



PQRS Group Practices Participating in the Group Practice Reporting Option (GPRO)



**GPRO Reporting Using
Registries**

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Agenda

- GPRO Overview
- GPRO Reporting Using Registries
- Physician Compare
- Value Modifier
- Resources & Where to Call for Help
- Time for Q&A

GPRO Overview

GPRO Background

- Originally modeled after CMS demonstration projects
 - Physician Group Practice (PGP)
 - Medicare Care Management Performance (MCMP)
- PQRS group practice participating in the group practice reporting option (GPRO) that satisfactorily report can earn an incentive payment
 - 2014 incentive is 0.5% of the TIN's total estimated Medicare Part B PFS allowed charges for covered professional services furnished during the reporting period (January 1 – December 31, 2014)
- PQRS group practices will be subject to a payment adjustment in 2016 based on PQRS reporting in program year 2014
 - Reference GPRO 101 - Part 2 for more information on the PQRS payment adjustment and Value-based Payment Modifier (VM)

GPRO Background (cont.)

- Benefits of Participating as a PQRS Group Practice
 - Billing and reporting staff may report one set of quality measures data on behalf of all EPs within a group practice, reducing the need to keep track of EPs' reporting efforts separately
 - Incentive-eligible group practices will receive a larger incentive payment as it is calculated at the TIN-level (0.5% of all Medicare Part B PFS claims submitted under that TIN)
 - Those EPs who have difficulty meeting the reporting requirements for individual EPs may benefit from group reporting

Who can Participate in GPRO?

- What is a group practice?
 - A “group practice” under 2014 PQRS consists of a physician group practice, as defined by a single TIN, with 2 or more individual EPs (as identified by individual NPIs) who have reassigned their billing rights to the TIN
 - If a TIN decides to report as a GPRO, any individual EP who has assigned billing rights to that TIN must report via GPRO and CANNOT participate as an individual using that TIN/NPI combination
 - If the EP also reports through a different TIN that is not participating as a GPRO, then the EP may report individually through that alternate TIN
 - If an organization or EP changes TINs, the participation under the old TIN does not carry over to the new TIN, nor is it combined for final analysis
- Other CMS programs, such as the SSP, CPC and Pioneer ACOs, will utilize the GPRO to meet physician quality reporting objectives
 - EPs should look to the respective quality program to ensure they satisfy the reporting requirements

2014 GPRO Participation

- Group practices wanting to participate in GPRO needed to register by October 8, 2014.
- GPRO participation will count for:
 - PQRS
 - VM
 - eCQM component of Meaningful Use
 - Only if the group registers to report via Web Interface or EHR reporting methods
 - Cannot meet this requirement through registry reporting

2014 Reporting Methods (cont.)



*CAHPS is required for groups of 100+ reporting via the GPRO Web Interface

What is Registry Reporting?

Registry Reporting

- Qualified registries aggregate measures and calculate the data on behalf of their clients.
- Qualified registries must be able to collect all needed data elements and transmit the data to CMS using registry XML specifications for PQRS program participation.

Where Can I Find Qualified Registries?

- The list of 2014 PQRS qualified registries is posted on the PQRS website under the Registry Reporting page at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Registry-Reporting.html>

Registry Capabilities

- This list shows which individual measures the registry supports, and if the registry supports the GPRO option
 - Not all registries support every individual measure
 - Not all registries support GPRO reporting
- You must select a registry that supports the individual measures you want to report, and that also supports GPRO reporting
 - Measure group reporting is not an option for GPROs

GPRO Registry Reporting

GPRO Reporting via Registry

- There are two sets of criteria for group practices participating in the 2014 PQRS GPRO via qualified registries
 - one to earn the 2014 PQRS incentive, which automatically excludes the group from the payment adjustment, and
 - one to only avoid the 2016 PQRS payment adjustment
 - more information about registry reporting is available in the *2014 PQRS: Registry Reporting Made Simple* document on the Registry Reporting page of the PQRS website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Registry-Reporting.html>

Earning the 2014 Incentive

- Criteria for satisfactory reporting via qualified registry for the 2014 PQRS incentive payment
 - Report at least 9 individual PQRS registry measures across 3 NQS domains for 50% or more of applicable Medicare Part B FFS patients for each GPRO (12 months)
 - Measures with 0 performance rate will not be counted

OR (for groups of 25 + EPs)

Report all CG-CAHPS summary survey modules (12)

AND

- Report at least 6 measures across 2 NQS domains for 50% or more of applicable Medicare Part B FFS patients for each GPRO (12 months)

**GPRO group practices wanting to submit their PQRS data via a qualified registry must elect to do so at the time of GPRO self-nomination/registration.*

Avoiding the 2016 Payment Adjustment

- Meet the criteria for satisfactory reporting via qualified registry for the 2014 PQRS incentive payment **OR**
- Report at least 3 individual measure covering at least 1 NQS domain as a group via qualified registry for 50% or more of the applicable Medicare Part B FFS patients;
 - measures with 0 percent rate will not be counted; **OR**
- Report 1-2 individual measures via qualified registry as a group for 50% or more of the group practice's applicable Medicare Part B FFS patients and successfully pass the MAV process

**GPRO group practices wanting to submit their PQRS data via a qualified registry must elect to do so at the time of GPRO self-nomination/registration.*

