

National Provider Call:
Physician Quality Reporting System
(Physician Quality Reporting, previously known as PQRI)
and
Electronic Prescribing (eRx)
Incentive Program

July 26, 2011

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Agenda



- ◆ Announcements
- ◆ 2012 Physician Fee Schedule (PFS)
Proposed Rule
- ◆ Questions & Answers

CMS Staff

ANNOUNCEMENTS

2012 PFS PROPOSED RULE

Christine Estella

PHYSICIAN QUALITY REPORTING SYSTEM

2012 PFS Proposed Rule



- ◆ Reporting requirements for Physician Quality Reporting and eRx Incentive Program have been modified over the years to encourage participation and successful reporting
- ◆ On July 1, 2011, CMS proposed changes to the 2012 Physician Fee Schedule (PFS)
 - ◆ 2012 PFS Proposed Rule may be viewed at http://www.ofr.gov/OFRUpload/OFRData/2011-16972_PI.pdf
 - ◆ 60-day public comment period ends August 30, 2011
 - ◆ Final 2012 PFS Rule will be available November 1, 2011 or shortly thereafter

Background: Physician Quality Reporting



- ◆ What is the Physician Quality Reporting System?
 - ◆ Since its inception in 2007, the Physician Quality Reporting System has grown to include several individual measures and measures groups as well as multiple reporting options of these measures
 - ◆ For 2012, eligible professionals and group practices participating under the group practice reporting option (GPRO) can qualify for an incentive payment of 0.5% of their total estimated Medicare Physician Fee Schedule (PFS) allowed charges for satisfactory reporting

Proposed Changes: Physician Quality Reporting



1. Amend the group practice reporting option (GPRO)
 - A. Consolidating two group reporting options into a single option that defines a “group practice” as a group of 25 or more individual eligible professionals
 - B. Changing criteria for satisfactory reporting to reflect change in the definition of “group practice”
 - C. Retiring 3 measures and introducing 18 new measures under the Physician Quality Reporting System GPRO in order to align with other CMS programs, thereby proposing that a GPRO report on 41 total measures

Proposed Changes: Physician Quality Reporting (cont.)



2. Introduce new proposed Physician Quality Reporting System individual measures
 - A. Introduce a core measures set made up of 7 measures aimed at promoting cardiovascular conditions
 - B. 26 new measures available for claims and registry
 - C. All 44 EHR measures currently reportable in Medicare EHR Incentive Program

Proposed Changes: Physician Quality Reporting (cont.)



3. Introduce 10 new proposed measures groups for reporting

Cardiovascular Prevention

Dementia

COPD

Parkinson's

Inflammatory Bowel Disease

Elevated Blood Pressure

Sleep Apnea

Radiology

Epilepsy

Cataracts

Proposed Changes: Physician Quality Reporting (cont.)



4. Modify 2011 criteria for satisfactory reporting on individual measures and measures groups in the following ways:
 - A. Eliminate the 6-month reporting period (except for measures groups via registry)
 - B. Require reporting at least 1 Physician Quality Reporting System core measure for eligible professionals reporting via claims or registry or ALL core measures via EHR for the following specialties: internal medicine, family practice, general practice, and cardiology
 - C. Allow 2 different EHR reporting options:
 - Direct Submission
 - Data Submission Vendor
 - D. Stipulate that measures with 0% performance rate will not be counted for all reporting options, except where an eligible professional is required to report on all Physician Quality Reporting System core measures via the EHR-based reporting mechanism
 - E. Include a reporting option for EHR-based reporting that is identical to the reporting requirements for reporting clinical quality measures (CQMs) under the EHR Incentive Program

Proposed Changes: Physician Quality Reporting (cont.)



