PQRS in 2016

James R. Christina, DPM

Payment Adjustment

- Failure to participate in PQRS successfully in 2016 will result in a 2% payment reduction for payments in 2018.

Changes to PQRS in 2016

- Definition of eligible professional (EP) for purposes of participating in PQRS
- Changes to the requirements for the qualified clinical data registry (QCDR) and qualified registries
- QCDRs and qualified registries have more time in which to self-nominate
- Revised auditing requirements for entities submitting PQRS quality measures data (qualified registries, QCDR, direct EHR, or direct Data Submission Vendor [DSV] product)

Changes to PQRS Reporting Criteria

- Changes to group practice reporting option (GPRO): New QCDR reporting option
  - Optional Consumer Assessment of Healthcare Providers and Systems (CAHPS) reporting for groups of 25-99 EPs
  - Required CAHPS reporting for groups of 100 or more EPs regardless of reporting mechanism
- Changes for QCDR Vendors –Support tax identification number (TIN)-level reporting
  - New process for self-nomination and attestation
  - Revised auditing requirements
- Changes Registry Vendors –New process for self-nomination and attestation
  - Revised auditing requirements
- EHR –Revised auditing requirements

Anatomy of a measure

Measure #126 (NQF 0417): Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients with diabetes mellitus seen during the reporting period. Evaluation of neurological status in patients with diabetes to assign risk category and therefore have appropriate foot and ankle care to prevent ulcerations and infections ultimately reduces the number and severity of amputations that occur. Risk categorization and follow up treatment plan should be done according to the following table:

DENOMINATOR:

- All patients aged 18 years and older with a diagnosis of diabetes mellitus

AND

- **Diagnosis for diabetes (ICD-10-CM):**

E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9

AND

- **Patient encounter during the reporting period (CPT):** 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97597, 97598, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:

- Patients who had a lower extremity neurological exam performed at least once within 12 months

Definition:

- **Lower Extremity Neurological Exam** – Consists of a documented evaluation of motor and sensory abilities and should include: 10-g monofilament plus testing any one of the following: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold), however the clinician should perform all necessary tests to make the proper evaluation.
  - ***Performance Met:*** Lower extremity neurological exam performed and documented (**G8404)**
  - ***Performance Not Met:*** Lower extremity neurological exam **not** performed (**G8405)**

Reporting versus Performance

- **Reporting means that you reporting one of the codes associated with a quality measure**
- **Performance means that you did the prescribed measure**
  - For example for measure 126 (Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation) you report the code: **G8405:** Lower extremity neurological exam **not** performed have successfully reported measure 126
  - However, if you report G8405 for measure 126, **performance would not be met (G8404 is what you report if you did the measure and performance would be met)**

The measure specifications will indicate with the code to report if performance is met or not

National Quality Strategy Domains

1. *Person and Caregiver-Centered Experience Outcomes*

(Formerly **Patient and Family Engagement –** *Ensuring that each person and family is engaged as partners in their care.*)

2. Patient Safety

Making care safer by reducing harm caused in the delivery of care.

3. Communication and Care Coordination

Promoting effective communication and coordination of care.

4. Community, Population and Public Health

Working with communities to promote wide use of best practices to enable healthy living.

5. Efficiency and Cost Reduction Use of Healthcare Resources

Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

6. Effective Clinical Care

Promoting the most effective prevention and treatment practices for the leading causes of mortality.

Individual Reporting

- Available reporting mechanisms for 2016 program year:
  - Claims
  - Registry
  - EHR (Direct or Data Submission Vendor)
  - QCDR

Individual Reporting: Claims

There were no changes for claims reporting for individual EPs:

- 9 measures covering at least 3 National Quality Strategy (NQS) domains **OR** if <9 measures or <3 domains apply, report on each applicable measure
- **AND** report each measure for at least 50% of the Medicare Part B Fee-for-Service (FFS) patients for which the measure applies

- If an EP sees one Medicare patient in a face-to-face encounter, they must report on at least 1 cross-cutting measure (included in the 9 measures)

- **Measures with 0% performance rate will not count**

Individual Reporting: Registry and Measures Groups via Registry

There were no changes for **registry-based reporting** for individual EPs:

- 9 measures covering at least 3 NQS domains **OR** if <9 measures or <3 domains apply, report on each applicable measure
- **AND** report each measure for at least 50% of the Medicare Part B FFS patients for which the measure applies

There were no changes for **measures groups via registry reporting** for individual EPs:

- 1 measures group for 20 applicable patients of each EP
- A majority of patients (11 out of 20) must be Medicare Part B FFS patients
- Measures groups containing a measure with a **0% performance** rate will not be counted

Individual Reporting: EHR (Direct or DSV)

- 9 measures covering at least 3 of the NQS domains. **If** an EP's EHR does not contain patient data for at least 9 measures covering at least 3 domains, then the EP must report on all the measures for which there is Medicare patient data.
- Report on at least 1 measure for which there is Medicare patient data.

