

### 2016 Physician Quality Reporting System (PQRS) Updates- Module 3

Module 3 of the Medicare Quality reporting programs presentation reviews the updates to the Physician Quality Reporting System for 2016.

The changes to the PQRS program for 2016 were done through the regular annual rule making process for the 2016 Medicare physician fee schedule. CMS published the proposed rule for the 2016 MPFS on July 15, 2015, with a 60 day comment period. The final rule with comment period was placed on display at the Federal Register on October 30, 2015.

In the 2016 PQRS program, there is a total of 281 measures, including 23 cross cutting measures, and 18 measures that are included in the GPRO Web Interface.

For those using the registry reporting option and reporting measures groups, 3 new measures groups have been developed: Multiple Chronic Conditions, Cardiovascular Prevention (in conjunction with the Million Hearts initiative), and Diabetic Retinopathy.

New to the 2016 PQRS program, as included in the MACRA legislation, the qualified clinical data reporting option, which had previously only been available to individual EPs is now a reporting option for groups who are reporting under the group practice reporting option.

And as mentioned previously, per the MACRA legislation, the 2018 PQRS payment adjustment is the final payment adjustment that will be assessed, with the MIPS incentives beginning in 2019.

Next, we will look at the various methods of reporting for PQRS in 2016, for both individual EPs and for groups who choose to report using the Group Practice Reporting Option.

For individual EPs who choose to report using claims, the requirement for 2016 is unchanged from 2015, and that is to choose 9 measures that come from at least 3 of the 6 National Quality Strategy domains, which include patient safety, person and caregiver centered experience and outcomes, communication and care coordination, effective clinical care, community and population health, and efficiency and cost reduction. The requirement to report on at least 1 cross cutting measure remains in place in 2016. These cross cutting measures must be reported if the EP has at least one face to face encounter with a Medicare beneficiary. Face to face encounters are identified by billable codes, and generally include office visits, outpatient visits and some surgical procedures. Services rendered using telehealth technology are not considered face to face encounters.

In the instance in which an EP cannot choose at least 9 measures from at least 3 of the quality domains, CMS will use the measures applicability validation process for EPs who report less than 9 measures, or measures from less than 3 of the quality domains. Note that the claims reporting option is available only to individual EPs, not to group practices reporting under the GPRO.

We have developed a set of decision trees, similar to the ones that were used in last year's presentation to help providers determine if they meet the criteria for the various reporting methods. The first decision tree we will look at is for individual EPs who are using the claims method of reporting. The

measure type that is available for claims are individual measures (as opposed to measures groups). The requirement again is at least 9 measures from at least 3 of the quality domains. If you are able to choose at least 9 measures from at least 3 domains, then that is what you will submit. If you cannot select 9 measures from at least 3 domains, then you will choose 1 to 8 measures from 1 to 3 of the domains. In either case, if there is at least one face to face encounter as described previously, you must report one cross cutting measure. You also must report each measure for at least 50 percent of your Medicare Part B fee for service patients seen during the entire 12 month reporting period, and any measure that has a 0% performance rate would not count toward your total.

The following slides give a listing of the cross cutting measures that are to be reported if an EP has at least one face to face encounter with a Medicare Part B fee for service patient during the reporting period. As you can see, all of the cross cutting measures are taken from each of the 6 quality domains. Please pay close attention to the reporting method that each cross cutting measure can be used to submit. An updated list of the codes that are considered face to face encounters can be found on the PQRS page of the CMS website, by clicking on Measures Codes on the left hand side of the page and scrolling to the section titled "2016 Cross Cutting Measures Requirement."

The use of a qualified registry is another way that both individuals and groups can report PQRS measures in 2016. It is also the only method that individual EPs can use who wish to report measures groups. Those using a registry and reporting on individual measures are also held to the requirement of reporting on at least one cross cutting measure if there is at least one face to face encounter with a Medicare patient as previously discussed. Registries may now use the web to attest to the accuracy of quality measure results and all associated data instead of a written attestation. Any registry that intends to self-nominate to be a PQRS registry must have done so no later than January 31, 2016.

For individuals using a qualified registry, the first question to ask is "which types of measures will you be reporting?" If you are reporting individual measures, then can you report at least 9 measures from at least 3 domains? If so, then that is what you will report. If you cannot find 9 measures from at least 3 domains, then you will choose 1 to 8 measures from 1 to 3 of the domains. As with the claims option, in either case, if there is at least one face to face encounter, you will report one cross cutting measure, and the same 50 percent rule applies. If you are able to report on one of the measures groups, and that is the route you go, then you may select one of the measures groups, which are listed on the next slide, report each measure contained within that group for at least 20 patients, with a majority of those patients being Medicare Part B fee for service patients. Any measure with a 0 performance rate would not be counted. So for example, if you choose a sample size of 20 patients, 11 of those patients must be Medicare Part B fee for service patients (Medicare advantage patients do not count in this total). As with the claims reporting option, any EP submitting less than 9 measures from 1 to 3 domains would be subject to the validation process.

