



2016 PQRS Progress Check

Presented by: Sarah Leake, HTS Consultant

Tuesday, 9/20/2016

2 – 3 PM MDT • 12 – 1 PM AKDT • 10 – 11AM HST

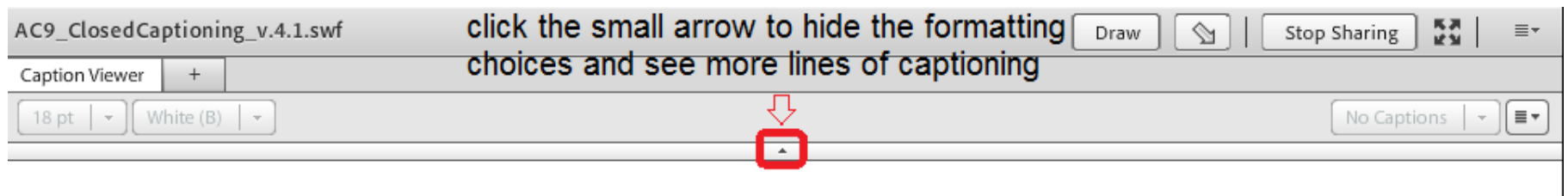
HTS, a department of Mountain–Pacific
Quality Health Foundation

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- Mountain–Pacific holds the Centers for Medicare & Medicaid Services (CMS) Quality Innovation Network–Quality Improvement Organization (QIN–QIO) contract for the states of Montana, Wyoming, Alaska and Hawaii, providing quality improvement assistance.
- HTS, a department of MPQHF, has assisted 1480 providers and 50 Critical Access Hospitals to reach Meaningful Use. We also assist healthcare facilities with utilizing Health Information Technology (HIT) to improve health care, quality, efficiency and outcomes.

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Session Presenter

- Sarah Leake – MBA, CPEHR



Health Technology and Quality
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Webinar Objectives

- Review of PQRS Steps for you to Measure your Progress
- Outline some key items to consider
- Identify helpful Tools and Resources
- MACRA Quality Payment Program Update

New PQRS Resource

- On August 23, HTS/Mountain Pacific launched the new PQRS Blog
- PQRS process throughout the year
- Important News and Changes
- Opportunity for you to ask questions, share information.

<http://mpqhf.com/blog/category/pqrs/>



*The
ORANGE
one!*

PQRS: Are higher scores better for PQRS measures?

September 11, 2016

Written by Sarah Leske

No. Higher scores are not **ALWAYS** better for PQRS measures.

When assessing and choosing measures to report for PQRS do not always assume that higher is better. Be careful to consider the performance notations for the particular measure which shows whether the higher or lower number is best performance. For measures with inverse performance rates a lower performance rate actually ... [Read the rest](#)

2016 PQRS Steps

Past – Present – Future

Suggested Steps for PQRS



A Dozen !

1. Determine program eligibility
2. Choose reporting method
3. Choose reporting mechanism
4. Engage with EHR Vendor for eCQM reporting or determine Registry or Web Interface reporting
 - a) Confirm EHR is Certified and Available for reporting
5. If required, create EIDM account and get correct access/permissions
6. Review QRUR report for past performance baselines, list of eligible providers and VBM info
7. **Select CQMs to report**
8. **Verify CQM reports and/or data is available in EHR or other extraction method**
9. **Validate CQM data**
10. Monitor and track data/work on improving workflows, performance, etc on CQMs
11. Test and verify data export format needed for reporting mechanism
12. Export final data and submit to CMS

Survey on Reporting PQRS

- What method and what mechanism are you using for reporting PQRS in 2016?
 - GPRO – Web Interface
 - GPRO – EHR
 - GPRO – Registry
 - GPRO – QCDR, Qualified Clinical Data Registry
 - Individual – Claim
 - Individual – EHR
 - Individual – Registry
 - Individual – QCDR– Qualified Clinical Data Registry
 - Thru ACO
 - Not Decided

Step 1: Determine Program Eligibility

- Added NP, PA, CNRA, CNA's to Eligible Providers for Value Modifier
 - How the Penalty works
- Resources on Checking Eligibility

