National Provider Call:

The CY 2013 Physician Fee Schedule Final Rule: Requirements for CMS Quality Reporting Programs

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Agenda

- CMS Updates/Announcements
- Presentation – CY 2013 MPFS Final Rule: Quality Reporting Program Updates
  - The Physician Quality Reporting System (PQRS)
    - Including updates for the Medicare EHR Incentive Program
    - Including updates for the Medicare Shared Savings Program
  - The Electronic Prescribing (eRx) Incentive Program
  - Physician Compare
- Question and Answer Session

CMS Staff

ANNOUNCEMENTS

CY 2013 MPFS Final Rule: Quality Reporting Program Updates

PQRS

PQRS Goals: What are CMS' Goals with PQRS? To what extent have we achieved these goals?

- Goals considered while establishing proposals for PQRS
  - Align with other Medicare quality reporting programs that have quality reporting requirements, such as the EHR Incentive Program, Medicare Shared Savings Program, and Value-based Modifier
  - Increase participation to 50% by CY 2015, which is the first year PQRS will not offer incentives for reporting, only payment adjustments
    - The *2010 Experience Report* indicated that the participation rate for 2010 was 26%; Therefore, CMS plans to nearly double the number of eligible professionals participating in PQRS
  - Ease eligible professionals into reporting for the PQRS payment adjustment by providing alternative means to avoiding the 2015 and 2016 payment adjustments (the first 2 years of the PQRS payment adjustment) other than the traditional PQRS methods and criteria for satisfactory reporting
  - We stress the importance of PQRS being viewed not simply as a program that adds administrative burden but rather a program that collects meaningful data that facilitates the overall improvement in quality of care

PQRS Goals: What are CMS' Goals with PQRS? To what extent have we achieved these goals? (cont.)

- PQRS and the EHR Incentive Program
  - Extension of the PQRS-Medicare EHR Incentive Pilot to 2013
  - Satisfactory reporting criteria for the 2014 PQRS Incentive via the EHR-based reporting mechanism and the criteria for meeting the CQM component of meaningful use under the EHR Incentive Program
  - Requirement of Certified Electronic Health Record Technology (CEHRT)

PQRS Goals: What are CMS' Goals with PQRS? To what extent have we achieved these goals? (cont.)

- PQRS Group Practice Reporting Option (GPRO) and the Medicare Shared Savings Program
  - GPRO measures
  - Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program can only participate in PQRS using the PQRS group practice reporting option (GPRO)
  - Adoption of the Medicare Shared Savings Program method of assignment and sampling
  - Under the Medicare Shared Savings Program, ACOs successfully reporting measures under the Medicare Shared Savings Program via the GPRO Web Interface will not be subject to the PQRS payment adjustments as long as the ACO satisfactorily reports at least 1 measure

PQRS Goals: What are CMS' Goals with PQRS? To what extent have we achieved these goals? (cont.)

- PQRS and the Value-based Payment Modifier
  - The Value-based Payment Modifier and meeting the criteria for satisfactory reporting for the 2013 PQRS incentive and 2015 PQRS payment adjustment
  - Group practices consisting of 100+ eligible professionals, beginning in 2013 will be subject to the Value-based Payment Modifier
    - A group practice with 100 or more eligible professionals may avoid a 2015 VBM downward payment adjustment by satisfactorily reporting to avoid the 2015 PQRS payment adjustment (as outlined in slide 23)
  - **Note:** The 2015 and 2016 Value-based payment modifier does not apply to ACOs

Summary of Changes to PQRS

Reporting Periods

- 2015 PQRS payment adjustment
  - 6-month and 12-month reporting periods that coincide with the 2013 PQRS incentive reporting periods
- 2016 PQRS payment adjustment
  - 6-month and 12-month reporting periods that coincide with the 2014 PQRS incentive reporting periods
- 2017 and subsequent PQRS payment adjustments
  - 12-month reporting periods only

Incentive and Payment Adjustment Amounts

- 2013: 0.5% Incentive
- 2014: 0.5% Incentive
- 2015: 1.5% Payment Adjustment (will be applied in 2015 based on reporting in 2013)
- 2016: 2.0% Payment Adjustment (will be applied in 2016 based on reporting in 2014)

Summary of Changes to PQRS (cont.)

