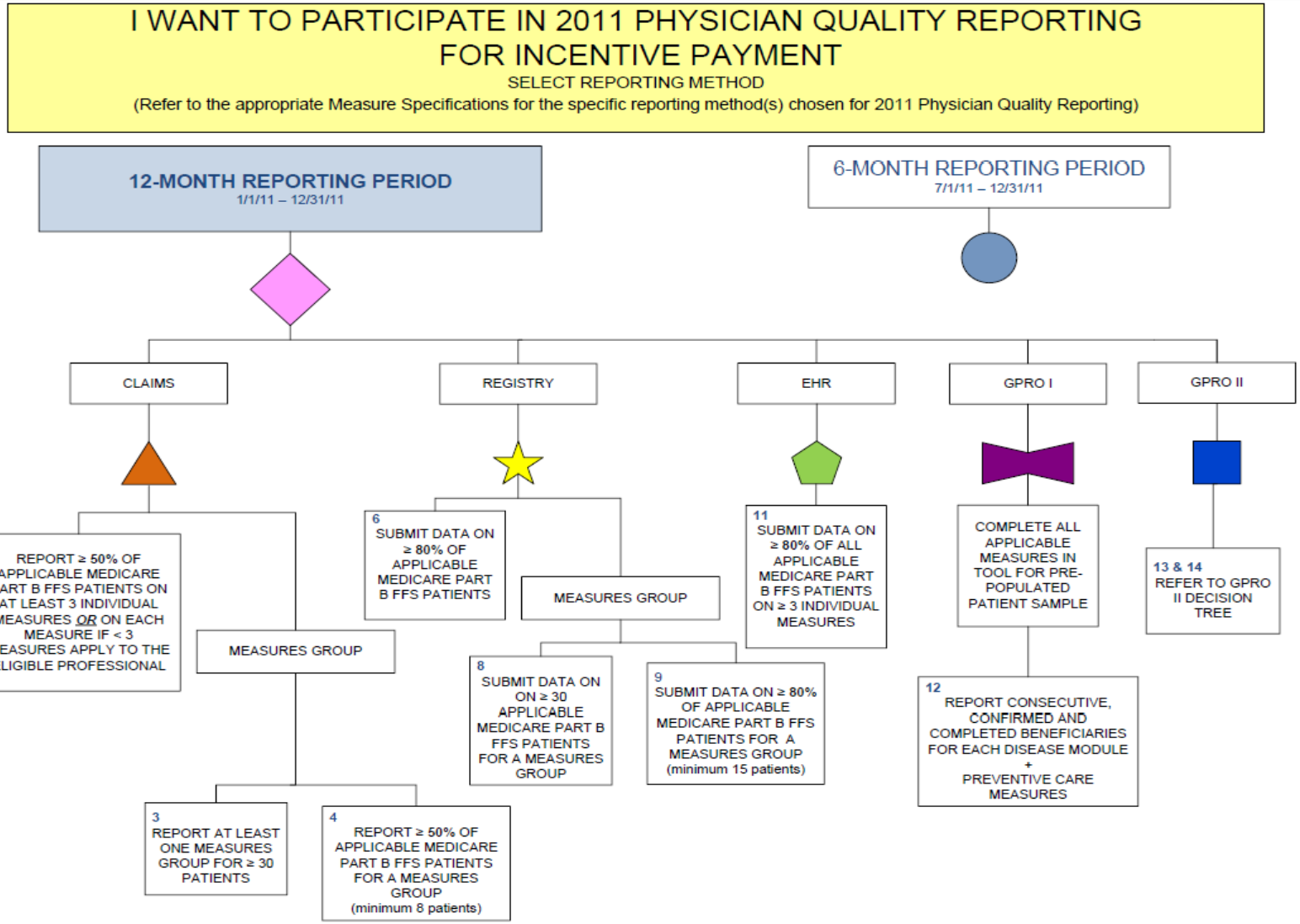
## DENOMINATOR

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

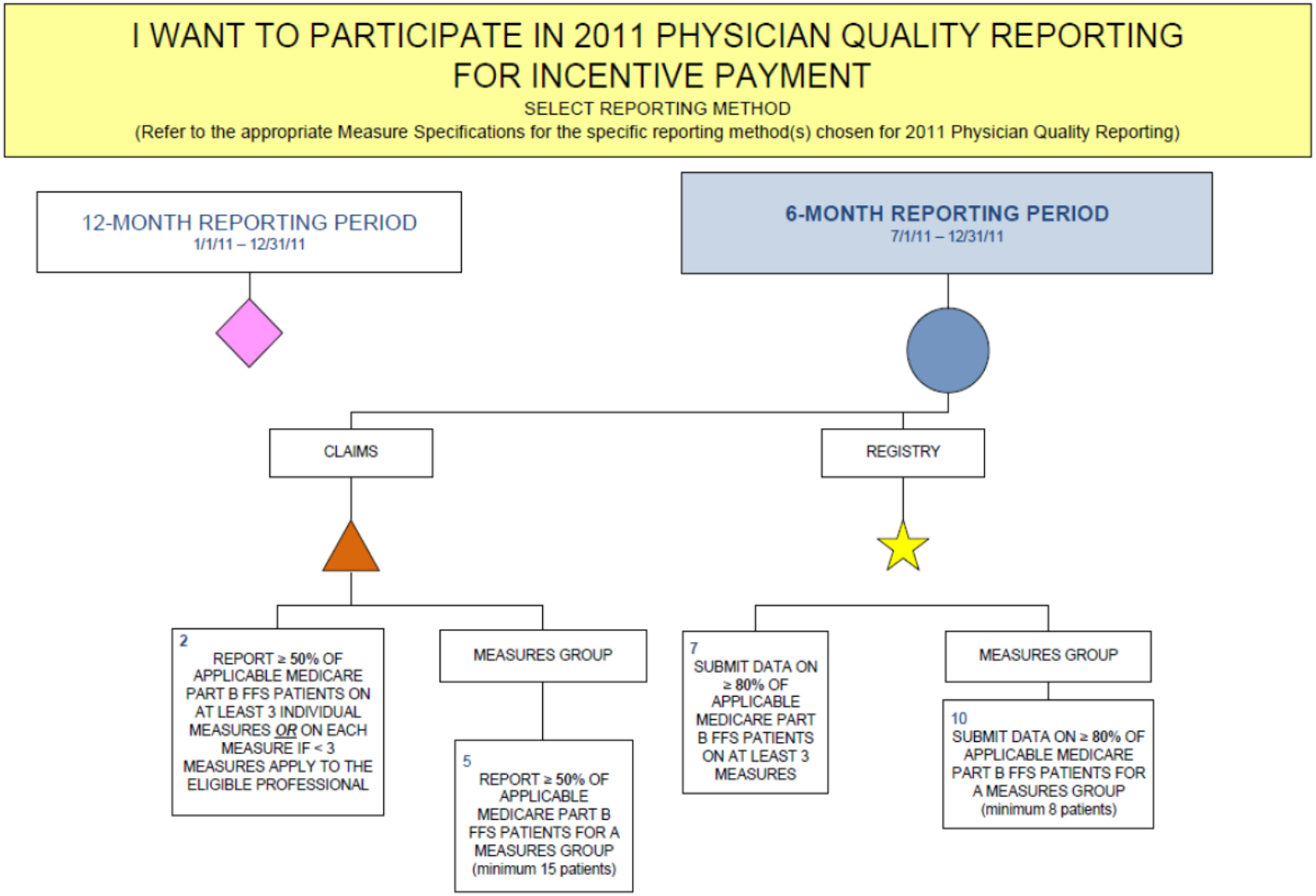
# 2011 Physician Quality Reporting

- Report quality measures
  - Large selection of measures from which to choose
  - Individual measures, measures groups
  - Participate as individual, large group, small group
  - Additional incentive (0.5%) for Maintenance of Certification Program
  - Report through qualified EHR, qualified registry, claims, GPRO I measure data submission method
- Incentives independent of participation in other CMS programs

# 2011 Decision Tree



# 2011 Decision Tree (cont.)



# 2011 Physician Quality Reporting

- Satisfactory reporting
  - No registration for individual participants
  - Large groups (GPRO I) and small groups (GPRO II) who wish to report as a group must self-nominate and be selected
  - Those reporting through registry or EHR methods must use qualified registry or EHR software
  - Claims reporting – 50% reporting rate
  - Registry or EHR reporting – 80% reporting rate
  - GPRO I reporting – complete patient sample in 4 disease modules and all preventive care measures

# 2011 Physician Quality Reporting System Measures

- 194 measures, including
  - 5 new measures for claims and registry reporting
  - 11 new registry-only measures
  - 4 new measures for EHR-based reporting only

# 2011 Physician Quality Reporting System Measures (cont.)

- 20 EHR measures
- 14 measures groups
  - Diabetes Mellitus
  - Chronic Kidney Disease (CKD)
  - Preventive Care
  - Rheumatoid Arthritis
  - Perioperative Care
  - Back Pain
  - Hepatitis C
  - Ischemic Vascular Disease (IVD)
  - Community-Acquired Pneumonia (CAP)
  - Asthma (new)
  - Coronary Artery Bypass Graft (CABG) (registry only)
  - Heart Failure (HF) (registry only)
  - Coronary Artery Disease (CAD) (registry only)
  - HIV/AIDS (registry only)

# 2011 Criteria for Satisfactory Reporting of Individual Measures

| Reporting Mechanism(s) | Reporting Period(s) | Criteria for Satisfactory Reporting of Individual Measures |