5. Change interpretation for earning additional 0.5% incentive under Maintenance of Certification Program Incentive
 - Provide more flexibility to entities sponsoring Maintenance of Certification Programs to define what an eligible professional is required to do “more frequently” to participate in a Maintenance of Certification Program for purposes of the Physician Quality Reporting System Maintenance of Certification Program Incentive
 - “More frequently” requirement to apply to at least 1 instead of all 4 components of a Maintenance of Certification Program
 - Require participation and successful completion in at least one Maintenance of Certification Program practice assessment for each year the physician participates in the Maintenance of Certification Program Incentive, regardless of whether or how often the physician is required to participate in a Maintenance of Certification Program to maintain board certification

Proposed Changes: Physician Quality Reporting (cont.)



6. Provide interim feedback reports to eligible professionals reporting individual measures and measures groups via *claims* for 2012 and beyond
 - Simplified version of annual feedback reports
 - Based on claims for dates of service occurring on or after January 1 and processed by March 31 of the respective program year
 - Will be available summer of 2012 for 2012 program year

Proposed Changes: Physician Quality Reporting (cont.)



7. Announce reporting period for 2015 Physician Quality Reporting payment adjustment will be the 2013 calendar year (January 1 – December 31, 2013)
 - 98.5 percent for 2015; and
 - 98.0 percent for 2016 and each subsequent year

Physician Quality Reporting: Proposed 2012 Criteria for Satisfactory Reporting



2012 Criteria for Satisfactory Reporting of Data on Individual Physician Quality Reporting System Quality Measures via Claims and Registry for the Following Specialties: Internal Medicine Family Practice, General Practice, and Cardiology

Reporting Mechanism	Reporting Criteria	Reporting Period
Claims-based reporting	<ul style="list-style-type: none"> • Report at least 3 Physician Quality Reporting System measures, which consist of one Physician Quality Reporting System core measure + 2 additional measures of the eligible professional's choosing; OR • If less than 3 measures apply to the eligible professional, 1-2 measures, of which at least 1 measure must consist of a Physician Quality Reporting System core measure; AND • Report each measure for at least 50% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. • Measures with a 0% performance rate will not be counted 	January 1 – December 31, 2012
Registry-based reporting	<ul style="list-style-type: none"> • Report at least 3 Physician Quality Reporting System measures, which consist of 1 Physician Quality Reporting System core measure + 2 additional measures of the eligible professional's choosing AND • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. • Measures with a 0% performance rate will not be counted 	January 1 – December 31, 2012
EHR – Aligning with the Medicare EHR Incentive Program	<ul style="list-style-type: none"> • Reports on ALL 3 Medicare EHR Incentive Program core measures • If the denominator for one or more of the Medicare EHR Incentive Program core measures is 0, report on up to 3 Medicare EHR Incentive Program alternate core measures; AND • Report on three (of the 38) additional measures available for the Medicare EHR Incentive Program 	January 1 – December 31, 2012
EHR	<ul style="list-style-type: none"> • Report on ALL Physician Quality Reporting System core measures AND • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. • Measures with a 0% performance rate will not be counted, unless the measure is a Physician Quality Reporting System core measure 	January 1 – December 31, 2012

* The Physician Quality Reporting System core measures are specified in the "Proposed 2012 Measures Available for EHR-based Reporting" section of this proposed rule.

Physician Quality Reporting: Proposed 2012 Criteria for Satisfactory Reporting (cont.)



2012 Criteria for Satisfactory Reporting of Data on Individual Physician Quality Reporting System Quality Measures via Claims and Registry for All Other Eligible Professionals

