Maine Quality Counts presents…

Provider Lunch and Learn

PQRS Reporting & the CMS Value-Based Payment Modifier: Why They Matter & What You Need to Know

January 6, 2015 (12PM – 1PM)

Remember to dial in for webinar audio!
1.866.740.1260, Access Code: 6223374#
Who We Are

Maine Quality Counts (QC) is a member-driven nonprofit organization working to improve the health of everyone in Maine by improving the way health care is delivered.
What We Do

We bring together the people who give, get and pay for health care and provide the tools and leadership they need to make sure Mainers receive care that is truly patient-centered.
How We Work

We’re driven by a spirit of collaboration. We work with over 70 partners from health care, government, civil society and the community to achieve shared quality improvement goals. More than 120 members, both organizations and individuals, inform and contribute to our success.
Become a QC Member

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• Members-only networking events
• Exclusive webinars with national experts
• Discounted registration for QC 2015
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@MEQualityCounts

Youtube.com/MaineQualityCounts
Featuring Keynote Speaker
Atul Gawande, MD, MPH

Registration opens in February
Check our website for updates:
www.mainequalitycounts.org/QC2015
Important Webinar Notes

Your phone line is muted to minimize background noise.

To ask questions or share comments, you can:

• Use the **Raise Your Hand button** to let us know you have a question. When we call on you, press *7 to unmute your line.

**Or**

• Type your question or comment into the **chat box** on the lower left-hand side of the screen.
After Today’s Webinar

• You’ll receive links to the slides and recording of today’s session this afternoon

• All QC Learning Community webinars are archived on our website:
  http://www.mainequalitycounts.org/qclc/archive
Phyllis Kaplan is currently a Program Administrator with Healthcentric Advisors, and the Regional Task Lead for New England's QIN-QIO. As a Registered Nurse, Phyllis spent the earlier part of her professional career in various clinical settings including hospitals, community health centers, VNA, home health care settings and public schools. For many years, her career followed a training and program development pathway concentrating on quality of care improvements.
Value-Based Modifier Webinar Series

Part I:
Physician Quality Reporting System (PQRS)

Phyllis Kaplan, RN, BSN
Program Administrator
January 6, 2015
New England Quality Innovation Network-Quality Improvement Organization (NE QIN-QIO)

• Regional approach, six New England states
  – Each state has a full compliment of QIO staff

• Assistance and education to physicians, hospitals, and nursing homes in achieving quality improvement goals

• Five year contract
Agenda

• Understanding PQRS and Eligibility
• 2014 PQRS Reporting Options
• Incentive and Payment Adjustments
• Reporting Once for Meaningful Use and PQRS
• The PQRS/Value-Based Modifier (VM) Program relationship
• 2015 PQRS Changes
What is PQRS?

• A reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs)

• Report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-For-Service (FFS) beneficiaries (includes Railroad Retirement Board and Medicare Secondary Payer)

• Aligns with other quality reporting programs, such a Meaningful Use, PCMH

• Key to VM participation
Have you been reporting to PQRS?

A. Yes
B. No
C. N/A
## PQRS Participation - Eligibility

<table>
<thead>
<tr>
<th>PQRS</th>
<th>Value Modifier</th>
<th>EHR Incentive Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Eligible for Incentive</td>
<td>Subject to Payment Adjustment</td>
</tr>
<tr>
<td><strong>Medicare Physicians</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor of Medicine</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Doctor of Osteopathy</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Doctor of Podiatric Medicine</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Doctor of Optometry</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Doctor of Oral Surgery</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Doctor of Dental Medicine</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Doctor of Chiropractic</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Practitioners</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Certified Registered Nurse</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Certified Nurse Midwife</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clinical Social Worker</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Clinical Psychologist</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Registered Dietician</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Nutrition Professional</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Audiologists</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Therapists</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Qualified Speech-Language Therapist</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
PQRS Participation

Some professionals may be eligible to participate per their specialty, but due to billing method, may not be able to participate

- Professionals who do not bill Medicare at an NPI level, where the rendering provider’s individual NPI is entered on CMS-1500 type paper or electronic claims billing, associated with specific line-item services