CMS Programs and Eligibility

	PQRS		Value Modifier	
	Eligible for Incentive	Subject to Payment Adjustment	Included in Definition of "Group" (1)	Subject to VM (2)
Medicare Physicians				
Doctor of Medicine	X	X	X	X
Doctor of Osteopathy	X	X	X	X
Doctor of Podiatric Medicine	X	X	X	X
Doctor of Optometry	X	X	X	X
Doctor of Oral Surgery	X	X	X	X
Doctor of Dental Medicine	X	X	X	X
Doctor of Chiropractic	X	X	X	X
Practitioners				
Physician Assistant	X	X	X	X
Nurse Practitioner	X	X	X	X
Clinical Nurse Specialist	X	X	X	X
Certified Registered Nurse Anesthetist (10)	X	X	X	X
Certified Nurse Midwife	X	X	X	
Clinical Social Worker	X	X	X	
Clinical Psychologist	X	X	X	
Registered Dietician	X	X	X	
Nutrition Professional	X	X	X	
Audiologists	X	X	X	
Therapists				
Physical Therapist	X	X	X	
Occupational Therapist	X	X	X	
Qualified Speech-Language Therapist	X	X	X	

Groups and solo practitioners subject to upward, neutral or downward adjustments derived under quality-tiering methodology

Exception: Groups consisting of only nonphysician EPs and solo practitioners who are nonphysician EPs held harmless from downward adjustments under quality-tiering methodology in CY 2018 **unless they do not satisfactorily report!**

Resources for Checking Eligibility

- Determine if you bill Medicare Part B PFS. (CMS1500 or CMS 1450 at NPI Level).
- Review Eligibility List (on previous slide)
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016_PQRS_List_of_EPs.pdf
- Determine who is billed under your TIN
 - Look at QRUR 2015 Mid Year Report. These are the providers that CMS is considering eligible if they are listed and report measures.
- Link to Guidance on the Physician Quality Reporting System for RHC, FQHC and CAHs
<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1606.pdf>

Step 2: Choose Reporting Method

– GPRO or Individual

- Registration **closed on June 30, 2016**
- **Reminder:**
 - Groups choosing to report individually, 50% of Providers must successfully report PQRS to avoid the VM penalties. PQRS penalty will apply to any provider that did not report PQRS successfully.
 - If reporting GPRO, successfully reporting will cover all providers in Group TIN from PQRS and VM penalties

Step 3: Choose Reporting Mechanism

- Summary Table on Reporting Methods
- Discussion on Methods

Methods for Reporting

Reporting Methods for 2016

METHOD	Individual	Group 2-24	Group 25-99	Group 100+
Claims	X			
Registry Individual Measures	X	X	X	X
Registry Measures Group	X			
Certified EHR or Direct Submission Vendor	X	X	X	X
Qualified Clinical Data Registry (QCDR)	X	X	X	X
GPRO Web Interface			X	X
Certified CG CAHPS Survey Vendor	N/A	Optional	Optional	Mandatory

Summary Requirements for Reporting Mechanisms

Criteria for 2016	Qualified Registry	QCDR	EHR
No of Measures/Domains	9/3	9/3	9/3
MEASURE GROUP	Yes, 20 Patients NO, if GPRO Reporting	No	No
Exception to # Measures & Domains	No, unless Reporting a Cluster	Not limited to PQRS, other endorsed and specialty measures	Yes, report those measures that have Medicare data
Subject to MAV	Yes	No	No
Cross Cutting Measure Required	Yes	No	No
% of Medicare Beneficiaries Required	Measures must have at least 50% of Medicare Part B FSS patients	Multiple Payers	Must have at least one measure with Medicare data
Full Year Reporting	Yes	Yes	Yes
Satisfy Meaningful Use	No	Depends upon Registry	Yes

Qualified Clinical Data Registry

- “QCDR is a CMS–approved entity that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients.”
- PQRS Related to Specialty Societies for example:
 - Ophthalmology, Dermatology, Neurology
- Cover Specialties that may not otherwise have measures
- Have authority to craft new measures that can qualify for PQRS
- Reporting Options
 - Report 9 measures over 3 Domains, 2 outcomes
 - EHR, Registry / Group or Individual
- Sometimes Free if Membership in the Society
- **EPs participating via QCDR should work with their selected QCDR to determine how to participate.*