Certified EHR Technology (CEHRT) Requirement for Electronic Clinical Quality Measures (CQM) reporting:

- Providers must use technology that is CEHRT
- Providers must create an electronic file using CEHRT that can be accepted by CMS for reporting

Individual Reporting: QCDR

- 9 measures (PQRS measures and/or non-PQRS measures) available for reporting under a QCDR covering at least 3 NQS domains

AND

each measure for at least 50% of the EP's patients

- Of these measures, EP would report on at least 2 outcome measures

OR

- If 2 outcome measures are not available, report on at least 1 outcome measure and at least 1 resource use, patient experience of care, efficiency/appropriate use, or patient safety measure

Group Practice Reporting Option (GPRO)

Available reporting mechanisms for 2016 program year:

- Web Interface (WI)
- Registry
- EHR (Direct or DSV)
- QCDR
- CAHPS for PQRS is:
  - **Optional** for PQRS group practices of 2-99 EPs reporting electronically, using a QCDR, or a Qualified Registry
  - **Optional** for PQRS group practices of 25-99 EPs reporting via GPRO WI
  - **Required** all PQRS group practices of 100 or more EPs, regardless of reporting mechanism

Groups must register to report via the GPRO

CAHPS: **Consumer Assessment of Healthcare Providers & Systems**

DIABETES MEASURES GROUP OVERVIEW

- **MEASURES IN DIABETES MEASURES GROUP**

#1 Diabetes: Hemoglobin A1c Poor Control

#110 Preventive Care and Screening: Influenza Immunization

#117 Diabetes: Eye Exam

#119 Diabetes: Medical Attention for Nephropathy

#126 Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation

#226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

INSTRUCTIONS FOR REPORTING:

- It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group-specific intent G-code has been created for registry only measures groupsf or use by registries that utilize claims data.
  - **G8485:** I intend to report the Diabetes Measures Group
- Report the patient sample method:

  20 Patient Sample Method via registries: 20 unique patients (a majority of which must be Medicare Part BFFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1through December 31, 2016).
- Patient sample criteria for the Diabetes Measures Group are patients aged **18 through 75 years** with a specific diagnosis of diabetes accompanied by a specific patient encounter:
  - **The following diagnosis codes indicating diabetes:ICD-10-CM:** E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331,E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44,E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630,E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29,E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36,E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618,E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9,E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331,E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44,E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630,E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9, O24.011, O24.012, O24.013, O24.019, O24.02,O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13
  - **Accompanied by:One of the following patient encounter codes:** 99201, 99202, 99203, 99204, 99205, 99212, 99213,99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

To satisfactorily report the Diabetes Measures Group requires reporting a numerator option on **all applicable** measures, for each patient within the eligible professional's patient sample, a minimum of once during the reporting period.

Measure #110

- Measure #110 only needs to be reported a minimum of once during the reporting period when the patient's visit included in the patient sample population is between January and March for the 2015-2016 influenza season **OR** between October and December for the 2016-2017 influenza season.
- When the patient's office visit is between April and September, Measure #110 is not applicable and will not affect the eligible provider's reporting or performance rate.

Measure #126

- Measure #126 is not reported (does not apply) when the clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure, for example patient bilateral amputee, patient has condition that would not allow them to accurately respond to a neurological exam (dementia, Alzheimer´s, etc.), patient has previously documented diabetic peripheral neuropathy with loss of protective sensation.

Inverse Measures:

- This measures group contains one or more inverse measures. An inverse measure is a measure that represents a poor clinical quality action as meeting performance for the measure. For these measures, a lower performance rate indicates a higher quality of clinical care. Composite codes for measures groups that contain inverse measures are only utilized when the appropriate quality clinical care is given.

QDC Options:

- The composite code for this measures group may be reported when codes in the summary table below are applicable for reporting of each measure within the measures group.