The table on slide 23 shows the 25 measures groups that are available for registry reporting in 2016. Each group contains at least 6 associated measures that are related to a particular condition. If an EP chooses a measures group, then all of the measures that are included within that group must be reported at least once for all patients included in the sample. CMS has developed specification documents for all measures groups, which can be found on the Measures Codes section of the PQRS page of the CMS

website.

CMS has been working diligently to assist specialty providers find appropriate measures for PQRS reporting that pertain to the specialty scope of practice. To that end, we have worked with numerous specialty societies to develop a suggested (but not required) list of measures that could be chosen for reporting purposes. The 17 specialties that are listed on slide 24 currently have suggested measures lists that can aid an EP in these fields to successfully meet the reporting requirements for this year's program. 12 of these measure sets were developed for the 2015 program, with a 5 new sets added for the 2016 PQRS. Details for these measures sets can be found on the Measures Codes section of the PQRS webpage.

The decision tree on slide 25 reviews the requirements for individuals choosing to report using a certified EHR or a Data Submission Vendor. The measure type that can be reported using this method is individual measures. And the requirement is to report 9 measures from at least 3 of the quality domains. If the certified system or DSV used by the EP does not have patient data to meet the 9 measure/3 domain requirement, then the provider would report on all measures for which there is Medicare patient data. Keep in mind that a EPs certified EHR will include data for the entire patient population. To that end, the EP must report on at least measure that has Medicare patient data.

EPs using a Qualified Clinical Data Registry in 2016 will have the opportunity to report on both PQRS measures, and non PQRS measures (up to 30) that are included to be reported in a qualified clinical data registry. A QCDR that is approved to be included in the PQRS will have at least 9 measures covering at least 3 of the quality domains and each measure must be reported for at least 50% of the EP's applicable patients during the 12 month period to which the measure applies.

EPs who choose to use a QCDR must report on at least 2 outcome measures as part of the quality codes they are submitting. If there are less than 2 outcome measures available to report, then the EP would report one outcome measure, and one additional measure from either the patient safety, the resource use, the patient experience of care or the efficiency/appropriate use quality domains. More information about the outcome measures can be found in the PQRS Implementation Guide on the PQRS page of the CMS website.

Now we will detail the reporting criteria for groups who choose to register for the group practice reporting option, or GPRO in 2016.

Group practices that wish to participate in the GPRO in 2016 must register in the PV PQRS system between April 1 and June 30, 2016. There is no requirement that groups must participate in the GPRO, though groups who have the capability to find measures that are applicable to all EPs in the practice are encouraged to do so. The size of the group, that is the total number of all eligible professionals under the TIN of the group, will determine which reporting methods are available for reporting purposes. For example, only groups of 25 or more EPs may use the GPRO web interface. Also, continuing in 2016, all groups that register for the GPRO that have more than 100 EPs will be required to submit patient survey data via the Consumer Assessment of Healthcare Providers and Systems, or CAHPS survey. However, some group practices of 100 or more EPs might not have a sufficient number of beneficiaries to produce

reliable data and it is recommended that they not choose this option. These group practices will be notified if they do not have a sufficient number of beneficiaries. Finally, groups now have the option of using the QCDR method of reporting that had previously only been available to individuals. Groups of all sizes that register for the GPRO can report measures using a qualified registry, but for purposes of this decision tree, we are going to focus on groups of 2-99 EPs, as well as groups of more than 100 EPs for which the CAHPS survey does not apply, as the requirements for groups of 100+ EPs who are required to report the CAHPS survey data are slightly different and will be discussed in a few slides. For these groups, again, the requirement would be similar to the requirement for individuals using a qualified registry reporting 9 measures from at least 3 of the quality domains. If the group can do so, that is what they will report. If 9 measures from at least 3 domains is not possible for the group, then the group can report 1-8 measures covering 1, 2 or 3 of the quality domains. The validation process would apply in this instance. And as with the individuals, for groups the requirement for one cross-cutting measure if there is at least one Medicare patient face-to-face encounter is in place, as is the requirement to report each measure for at least 50% of the Medicare Part B FFS patients.

For groups that will use their certified EHR system, or use a data submission vendor, and again here we will focus on groups of 2-99 EPs as well as groups of more than 100 EPs for which the CAHPS survey does not apply, the requirement is to report 9 measures covering at least 3 of the quality domains, just as it is for EPs reporting as individuals. If 9 measures from the 3 domains cannot be reported, then the group will report the measures for which there is Medicare patient data. Keep in mind that at least one measure reported must pertain to Medicare patients.