Requirements for GPRO Web Interface

- List provided by CMS Jan2017
- Submitted through online Spreadsheet
- 248 Beneficiary Reported
- 18 measures per beneficiary
- Complete by 3/30/17 (still to be confirmed)
- Actions Now:
 - Educate on 18 Measures
 - Run List of Medicare Patients to date for 2016
 - Review Sample Medicare Patient Chart for Data
 - Define Method for Extraction
- GPRO CARE-2: Falls: Screening for Future Fall Risk
- GPRO CARE-3: Documentation of Current Medications in the Medical Record
- GPRO CAD-7: Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)
- GPRO DM-2: Diabetes: Hemoglobin A1c Poor Control
- GPRO DM-7: Diabetes: Eye Exam
- GPRO HF-6: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- GPRO HTN-2: Controlling High Blood Pressure
- GPRO IVD-2: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
- GPRO MH-1: Depression Remission at Twelve Months
- GPRO PREV-5: Breast Cancer Screening
- GPRO PREV-6: Colorectal Cancer Screening
- GPRO PREV-7: Preventive Care and Screening: Influenza Immunization
- GPRO PREV-8: Pneumonia Vaccination Status for Older Adults
- GPRO PREV-10: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- GPRO PREV-11: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
- GPRO PREV-12: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- GPRO PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

NOTES

Web Interface Measures (18 measures)

Reporting Options Links

- Qualified Registry
 - [Qualified Registry CMS Link](#)
 - [List of Qualified Registries](#)
- QCDR Reporting
 - [Qualified Clinical Data Registry Reporting Page \(CMS\)](#)
 - [2016 Qualified Clinical Data Registry Link](#)
- EHR Reporting
 - [Electronic Reporting using EHR Link](#)
 - EHR eCQM List
- [Web Interface Reporting CMS Link](#)

Step 4: Decision: Select Registry or Engage with EHR Vendor

- What to look for in Registry?
- Registry or QCDR?
- What are EHR Vendor Capabilities?

Registry (and QCDR) Vendor Selection

- Vendor Sites have helpful Information
 - Steps for Reporting, Videos on Uploading Data
 - Requirements specific to them
- Good Vendors are experienced at Registry Reporting
 - TIPS, Ask Questions, Interview them, Learn from them!
 - HAVE a DEFINED Schedule – WATCH FOR THIS!

Registry/QCDR Reporting – Selection

- Have they participated in Previous Years?
- What Measures are available for Reporting and do they support Measure Group Reporting? GPRO Reporting?
- What are ACTUAL services offered and Cost?
- May be at No Cost
 - Is Provider a Member of a Professional Organization that is a Registry?
 - Is your EHR also a Registry?
 - Does Provider Practice in a Medical Group offering services?

Registry Name	Contact Information	Participated in Prior Year Registry Program	Reporting Options Individual or GPRO	Individual Measures Supported	Measure Groups Supported	Services offered and Cost
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QCDR Name	Contact Information	Participated in QCDR in Previous Year	Reporting Options GPRO or Individual	EHR Incentive Program Supported	Public Reporting Location	PQRS Measures Supported (Indiv, Meas Grp, eQCM)	Non-PQRS Measures Supported	Non-PQRS Measures Info	Services offered and Cost
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Confirm EHR Certified Version and Reporting Capabilities

- For 2016, verify your current **EHR Version is certified to 2014 CHPL** requirements (or 2015 or combination of the two. Check with your vendor if you are not sure)
 - <http://oncchpl.force.com/ehrcert>
- Conversation & Confirmation with EHR Vendor
 - Verify with your EHR vendor that all needed functionality is implemented and configured.
- **IMPORTANT:** Individual EPs and PQRS group practices reporting electronically are required to use the July 2015 version of the eCQMs for 2016 reporting. To view more information, click on this direct link to the Medicare EHR Incentive Program's [eCQM Library](#).

<https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Certification.html>

Step 5: Create or Verify EIDM Account and Access

- What is EIDM?
- What Role do you need?

EIDM

- **CMS's Enterprise Identity Management System**, is a single access point for multiple CMS applications.
- Choose the PV-PQRS Domain for Roles
- Ability to obtain access for:
 - Viewing QRUR and feedback reports
 - Submitting quality data (EHR, Web Interface)
 - GPRO self-nomination

Which Role do you need?