Reporting Mechanism	Reporting Criteria	Reporting Period
Claims-based reporting	<ul style="list-style-type: none"> • Report at least 3 Physician Quality Reporting System measures; OR • If less than 3 measures apply to the eligible professional, 1-2 measures; AND • Report each measure for at least 50% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies • Measures with a 0% performance rate will not be counted 	January 1 – December 31, 2012
Registry-based reporting	<ul style="list-style-type: none"> • Report at least 3 Physician Quality Reporting System measures AND • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies • Measures with a 0% performance rate will not be counted 	January 1 – December 31, 2012
EHR – Aligning with the Medicare EHR Incentive Program	<ul style="list-style-type: none"> • Reports on ALL 3 Medicare EHR Incentive Program core measures • If the denominator for one or more of the Medicare EHR Incentive Program core measures is 0, report on up to 3 Medicare EHR Incentive Program alternate core measures; AND • Report on 3 (of the 38) additional measures available for the Medicare EHR Incentive Program. 	January 1 – December 31, 2012
EHR	<ul style="list-style-type: none"> • Report at least 3 Physician Quality Reporting System measures AND • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies • Measures with a 0% performance rate will not be counted 	January 1 – December 31, 2012

* The Physician Quality Reporting System core measures are specified in the “Proposed 2012 Measures Available for EHR-based Reporting” section of this proposed rule.

Physician Quality Reporting: Proposed 2012 Criteria for Satisfactory Reporting (cont.)



2012 Criteria for Satisfactory Reporting on Measures Groups via Claims for the Following Specialties: Internal Medicine Family Practice, General Practice, and Cardiology

Reporting Mechanism	Reporting Criteria	Reporting Period
Claims-based reporting	<ul style="list-style-type: none"> ● Report at least 1 Physician Quality Reporting System measures group; AND ● If the measures group does not contain at least 1 Physician Quality core measure, then report 1 Physician Quality core measure; AND ● Report each measures group and, if applicable, Physician Quality Reporting System core measure for at least 30 Medicare Part B FFS patients ● Measures groups containing a measure with a 0% performance rate will not be counted 	January 1 – December 31, 2012
Claims-based reporting	<ul style="list-style-type: none"> ● Report at least 1 Physician Quality Reporting System measures group; AND ● If the measures group does not contain at least 1 Physician Quality core measure, then report 1 Physician Quality core measure; AND ● Report each measures group and, if applicable, Physician Quality Reporting System core measure for at least 50 % of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; BUT ● Report each measures group on no less than 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies ● Measures groups containing a measure with a 0% performance rate will not be counted 	January 1 – December 31, 2012

* The Physician Quality Reporting System core measures are specified in the "Proposed 2012 Measures Available for EHR-based Reporting" section of this proposed rule.

Physician Quality Reporting: Proposed 2012 Criteria for Satisfactory Reporting (cont.)



2012 Criteria for Satisfactory Reporting on Measures Groups via for All Other Eligible Professionals

Reporting Mechanism	Reporting Criteria	Reporting Period
Claims-based reporting	<ul style="list-style-type: none"> • Report at least 1 Physician Quality Reporting System measures group; AND • Report each measures group for at least 30 Medicare Part B FFS patients • Measures groups containing a measure with a 0% performance rate will not be counted 	January 1 – December 31, 2012
Claims-based reporting	<ul style="list-style-type: none"> • Report at least 1 Physician Quality Reporting System measures group; • Report each measures group for at least 50 % of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; BUT • Report each measures group on no less than 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies • Measures groups containing a measure with a 0% performance rate will not be counted 	January 1 – December 31, 2012

Physician Quality Reporting: Proposed 2012 Criteria for Satisfactory Reporting (cont.)



2012 Criteria for Satisfactory Reporting on Measures Groups via Registry for the Following Specialties: Internal Medicine Family Practice, General Practice, and Cardiology