|---|---|---|
| Claims | Jan 1, 2011-Dec 31, 2011<br><br>or<br><br>July 1, 2011-Dec 31, 2011 | Report at least 3 Physician Quality Reporting System measures, (or 1-2 measures if fewer than 3 apply*); and<br><br>Report each measure for at least 50% of applicable Medicare Part B FFS patients seen during the reporting period **(revised)** |

*Eligible professionals who report on fewer than 3 measures may be subject to the Measure-Applicability Validation process.

# 2011 Criteria for Satisfactory Reporting Individual Measures (cont.)

| Reporting Mechanism(s) | Reporting Period(s) | Criteria for Satisfactory Reporting of Individual Measures |
|---|---|---|
| Registry | Jan 1, 2011 - Dec 31, 2011<br>or<br>July 1, 2011- Dec 31, 2011 | Report at least 3 Physician Quality Reporting System measures*; and<br>Report each measure for at least 80% of applicable Medicare Part B FFS patients seen during the reporting period |
| EHR | Jan 1, 2011- Dec 31, 2011 | Report at least 3 Physician Quality Reporting System EHR measures*; and<br>Report each measure for at least 80% of applicable Medicare Part B FFS patients seen during the reporting period |

*Measures with a 0% performance rate will not be counted **(new)**

# 2011 Criteria for Satisfactory Reporting of Measures Groups

| Reporting Mechanism(s) | Reporting Period(s) | Criteria for Satisfactory Reporting of Measures Groups |
|---|---|---|
| Claims or Registry | Jan 1, 2011-Dec 31, 2011 | Report at least 1 Physician Quality Reporting System measures group*; and<br><br>Report each measures group for at least 30 Medicare FFS patients seen during the reporting period** |

***For registry-based reporting, measures groups with a 0% performance rate will not be counted **(new)**

****Eligible professionals reporting measures groups using the registry-based reporting mechanism will no longer be able to report on non-Medicare FFS patients **(new)**