Role within Group	Security Official Role	Group Representative Role
Register the group practice to participate in the PQRS GPRO	y	y
Obtain the group practice's QRUR and PQRS Feedback Report	y	y
Submit a Value Modifier Informal Review Request on behalf of the group practice	y	y
Approve requests for the 'Group Representative' role in the EIDM	Y	N

Role within Individual	Individual Practitioner Role	Individual Practitioner Representative Role
Obtain the solo practitioner's QRUR and PQRS Feedback Reports	y	y
Submit a Value Modifier Informal Review Request on behalf of a solo practitioner,	y	y
Approve requests for the 'Individual Practitioner Representative' role in the EIDM	y	N

EIDM System

1. Request Access

The screenshot shows the CMS Enterprise Portal 'My Access' page. The 'Access Catalog' section contains a search bar and a 'REQUEST ADMIN ROLE' checkbox. Below are several application cards, each with a 'Request Access' button. A blue arrow points from the 'Request Access' button in the top right of the screenshot to a larger 'Request Access Now' button in a separate box. Another blue arrow points from the 'Request Access' button in the bottom center of the screenshot to a box containing the text 'Physician Quality and Value Programs'.

Request Access

Use the link below to request access to Systems/Applications

Request Access Now

Contact Help Desk

FFE / HIOS / Agents & Brokers Help Desk - Contact the Exchange Operations Support Center [XOSC] at CMS_FEPS@cms.hhs.gov or 1-855-CMS-1515

Physician Value / PQRS Help Desk - Contact the PV/PQRS Information Center at 1-888-734-6433.

ACO Help Desk - Contact the ACO Information Center at 1-888-734-6433 (select option 2) if you have any questions about using the ACO Portlet features. TTY users should call 1-888-734-6563.

Open Payments Help Desk - Contact the Open Payments Help Desk at Openpayments@cms.hhs.gov.

2. Choose Physician Quality box..

Physician
Quality and
Value Programs

Helpful Links

- [Guide for Obtaining a New EIDM Account with a 'Physician Quality and Value Programs' Role](#)
- [Guide for Obtaining a 'Physician Quality and Value Programs' Role for an Existing EIDM User](#)
- [Requesting an Approver Role in the Physician Quality and Value Programs Domain](#)
- [Requesting a Provider Role in the Physician Quality and Value Programs Domain](#)
- The entire 192 page [CMS Enterprise Identity Management \(EIDM\) User Guide](#)

and see the May 1, 2016 PQRS Post!

Step 6: Review Performance and QRUR Report

- Why is it important?
- How do I Access?
- Types of Reports

Why review the Quality Resource and Use Reports (QRURs) ?

- The Quality Resource Use Reports (QRURs) are a tool for analysis as part of the CMS Physician Quality and Value Based Program
 - How do my measures compare to benchmarks
 - Costs of care and how it affects revenue
- Provides comparative information about the **Quality of Care** and **Cost of the Care** delivered to Physicians Medicare Fee-for-Service Patients
- CMS will use the performance scores used in calculating the value-based payment modifier (VBM) to apply differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule (PFS).
- Even if you have not reported PQRS you will have information in the Feedback Reports (ie. providers under the TIN) and QRUR

CMS Enterprise Portal

Waiting for tool.hostedaccess... CMS Enterprise Portal - My ... x

Portal Help & FAQs Print Log Out

CMS.gov Enterprise Portal

My Portal PV-PQRS Quality Reporting Programs

CMS Port Overview Registration
Value Modifier Informal Review Feedback Reports

Welcome to CMS Enterprise Portal

The Enterprise Portal combines and displays content and forms from multiple applications, supports users with

Request Access

Use the link below to request access to Systems/Applicators

Request Access Now

The PV-PQRS Reports

- **Feedback Report** – Information on reporting for PQRS data.
- **QRUR** – Information on Value Modifier (Quality and Claims data to determine Quality Tiering Composite Score)
 - **Mid-Year QRUR** – available in April 2016 and reports the period of July 1, 2014 thru June 30, 2015
 - **Annual QRUR** is issued for the period January 1, 2015 through December 31, 2015 and shows the TIN's actual performance

Links to QRUR Reports

- For information on the Mid-Year QRUR:
 - [2015 QRUR and 2017 Value Modifier](#)
- Access 2015 Mid-Year QRUR at [CMS Enterprise Portal](#) using EIDM account with correct role
- For information about obtaining Mid-Year QRUR: [How to Obtain a QRUR](#)

..and look at the July 15, 2016 PQRS Blog !





Step 7: Select Clinical Quality Measures for Reporting

- What to Consider
- Resources and Tools

Should be at this step in the Process for your PQRS Project.