Reporting Mechanism	Reporting Criteria	Reporting Period
Registry-based reporting	<ul style="list-style-type: none"> • Report at least 1 Physician Quality Reporting System measures group; AND • If the measures group does not contain at least 1 Physician Quality core measure, then 1 Physician Quality core measure; AND • Report each measures group and, if applicable, Physician Quality Reporting System core measure for at least 30 Medicare Part B FFS patients • Measures groups containing a measure with a 0% performance rate will not be counted 	January 1 – December 31, 2012
Registry-based reporting	<ul style="list-style-type: none"> • Report at least 1 Physician Quality Reporting System measures group; • If the measures group does not contain at least 1 Physician Quality core measure, then 1 Physician Quality core measure; AND • Report each measures group and, if applicable, Physician Quality Reporting System core measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; BUT • Report each measures group on no less than 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies • Measures groups containing a measure with a 0% performance rate will not be counted 	January 1 – December 31, 2012
Registry-based reporting	<ul style="list-style-type: none"> • Report at least 1 Physician Quality Reporting System measures group; • If the measures group does not contain at least 1 Physician Quality core measure, then 1 Physician Quality core measure; AND • Report each measures group and, if applicable, Physician Quality Reporting System core measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; BUT • Report each measures group on at least 8 Medicare Part B FFS patients seen during the reporting period to which the measures group applies • Measures groups containing a measure with a 0% performance rate will not be counted 	July 1, 2012 – December 31, 2012

* The Physician Quality Reporting System core measures are specified in the "Proposed 2012 Measures Available for EHR-based Reporting" section of this proposed rule.

Physician Quality Reporting: Proposed 2012 Criteria for Satisfactory Reporting (cont.)



2012 Criteria for Satisfactory Reporting on Measures Groups via Registry for All Other Eligible Professionals

Reporting Mechanism	Reporting Criteria	Reporting Period
Registry-based reporting	<ul style="list-style-type: none"> • Report at least 1 Physician Quality Reporting System measures group; AND • Report each measures group for at least 30 Medicare Part B FFS patients • Measures groups containing a measure with a 0% performance rate will not be counted 	January 1 – December 31, 2012
Registry-based reporting	<ul style="list-style-type: none"> • Report at least 1 Physician Quality Reporting System measures group; AND • Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; BUT • Report each measures group on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies • Measures groups containing a measure with a 0% performance rate will not be counted 	January 1 – December 31, 2012
Registry-based reporting	<ul style="list-style-type: none"> • Report at least 1 Physician Quality Reporting System measures group; AND • Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; BUT • Report each measures group on no less than 8 Medicare Part B FFS patients seen during the reporting period to which the measures group applies • Measures groups containing a measure with a 0% performance rate will not be counted 	July 1, 2012 – December 31, 2012

Physician Quality Reporting: Proposed 2012 Criteria for Satisfactory Reporting (cont.)



2012 Criteria for Satisfactory Reporting for Group Practices Participating in the Physician Quality Reporting System Group Practice Reporting Option (GPRO)

Group Practice Size	Reporting Mechanism	Reporting Criteria	Reporting Period
25-99 Eligible Professionals	A submission web interface provided by CMS	<ul style="list-style-type: none"> • Report on all measures included in the web interface; and • Populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample (with an over-sample of 327) for each disease module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100% of assigned beneficiaries 	January 1 – December 31, 2012
100+ Eligible Professionals	A submission web interface provided by CMS	<ul style="list-style-type: none"> • Report on all measures included in the web interface; and • Populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample (with an over-sample of 616) for each disease module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries 	January 1 – December 31, 2012

Christine Estella

ELECTRONIC PRESCRIBING (eRx) INCENTIVE PROGRAM

Background: eRx Incentive Program



- ◆ What is the Medicare eRx Incentive Program?
 - ◆ Program established by Medicare in 2009 to encourage providers to adopt electronic prescribing systems
 - ◆ Provides incentive payments for successful reporting through 2013
 - ◆ Beginning in 2012, the program is legislatively mandated to assess payment adjustments on eligible professionals who fail to successfully report the eRx measure

Proposed Changes: eRx Incentive Program (cont.)