# 2011 Criteria for Satisfactory Reporting of Measures Groups (cont.)

| Reporting Mechanism(s) | Reporting Period | Criteria for Satisfactory Reporting of Measures Groups |
|---|---|---|
| Claims | Jan 1, 2011-Dec 31, 2011 | Report at least 1 Physician Quality Reporting System measures group;<br><br>Report each measures group for at least 50% of applicable Medicare Part B FFS patients seen during the reporting period **(revised)**; and<br><br>Report each measures group for at least 15 Medicare Part B FFS patients seen during the reporting period |

# 2011 Criteria for Satisfactory Reporting of Measures Groups (cont.)

| Reporting Mechanism(s) | Reporting Period | Criteria for Satisfactory Reporting of Measures Groups |
|---|---|---|
| Claims | July 1, 2011-Dec 31, 2011 | Report at least 1 Physician Quality Reporting System measures group;<br><br>Report each measures group for at least 50% of applicable Medicare Part B FFS patients seen during the reporting period **(revised)**; and<br><br>Report each measures group for at least 8 Medicare Part B FFS patients seen during the reporting period |

# 2011 Criteria for Satisfactory Reporting of Measures Groups (cont.)

| Reporting Mechanism(s) | Reporting Period(s) | Criteria for Satisfactory Reporting of Measures Groups |
|---|---|---|
| Registry | Jan 1, 2011-Dec 31, 2011 | Report at least 1 Physician Quality Reporting System measures group*;<br><br>Report each measures group for at least 80% of applicable Medicare Part B FFS patients seen during the reporting period; and<br><br>Report each measures group for at least 15 Medicare Part B FFS patients seen during the reporting period |

*Measures groups with a 0% performance rate will not be counted **(new)**

# 2011 Criteria for Satisfactory Reporting of Measures Groups (cont.)

| Reporting Mechanism(s) | Reporting Period(s) | Criteria for Satisfactory Reporting of Measures Groups |
|---|---|---|
| Registry | July 1, 2011-Dec 31, 2011 | Report at least 1 Physician Quality Reporting System measures group*;<br><br>Report each measures group for at least 80% of applicable Medicare Part B FFS patients seen during the reporting period; and<br><br>Report each measures group for at least 8 Medicare Part B FFS patients seen during the reporting period |

*Measures groups with a 0% performance rate will not be counted **(new)**

# Registry Submission

- What is a registry?
  - Captures and stores clinically related data submitted by the eligible professional (or group practice)
  - Registry submits information on Physician Quality Reporting System individual measures or measures groups (or eRx measure) to CMS on behalf of eligible professionals (or group practice)
- Registries provide CMS with calculated reporting and performance rates at the end of the reporting period
  - Data must be submitted to CMS via defined .xml specifications
- CMS qualifies registries annually
  - Current list of ***Qualified Registries for 2010 PQRI Reporting*** is available at: http://www.cms.gov/PQRI/Downloads/Qualified_Registries_Phase4_eRxPQRI_06282010_FINAL.pdf

# EHR Submission

- CMS qualifies EHR vendors annually
  - List of ***Qualified EHR Vendors for the 2011 Physician Quality Reporting and eRx Incentive Programs*** (including the specific product(s) and version(s) that are qualified) will be available at: http://www.cms.gov/PQRI/20_AlternativeReportingMechanisms.asp#TopOfPage > Downloads
- Using a qualified EHR, eligible professionals submit raw clinical data to CMS and measures are calculated by CMS

# Group Practice Reporting Option (GPRO)

- To participate, a group practice must:
  - Submit self-nomination letter to CMS – information is posted on the Group Practice Reporting Option section of the Physician Quality Reporting website
  - Meet certain technical and/or other requirements
  - Be selected to participate

# 2011 GPRO I

- GPRO I: self-nominated group practices with 200 or more eligible professionals
  - Complete pre-populated data collection tool for an assigned set of Medicare beneficiaries
    - 26 total measures (4 disease modules + 4 individual preventive care measures)
    - Access to tool no later than first quarter of 2012
      - 2011 data submitted in 2012

# 2011 GPRO II

- GPRO II: group practices with 2-199 eligible professionals (new for 2011)
  - CMS will select approximately 500 groups meeting the eligibility requirements
    - Reported via claims (unless only applicable measures group(s) is registry-only)
  - No data collection tool; will use:
    - *2011 Physician Quality Reporting System Individual Measure Specifications for Claims and Registry*
    - *2011 Physician Quality Reporting System Measures Groups Specifications Manual*

# How to Participate in GPRO for 2011

- To be eligible for 2011 GPRO, potential participants must:
  - Meet “group practice” definition
  - Have billed Medicare Part B on or after January 1, 2010 and prior to October 29, 2010
  - Must self-nominate
    - For 2011 GPRO I practices currently participating in 2010 GPRO, notify CMS via e-mail if planning to continue participation
  - Provide group practice’s TIN
  - Agree to attend/participate in mandatory training sessions and kick-off meeting

# 2011 Physician Quality Reporting (cont.)

- Deadlines
  - GPRO I and must self-nominate by January 31, 2011
  - GPRO II must self-nominate between January 1 and January 31, 2011
  - All claims must be received by end of February 2012
  - Registry, EHR, and GPRO I must submit all data by end of March 2012
  - Maintenance of Certification information must be received by end of March 2012
  - Qualified registries/EHR software, and Maintenance of Certification entities will be listed on the CMS web site

# Resources

- Visit the *How to Get Started* section of the CMS Physician Quality Reporting System website at http://www.cms.gov/pqri
  - *2011 Measures List*
  - *Measure Specifications* for individual measure reporting
  - *Measures Groups Specifications*
  - *EHR Specifications*
  - *GPRO I Specifications*
  - *2011 Implementation Guide*
  - *What's New for 2011*

# Resources (cont.)

- Also see:
  - Frequently Asked Questions
  - Supplemental education materials
  - National Provider Calls
  - Special Open Door Forums
- **Reminder:** Be sure to use the measure specifications for the correct program year and method of reporting!