Services payable under fee schedules or methodologies other than PFS (Physician Fee Schedule) are not included in PQRS

Beginning in 2014, professionals who reassign benefits to a Critical Access Hospital (CAH) that bills professional services at a facility level, can participate (in all reporting methods except for claims-based)

- To participate, CAH must include the individual provider NPI on their Institutional (FI) claims
Physician Quality Reporting System (PQRS)

HOW DO I GET STARTED WITH PQRS?
Polling Question

Size of Eligible Provider Practice:

A. Solo provider
B. 2-24
C. 25-99
D. 100+
Steps for Reporting PQRS

1. Decide how to participate – individual vs group
2. Decide method for reporting
3. Decide what measures to report
4. Decide if reporting individual measures or measures group(s)
5. Register for an IACS* account at CMS – needed in order to submit data with most reporting methods (and to access Feedback Reports)
6. Submit data by reporting deadline

* Individuals Authorized Access to the CMS Computer Services (IACS)
Definition of Group Practice

- A single Tax Identification Number (TIN) with 2 or more individual EPs (as identified by Individual National Provider Identifier [NPI]) who have reassigned their billing rights to the TIN

- If group registered to participate in PQRS GPRO, the method chosen is the only PQRS submission method available to the group and all individual NPIs who bill Medicare under the group's TIN

- If an organization or eligible professional changes TINs, the participation under the old TIN does not carry over to the new TIN, nor is it combined for final analysis
Individual vs Group Reporting

• If not already registered for Group Practice Reporting Option, only way to participate in 2014 PQRS reporting is as an individual

• If you are a member of a group practice that did not register for 2014 Group Practice Reporting Option (GPRO), then the group may avoid the VM payment adjustment in 2016 IF 50% of the group successfully reports to PQRS.
  – Those in the group who do not report to PQRS, however, will be subject to the -2% PQRS payment adjustment in 2016.
Physician Quality Reporting System (PQRS)

REPORTING METHODS
**Individual Reporting Methods**

<table>
<thead>
<tr>
<th>Reporting Method</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>Individual measures</td>
</tr>
<tr>
<td>Qualified Registry</td>
<td>Individual measures/measures groups</td>
</tr>
<tr>
<td>Direct EHR product (CEHRT)</td>
<td>Individual measures*</td>
</tr>
<tr>
<td>EHR Data Submission Vendor (DSV) (CEHRT)</td>
<td>Individual measures</td>
</tr>
<tr>
<td>Qualified Clinical Data Registry (QCDR)</td>
<td>Measures selected by QCDR</td>
</tr>
</tbody>
</table>

* EPs and group practices reporting electronically are required to use the June 2013 version of the eCQM with the exception of CMS140, which is to be reported using the December 2012 version (CMS140v1).
# Reporting Methods for Groups

<table>
<thead>
<tr>
<th>Group Size: 2-24</th>
<th>Group Size: 25-99</th>
<th>Group Size: 100+</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Qualified Registry</td>
<td>• Qualified Registry</td>
<td>• Same as 25-99 EXCEPT CG-CAHPS is REQUIRED</td>
</tr>
<tr>
<td>• Direct EHR – CEHRT</td>
<td>• Direct EHR – CEHRT</td>
<td></td>
</tr>
<tr>
<td>• DSV</td>
<td>• DSV</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Group Practice Reporting Option (GPRO) – Web Interface</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• CG-CAHPS* optional</td>
<td></td>
</tr>
</tbody>
</table>

*Clinician & Group Surveys-Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)
Most PQRS reporting options require individual eligible providers (EPs) or Group Practices to report 9 measures covering at least 3 NQS domains for incentive purposes:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Safety</td>
<td>Person-and Caregiver Centered Experience and outcomes</td>
</tr>
<tr>
<td>Communication and Care Coordination</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td>Community/Population Health</td>
<td>Efficiency and cost reduction</td>
</tr>
</tbody>
</table>

All are same domains for Meaningful Use Clinical Quality Measures

What to Consider When Selecting Measures

Clinical conditions usually treated

Types of care provided – e.g., preventive, chronic, acute

Settings where care is usually delivered (office, emergency setting, etc.)