Reporting Mechanisms

- Registry
  - Expand use of the registry-based reporting mechanism to group practices participating in the GPRO
- EHR
  - Beginning in 2014:
    - All direct EHR products and EHR data submission vendor's products must be certified by the Office of the National Coordinator as CEHRT.
    - Expand use of the EHR-based reporting mechanism to group practices participating in the GPRO
- GPRO Web Interface
  - Adoption of the Medicare Shared Savings Program method of assignment and sampling
- Administrative Claims
  - A reporting mechanism under which an eligible professional or group practice elects to have CMS analyze claims data to determine which measures an eligible professional or group practice reports
  - For the 2015 PQRS payment adjustment only
  - Under this reporting mechanism, eligible professionals or group practices need to complete this election by the January 31, 2013 deadline

PQRS Reporting as an Individual Eligible Professional

- Benefits of Participating as an Individual Eligible Professional
  - There is no requirement to register to participate as an individual
    - **Exception:** If an individual eligible professional wishes to elect the administrative claims-based reporting mechanism to avoid the 2015 PQRS payment adjustment, the eligible professional must affirmatively elect to be analyzed under this reporting mechanism
  - For eligible professionals in solo practices, participating in PQRS as an individual is the only option for you
  - Eligible professionals within your group practice may freely choose which PQRS measures to report

PQRS Reporting as an Individual Eligible Professional (cont.)

- How to Participate as an Individual
  1. Choose a reporting period, reporting mechanism, and reporting criterion
     - Available Reporting Periods: 6-month, 12-month
     - Available Reporting Mechanisms: Claims, Registry, EHR (EHR direct product and EHR data submission vendor), and Administrative Claims (to avoid the 2015 PQRS payment adjustment only)
  2. Choose the individual measures or measures groups you wish to report

     Note: For help on choosing measures, please see the "How to Get Started" section of the CMS PQRS website and contact the QualityNet Help Desk if you still have questions
  3. Start Reporting!

PQRS Reporting as an Individual Eligible Professional: Summary of Criteria for Satisfactory Reporting by Individual Eligible Professionals of Data on PQRS Quality Measures for the 2013 PQRS Incentive

Reporting Period	Measure Type	Reporting Mechanism	Proposed Reporting Criteria
Jan 1, 2013 - Dec 31, 2013	Individual Measures	Claims	Report at least 3 measures, OR, If less than 3 measures apply to the eligible professional, report 1—2 measures (subject to the MAV); AND Report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate will not be counted.
Jan 1, 2013- Dec 31, 2013	Individual Measures	Registry	Report at least 3 measures, AND Report each measure for at least 80 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate will not be counted.
Jan 1, 2013- Dec 31, 2013	Individual Measures	Qualified Direct EHR Product	Option 1: Report on ALL three PQRS EHR measures that are also 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 three PQRS EHR measures that are also Medicare EHR Incentive Program alternate core measures; AND Report on three additional PQRS EHR measures that are also measures available for the Medicare EHR Incentive Program Option 2: Report at least 3 measures, AND Report each measure for at least 80 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate will not be counted.
Jan 1, 2013 - Dec 31, 2013	Individual Measures	Qualified EHR Data Submission Vendor	Option 1: Report on ALL three PQRS EHR measures that are also 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 three PQRS EHR measures that are also Medicare EHR Incentive Program alternate core measures; AND Report on three additional PQRS EHR measures that are also measures available for the Medicare EHR Incentive Program Option 2: Report at least 3 measures, AND Report each measure for at least 80 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate will not be counted.
Jan 1, 2013- Dec 31, 2013	Measures Groups	Claims	Report at least 1 measures group, AND Report each measures group for at least 20 Medicare Part B FFS patients. Measures groups containing a measure with a 0 percent performance rate will not be counted.
Jan 1, 2013- Dec 31, 2013	Measures Groups	Registry	Report at least 1 measures group, AND Report each measures group for at least 20 patients, a majority (11) of which must be Medicare Part B FFS patients. Measures groups containing a measure with a 0 percent performance rate will not be counted
Jul 1, 2013- Dec 31, 2013	Measures Groups	Registry	Report at least 1 measures group, AND Report each measures group for at least 20 patients, a majority (11) of which must be Medicare Part B FFS patients. Measures groups containing a measure with a 0 percent performance rate will not be counted