Measure Applicability Validation

- 2014 Registry Measure Applicability Validation (MAV) Process
 - The MAV process will determine whether an EP or GPRO should have submitted for additional measures. Eligible professionals or group practices who fail MAV will not earn the PQRS incentive payment for 2014 and may be subject to the 2016 Payment Adjustment.
 - EPs and GPROs who satisfactorily submit quality data for less than 9 measures and/or less than 3 NQS will be subject to the MAV process to determine whether they should be considered incentive eligible or avoid the payment adjustment.
 - For more information, refer to the 2014 PQRS Registry Measure Applicability Validation zip file on the CMS PQRS web site, Analysis and Payments web page at: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html>

PHYSICIAN COMPARE

2014 Data to be Publicly Reported CY2015

- 2014 GPRO Web Interface measures
 - Expanded to all measures and for groups of all sizes
- All 2014 measures data from Shared Savings Program and Pioneer ACOs
- GPRO registry and EHR measures
 - Measures mirror those available for reporting via the GPRO Web Interface
- Patient experience data via CAHPS for PQRS and CAHPS for ACOs
 - ACOs and group practices of 100 or more EPs reporting via the Web Interface or other CMS-approved tool or interface
 - CMS will administer data collection for groups of 100 or more EPs participating via the Web Interface
 - Measures collected via a certified survey vendor for groups of 25-99 Eps
- Million Hearts Initiative
 - The Cardiovascular Prevention measures group for individual Eps
- Individual quality measures
 - A sub-set of 20 PQRS measures collected through EHR, registry, or claims that are in line with those reported by groups through the GPRO Web Interface

Physician Compare Registry Measures

- Diabetes: Hemoglobin A1c Poor Control
- Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- Care Coordination/Patient Safety: Medication Reconciliation
- Preventive Care: Influenza Immunization
- Preventive Care: Pneumococcal Vaccination Status for Older Adults
- Preventive Care: Breast Cancer Screening
- Preventive Care: Colorectal Cancer Screening
- Coronary Artery Disease (CAD): Angiotensin-converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy -- Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)
- Preventive Care: Adult Weight Screening and Follow-Up
- Preventive Care: Screening for Clinical Depression
- Coronary Artery Disease (CAD): Lipid Control
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
- Preventive Care: Tobacco Use: Screening and Cessation Intervention
- Hypertension (HTN): Controlling High Blood Pressure
- Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
- Preventive Care: Screening for High Blood Pressure and Follow-Up Documented

Value Modifier

Value Modifier

- Effective in 2013, the implementation of the Value-based Payment Modifier (VM) is based on participation in PQRS
 - EPs must satisfactorily report or participate in PQRS for purposes of VM adjustment
- VM assesses both quality of care furnished and cost of that care under the Medicare PFS
- For the 2014 PQRS program year, 2016 VM will apply to groups of physicians with 10 or more EPs
 - if groups participate in 2014 PQRS successfully to avoid the 2016 PQRS payment adjustment, then any downward VM adjustment that is based on their Quality Tiering score will only apply to group practices with 100 or more EPs
- Complete information about VM is available on the CMS Physician Feedback Program/Value-Based Payment Modifier website
 - <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>

Value Modifier (cont'd)

- The value modifier provides for differential payment to physicians and groups of physicians under the Medicare PFS based upon the quality of care furnished compared to cost during a specified performance period
 - Differential payments can result in an upward, neutral, or downward adjustment
- The VM calculation is based on:
 - Performance on the quality measures reported through a PQRS reporting mechanism, either as an individual or as a group (e.g., GPRO Web Interface, qualified registry, or EHR) and three outcome measures, and
 - Performance on six cost measures
- The VM will begin to be applied in 2015 and it will be fully implemented by 2017

CMS Initiatives

Resources & Where to Call for Help

Acronyms

- **ACO** – Accountable Care Organization
- **CAHPS** – Consumer Assessment of Healthcare Providers and Systems summary surveys
- **CMS** – Centers for Medicare & Medicaid Services
- **CQMs** – Clinical Quality Measures [for attestation]
- **eCQMs** – Electronic Clinical Quality Measures [for PQRS Portal submission]
- **EHR** – Electronic Health Record
- **EP** – Eligible Professional
- **FFS** – Fee-for-Service
- **GPRO** – Group Practice Reporting Option
- **NPI** – National Provider Identifier
- **ONC** – Office of the National Coordinator
- **PQRS** – Physician Quality Reporting System
- **PFS** – Physician Fee Schedule
- **VM** – Value-based Payment Modifier

Resources

- **CMS PQRS Website**
<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS>
- **PFS Federal Regulation Notices**
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html>
- **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/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>
- **Physician Compare**
<http://www.medicare.gov/physiciancompare/search.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

Where to Call for Help

- **QualityNet Help Desk:**

- Portal password issues
- Feedback report availability and access
- IACS registration questions
- IACS login issues
- PQRS program questions

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

- **Provider Contact Center:**

- Questions on status of 2013 PQRS/eRx Incentive Program incentive payment (during distribution timeframe)
- See *Contact Center Directory* at <http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>

- **EHR Incentive Program Information Center:**

888-734-6433 (TTY 888-734-6563)

Time for

Questions & Answers