Quality improvement goals in 2014

Other quality programs being used or under consideration
Physician Quality Reporting System (PQRS)

REPORT INDIVIDUAL MEASURES OR MEASURE GROUPS?
Measures Groups

• Include reporting on a group of clinically-related measures identified by CMS for use in PQRS through a registry-based submission process - only report through Qualified Registry

• Criteria:
  – 12-month reporting period
  – Submit one measures group (may submit more than 1)
  – At least 20 patients, 11 or more must be Medicare patients

• If any measure has 0% performance, the Measures Group will not be counted

<table>
<thead>
<tr>
<th>Condition</th>
<th>Chronic Kidney Disease</th>
<th>Preventive Care</th>
<th>Coronary Artery Bypass Graft</th>
<th>Rheumatoid Arthritis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perioperative Care</td>
<td>Back Pain</td>
<td>Hepatitis C</td>
<td>Heart Failure</td>
<td>Coronary Artery Disease</td>
</tr>
<tr>
<td>Ischemic Vascular Disease</td>
<td>HIV/AIDS</td>
<td>Asthma</td>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>Inflammatory Bowel Disease</td>
</tr>
<tr>
<td>Sleep Apnea</td>
<td>Dementia</td>
<td>Parkinson’s Disease</td>
<td>Hypertension</td>
<td>Cardiovascular Prevention</td>
</tr>
<tr>
<td>Cataracts</td>
<td>Oncology</td>
<td>Total Knee Replacement</td>
<td>General Surgery</td>
<td>Optimizing Patient Exposure to Ionizing Radiation</td>
</tr>
</tbody>
</table>
## Measures Group Example

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure Title</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overview</strong></td>
<td>Diabetes Measures Group</td>
</tr>
<tr>
<td>1</td>
<td>Diabetes: Hemoglobin A1c Poor Control</td>
</tr>
<tr>
<td>2</td>
<td>Diabetes: Low Density Lipoprotein (LDL-C) Control (&lt; 100 mg/dL)</td>
</tr>
<tr>
<td>117</td>
<td>Diabetes: Eye Exam</td>
</tr>
<tr>
<td>119</td>
<td>Diabetes: Medical Attention for Nephropathy</td>
</tr>
<tr>
<td>163</td>
<td>Diabetes: Foot Exam</td>
</tr>
<tr>
<td><strong>Overview</strong></td>
<td>Preventive Care Measures Group</td>
</tr>
<tr>
<td>39</td>
<td>Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older</td>
</tr>
<tr>
<td>48</td>
<td>Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older</td>
</tr>
<tr>
<td>110</td>
<td>Preventive Care and Screening: Influenza Immunization</td>
</tr>
<tr>
<td>111</td>
<td>Pneumonia Vaccination Status for Older Adults</td>
</tr>
<tr>
<td>112</td>
<td>Breast Cancer Screening</td>
</tr>
<tr>
<td>113</td>
<td>Colorectal Cancer Screening</td>
</tr>
</tbody>
</table>
## PQRS Reporting Deadlines for PY2014