# Where to Call for Help

- Contact the **QualityNet Help Desk** for:
  - Portal password issues
  - Feedback report availability and access
  - PQRI-IACS registration questions
  - PQRI-IACS login issues
  - Program and measure-specific questions

**866-288-8912** (7:00 a.m. – 7:00 p.m. CST M-F)
or **qnetsupport@sdps.org**
(TTY 877-715-6222)

Dr. Daniel Green

# Understanding Claims-Based Reporting for eRx Incentive Program

# What is eRx?

- eRx is the transmission of prescriptions or prescription-related information through electronic media
- eRx takes place between a prescriber, dispenser, pharmacy benefit manager, or health plan
  - Can take place directly or through an intermediary (eRx network)

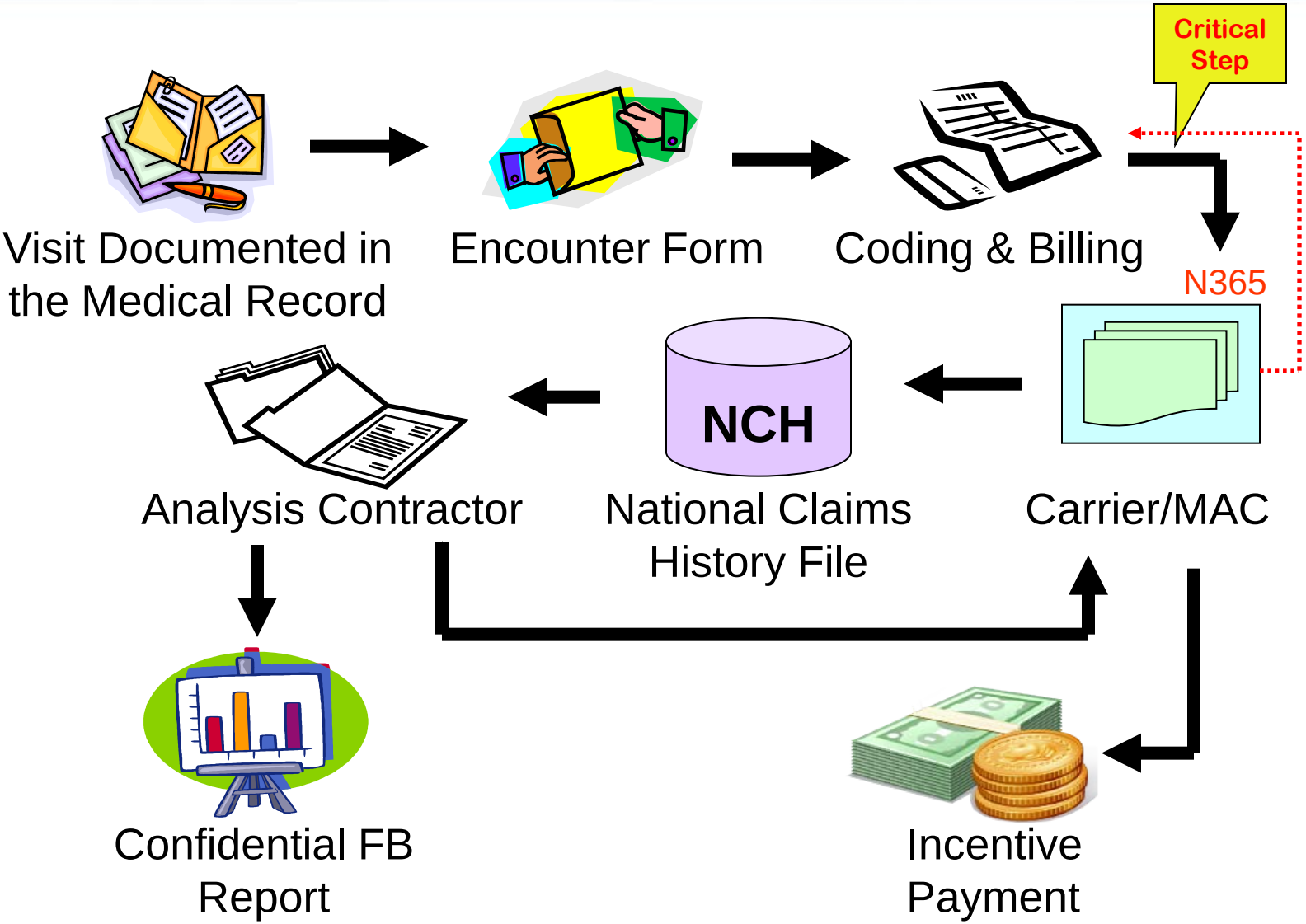
# What is the Medicare eRx Incentive Program?