Table 2 - QDC Options

Measure	#1*	#110	#117	#119	#126	#226
QDC options for acceptable use of the composite QDC	3044F or 3045F	G8482	2022F or 2024F or 2026F or 3072F	3060F or 3061F or 3062F or 3066F or G8506	G8404	4004F or 1036F

*Indicates an inverse measure

Measure Group Reporting Calculations:

- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each applicable measure within the measures group reported by the eligible professional.
- Performance exclusion QDCs are not counted in the performance denominator. If the eligible professional submits all performance exclusion QDCs, the performance rate would be 0/0 (null) and would be considered satisfactorily reporting.

♦ Measure #1 (NQF 0059): Diabetes: Hemoglobin A1c Poor Control -- National Quality Strategy Domain: Effective Clinical Care

DESCRIPTION:
Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period

NUMERATOR:
Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%

Numerator Instructions:
INVERSE MEASURE - A lower calculated performance rate for this measure indicates better clinical care or control. The "Performance Not Met" numerator option for this measure is the representation of the better clinical quality or control. Reporting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control, and therefore an inverse measure at 100% does not qualify for reporting purposes, however any reporting rate less than 100% does qualify.

Patient is numerator compliant if most recent HbA1c level >9% or is missing a result or if an HbA1c test was not done during the measurement year. Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

Numerator Options:

Performance Met:	Most recent hemoglobin A1c level > 9.0% **(3046F)**
OR	
Performance Met:	Hemoglobin A1c level was not performed during the measurement period (12 months) **(3046F *with* 8P)**
OR	
Performance Not Met:	Most recent hemoglobin A1c (HbA1c) level < 7.0% **(3044F)**
OR	
Performance Not Met:	Most recent hemoglobin A1c (HbA1c) level 7.0 to 9.0% **(3045F)**

♦ Measure #117 (NQF 0055): Diabetes: Eye Exam -- National Quality Strategy Domain: Effective Clinical Care

DESCRIPTION:
Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal or dilated eye exam (no evidence of retinopathy) in the 12 months prior to the measurement period

NUMERATOR:
Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following: A retinal or dilated eye exam by an eye care professional in the measurement period or a negative retinal or dilated exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement period

NUMERATOR NOTE: *The eye exam must be performed or reviewed by an ophthalmologist or optometrist. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.*

Numerator Options:

Performance Met:	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed **(2022F)**
OR	
Performance Met:	Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed **(2024F)**
OR	
Performance Met:	Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed **(2026F)**
OR	
Performance Met:	Low risk for retinopathy (no evidence of retinopathy in the prior year) **(3072F)***

****NOTE:*** *This code can only be used if the encounter was during the measurement period because it indicates that the patient had "no evidence of retinopathy in the prior year". This code definition indicates results were negative, therefore a result is not required.*

OR

Performance Not Met:	Dilated eye exam was not performed, reason not otherwise specified **(2022F or 2024F or 2026F *with* 8P)**

♦Measure #119 (NQF 0062): Diabetes: Medical Attention for Nephropathy -- National Quality Strategy Domain: Effective Clinical Care

DESCRIPTION:
The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period

NUMERATOR:
Patients with a screening for nephropathy or evidence of nephropathy during the measurement period

Numerator Instructions: This measure is looking for a nephropathy screening test or evidence of nephropathy.

Numerator Options:

Performance Met:	Positive microalbuminuria test result documented and reviewed **(3060F)**
OR	
Performance Met:	Negative microalbuminuria test result documented and reviewed **(3061F)**
OR	
Performance Met:	Positive macroalbuminuria test result documented and reviewed **(3062F)**
OR	
Performance Met:	Documentation of treatment for nephropathy (eg, patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist) **(3066F)**
OR	
Performance Met:	Patient receiving angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy **(G8506)**
OR	
Performance Not Met:	Nephropathy screening was not performed, reason not otherwise specified **(3060F or 3061F or 3062F *with* 8P)**

▲Measure #110 (NQF 0041): Preventive Care and Screening: Influenza Immunization -- National Quality Strategy Domain: Community/Population Health

DESCRIPTION:
Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

NUMERATOR:
Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization

Numerator Instructions:

- If reporting this measure between January 1, 2016and March 31, 2016, quality-data code **G8482** should be reported when the influenza immunization is administered to the patient during the months of August, September, October, November, and December of 2015 or January, February, and March of 2016 for the flu season ending March 31, 2016.
- If reporting this measure between October 1, 2016 and December 31, 2016, quality-data code **G8482** should be reported when the influenza immunization is administered to the patient during the months of August, September, October, November, and December of 2016 for the flu season ending March 31, 2017.
- Influenza immunizations administered during the month of August or September of a given flu season (either 2015-2016 flu season OR 2016-2017 flu season) can be reported when a visit occurs during the flu season (October 1 - March 31). In these cases, **G8482** should be reported.