1. Define requirements for remainder of eRx Incentive Program, which ends in 2014
 - A. Continue incentive requirements used in 2010 and 2011 for 2012 and 2013, based on the broadly supported criteria of 25 eRx events for patients who fit within measure's denominator
 - B. Define payment adjustment requirements for 2013 and 2014, based on 2012 requirements
 - 6-month reporting period for individual eligible professionals to avoid 2013 payment adjustment (January 1-June 30, 2012)
 - 12-month reporting period for individual eligible professionals to avoid 2014 payment adjustment (January 1-December 31, 2012)
 - 6-month reporting period for individual eligible professionals and group practices to avoid 2014 payment adjustment (January 1-June 30, 2013)

Proposed Changes: eRx Incentive Program (cont.)



1. Define requirements for remainder of eRx Incentive Program

- A. If finalized, the definition of “group practice” proposed for Physician Quality Reporting would also apply to the eRx Incentive program

Proposed Criteria for Being a Successful Electronic Prescriber for the 2013 eRx Payment Adjustment for the Proposed 6-month Reporting Period- Group Practices

eRx GPRO Size	Reporting Criteria	Reporting Period
25-99 Eligible Professionals	Report the electronic prescribing measure’s numerator code at least 625 times	6-month (January 1 - June 30, 2012)
100+ Eligible Professionals	Report the electronic prescribing measure’s numerator code at least 2,500 times	6-month (January 1 - June 30, 2012)

Proposed Changes: eRx Incentive Program (cont.)



1. Define requirements for remainder of eRx Incentive Program (cont.)

Proposed Criteria for Being a Successful Electronic Prescriber for the 2014 eRx Payment Adjustment - Group Practices Using the eRx GPROs

eRx GPRO Size	Reporting Criteria	Reporting Period
25-99 Eligible Professionals	Report the electronic prescribing measure's numerator for at least 625 times for encounters associated with at least 1 of the denominator codes (the same criteria as the 2012 eRx incentive)	12-month (January 1 - December 31, 2012)
100+ Eligible Professionals	Report the electronic prescribing measure's numerator for at least 2,500 times for encounters associated with at least 1 of the denominator codes (the same criteria as the 2012 incentive)	12-month (January 1 - December 31, 2012)
25-99 Eligible Professionals	Report the electronic prescribing measure's numerator code at least 625 times	6-month (January 1 - June 30, 2013)
100+ Eligible Professionals	Report the electronic prescribing measure's numerator code at least 2,500 times	6-month (January 1 - June 30, 2013)

Proposed Changes: eRx Incentive Program (cont.)



2. Modify the eRx measure

- A. Maintain modifications to eRx measure proposed in 2011 NPRM (i.e., eligible professionals can use either a qualified eRx system (based on original criteria in measure) or certified EHR technology)
 - Also retain requirement that the system meet the 4 functionalities of a “qualified” eRx system
- B. Eliminate requirement that the measure may only be reported during an instance indicated in the denominator of the eRx Measure for 2013 and 2014 payment adjustments

Proposed Changes: eRx Incentive Program (cont.)



3. Propose hardship categories for purposes of 2013 and 2014 payment adjustments

A. Provide significant hardship exemption categories for eligible professionals who:

- Practice in a rural area with limited high-speed Internet access
- Practice in an area with limited available pharmacies for electronic prescribing
- Are unable to electronically prescribe due to local, state, or federal law; or
- Prescribe fewer than 100 prescriptions during a 6-month, payment adjustment reporting period

Proposed Changes: eRx Incentive Program (cont.)



4. Adopt criteria parallel to 2012 payment adjustment
 - 2013
 - A: Qualify for eRx incentive in 2011 (finalized 2011 PFS Rule); or
 - B: Report numerator of measure for 10 eRx events for any service provided during first 6 months of 2012; payment adjustment reporting not limited to billing codes in measure's denominator, but reportable on any claim
 - 2014
 - A: Qualify for eRx incentive in 2012 (new); or
 - B: Report numerator of measure for 10 eRx events for any service provided during first 6 months of 2013; payment adjustment not limited to billing codes in measure's denominator, but reportable on any claim

Proposed Changes: eRx Incentive Program (cont.)