PQRS Measure Selection Activity

Task	Date Complete	Tasks for Measure Selection	
1		Understand requirements for measure reporting # of measures, # of domains, cross cutting measures	
2		Identify measures available for your reporting mechanism	
3		Consider factors specific to your practice/clinic Clinical Conditions, Types of Care, Settings of Care	
4		Align with your other Quality Reporting initiatives and measures	
5		Review QRUR report – Cost & Quality data	
6		Identify measures for your Practice and Review *Create your list with possible measures (crosswalk)	
7		Assess the current baseline data	
8		Identify Improvement Notation for each measure (high/low performance better)	
9		Verify Medicare beneficiary requirements	
10		Confirm Measures to Monitor	

Align with your Quality Goals and Reporting Initiatives

➤ *Combining PQRS reporting with other health care programs will reduce administrative burden and help focus quality initiative energy and resources*

- *Million Hearts*
- *Performance Improvement Network*
- *National Diabetes Prevention Program*
- *Centers for Disease Control and Prevention*
- *Accountable Care Organizations*
- *Quality Improvement Organizations*



Consider the Value Modifier Performance and Cost Components

Performance Category	Measure Number	Measure Name
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care Sensitive Conditions	CMS-1	Acute Conditions Composite
	-	Bacterial Pneumonia
	-	Urinary Tract Infection
	-	Dehydration
	CMS-2	Chronic Conditions Composite
-	Diabetes (composite of 4 indicators)	
-	Chronic Obstructive Pulmonary Disease (COPD) or Asthma	
-	Heart Failure	
Hospital Readmissions	CMS-3	All-Cause Hospital Readmissions

Performance Category	Cost Measure
Per Capita Costs for All Attributed Beneficiaries	Per Capita Costs for All Attributed Beneficiaries
	Medicare Spending per Beneficiary
Per Capita Costs for Beneficiaries with Specific Conditions	Diabetes
	Chronic Obstructive Pulmonary Disease (COPD)
	Coronary Artery Disease (CAD)
	Heart Failure

*Look at these Conditions as Areas of Concentration for PQRS:
Diabetes, COPD/Asthma, Heart Failure, CAD*

PQRS Web –Based Measure Tool

- **New for 2016 PQRS:** The "2016 PQRS Individual Measure Specifications for Claims and Registry Reporting" can be viewed on the [PQRS Web–Based Measure Search Tool](#).

The screenshot displays the CMS.gov Physician Quality Reporting System interface. The top navigation bar includes 'CMS.gov', 'Physician Quality Reporting System', and links for 'PQRS Home', 'Explore data', and 'Help'. A search bar is located on the left side of the main content area. Below the search bar, a 'Filter Options' sidebar lists several criteria: Measure Number, Reporting Method, NQS Domain, Measure Steward, and Cross cutting, each with a dropdown arrow. At the bottom of the sidebar are 'SEARCH' and 'RESET' buttons. The main content area features a 'BACK TO RESULTS' button at the top. The primary heading is 'Initiation and Engagement of Alcohol and Other Drug Dependence Treatment'. Below this heading is a descriptive paragraph: 'Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported. a. Percentage of patients who initiated treatment within 14 days of the diagnosis. b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.' The results are presented in a grid of eight cards:

Measure Number	Measure Steward	Cross-cutting Measure	NQS Domain
NQF: 0004 PQRS: 305	National Committee for Quality Assurance	No	Effective Clinical Care
Measure Type	Reporting Method	Measures Groups	Use in Other Reporting Programs
Process	EHR	-	Meaningful Use II

Choose Correct Measure Specs

- Caution: Use the Measure Specifications for the Specific Method of Reporting

Medicare	Medicaid/CHIP	Medicare-Medicaid Coordination	Private Insurance	Innovation Center	Regulations & Guidance	Research, Statistics, Data & Systems	Outreach & Education
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Home > Medicare > Physician Quality Reporting System > Measures Codes

Physician Quality Reporting System

- [Spotlight](#)
- [How To Get Started](#)
- [CMS Sponsored Calls](#)
- [Statute Regulations Program Instructions](#)
- [ICD-10 Section](#)
- Measures Codes**
- [Registry Reporting](#)
- [Electronic Reporting Using an Electronic Health Record \(EHR\)](#)
- [CMS-Certified Survey Vendor](#)
- [Qualified Clinical Data Registry Reporting](#)
- [Group Practice Reporting Option](#)
- [GPRO Web Interface](#)

Measures Codes

The Measures Codes webpage contains measures, including detailed specific measures groups. This page also contains information for reporting the measures to Medicare and Medicaid professionals (EPs) for reporting the measures.