- The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized the Medicare eRx Incentive Program to promote adoption/use of eRx systems
- Provides a combination of incentives and payment adjustments for individual eligible professionals and group practices to encourage electronic prescribing
- See http://www.cms.gov/ERXincentive

# eRx Incentive Program

- The eRx incentive is similar to Physician Quality Reporting as it's based on the Medicare Part B PFS covered professional services furnished by the eligible professional during a reporting period
  - To be incentive eligible, must meet the criteria for being a successful electronic prescriber
    - Criteria are established for each program year through rulemaking

# Claims-Based Process



# Determining Participation: Step 1

- Determine whether or not you are eligible to participate in the program
  - A list of professionals who are eligible and able to receive an incentive for participating in the Electronic Prescribing Incentive Program is available on the CMS website at: http://www.cms.gov/ERXincentive

# Determining Participation: Step 2

- Review the *2010 eRx Measure Specification,* which is available as a downloadable document in the E-Prescribing Measure section of the CMS eRx website, to determine if this measure applies to your practice

# Determining Participation: Step 3

- Determine if your practice has the resources needed to participate:
  - Do you have a "qualified" electronic prescribing system/program that is being used routinely?
    - Generates a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers (PBMs), if available
    - Selects medications, prints prescriptions, electronically transmits prescriptions, and conducts all alerts (defined below)
    - Provides information related to lower-cost, therapeutically appropriate alternatives, if any (the availability of an eRx system to receive tiered formulary information would meet this requirement for 2011)
    - Provides information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan, if available

# Determining Participation: Step 3 (cont.)

- Do you expect your Medicare Part B PFS charges for the codes in the denominator of the measure (listed below) make up at least 10% of your total Medicare Part B PFS allowed charges for 2011?
  - Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) G-codes:
    - 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

# Reporting eRx

- Once you have decided to participate in the 2011 eRx Incentive Program, follow these steps when reporting the measure:

# Reporting eRx: Step 1

- You must bill one of the CPT or HCPCS G-codes noted on slide 40 for the patient you are seeing

# Reporting eRx: Step 2

- Report the following G-code (or numerator code) on the claim form that is submitted for the Medicare patient visit:
  - G8553 - At least one prescription created during the encounter was generated and transmitted electronically using a qualified electronic prescribing system

# Reporting eRx: Step 3

- A “successful electronic prescriber”, eligible to receive an incentive payment, must generate and report one or more electronic prescriptions associated with a patient visit
  - A minimum of 25 unique visits per year is required for individual and varies for selected group practice
  - Each visit must be accompanied by the eRx G-code attesting that during the patient visit at least one prescription was electronically prescribed
    - Electronically generated refills do not count and faxes do not qualify as eRx
    - New prescriptions not associated with a code in the denominator of the measure specification are not accepted as an eligible patient visit and do not count towards the minimum 25/75-2,500 unique eRx events

# Reporting eRx: Step 4

- 10% of an eligible professional's or group's Medicare Part B PFS charges must be comprised of the codes in the denominator of the measure to be eligible for an incentive

# 2011 eRx Program Details

- What Do the Codes Mean?
  - Each measure has detailed specifications consisting of a **reporting numerator** and a **reporting denominator**
  - The **reporting numerator** includes a G-code which indicates a specific clinical action (an eRx event) took place
  - The **reporting denominator**, indicating eligible cases, includes patient demographics and encounter (CPT or HCPCS) codes

# 2011 eRx Program Details

- 1% incentive payment
- Reporting mechanisms:
  - Claims
  - Qualified* registry
  - Qualified* EHR
- Reporting period:
  - January 1-December 31, 2011
- No need to register for eRx Incentive Program
  - Note: Group practices must self-nominate and be selected

** Only registries and EHR vendors considered "qualified" for the 2010 Electronic Prescribing Incentive Program are eligible to report this measure using this method.*

# Claims-based Reporting for eRx: Use of G-code

- For successful reporting under the 2011 eRx Incentive Program, a single quality-data code (eRx G-code) should be reported, according to coding and reporting principles shown in this presentation

# Claims-based Reporting for eRx: Use of G-code (cont.)

- The eRx G-code, which supplies the numerator, must be reported:
  - on the claim(s) with the denominator billing code(s) that represent the eligible encounter
  - for the same beneficiary
  - for the same date of service (DOS)
  - by the same eligible professional (individual NPI) who performed the covered service as the payment codes, usually ICD-9-CM, CPT Category I or HCPCS codes, which supply the denominator

# Claims-based Reporting for eRx: Use of G-code (cont.)

- The eRx G-code must be submitted with a line-item charge of zero dollars ($0.00) at the time the associated covered service is performed:
  - The submitted charge field cannot be blank
  - The line item charge should be $0.00
  - If a system does not allow a $0.00 line-item charge, a nominal amount can be substituted - the beneficiary is not liable for this nominal amount
  - Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be $0.00.)
  - Whether a $0.00 charge or a nominal amount is submitted to the Carrier/MAC, the eRx G-code line is denied and tracked

# Claims-based Reporting for eRx: Use of G-code (cont.)

- eRx line items will be denied for payment, but are passed through the claims processing system to the National Claims History database (NCH), used for eRx claims analysis
  - Eligible professionals will receive a Remittance Advice (RA) which includes a standard remark code (N365)
    - N365 reads: "This procedure code is not payable. It is for reporting/information purposes only."
  - The N365 remark code **does NOT indicate whether the eRx G-code is accurate for that claim or for the measure the eligible professional is attempting to report. N365 only indicates that the eRx G-code passed into NCH.**