PQRS Reporting as an Individual Eligible Professional: Summary of Criteria for Satisfactory Reporting by Individual Eligible Professionals of Data on PQRS Quality Measures for the 2014 PQRS Incentive

Reporting Period	Measure Type	Reporting Mechanism	Proposed Reporting Criteria
Jan 1, 2014-Dec 31, 2014	Individual Measures	Claims	Report at least 3 measures, OR, If less than 3 measures apply to the eligible professional, report 1—2 measures (subject to the MAV); AND Report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate will not be counted.
Jan 1, 2014-Dec 31, 2014	Individual Measures	Registry	Report at least 3 measures, AND Report each measure for at least 80 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate will not be counted.
Jan 1, 2014-Dec 31, 2014	Individual Measures	Direct EHR product that is CEHRT	Report 9 measures covering at least 3 domains. If an eligible professional's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional must report the measures for which there is patient data. (Aligns with CQM criteria for achieving meaningful use under the EHR Incentive Program,)
Jan 1, 2014-Dec 31, 2014	Individual Measures	EHR data submission vendor's product that is CEHRT	Report 9 measures covering at least 3 domains. If an eligible professional's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional must report the measures for which there is patient data. (Aligns with CQM criteria for achieving meaningful use under the EHR Incentive Program,)
Jan 1, 2014-Dec 31, 2014	Measures Groups	Claims	Report at least 1 measures group, AND Report each measures group for at least 20 Medicare Part B FFS patients. Measures groups containing a measure with a 0 percent performance rate will not be counted.
Jan 1, 2014-Dec 31, 2014	Measures Groups	Registry	Report at least 1 measures group, AND Report each measures group for at least 20 patients, a majority (11) of which must be Medicare Part B FFS patients. Measures groups containing a measure with a 0 percent performance rate will not be counted.
Jul 1, 2014-Dec 31, 2014	Measures Groups	Registry	Report at least 1 measures group, AND Report each measures group for at least 20 patients, a majority (11) of which must be Medicare Part B FFS patients. Measures groups containing a measure with a 0 percent performance rate will not be counted.

PQRS Reporting as an Individual:
The PQRS Payment Adjustment

- For 2015 and subsequent years, a payment adjustment with respect to covered professional services furnished by an eligible professional will be applied if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year
  - Applicable adjustment amount:
    - 2015: 1.5%
    - 2016 and subsequent years: 2.0%

PQRS Reporting as an Individual:
The PQRS Payment Adjustment (cont.)

- There are 3 ways an individual eligible professional may meet the criteria for satisfactory reporting for the 2015 PQRS payment adjustment:
  1. Meet the criteria for satisfactory reporting for the 2013 PQRS Incentive
  2. Report 1 valid measure or measures group using the claims, registry, or EHR-based reporting mechanisms
  3. Elect to be analyzed under the administrative claims-based reporting mechanism

  Note: If participating in PQRS through another CMS program (such as the Medicare Shared Savings Program), please check the program's requirements for information on how to simultaneously report under PQRS and the respective program.

- There is 1 way an eligible professional may meet the criteria for satisfactory reporting for the 2016 PQRS payment adjustment:
  1. Meet the criteria for satisfactory reporting for the 2014 PQRS Incentive

  Note: We may establish additional ways to meet the criteria for satisfactory reporting for the 2016 PQRS payment adjustment in future rulemaking.

PQRS Reporting as a Group Practice: The PQRS Group Practice Reporting Option (GPRO)

- Benefits of Participating as a Group Practice:
  - Billing and reporting staff may report one set of quality measures data on behalf of all eligible professionals within a group practice, reducing the need to keep track of eligible professionals' reporting efforts separately
- How to Participate as a Group Practice:
  1. Meet the Definition of a PQRS Group Practice
     - Group Practice = a single Tax Identification Number (TIN) with 2 or more eligible professionals, as identified by their individual National Provider (NPI), who have reassigned their Medicare billing rights to the TIN
     - As proposed, we have changed the definition of group practice to include groups of 2-24 eligible professionals; Therefore, beginning in 2013, we are allowing all group practices to participate in the PQRS group practice reporting option (GPRO)

PQRS Reporting as a Group Practice: The PQRS Group Practice Reporting Option (GPRO) (cont.)