Selecting Measures for 2016 PQR:

At a minimum, the following factors should be considered when selecting measures for 2016 PQR:

- Clinical conditions usually treated
- Types of care typically provided
- Settings where care is usually provided
- Quality improvement goals for the practice
- Other quality reporting programs

2016 Cross-Cutting Measures Requirements

In order to satisfactorily report PQR (1) cross-cutting measure if they have a measure that is defined as a measure that is reported to Medicare & Medicaid Services (CMS).

The following resources are available when trying to determine which 2016 PQR quality measures to report and understand the basics on how to report:

- [2016 PQR Claims Reporting Made Simple](#) – This beginner-level resource describes claims-based reporting and outlines steps EPs should take prior to participating in 2016 PQR.
- [2016 PQR Claims Based-Coding and Reporting Principles](#) - This beginner-level resource provides detailed instructions for EPs participating in 2016 PQR via claims, including coding tips and reporting guidance.
- [2016 PQR Measures List](#) – Identifies and describes the measures used in PQR, including all available reporting mechanisms, corresponding PQR number and National Quality Forum (NQF) number, National Quality Strategy (NQS) domains, plus measure developers and their contact information.
- **New for 2016 PQR:** The "2016 PQR Individual Measure Specifications for Claims and Registry Reporting" can be viewed on the [PQR Web-Based Measure Search Tool](#). This is a measures list tool that EPs can use to search for measures to report for 2016 PQR. The web-based measures list tool allows users to search for measures using a number of criteria and then access detailed information about each measure, including measure specifications materials.

The following documents pertaining to the 2016 PQR individual measures are included in the zip file titled [2016 PQR Individual Claims Registry Measure Specifications](#).

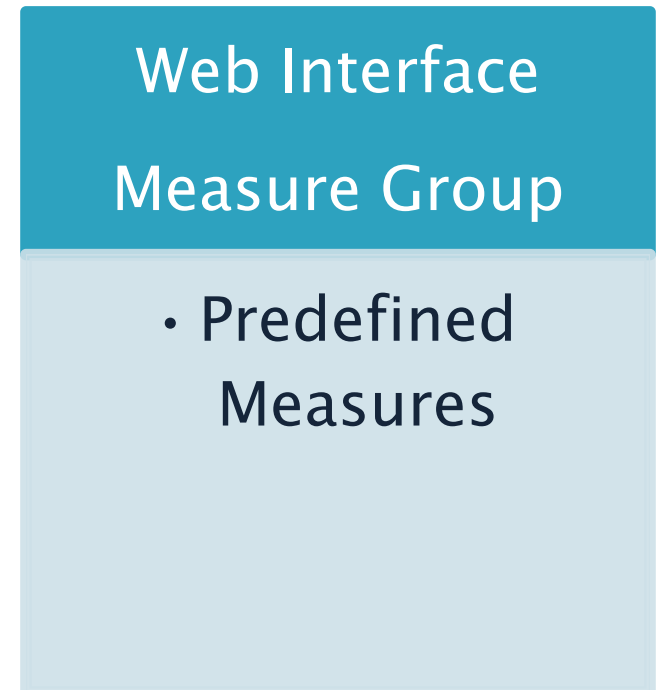
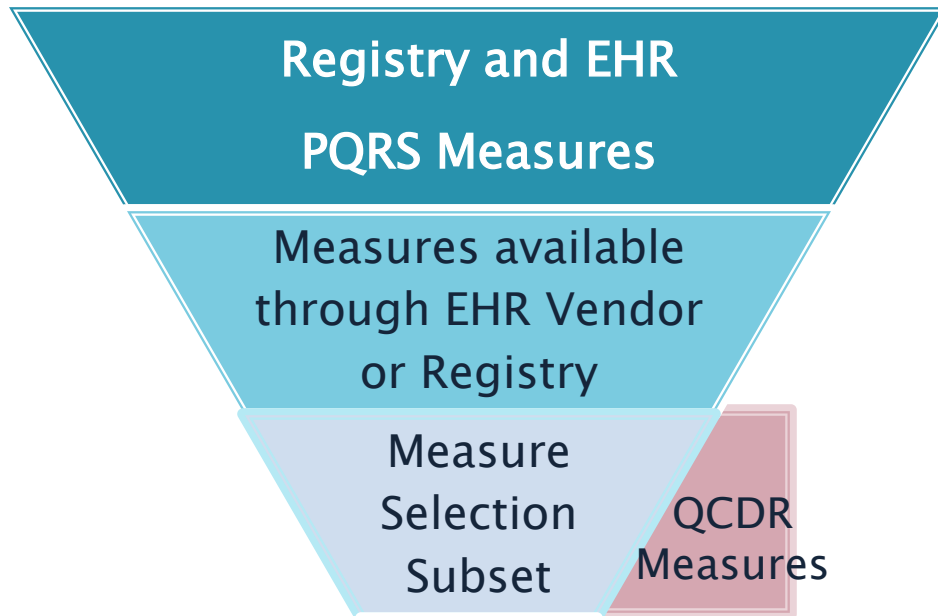
- **2016 Physician Quality Reporting System (PQRS) Individual Measure Specifications for Claims and Registry Reporting** – Documents that include reporting instructions, coding to identify the measure's intended patient population, and numerator options for the 2016 PQR claims and/or registry-based reporting measures.
- **New for 2016 PQR** - The "2016 PQR Measure Flows" have been incorporated within the "2016 PQR Individual Measure Specifications". Each measure flow is currently displayed after the individual measure specification as a visualization of the reporting and performance algorithm for each individual specification.