As mentioned, groups of 25 or more EPs can register to use the GPRO Web Interface in 2016 to submit quality measures data. CMS is maintaining that the reported beneficiary sample size should be the same for groups of all sizes. The sample size has been set at 248 beneficiaries or the maximum number available to you if less than 248, for each disease module or patient care measure. An oversample of beneficiaries will be provided if available for each disease module or patient care measure. If a group using the GPRO Web Interface has less than 248 patients included in the sample, then 100% of the patients attributed would need to be reported. Important note: if the group does not have any Medicare patients for any of the measures that are included in the Web interface, then the group should choose a different reporting mechanism.

The requirements for the GPRO Web Interface is the same for all groups of 25 or more EPs. All groups will report on all of the measures in the GPRO Web Interface (18 in all), and they will populate the data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the sample for each module or preventive care measure. As mentioned if there are fewer than 248 patients available, then the group will report on 100% of their patients.

For groups of 100 or more EPs, in addition to reporting on all of the measures in the Web Interface, these groups will be required in 2016 to report the CAHPS survey measures as well if the CAHPS survey pertains to their practice.

The 18 measures that are listed on this slide and the next are all of the measures that have been finalized for the GPRO web interface in 2016. Keep in mind that if a group that chooses the GPRO web

interface reporting mechanism should be able to report on all 18 measures listed on these slides.

As mentioned earlier, Section 101 (d) (1) (B) of MACRA allows for groups to now choose the QCDR reporting option. The reporting period is the same as for individuals a full twelve months, and the same criteria in terms of what must be reported via the QCDR are in place.

Groups using a Qualified Clinical Data Registry in 2016 will have the opportunity to report on both PQRS measures, and non PQRS measures (up to 30) that are included to be reported in a qualified clinical data registry. A QCDR that is approved to be included in the PQRS will have at least 9 measures covering at least 3 of the quality domains and each measure must be reported for at least 50% of the group's applicable patients during the 12 month period to which the measure applies. This applies to groups of 2-99 EPs, and to groups of 100+ EPs to which the CAHPS survey does not apply. The requirements for those groups of 100+ EPs that must report the CAHPS survey data will be discussed in a few slides.

As with individual EPs, groups that choose to use a QCDR must report on at least 2 outcome measures as part of the quality codes they are submitting. If there are less than 2 outcome measures available to report, then the group would report one outcome measure, and one additional measure from either the patient safety, the resource use, the patient experience of care or the efficiency/appropriate use quality domains.

The CAHPS survey that is required for groups of 100 or more EPs is an optional method of reporting for other groups comprising of 2-99 EPs if they wish to include the patient survey data as part of their quality measures. Regardless of group size, groups who are using the CAHPS survey will be required to contract with a certified vendor who will collect the survey data and submit that data to CMS on behalf of the group. Starting in 2015, groups will be responsible for the cost of administering the survey. The measures that are included in the 2015 CAHPS survey are the same 12 measures that were included in the survey in 2014, which include measures such as getting timely care, communication, shared decision making, care coordination, helpfulness of office staff, among others.

The CAHPS for PQRS Survey measures the twelve key domains of beneficiaries' experiences of care listed on this slide that we refer to as summary survey measures. A summary survey measure is a collection of survey items that assess the same patient experience domain of care.

Groups who submit the CAHPS survey data, either voluntarily or because it is mandatory, will do so in conjunction with one of the other reporting methods for submission of additional quality measures. Groups opting for the qualified registry will be required to report on just 6 measures from at least 2 of the quality domains. If the group cannot report on at least 6 measures from at least 2 domains, then they may report on 1-5 measures, with a cross cutting measure being included. The validation process would apply in this case.

Groups choosing to use the GPRO web interface, the requirement is the same reporting on all measures, adhering to the patient sample size and the other parameters discussed earlier. For groups using a certified EHR system or a data submission vendor, they would report 6 measures from at least 2 domains, or up to 5 measures if 6 do not apply to the scope of the group's practice. And at least one

measure reported must contain Medicare patient data. Finally, groups that will avail themselves of the new option of using a QCDR would report at least 6 additional measures from at least 2 domains, with at least one of those measures being an outcome measure.

If providers have questions about the PQRS, they should call the Quality Net Help Desk at 866 288 8912. For questions to be addressed by your Medicare Administrative Contractor, you can find the phone number for your MAC's call center at the link on this slide, which can also be found in the Descriptions section below this video.

A list of online resources available on the CMS website for each of the programs is found on this slide. You can find links to these sites in the Description section below this video.

That concludes Module three of the Medicare Quality Reporting Programs presentation for 2016. Thank you for watching. To view the remaining modules of this presentation, please see the links in the "Descriptions" section of this video.