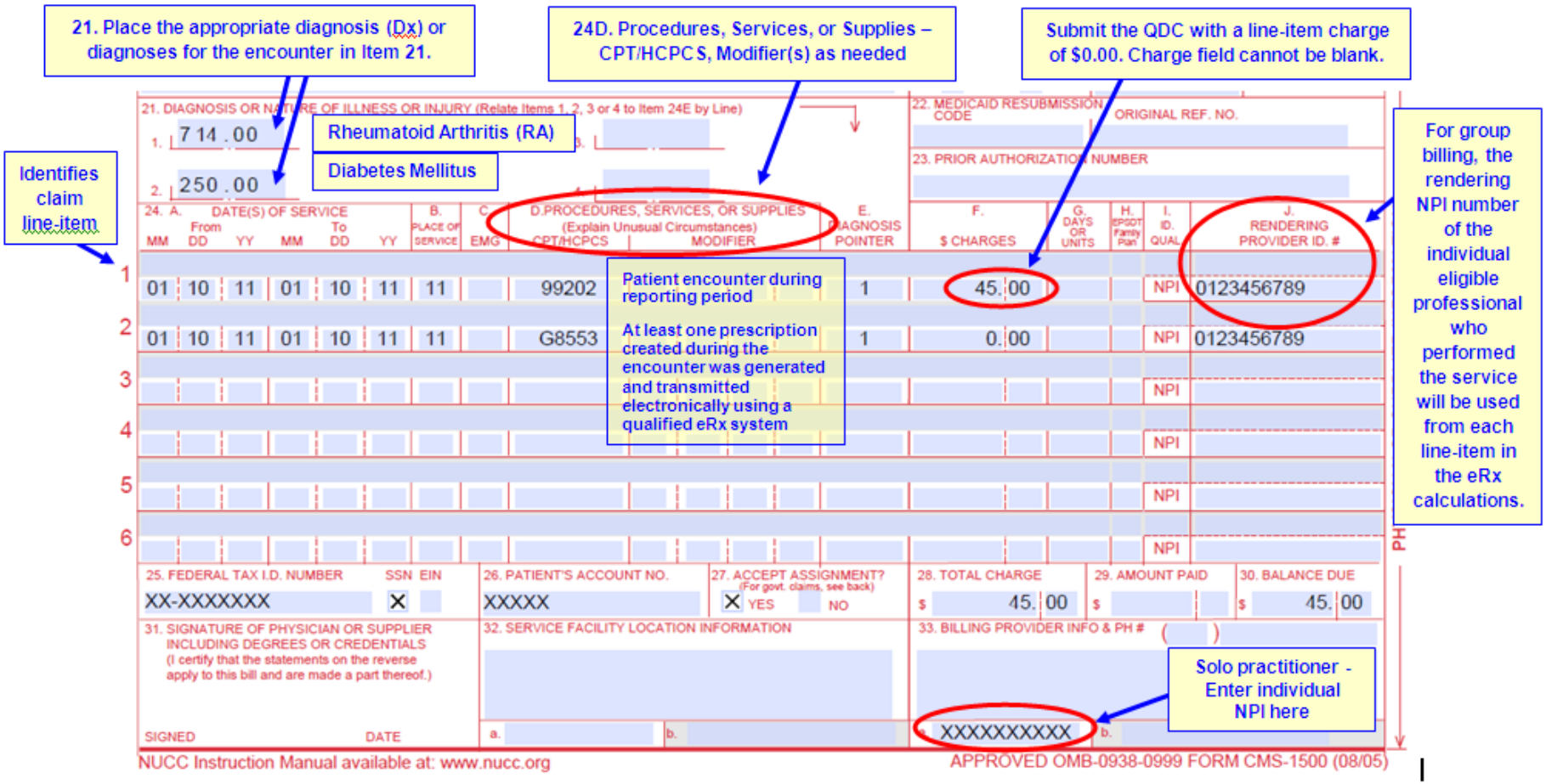
# Claims-based Reporting for eRx: Use of G-code (cont.)

- When a group bills, the group NPI is submitted at the claim level, therefore, the individual rendering/performing physician's NPI must be placed on each line item, including all allowed charges and quality-data line items
- Solo practitioners should follow their normal billing practice of placing their individual NPI in the billing provider field, (#33a on the CMS-1500 form or the electronic equivalent)
- Claims may **NOT** be resubmitted for the sole purpose of adding or correcting an eRx code

# See *2011 eRx Claims-Based Reporting Principles*

**Appendix A: CMS-1500 Claim Electronic Prescribing Example**

A detailed sample of an individual NPI reporting the Electronic Prescribing (eRx) measure on a CMS-1500 claim is shown below.




The patient was seen for an **office visit (99202)**. The provider is reporting the **eRx measure:**

- eRx QDC G8553 (indicating all prescriptions generated via qualified eRx system).
- **Note:** eRx includes encounter (CPT Category I) codes only. All diagnoses listed in **Item 21** from the encounter will be used for PQRI analysis.
- **NPI placement: Item 24J** must contain the NPI of the individual provider who rendered the service when a group is billing.

For more information on the CMS 1500 claim form, see http://cms.gov/manuals/downloads/clm104c26.pdf.

# Submissions Through Carriers/MACs

- eRx G-codes shall be submitted to Carriers/ MACs either through:
  - Electronic submission using the ASC X 12N Health Care Claim Transaction (Version 4010A1) **OR**
  - Paper-based submission, using the CMS-1500 claim form

# Electronic Submission

- The eRx G-code should be submitted in the **SV101-2 "Product/Service ID" Data Element on the SV1 "Professional Service" Segment of the 2400 "Service Line" Loop**
  - It is also necessary to identify in this segment that a HCPCS code is being supplied by submitting the HC in data element SV101-1 within the SV1 "Professional Service" Segment
  - Diagnosis codes are submitted at the claim level, **Loop 2300, in data element HI01, and if there are multiple diagnosis codes, in HI02 through HI08 as needed with a single reference number in the diagnosis pointer**
  - In general for group billing, report the NPI for the rendering provider in **Loop 2310B (Rendering Provider Name, claim level) or 2420A (Rendering Provider Name, line level), using data element NM109 (NM108=XX)**

# Paper-based Submission

- Paper-based submissions are accomplished using the CMS-1500 claim form (version 08-05) as described in the claim sample below. Relevant ICD-9-CM diagnosis codes are entered in Field 21. Service codes (including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers are entered in **Field 24D with a single reference number in the diagnosis pointer Field 24E that corresponds with the diagnosis number in Field 21**
  - For group billing, the NPI of the rendering/performing provider is entered in **Field 24J and the TIN of the employer is entered in Field 25**