The following supporting documents pertaining to the 2016 PQR individual measures are also helpful resources to supplement the "2016 PQR Individual Measure Specifications":

- [2016 Physician Quality Reporting System \(PQRS\) Measure Specification and Measure Flow Guide for Claims and Registry Reporting of Individual Measures](#) – This document contains general guidance to better understand the "2016 PQR Individual Measure Specifications and Measure Flows" for claims and registry reporting.

Step 8: Verify CQMs are Available

PQRS Measures available depend upon
Reporting Mechanism



What is EHR Capability in Reporting PQRS Measures?

- What methods are available for Reporting out of the EHR?
- Does Vendor support EHR Direct or Direct Vendor Submission method?
- What measures are available for each Method?
- Do you have the specific software modules to report PQRS measures in the QRDA Format?
- Can the EHR report the entire year of CQM Data?

Using the EHR for Reporting is Preferred; if you can report data that is good for your clinic/provider!

Step 9: Validate CQM Data

- Can CQM data be reported from system?
- Review How Data is Collected
- EHR Consideration

Extracting Data from System

- Understand the data fields in your system(s)
- Verify coding and billing is correct for actual patient visit and conditions
- Define logic and queries for correct data extraction
 - Does EHR have capability to report EHR and Registry data?
 - Does the EHR have a report writer to pull quality information from patient registration, billing, coding, clinical?

Using EHR for Validating eCQMs

- Check that data fields are mapped correctly
- Verify with your EHR vendor the correct workflow needed to populate measures correctly
- Train all your staff on the correct workflows
- Run CQM Reports to verify data collection is happening correctly

Step 10: Monitor and Track Data and Workflows

- Involve Clinicians performing the tasks
- Performance Matters → Define a **Quality Measure Monitoring Process**

Define a Quality Measure Monitoring Process

- Assign Responsibilities
- Use your selected set of Measures
- Set Performance Goals for tracking
- Identify whose job it is to systematically check performance
- What are critical values where action is needed?
- Define steps for Gathering Data/Validating Data
 - PDSA and Sprints for Small Improvements
- Involve all Staff affecting measures – Train/Educate

Step 11: Test Data Export and Formats for Reporting

- Dependant upon Mechanism for Reporting
- Quality Net – Self Check or Vendor for EHR
 - SEVT ([Submission Engine Validation Tool](#))
- Registry – Vendor
- Look at Data and if it makes Sense!
- Review throughout Year so you can Adjust.
- Entire team must understand the Measures and how they affect the data and if data looks correct.



Part of your
Measure
Monitoring
Process

TEST DATA !