2. Self-Nominate to Participate in the PQRS Group Practice Reporting Option (GPRO)
   - ◇ How to Self-Nominate: Group practices will submit a self-nomination statement via a CMS developed website
   - ◇ Deadline to Self-Nominate: October 15, 2013

     Note: If participating in PQRS through another CMS program (such as the Medicare Shared Savings Program), please check the program's requirements for information on how to simultaneously report under PQRS and the respective program
3. Choose a Reporting Mechanism and Reporting Criterion
   - ◇ Available Reporting Mechanisms in 2013: The GPRO Web Interface, Registry, and Administrative Claims (for the 2015 PQRS payment adjustment only)
   - ◇ Beginning in 2014, the EHR-based reporting mechanism will also be available for use under the GPRO
4. Start Reporting!

Note: If you are a group practice consisting of 100+ eligible professionals, beginning in 2013, you will be subject to the Value-based Payment Modifier

PQRS Reporting as Group Practice:
Criteria for Satisfactory Reporting of Data on PQRS Quality Measures via the GPRO for the 2013 Incentive

Reporting Period	Reporting Mechanism	Group Practice Size	Proposed Reporting Criterion
12-month (Jan 1 — Dec 31)	GPRO Web Interface	25-99 eligible professionals	Report on all measures included in the Web Interface in Table 96; 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 for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100 percent of assigned beneficiaries.
12-month (Jan 1 — Dec 31)	GPRO Web Interface	100+ eligible professionals	Report on all measures included in the Web Interface in Table 96; 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 for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100 percent of assigned beneficiaries.
12-month (Jan 1 — Dec 31)	Registry	2+ eligible professionals	Report at least 3 measures, AND Report each measure for at least 80 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate will not be counted.

PQRS Reporting as Group Practice:
Criteria for Satisfactory Reporting of Data on PQRS Quality Measures via the GPRO for the 2014 Incentive

Reporting Period	Reporting Mechanism	Group Practice Size	Proposed Reporting Criterion
12-month (Jan 1 — Dec 31)	GPRO Web Interface	25-99 eligible professionals	Report on all measures included in the Web Interface in Table 96; 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 for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100 percent of assigned beneficiaries.
12-month (Jan 1 — Dec 31)	GPRO Web Interface	100+ eligible professionals	Report on all measures included in the Web Interface in Table 96; 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 for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100 percent of assigned beneficiaries.
12-month (Jan 1 — Dec 31)	Registry	2+ eligible professionals	Report at least 3 measures, AND Report each measure for at least 80 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate will not be counted.
12-month (Jan 1 — Dec 31)	Direct EHR product that is CEHRT or EHR Data Submission Vendor's Product that is CEHRT	2+ eligible professionals	Report 9 measures covering at least 3 domains. If the group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is patient data.

PQRS Reporting as a Group Practice: The PQRS Payment Adjustment

- For 2015 and subsequent years, a payment adjustment with respect to covered professional services furnished by an eligible professional will be applied if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year
  - Applicable adjustment amount:
    - 2015: 1.5%
    - 2016 and subsequent years: 2.0%

PQRS Reporting as a Group Practice: The PQRS Payment Adjustment (cont.)

- There are 3 ways a group practice may meet the criteria for satisfactory reporting for the 2015 PQRS payment adjustment:
  1. Meet the criteria for satisfactory reporting for the 2013 PQRS Incentive under the GPRO
  2. Report 1 valid measure or Measures Group using the registry or GPRO Web Interface reporting mechanisms
  3. Elect to be analyzed under the administrative claims-based reporting mechanism
     - The election will be made when the group practice self-nominates to participate in PQRS via the GPRO

Note: ACOs participating in the Medicare Shared Savings Program may only choose options 1 or 2 to meet the criteria for satisfactory reporting for the 2015 PQRS payment adjustment. ACOs may NOT elect the administrative claims-based reporting mechanism.

PQRS Reporting as a Group Practice: The PQRS Payment Adjustment (cont.)

- There is 1 way a group practice may meet the criteria for satisfactory reporting for the 2016 PQRS payment adjustment:
  1. Meet the criteria for satisfactory reporting for the 2014 PQRS Incentive under the GPRO

  Note: We may establish additional ways to meet the criteria for satisfactory reporting for the 2016 PQRS payment adjustment in future rulemaking.