<table>
<thead>
<tr>
<th>Reporting Method</th>
<th>Submission Period</th>
<th>Submission Deadline Time (All Times are Eastern)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR Direct or Data Submission Vendor that is certified EHR technology (CEHRT)</td>
<td>1/1/15 - 2/28/15</td>
<td>8:00 p.m.</td>
</tr>
<tr>
<td>Qualified clinical data registries (QCDRs) (using QRDA III format) reporting for PQRS and the clinical quality measure (CQM) component of meaningful use for the Medicare Electronic Health Record (EHR) Incentive Program</td>
<td>1/1/15 - 2/28/15</td>
<td>8:00 p.m.</td>
</tr>
<tr>
<td>Group practice reporting option (GPRO) Web Interface</td>
<td>1/26/15 - 3/20/15</td>
<td>8:00 p.m.</td>
</tr>
<tr>
<td>Qualified registries</td>
<td>1/1/15 - 3/31/15</td>
<td>8:00 p.m.</td>
</tr>
<tr>
<td>QCDRs (using XML format) reporting for PQRS only</td>
<td>1/1/15 - 3/31/15</td>
<td>8:00 p.m.</td>
</tr>
<tr>
<td>Maintenance of Certification Organizations (MOCs)</td>
<td>1/1/15 - 3/31/15</td>
<td>8:00 p.m.</td>
</tr>
<tr>
<td></td>
<td>PQRS Incentive</td>
<td>Value Modifier</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td></td>
<td>Pay Adj</td>
<td>10-99 EPs</td>
</tr>
<tr>
<td><strong>MD &amp; DO</strong></td>
<td>0.5% of MPFS</td>
<td>-2.0% of MPFS</td>
</tr>
<tr>
<td><strong>DDM</strong></td>
<td>0.5% of MPFS</td>
<td>-2.0% of MPFS</td>
</tr>
<tr>
<td><strong>Oral Surg</strong></td>
<td>-2.0% of MPFS</td>
<td>-2.0% of MPFS</td>
</tr>
<tr>
<td><strong>Pod.</strong></td>
<td>-2.0% of MPFS</td>
<td>-2.0% of MPFS</td>
</tr>
<tr>
<td><strong>Opt.</strong></td>
<td>-2.0% of MPFS</td>
<td>-2.0% of MPFS</td>
</tr>
<tr>
<td><strong>Chiro.</strong></td>
<td>-2.0% of MPFS</td>
<td>-2.0% of MPFS</td>
</tr>
</tbody>
</table>

Notes:
- **PQRS Reporting:** PQRS-Reporting (Up or Neutral Adj)
- **Non-PQRS Reporting:** PQRS-Reporting (Down Adj)
- **Medicare Inc.:** $8,500 or $21,250 (based on when EP did A/I/U)
- **Medicaid Inc.:** $8,500 or $21,250 (based on when EP did A/I/U)
- **Medicare Pay Adj.** $4,000 to $12,000 (based on when EP 1st demo MU)
- **N/A**
## 2014 Incentives and 2016 Payment Adjustments

<table>
<thead>
<tr>
<th>Practitioners</th>
<th>PQRS Incentive</th>
<th>Value Modifier</th>
<th>EHR Incentive Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Assistant</td>
<td>0.5% of MPFS</td>
<td>-2.0% of MPFS</td>
<td>EPs included in the definition of “group” to determine group size for application of the value modifier in 2016 (10 or more EPs); VM only applied to reimbursement of physicians in the group</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certified Registered Nurse Anesthetist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certified Nurse Midwife</td>
<td>0.5% of MPFS</td>
<td>-2.0% of MPFS</td>
<td></td>
</tr>
<tr>
<td>Clinical Social Worker</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered Dietician</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Nutrition Professional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audiologits</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Therapists

<table>
<thead>
<tr>
<th>Therapists</th>
<th>PQRS Incentive</th>
<th>Value Modifier</th>
<th>EHR Incentive Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapist</td>
<td>0.5% of MPFS</td>
<td>-2.0% of MPFS</td>
<td>See above</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified Speech-Language Therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Avoiding 2016 PQRS Payment Adjustment – Individual Reporting

Individual Reporting Criteria for Avoiding the 2016 Payment Adjustment

- **Qualified Registry**
  - **What Measure Type?**
    - Measures Groups

- **Individual Measures**
  - Do you plan to meet 2014 incentive criteria?
    - Yes
      - You will avoid the 2016 PQRS payment adjustment
    - No

- Can you report at least 3 measures?
  - Yes
    - Report at least 3 measures
  - No
    - If less than 3 measures apply to the EP, report 1—2 measures

- Reporting Period?
  - 12 month
  - 6 month

- Must meet the criteria for successfully reporting for 2014 incentive

Report each measure for at least 50 percent of the EP’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. *(Subject to MAV if reporting 1-2 measures)*
Avoiding 2016 PQRS Payment Adjustment – Group Reporting

If participating in the Group Practice Reporting Option (GPRO), avoid 2016 payment adjustments by meeting one of the following criteria during the 2014 PQRS program year:

Meet the requirements for satisfactorily reporting for incentive eligibility as defined in the applicable 2014 PQRS measure specifications.