# eRx Submission

- Claims processed by the Carrier/MAC must reach the national Medicare claims system data warehouse (NCH file) by February 24, 2012 to be included in the analysis for 2011
- Claims for services furnished toward the end of the reporting period should be filed promptly
- Claims that are resubmitted only to add QDCs will **not** be included in the analysis

# eRx for GPRO I & II

- Groups self-nominating for 2011 GPRO I or II must indicate whether they intend to report on the eRx measure as a group practice or individually
- Information on the eRx measure for GPRO is located on the Group Practice Reporting Option section of the CMS eRx website

# eRx Payment Adjustments Planned for Future

- Per legislation, payment adjustments may occur for not being a successful electronic prescriber
  - Applies whether or not eligible professional is planning to participate in eRx Incentive Program
  - Requirements apply to determine if payment adjustment will or will not be levied, not to determine incentive eligibility
    - 2012 – receive 99% of eligible professional's (or group practice's) Part B covered professional services
    - 2013 – receive 98.5%

# 2012 eRx Payment Adjustment

- The PFS amount for covered professional services furnished by an eligible professional (or group practice) who is not a successful electronic prescriber will be reduced by 1% in 2012
- **Reporting Period: January 1 – June 30, 2011**
- Reporting Mechanism: Claims
  - Payment adjustment does not necessarily apply if <10% of an eligible professional's (or group practice's) allowed charges for the January 1 – June 30, 2011 reporting period are comprised of codes in the denominator of 2011 eRx measure
- Earning an eRx incentive (25 unique eRx events for between January 1 and December 31, 2011) for 2011 will not exempt an eligible professional or group practice from the payment adjustment (must have 10 unique eRx events between January 1 and June 30, 2011)

# How an Individual Eligible Professional Can Avoid 2012 eRx Payment Adjustment

- The eligible professional:
  - is not a Physician (MD, DO, or podiatrist), Nurse Practitioner, or Physician Assistant as of June 30, 2011
    - Based on primary taxonomy code in NPPES or
    - The eligible professional reports the G-code indicating that (s)he does not have prescribing privileges at least once **on a claim(s)** prior to June 30, 2011 (G8644)
  - does not have at least 100 cases containing an encounter code in the measure denominator
  - does not meet the 10% denominator threshold
  - becomes a successful electronic prescriber
    - Report the eRx measure for at least 10 unique eRx events for patients in the denominator of the measure

# How a Group Practice Can Avoid 2012 eRx Payment Adjustment

- For group practices participating in eRx GPRO I or GPRO II during 2011, the group practice must become a successful electronic prescriber
  - Depending on the group's size, report the eRx measure on 75-2,500 unique eRx events for patients in the denominator of the measure for services occurring between January 1 and June 30, 2011

# eRx for GPRO: Required Reporting for GPRO II

- To avoid 2012 payment adjustment, Physician Quality Reporting GPRO II groups must report the eRx measure at an eligible patient encounter (meeting the eRx measure's denominator) according to group size

| Group size (Number of Eligible Professionals) | Required Number of Unique Visits Where an Electronic Prescription was Generated to be a Successful Electronic Prescriber |
|---|---|
| 2-10 | 75 |
| 11-25 | 225 |
| 26-50 | 475 |
| 51-100 | 925 |
| 101-199 | 1875 |

# Hardship Exemption for eRx Payment Adjustment

- CMS may, on a case-by-case basis, exempt an eligible professional from the application of the eRx payment adjustment if compliance with the requirement for being a successful electronic prescriber would result in a significant hardship
- This exemption is subject to annual renewal
- For the 2012 eRx payment adjustment, the following circumstances would constitute a hardship:
  - The eligible professional practices in rural area with limited high-speed internet access, or
  - The eligible professional practices in an area with limited available pharmacies that can receive electronic prescriptions

# Hardship Exemption for eRx Payment Adjustment (cont.)

- G-codes have been created to address two hardship circumstances (G8642 and G8643)
- To request a hardship exemption for 2012 payment adjustment:
  - An eligible professional must report the appropriate G-code **on at least 1 claim** for a service that appears in the denominator of the measure between January 1 and June 30, 2011
  - A group practice must submit this request at the time it self-nominates to participate in eRx GPRO I or GPRO II

# 2013 eRx Payment Adjustment

- The PFS amount paid in 2013 for covered professional services furnished by an eligible professional (or group practice) who is not a successful electronic prescriber will be reduced by 1.5% (in 2013)
- The reporting period used to determine those who are subject to the payment adjustment will occur *before* 2013
- An eligible professional or group practice who is a successful electronic prescriber for the 2011 eRx incentive (i.e., 25 unique eRx events in 2011 for an individual or the requisite number of eRx events for the specific group practice size) will be considered exempt from the 2013 payment adjustment

# eRx Payment Adjustment (cont.)

- Summary
  - Beginning in 2012, those identified as not "successful electronic prescribers" may be subject to a payment adjustment
    - **Ensure submission of required number of eRxs (10 for individual, varies for GPROs) before June 30, 2011 OR one of the hardship G-codes to avoid payment adjustment in 2012**
    - Ensure specialty information is correct in NPPES
    - Need a "qualified" eRx system to participate (see http://www.cms.gov/ERXincentive)
    1. Only way to report eRx to avoid the payment adjustment is ***claims*** but to be incentive eligible you can use claims, a qualified EHR or registry
    - Check for state-specific eRx requirements; all states allow eRx, but some have certain regulatory requirements
    - It is possible to receive an eRx incentive payment for 2011 AND also an eRx payment adjustment for 2012

# Registry-Based Reporting for eRx Incentive Program

- If interested in being able to report the measure for the eRx Incentive Program, registry-based reporting is applicable
- Registry-based reporting is NOT applicable for avoiding the eRx Payment Adjustment
  - **Must report via claims**