PQRS Measures

HHS Million Hearts Measures

PQRS Measure Number	Measure	NQF Measure Number	Measure Developer	Reporting Mechanism(s)
2	**Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control:** Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dL)	0064	NCQA	Claims, Registry, EHR, DM Measures Group (C/R), Cardiovascular Prevention Measures Group (C/R)
204	**Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic:** Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) with documented use of aspirin or another antithrombotic	0068	NCQA	Claims, Registry, EHR, GPRO/ACO, IVD Measures Group (C/R), Cardiovascular Prevention Measures Group (C/R)
226	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients 18 years and older who were screened for tobacco use one or more times within 24 months **AND** who received cessation counseling intervention if identified as a tobacco user	0028	AMA-PCPI	Claims, Registry, EHR, GPRO/ACO, CAD Measures Group (R), COPD Measures Group (C/R), HF Measures Group (R), IBD Measures Group (R), IVD Measures Group (C/R), Preventive Care Measures Group (C/R), Cardiovascular Prevention Measures Group (C/R), Oncology Measure Group (R)

PQRS Measures (cont.)

HHS Million Hearts Measures (cont.)

PQRS Measure Number	Measure	NQF Measure Number	Measure Developer	Reporting Mechanism(s)
236	**Hypertension (HTN): Controlling High Blood Pressure:** Percentage of patients aged 18 through 85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (< 140/90 mmHg)	0018	NCQA	Claims, Registry, EHR, GPRO/ACO, Cardiovascular Prevention Measures Group (C/R)
241	**Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low Density Lipoprotein (LDL-C) Control:** Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who received at least one lipid profile within 12 months and whose most recent LDL-C level was in control (less than 100 mg/dL)	0075	NCQA	Claims, Registry, EHR, GPRO/ACO, IVD Measures Group (C/R), Cardiovascular Prevention Measures Group (C/R)
316	**Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL) Test Performed AND Risk-Stratified Fasting LDL:** Percentage of patients aged 20 through 79 years whose risk factors* have been assessed and a fasting LDL test has been performed	N/A	CMS/QIP	EHR

PQRS Measures (cont.)

- **HHS Million Hearts Measures** (cont.)

PQRS Measure Number	Measure	NQF Measure Number	Measure Developer	Reporting Mechanism(s)
317	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure (BP) AND a recommended follow-up plan is documented based on the current blood pressure reading as indicated	N/A	CMS/QIP	Claims, Registry, EHR, GPRO/ACO, Cardiovascular Prevention Measures Group (C/R)
Cardiovascular Prevention Measures Group	**Includes measures #2, #204, #226, #236, #241, #317**	N/A	NCQA, AMA-PCPI, CMS/QIP	Claims, Registry

PQRS Measures (cont.)

- **HHS Million Hearts Measures (cont.)**
  - **Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low Density Lipoprotein (LDL-C) Control:** Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who received at least one lipid profile within 12 months and whose most recent LDL-C level was in control (less than 100 mg/dL)
  - **Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL) Test Performed AND Risk-Stratified Fasting LDL:** Percentage of patients aged 20 through 79 years whose risk factors* have been assessed and a fasting LDL test has been performed
  - **Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure (BP) AND a recommended follow-up plan is documented based on the current blood pressure reading as indicated

PQRS Measures (cont.)

- **Total # of Individual PQRS Measures**: 259 for 2013 → 288 in 2014

- GPRO Measures: 18 measures, including 2 composites, for a total of 22 measures (same as the measures available for reporting under the Medicare Shared Savings Program)

- **Note:** For help on selecting measures on which to report, please see the "How to Get Started" section of the CMS PQRS website and contact the QualityNet Help Desk if you still have questions