Report at least 3 measures covering one NQS domain for at least 50 percent of the group practice’s Medicare Part B FFS patients via qualified registry.

Report 1-8 measures covering 1-3 NQS domains for which there is Medicare patient data (subjecting the group practice to the MAV process*), AND report each measure for at least 50% of the group practice’s Medicare Part B FFS patients seen during the reporting period to which the measure applies.

*A group that reports fewer than 3 measures covering at least 1 NQS domain via qualified registry reporting will be subject to the Measure-Applicability Validation (MAV) process, which will allow CMS to determine whether additional measures should have been reported.
Polling Question

I/We are participating in EHR Incentive Program (Meaningful Use):

A. Yes
B. No
C. Have not been participating but plan to
PQRS and Meaningful Use (MU)

- MU clinical quality measures (CQMs) are PQRS measures

- In 2014, if you report your MU CQMs to PQRS, then you only need to report these one time.
  - You still must report the other MU core measures for Meaningful Use

- Your MU payment will not occur until after PQRS reporting is completed
Physician Quality Reporting System (PQRS)

WHY IS PQRS IMPORTANT?
Value-Based Modifier Program (VM)

Must report to PQRS to participate in VM

Increase provider demonstration of improvement in quality of care

Increase provider participation in electronic Quality Improvement initiatives (PQRS)

Potential for upward, neutral or downward payment adjustments

Focus on quality and cost efficiency

Watch for webinar invite scheduled for January 27th
Physician Quality Reporting System (PQRS)

WHAT’S NEW FOR 2015 PQRS?
2015 PQRS Changes - Final Rule

- 2015 Medicare Physician Fee Schedule (MPFS)
- Final Rule 2017 Payment Adjustments
- Physician Quality Reporting System (PQRS)
- Public Reporting
### 2017 Payment Adjustments

#### PQRS
- All providers who are eligible and able to report should be reporting to PQRS – solo practitioners and group members
- Non-reporting eligible providers will be subject to 2017 PQRS payment adjustment
  - **-2.0% of Medicare Physician Fee Schedule (MPFS)**

#### Medicare EHR Incentive Program
- Applies to Medicare physicians (if not a meaningful user)
  - **-3.0% of MPFS**
2015 PQRS Cross-Cutting Measures Requirement

• New reporting criterion has been added for the **claims** and registry reporting of individual measures.

• Eligible professionals or group practices are **required** to report one (1) cross-cutting measure if they have at least one (1) Medicare patient with a face-to-face encounter.

• Cross-cutting measures are not specific to a specialty and are available for all 6 NQS domains
Cross-Cutting 2015 PQRS Measures - Examples

Effective Clinical Care

- Controlling High Blood Pressure
- Diabetes: Hemoglobin A1c Poor Control
- Hepatitis C: One-Time Screening for Hepatitis C Virus for Patients at Risk

Patient Safety

- Documentation of Current Medications in the Record
- Falls: Screening for Fall Risk—EHR or GPRO Web Interface only

Communication and Care Coordination

- Advance Care Plan
- Closing the Referral Loop: Receipt of Specialist Report—EHR only
- Functional Outcome Assessment for OT/PT
- Medication Reconciliation Following Discharge
- Pain Assessment and Follow-Up
2015 PQRS Updates

• Modify the deadline for group practice registration (GPRO) in the Physician Value-Physician Quality Reporting System (PV-PQRS) registration system to **June 30th** of the year in which the reporting period occurs.

• Measure-applicability validation (MAV) process will now check whether an EP or a group practice should have reported on any of the cross-cutting measures.
CAHPS Reporting 2015 Update

- CG-CAHPS has been renamed CAHPS for PQRS
- Medicare no longer pays for the CAHPS survey vendor
- CAHPS is required for all GPRO submissions for groups of 100+
- CAHPS is optional in all other methods
2015 PQRS Reporting - Method Updates

**QUALIFIED REGISTRY**

- Require an EP or group practice (reporting individual measures) who treats at least 1 Medicare patient in a face-to-face encounter to report on at least one cross-cutting PQRS measure.