5. Expand reporting mechanisms where payment adjustment can be avoided:
 - Allow registry and EHR reporting in addition to claims-based reporting
 - Two submission periods for registry and EHR reporting, one to submit 6-month data and one to submit 12-month data
 - As in the past, data submitted using multiple reporting mechanisms cannot be combined

eRx Incentive Program: 2013 and 2014 Payment Adjustment Reporting Periods and Reporting Criteria



	2012 Incentive	2013 Incentive	2013 Payment Adjustment	2014 Payment Adjustment
Incentive/ Payment Adjustment Amounts	1% of total estimated MPFS allowed charges	0.5% of total estimated MPFS allowed charges	1.5% reduction in PFS amount	2.0% reduction in PFS amount
Reporting Period	12 months (January 1- December 31, 2012)	12 months (January 1- December 31, 2013)	12 months (January 1- December 31, 2011)* OR 6 months (January 1- June 30, 2012)	12 months (January 1- December 31, 2012) OR 6 months (January 1- June 30, 2013)
Reporting Methods	Claims, Registry, EHR	Claims, Registry, EHR	Claims, Registry, EHR	Claims, Registry, EHR
Criteria for Successful Reporting	Report eRx measure for denominator-eligible visit 25 times during the reporting period	Report eRx measure for denominator-eligible visit 25 times during the reporting period	Report eRx measure for denominator-eligible visit 25 times (for 12-month reporting period)* OR Report eRx measure 10 times for any service (for 6-month reporting period)	Report eRx measure for denominator-eligible visit 25 times (for 12-month reporting period)* OR Report eRx measure 10 times for any service (for 6-month reporting period)

*Established in 2011 MPFS Final Rule

eRx Incentive Program: 2013 and 2014 Payment Adjustment Reporting Periods and Reporting Criteria (cont.)



	2012 Incentive	2013 Incentive	2013 Payment Adjustment	2014 Payment Adjustment
Exceptions	<10% of the eligible professional's MPFS allowed charges are comprised of the codes in the eRx measure's denominator	<10% of the eligible professional's MPFS allowed charges are comprised of the codes in the eRx measure's denominator	<p>The 2013 payment adjustment will not apply to an eligible professional if any of the following applies:</p> <ul style="list-style-type: none"> (1) Eligible professional is not an MD, DO, podiatrist, nurse practitioner, or physician assistant; (2) Eligible professional has <100 denominator-eligible visits during the 6-month reporting period (3) Eligible professional reports 1 time during the 6-month reporting period the G-code indicating that (s)he does not have prescribing privileges (4) <10% of the eligible professional's MPFS allowed charges are comprised of the codes in the eRx measure's denominator (5) Eligible professional requests a significant hardship exemption 	<p>The 2014 payment adjustment will not apply to an eligible professional if any of the following applies:</p> <ul style="list-style-type: none"> (1) Eligible professional is not an MD, DO, podiatrist, nurse practitioner, or physician assistant; (2) Eligible professional has <100 denominator-eligible visits during the 6-month reporting period (3) Eligible professional reports 1 time during the 6-month reporting period the G-code indicating that (s)he does not have prescribing privileges (4) <10% of the eligible professional's MPFS allowed charges are comprised of the codes in the eRx measure's denominator (5) Eligible professional requests a significant hardship exemption

Self-nomination Deadlines



- ◆ **Physician Quality Reporting GPRO and eRx GPRO**
 - ◆ New group practices: January 31, 2012
 - ◆ Successful 2011 group practices automatically qualified for 2012
- ◆ **Maintenance of Certification Program**
 - ◆ 2012 Maintenance of Certification Program Entities: January 31, 2012
- ◆ **EHR**
 - ◆ 2012 Direct Vendors: December 31, 2011
 - ◆ 2012 Data Submission Vendors: December 31, 2011
 - ◆ Qualify EHR system for 2013 submission: January 31, 2012
 - ◆ Successful 2012 Vendors automatically qualified for 2013
- ◆ **Registries**
 - ◆ New 2012 Registry Vendors: January 31, 2012
 - ◆ Successful 2011 Registries: October 31, 2011
 - ◆ Unsuccessful 2011 Registries: March 31, 2012