2013/2014 Measure Changes

New 2013 PQRS Individual Measures
1. #319 GPRO DM-13 thru DM-17 Diabetes Composite: Optimal Diabetes Care
2. #320 Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
3. #321 Participation by a Hospital, Physician or Other Clinician in a Systematic Clinical Database Registry that Includes Consensus Endorsed Quality
4. #322 Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients
5. #323 Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI)
6. #324 Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients
7. #325 Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions
8. #326 Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy
9. #327 Pediatric Kidney Disease: Adequacy of Volume Management
10.#328 Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10g/dL
Retired 2013 PQRS Individual Measures
1. #10 Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports
2. #57 Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation
3. #58 Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Mental Status
4. #92 Acute Otitis Externa (AOE): Pain Assessment
5. #105 Prostate Cancer: Three-Dimensional (3D) Radiotherapy
6. #124 Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)
7. #158 Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy
8. #186 Chronic Wound Care: Use of Compression System in Patients with Venous Ulcers
9. #189 Referral for Otologic Evaluation for Patients with a History of Active Drainage from the Ear Within the Previous 90 Days
10.#190 Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss
11.#196 Coronary Artery Disease (CAD): Symptom and Activity Assessment
12.#206 HIV/AIDS: Screening for High Risk Sexual Behaviors
13.#207 HIV/AIDS: Screening for Injection Drug Use
14.#235 Hypertension (HTN): Plan of Care
15.#253 Pregnancy Test for Female Abdominal Pain Patients

2013/2014 Measure Changes (cont.)

2013 EHR
No measure changes.

Retired from GPRO for 2013
1. PQRS GPRO COPD-1: Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy 2. PQRS GPRO CAD-1: Coronary Artery Disease (CAD): Antiplatelet Therapy 3. PQRS GPRO DM-3: Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus (NOTE: See DM-13; For 2013, DM-3 is being replaced with DM-13. This measure has a different Measure Owner and will be analyzed as a Composite) 4. PQRS GPRO DM-5: Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus (NOTE: See DM-14; For 2013, DM-5 is being replaced with DM-14. This measure has a different Measure Owner and will be analyzed as a Composite) 5. PQRS GPRO DM-7: Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient 6. PQRS GPRO DM-8: Diabetes Mellitus: Foot Exam 7. PQRS GPRO DM-10: Diabetes Mellitus: Hemoglobin A1c Control (< 8%) NOTE: See DM-15; For 2013, DM-10 is being replaced with DM-15. This measure has a different Measure Owner and will be analyzed as a Composite 8. PQRS DM-12: Diabetes Mellitus: Tobacco Non-Use NOTE: Measure Number Change (Now DM-17), Updated Description, Denominator, and Numerator; Analyzed as a Composite 9. PQRS GPRO HF-1: Heart Failure: Left Ventricular Ejection Fraction (LVEF) Assessment 10. PQRS GPRO HF-2: Heart Failure (HF): Left Ventricular Function (LVF) Testing 11. PQRS GPRO HF-5: Heart Failure: Patient Education 12. PQRS GPRO HF-7: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

New GPRO Measure for 2013
1. PQRS GPRO PREV-12: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

PQRS Measures Groups

Total # of Measures Groups: 22 in 2013 → 26 in 2014

Current 2012 Measures Groups that will be available for Reporting for 2013 and Beyond	New Measures Group Available for Reporting for 2013 and Beyond	New Measures Groups Available for Reporting for 2014 and Beyond
1. Diabetes Mellitus 2. Chronic Kidney Disease (CKD) 3. Preventive Care 4. *Coronary Artery Bypass Graft (CABG) 5. Rheumatoid Arthritis (RA) 6. Perioperative Care 7. Back Pain 8. Hepatitis C 9. Heart Failure (HF) 10. *Coronary Artery Disease (CAD) 11. Ischemic Vascular Disease (IVD) 12. *HIV/AIDS 13. Asthma 14. *Chronic Obstructive Pulmonary Disease (COPD) 15. Inflammatory Bowel Disease (IBD) 16. Sleep Apnea 17. *Dementia 18. Parkinson's Disease 19. *Hypertension 20. Cardiovascular Prevention 21. Cataracts *indicates measures group composition changes	1. Oncology	1. Osteoporosis 2. Total Knee Replacement 3. Radiation Dose 4. Preventive Cardiology

THE ELECTRONIC PRESCRIBING (eRx) INCENTIVE PROGRAM

The eRx Incentive Program: Updates

- Most of the requirements for the remainder of the eRx Incentive Program were established in the CY 2012 Medicare PFS final rule. Please note that, although the self-nomination deadline to participate in the PQRS GPRO was extended to October 15, the self-nomination deadline to participate in the eRx GPRO remains January 31.