- Extend the deadline for qualified registries to submit quality measures data, including, but not limited to, calculations and results, to **March 31, 2016**, for reporting periods ending in 2015.

**CLAIMS**

- Require an EP or group practice (reporting individual measures) who treats at least 1 Medicare patient in a face-to-face encounter to report on at least one cross-cutting PQRS measure.

- EPs in Critical Access Hospitals billing method II are able to participate in PQRS using **ALL** reporting mechanisms, **including claims**.

- CMS has not finalized any updates for the claims-based reporting mechanism.
2015 PQRS Reporting Method Updates – Direct EHR and DSV

• CMS is still requiring providers who report clinical quality measures electronically to use the most recent version of eCQMs

• An EPs certified EHR technology (CEHRT) does not need to be tested and certified to the most recent version of the electronic specifications for the CQMs
2015 PQRS Reporting Method Updates – Web Interface (WI)

• If a group practice does not have any Medicare patients for any of the GPRO measures, the group practice will not meet the criteria for satisfactory reporting using the Web Interface (WI)

• Group practices of 25 or more must report on all measures in the WI, AND populate data fields for the first 248 consecutively ranked in the group’s sample for each module or preventive care measure.

• If less than 248, the group practice would report on 100% of assigned beneficiaries.
2015 PQRS Reporting Method Updates - QCDR

- Increase to 30, the limit on the number of non-PQRS measures that a Qualified Clinical Data Registry (QCDR) may submit on behalf of an EP

- Report on at least 2 outcome measures (or if less than 2 outcome measures, report on at least 1 outcome measure and at least 1 of the following types of measures:
  - Patient safety
  - Resource use
  - Patient experience of care
  - Efficiency/appropriate use)
Public Reporting Update

- The 2015 final rule outlines further expansion of public reporting on Physician Compare.

<table>
<thead>
<tr>
<th>Groups</th>
<th>Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All PQRS GPRO measures via the GPRO Web Interface, Registry, &amp; EHR and all ACO measures</td>
<td>• All 2015 individual PQRS measures via Registry, EHR, &amp; Claims.</td>
</tr>
<tr>
<td>• Consumer Assessment of Healthcare Providers &amp; Systems (CAHPS) for PQRS and CAHPS for ACOs</td>
<td>• 2015 QCDRs Measures Data</td>
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<td>• Individual EP-level</td>
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<td>• PQRS and Non-PQRS</td>
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<td>• No first year measures</td>
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</tbody>
</table>
Resources

• **QualityNet Help Desk**: 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

• **EHR Incentive Program Information Center**: 888-734-6433 (TTY 888-734-6563)

• **ACO Help Desk via the CMS Information Center**: 888-734-6433 Option 2

• **MLN Connects™ Provider eNews**: [http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive.html](http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive.html)


Resources (cont.)


Contact Us

www.healthcarefornewengland.org/contact-us/
Contact Your NE QIN-QIO
PQRS State Lead

- **Connecticut**
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- **Maine**
  Doreen Bedaw: Dbedaw@healthcentricadvisors.org

- **Massachusetts**
  Phyllis Kaplan: pkaplan@healthcentricadvisors.org

- **New Hampshire**
  Georgette Verhelle: georgette.verhelle@hcqis.org

- **Rhode Island**
  Lauren Capizzo: Lcapizzo@healthcentricadvisors.org

- **Vermont**
  Mary Smith: Mary.Smith@hcqis.org
Upcoming QC Learning Community Webinars

January 27th, 12:00PM - 1:00PM
The CMS Value-Based Modifier Program: What It Is & What It Means to Physician Practices

February 3rd, 12:00PM - 1:00PM
Medicare’s New Payment for Chronic Care Management

Find more information and register:
www.mainequalitycounts.org/QCLC