Step 12: Extract Final Data and Submit to CMS

- Again...Dependant upon Mechanism for Reporting
- Engage Vendor or Registry
- Responsibility lies within your organization
 - *Vendor and Registry are only a means to report*
- Know your Deadlines and Plan accordingly



PQRS 2016 Data Submission Timeline

- Last day Claims are Processed–2/24/2017
- Qualified Clinical Data Registry (QRDA) – 2/28/2017
- EHR Direct Submission – 2/28/2017
- EHR Direct Submission Vendor – 2/28/2017
- Qualified Clinical Data Registry (XML) – 3/31/2017
- Registry – 3/31/2017
- Group Practice Reporting Option (GPRO) Web Interface – First Quarter (exact dates pending)

QPP – MIPS

As we know it TODAY!

MACRA Overview

- MACRA = Medicare Access and CHIP Reauthorization Act – that creates the Quality Payment Program (QPP)
- The Quality Payment Program has 2 paths:
 - Merit-based Incentive Payment System (MIPS)
 - Combines what used to be PQRS, VBM and MU
 - Alternative Payment Model (APM)
 - ACO's, Bundled Payment Models, etc

The Quality Payment Program Ruling
has not been finalized so all
information in this presentation is
based on the proposed rule –

focusing on MIPS only

CMS Plans for First Year Reporting

- CMS Blog – September 8
<https://blog.cms.gov/2016/09/08/qualitypaymentprogram-pickyourpace/>
- Eligible physicians and clinicians have multiple options for participation (*Pick your Pace*)
- Any one of these options ensures no negative payment adjustment in 2019
- Final Rule released by November 1, 2016 – more details

QUALITY PAYMENT PROGRAM



Four Options in 2017

- 1st Option: Test the Quality Payment Program
 - Avoid Negative Payment Adjustment
- 2nd Option: Participate for part of the Calendar Year
 - Qualify for a small positive payment adjustment
- 3rd Option:
 - Qualify for a modest positive payment adjustment
- 4th Option: Participate in an Advanced Alternative Payment Model
 - Qualify for a 5 percent incentive payment

MIPS – High Level

- If you currently report to PQRS, you will want to confirm if you report to MIPS.
- If you are part of an alternative payment model, you might not have to report to MIPS (APM must qualify)
- Only providers who bill Medicare Part B need to worry about MIPS/APM
- Similar to the current PQRS program MIPS will allow reporting by individual or groups

Who Will Participate in MIPS?

Affected clinicians are called “**MIPS eligible clinicians**” and will participate in MIPS. The types of **Medicare Part B** eligible clinicians affected by MIPS may expand in future years.

Years 1 and 2



Physicians (MD/DO and DMD/DDS),
PAs, NPs, Clinical nurse specialists,
Certified registered nurse
anesthetists

Years 3+

Secretary may
broaden Eligible
Clinicians group to
include others
such as



Physical or occupational therapists,
Speech-language pathologists,
Audiologists, Nurse midwives,
Clinical social workers, Clinical
psychologists, Dietitians /
Nutritional professionals

MIPS Performance Categories

A single MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale**:



Quality



Resource
use



Clinical
practice
improvement
activities



Advancing
care
information



MIPS
Composite
Performance
Score (CPS)

PROPOSED RULE
MIPS: Quality Performance Category

Summary:

- ✓ **Selection of 6 measures**
- ✓ **1 cross-cutting measure and 1 outcome measure, or another high priority measure if outcome is unavailable**
- ✓ **Select from individual measures or a specialty measure set**
- ✓ **Population measures automatically calculated**
- ✓ **Key Changes from Current Program (PQRS):**
 - **Reduced from 9 measures to 6 measures with no domain requirement**
 - **Emphasis on outcome measurement**
 - **Year 1 Weight: 50%**

PROPOSED RULE

MIPS: Resource Use Performance Category

Summary:

- ✓ **Assessment under all available resource use measures, as applicable to the clinician**
- ✓ **CMS calculates based on claims so there are no reporting requirements for clinicians**
- ✓ **Key Changes from Current Program (Value Modifier):**
 - **Adding 40+ episode specific measures to address specialty concerns**
 - **Year 1 Weight: 10%**

Webinars & Links MACRA/MIPS/QPP

- [CMS Site on Learning Opportunities for MACRA Proposed Rule](#)
 - [Quality Payment Program CMS Site](#) – Fact Sheet, Timeline, Past and Future Webinars, Slide Deck
 - [Federal Register \(Full MACRA/MIPS Proposed Rule\)](#)
- 

Questions?



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thank
you!

Please complete the survey and thank you for your
time today!