Updates to the eRx Incentive Program:

- New Criteria for the eRx group practice reporting option (eRx GPRO)
  - Since, accordingly with PQRS, we expanded definition of group practice to include groups of 2-24 eligible professionals, we finalized new criteria for becoming a successful electronic prescriber under the eRx GPRO:
    - Report the electronic prescribing measure for at least 75 instances during the applicable 2013 eRx incentive or 2014 eRx payment adjustment reporting period

The eRx Incentive Program: Updates (cont.)

- New Significant Hardship Exemption Categories for the 2013 and 2014 eRx payment adjustments:
  - Eligible professionals or group practices who achieve meaningful use during certain eRx payment adjustment reporting period
  - Eligible professionals or group practices who demonstrate intent to participate in the EHR Incentive Program and adoption of Certified EHR Technology
  - Eligible professionals or group practices will not need to affirmatively request an exemption for these categories. Rather, CMS will use the information provided in the EHR Incentive Program's Registration and Attestation page to determine whether the exemption applies.

The eRx Incentive Program: Updates (cont.)

- Implementation of an eRx Informal Review process
  - How to Request an eRx Informal Review for the 2012 or 2013 eRx Incentives:
    - Informal Review Request Method: email
    - Deadline: 90 days following the receipt of the applicable full year eRx feedback reports
  - How to Request an eRx Informal Review for the 2013 or 2014 eRx Payment Adjustments:
    - Informal Review Request Method: email
    - Deadline:
      - For the 2013 eRx payment adjustment: February 28, 2013
      - For the 2014 eRx payment adjustment: February 28, 2014

CY 2013 MPFS Final Rule: Quality Reporting Program Updates

PHYSICIAN COMPARE

Plan for Future Public Reporting on Physician Compare

- As required by the Affordable Care Act, CMS has implemented a plan for publicly reporting physician quality and patient experience metrics through the Physician Compare website. CMS continues to outline elements of that plan through rule making.
- Targeted for Posting in 2014:
  - Quality measures reported by group practices and ACOs participating in 2013 PQRS GPRO and reporting via the GPRO Web Interface
    - Composite measures for DM and CAD
  - Patient Experience Data for group practices and ACOs of 100+ EPs reporting through the GPRO Web Interface for 2013 PQRS GPRO
  - Million Hearts Recognition for EPs reporting on the PQRS Cardiovascular Prevention measures group in PY 2013
  - Recognition of EPs who earn a PQRS Maintenance of Certification Incentive

Plan for Future Public Reporting on Physician Compare (cont.)

- Targeted for Posting in 2015:
  - Individual-level measure data collect in PY 2014
- Additional updates and information to be posted on Physician Compare:
  - Reduced Public Reporting Threshold from 25 patients to 20 patients
  - Measures developed and collected by specialty societies
  - 30-day preview period

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RESOURCES & WHO TO CALL FOR HELP

Resources

- **CMS PQRS Website**
  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS
- **CMS eRx Incentive Program Website**
  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive
- **2013 PFS Final Rule**
  http://www.ofr.gov/(X(1)S(vp32o25ckyhpvspfpzx3owe4))/OFRUpload/OFRData/2012-26900_PI.pdf
- **Medicare and Medicaid EHR Incentive Programs**
  http://www.cms.gov/EHRIncentivePrograms
- **Physician Compare**
  http://www.medicare.gov/find-a-doctor/provider-search.aspx
- **FFS Provider Listserv**
  https://list.nih.gov/cgi-bin/wa.exe?A0=PHYSICIANS-L
- **PQRS Frequently Asked Questions (FAQs)**
  https://questions.cms.gov/

Where to Call for Help

- **QualityNet Help Desk:**
  - Portal password issues
  - PQRS/eRx feedback report availability and access
  - IACS registration questions
  - IACS login issues
  - Program and measure-specific questions

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

- **Provider Contact Center:**
  - Questions on status of 2011 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)

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QUESTIONS & ANSWERS

Evaluate Your Experience with Today's National Provider Call

- To ensure that the National Provider Call (NPC) Program continues to be responsive to your needs, we are providing an opportunity for you to evaluate your experience with today's NPC. Evaluations are anonymous and strictly voluntary.

- To complete the evaluation, visit http://npc.blhtech.com/ and select the title for today's call from the menu.

- All registrants will also receive a reminder email within two business days of the call. Please disregard this email if you have already completed the evaluation.

- We appreciate your feedback!

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