Definition:
Previous Receipt - Receipt of the current season's influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st).

NUMERATOR NOTE: *The numerator for this measure can be met by reporting either administration of an influenza vaccination or that the patient reported previous receipt of the current season's influenza immunization. If the performance of the numerator is not met, a clinician can report a valid performance exclusion for having not administered an influenza vaccination. For clinicians reporting a performance exclusion for this measure, there should be a clear rationale and documented reason for not administering an influenza immunization if the patient did not indicate previous receipt, which could include a medical reason (e.g., patient allergy), patient reason (e.g., patient declined), or system reason (e.g., vaccination not available). The system reason should be indicated only for cases of disruption or shortage of influenza vaccination supply.*

Numerator Options:

	Performance Met:	Influenza immunization administered or previously received **(G8482)**
OR		
	Other Performance Exclusion:	Influenza immunization was not administered for reasons documented by clinician (e.g., patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons) **(G8483)**
OR		
	Performance Not Met:	Influenza immunization was not administered, reason not given **(G8484)**

Suggested individual measures to report using the claims method:

- **Measure #1** (NQF 0059): Diabetes: Hemoglobin A1c Poor Control – National Quality Strategy Domain: Effective Clinical Care
- **Measure #47** (NQF 0326): Care Plan – National Quality Strategy Domain: Communication and Care Coordination
- **Measure #110** (NQF 0041): Preventive Care and Screening: Influenza Immunization – National Quality Strategy Domain: Community/Population Health
- **Measure #111** (NQF 0043): Pneumonia Vaccination Status for Older Adults – National Quality Strategy Domain: Community/Population Health
- **Measure #128** (NQF 0421): Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan – National Quality Strategy Domain: Community/Population Health
- **Measure #130** (NQF 0419): Documentation of Current Medications in the Medical Record – National Quality Strategy Domain: Patient Safety
- **Measure #131** (NQF 0420): Pain Assessment and Follow-Up – National Quality Strategy Domain: Communication and Care Coordination
- **Measure #154** (NQF: 0101): Falls: Risk Assessment – National Quality Strategy Domain: Patient Safety
- **Measure #155** (NQF: 0101): Falls: Plan of Care – National Quality Strategy Domain: Communication and Care Coordination
- **Measure #226** (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention – National Quality Strategy Domain: Community / Population Health
- **Measure #317**: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented – National Quality Strategy Domain: Community / Population Health

Suggested individual measures to report using a registry:

- **Measure #1** (NQF 0059): Diabetes: Hemoglobin A1c Poor Control – National Quality Strategy Domain: Effective Clinical Care
- **Measure #47** (NQF 0326): Care Plan – National Quality Strategy Domain: Communication and Care Coordination
- **Measure #110** (NQF 0041): Preventive Care and Screening: Influenza Immunization – National Quality Strategy Domain: Community/Population Health
- **Measure #111** (NQF 0043): Pneumonia Vaccination Status for Older Adults – National Quality Strategy Domain: Community/Population Health
- **Measure #126 (NQF 0417):** Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation – National Quality Strategy Domain: Effective Clinical Care
- **Measure #127 (NQF 0416):** Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear – National Quality Strategy Domain: Effective Clinical Care
- **Measure #128** (NQF 0421): Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan – National Quality Strategy Domain: Community/Population Health
- **Measure #130** (NQF 0419): Documentation of Current Medications in the Medical Record – National Quality Strategy Domain: Patient Safety
- **Measure #131** (NQF 0420): Pain Assessment and Follow-Up – National Quality Strategy Domain: Communication and Care Coordination
- **Measure #154** (NQF: 0101): Falls: Risk Assessment – National Quality Strategy Domain: Patient Safety
- **Measure #155** (NQF: 0101): Falls: Plan of Care – National Quality Strategy Domain: Communication and Care Coordination
- **Measure #226** (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention – National Quality Strategy Domain: Community / Population Health
- **Measure #317**: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented – National Quality Strategy Domain: Community / Population Health

*Red indicates cross-cutting measure

Measure-Applicability Validation (MAV)

For Claims and Registry Reporting of Individual Measures:

- MAV will apply to those who report on <9 measures or fewer than 3 NQS domains.
- For more information: https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/analysisandpayment.html

Quality Measures Updates

- **New Measures:** 4 additional cross cutting measures (being added to the existing cross-cutting measures)
  - 37 for individual reporting

- NQS domains covered:
  - **Effective Clinical Care** **18**
  - **Patient Safety** **9**
  - **Efficiency and Cost Reduction** **4**
  - **Community/ Population Health** **1**
  - **Communication and Care Coordination** **3**
  - **Person and Caregiver-Centered Experience and Outcomes** **2**

Measures for Removal:

10 total removals from PQRS:

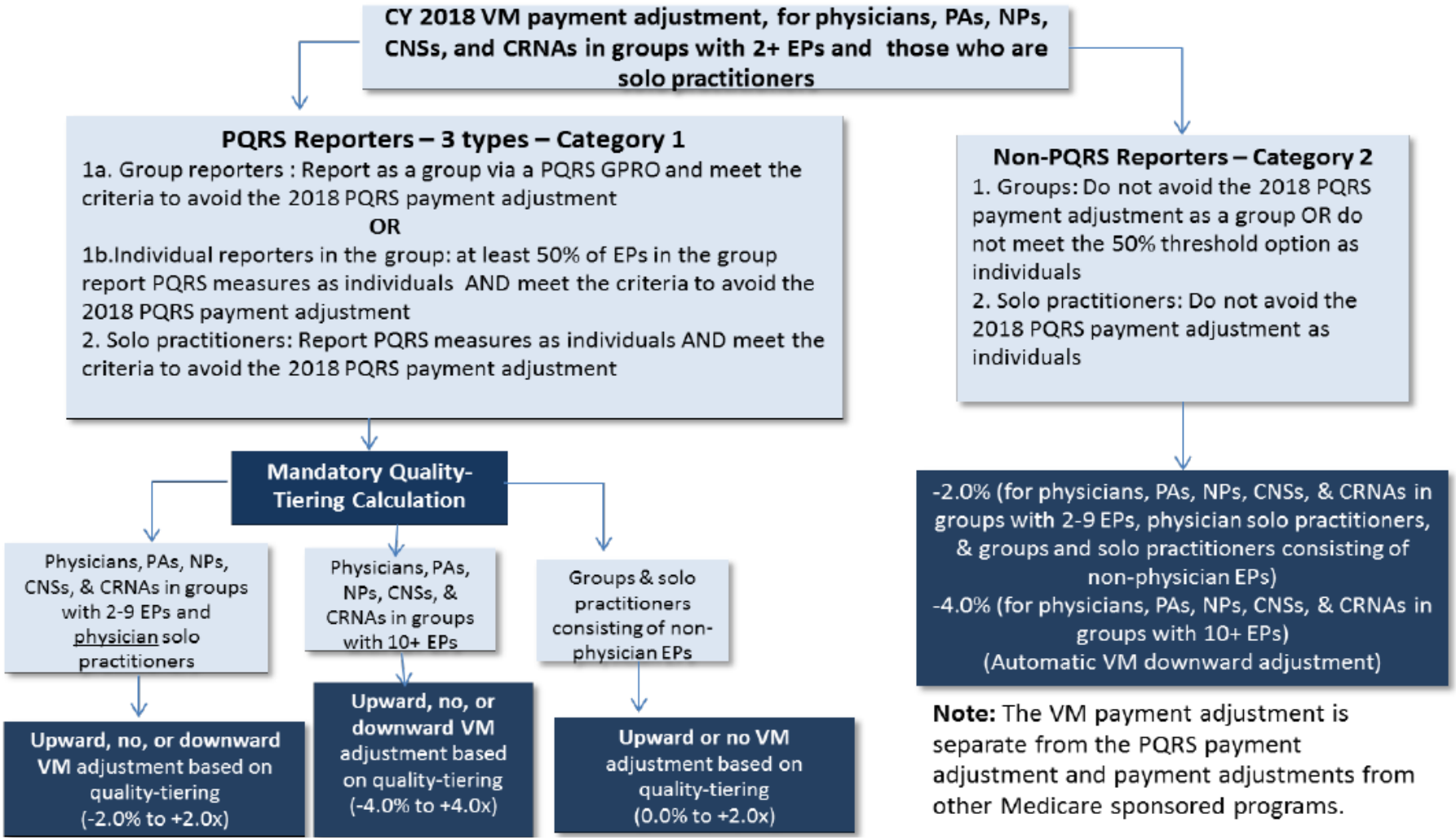
9 measures being removed from claims and/or registry