# EHR-Based Reporting for eRx Incentive Program

- If interested in being able to report the measure for the eRx Incentive Program, EHR-based reporting is applicable
- EHR-based reporting is NOT applicable for avoiding the eRx Payment Adjustment
  - **Must report via claims**

# eRx Resources

- Visit the *How to Get Started* section of the CMS eRx Incentive Program website at http://www.cms.gov/ERXincentive for documents with additional information regarding getting started with electronic prescribing
  - *2011 eRx Measure Specification*
  - *2011 eRx Incentive Program Made Simple Fact Sheet*
  - *What's New for 2011 eRx Incentive Program*
  - Link to Frequently Asked Questions

# Where to Call for Help

- Contact the **QualityNet Help Desk** for:
  - Portal password issues
  - Feedback report availability and access
  - PQRI-IACS registration questions
  - PQRI-IACS login issues
  - Program and measure-specific questions

**866-288-8912** (7:00 a.m. – 7:00 p.m. CST M-F)
or **qnetsupport@sdps.org**
(TTY 877-715-6222)

Molly MacHarris

# Maintenance of Certification Program Incentive – Reporting Requirements

# 2011 Maintenance of Certification Program Incentive

- Beginning in 2011, physicians who are incentive eligible for the 12-month reporting period for Physician Quality Reporting can receive an additional 0.5% incentive payment when Maintenance of Certification Program Incentive requirements have also been met
- In order to qualify for the additional 0.5% incentive payment, the physician will need to complete the following:
  - Satisfactorily submit data, without regard to method, on quality measures under Physician Quality Reporting, for a 12-month reporting period either as an individual physician or as a member of a selected group practice

    *AND*
  - More frequently than is required to qualify for or maintain board certification:
    - Participate in a Maintenance of Certification Program, and
    - Successfully complete a qualified Maintenance of Certification Program practice assessment

# 2011 Maintenance of Certification Program Incentive (cont.)

- A “Maintenance of Certification Program” is a continuous assessment program that advances quality and the lifelong learning and self-assessment of board-certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills, and professionalism. Such a program shall require a physician to do the following:
  - Maintain a valid, unrestricted medical license in the United States
  - Participate in educational and self-assessment programs that require an assessment of what was learned
  - Demonstrate through a formalized, secure examination that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty
  - Successfully complete a qualified Maintenance of Certification program practice assessment

# 2011 Maintenance of Certification Program Incentive (cont.)

- Maintenance of Certification vendors/registries/entities will manage the program for physicians
- Only those organizations that meet the definition of a Maintenance of Certification Program need to self-nominate by January 31, 2011 to become a qualified Maintenance of Certification entity
- A listing of the conditionally qualified entities will be posted on the CMS website this spring
- Individual physicians do not need to self-nominate
  - Physicians will need to work directly with the entity to complete the Maintenance of Certification required activities during 2011
- The qualified entity will submit 2011 information during the February-March 2012 submission period on behalf of physicians

# 2011 Maintenance of Certification Program Incentive Self-Nomination Letters

- Please refer to http://www.cms.gov/pqri > Spotlight
  - See *Requirements of Self-Nomination for 2011*
- CMS has issued additional guidance on the "more frequently" requirement for the Maintenance of Certification Program Incentive
  - See http://www.cms.gov/pqri/ > Overview > Downloads
- Maintenance of Certification Program Incentive self-nomination letters must be received by CMS no later than **5:00 p.m. EST on January 31, 2011**

# Reporting Requirements for Entities

- All information must be submitted (in a secure format) to CMS by a qualified Maintenance of Certification Program entity by March 31, 2012, including:
  - Eligible physician's name
  - Individual National Provider Identifier (NPI), not the group NPI
  - Applicable Tax Identification Number (s) or Social Security Number (SSN) used to bill and receive Medicare reimbursement
  - Attestation from the board that the information provided to CMS is accurate and complete
  - Entity has signed documentation from physician that s/he wishes to have the information released to CMS
  - Information from the experience of care (patient satisfaction) survey
  - Physician successfully completed a qualified Maintenance of Certification Program practice assessment for the year

# Reporting Requirements for Entities (cont.)

- Information certifying the physician participated in a Maintenance of Certification Program for a year, “more frequently” than required to qualify for/maintain board certification status, including the year the physician met the board certification requirements for the Maintenance of Certification Program and the year s/he participated in it “more frequently” than required
- Information certifying the physician completed the Maintenance of Certification Program practice assessment one additional time more than is required to qualify for/maintain board certification, including the year of the original practice assessment or that one is not required for the physician, and the year of the additional practice assessment completion

# Incentive Payment

- Potential 0.5% incentive only applies to those physicians who qualify for a 2011 Physician Quality Reporting incentive
  - Incentive is for physicians, not all eligible professionals
- Incentive will be paid at the same time as the 2011 Physician Quality Reporting incentive for those physicians who qualify
  - Identified separately on the 2011 feedback report
- Physicians cannot receive more than one additional 0.5% incentive even if they complete a Maintenance of Certification Program in more than one specialty

# Incentive Payment (cont.)

- System will determine incentive payments for group practices participating in GPRO I or II who had Maintenance of Certification incentive-eligible members
  - If group practice satisfactorily reported Physician Quality Reporting, the group practice will receive an additional 0.5% incentive payment based on the allowed charges attributed to group practice members who were found eligible for the Maintenance of Certification Program incentive payment

# Where to Call for Help

- Contact the **QualityNet Help Desk**:

**866-288-8912** (7:00 a.m. – 7:00 p.m. CST M-F)
or **qnetsupport@sdps.org**
(TTY 877-715-6222)

# Thank You

- Questions?