Lauren Fuentes

PHYSICIAN COMPARE WEBSITE

Physician Compare Website



- ◆ CMS is required (by the Affordable Care Act) by no later than January 1, 2013 to implement a plan for making physician performance information publicly available
 - ◆ Goal: Foster transparency and public reporting by providing consumers with quality of care information to make informed health care decisions, while encouraging clinicians to improve quality of care provided to their patients

Physician Compare Website

(cont.)



◆ Proposed:

- ◆ Develop plan initially based on public reporting of performance rates for group practices who submitted data under the Physician Quality Reporting GPRO I reporting option for 2012
- ◆ Report performance rates of other CMS demonstrations using the Group Practice Reporting Option
 - ◇ Post as early as 2013
 - ◇ Establish a minimum sample size of 25 patients
- ◆ Web Interface calculates numerator, denominator, and measure performance rate for group practices to review before results are publicly reported
- ◆ GPROs would agree to public reporting prior to 2012 participation
 - ◇ Individual eligible professionals within a group practice would be listed as being associated with the group practice but individual results would not be posted

Molly MacHarris

MEDICARE EHR INCENTIVE PROGRAM

Physician Quality Reporting System-Medicare EHR Incentive Pilot



- ◆ Eligible professionals may demonstrate meaningful use by participating in a Physician Quality Reporting System-Medicare EHR Incentive Pilot that relies on the infrastructure of the Physician Quality Reporting System. Clinical quality measure (CQM) results could be reported via the following methods:
 - ◆ Attestation
 - ◆ By using a Physician Quality Reporting System qualified EHR data submission vendor to submit calculated results from the eligible professional's certified EHR to CMS on the eligible professional's behalf; or
 - ◆ By submitting CQM data directly from his or her certified EHR to CMS via a secure portal. The EHR also must be a qualified Physician Quality Reporting System EHR product
- ◆ Successful participation in pilot will allow receipt of Physician Quality Reporting System incentives and demonstrate meaningful use of CQM component of EHR Incentive Program

2012 PFS Proposed Rule: Public Comment Period



- ◆ Proposed Rule published on July 1, 2011
- ◆ 60-day public comments due no later than 5:00 p.m. on August 30, 2011
- ◆ Comment submission:
 1. Electronically. You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the instructions for "submitting a comment."
 2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1524-P
P.O. Box 8013
Baltimore, MD 21244-8013

Please allow sufficient time for mailed comments to be received before the close of the comment period.

- ◆ CMS will respond to comments in Final Rule by November 1, 2011 or shortly thereafter

Resources



- ◆ CMS Physician Quality Reporting website
<http://www.cms.gov/PQRS>
- ◆ CMS eRx Incentive Program website
<http://www.cms.gov/ERxIncentive>
- ◆ 2012 PFS Proposed Rule
http://www.ofr.gov/OFRUpload/OFRData/2011-16972_PI.pdf
- ◆ eRx Proposed Rule
http://www.cms.gov/ERxIncentive/04_Statute_Regulations.asp >
Downloads or directly at <http://www.gpo.gov/fdsys/pkg/FR-2011-06-01/pdf/2011-13463.pdf>
- ◆ Frequently Asked Questions
- ◆ Medicare and Medicaid EHR Incentive Programs
<http://www.cms.gov/EHRIncentivePrograms>
- ◆ Physician Compare
<http://www.medicare.gov/find-a-doctor/provider-search.aspx>

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@sdps.org

- ◆ You will be asked to provide basic information such as name, practice, address, phone, and e-mail

◆ EHR-ARRA Information Center:

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

CMS Staff

QUESTIONS and ANSWERS