Changes to Existing Measures:

18 measures have a reporting mechanism update

Value-Based Payment Modifier (VM)

- Performance year is 2016
- Applies to physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs) in groups with 2+ EPs and those who are solo practitioners, as identified by their TIN
- Quality-tiering is mandatory –TINs that consist of non-physician EPs only will be held harmless from downward adjustments
- All other TINs will be subject to upward, neutral, or downward adjustments
- All TINs receiving an upward adjustment are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25 percent of all beneficiary risk scores nationwide
- 2018 will be the final year of the VM


CY 2018 VM payment adjustment, for physicians, PAs, NPs, CNSs, and CRNAs in groups with 2+ EPs and those who are solo practitioners
PQRS Reporters – 3 types – Category 1
1a. Group reporters : Report as a group via a PQRS GPRO and meet the criteria to avoid the 2018 PQRS payment adjustment
OR
1b.Individual reporters in the group: at least 50% of EPs in the group report PQRS measures as individuals AND meet the criteria to avoid the 2018 PQRS payment adjustment
2. Solo practitioners: Report PQRS measures as individuals AND meet the criteria to avoid the 2018 PQRS payment adjustment
Non-PQRS Reporters – Category 2
1. Groups: Do not avoid the 2018 PQRS payment adjustment as a group OR do not meet the 50% threshold option as individuals
2. Solo practitioners: Do not avoid the 2018 PQRS payment adjustment as individuals
Mandatory Quality-Tiering Calculation
Physicians, PAs, NPs, CNSs, & CRNAs in groups with 2-9 EPs and physician solo practitioners
Physicians, PAs, NPs, CNSs, & CRNAs in groups with 10+ EPs
Groups & solo practitioners consisting of non-physician EPs
Upward, no, or downward VM adjustment based on quality-tiering (-2.0% to +2.0x)
Upward, no, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x)
Upward or no VM adjustment based on quality-tiering (0.0% to +2.0x)
-2.0% (for physicians, PAs, NPs, CNSs, & CRNAs in groups with 2-9 EPs, physician solo practitioners, & groups and solo practitioners consisting of non-physician EPs)
-4.0% (for physicians, PAs, NPs, CNSs, & CRNAs in groups with 10+ EPs)
(Automatic VM downward adjustment)
Note: The VM payment adjustment is separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs.

2018 VM Final Policies for Physicians, NPs, PAs, CNSs, & CRNAs in Groups of Physicians with 10+ EPs

- Maintain the 2017 VM payment adjustment levels
- An automatic -4.0% VM downward adjustment will be applied for not meeting the satisfactory reporting criteria to avoid the 2018 PQRS payment adjustment
- Under quality-tiering, the maximum upward adjustment is up to +4.0x ('x' represents the upward VM adjustment factor), and the maximum downward adjustment is -4.0% payment

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+2.0x*	+4.0x*
Average Cost	-2.0%	+0.0%	+2.0x*
High Cost	-4.0%	-2.0%	+0.0%

** Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25% of all beneficiary risk scores*

2018 VM Final Policies for Physicians, PAs, NPs, CNSs, & CRNAs in Groups of Physicians with 2-9 EPs and Physician Solo Practitioners

- Maintain the 2017 VM payment adjustment levels, except apply both upward and downward adjustments under quality-tiering
- An automatic -2.0% VM downward adjustment will be applied for not meeting the satisfactory reporting criteria to avoid the 2018 PQRS payment adjustment
- Under quality-tiering, the maximum upward adjustment is up to +2.0x ('x' represents the upward VM payment adjustment factor), and the maximum downward adjustment is -2.0%

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0x*	+2.0x*
Average Cost	-1.0%	+0.0%	+1.0x*
High Cost	-2.0%	-1.0%	+0.0%

** Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25% of all beneficiary risk scores*

Who to Call for Help

- **QualityNet Help Desk:**

  866-288-8912 (TTY 877-715-6222)

  7:00 a.m.–7:00 p.m. CST M-F or qnetsupport@hcqis.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 2013 PQRS/eRx Incentive Program incentive payment (during distribution timeframe)

  See *Contact Center Directory* at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html

- **EHR Incentive Program Information Center:**

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

- **Physician Value Help Desk (for VM questions)**

  Monday – Friday: 8:00 am – 8:00 pm EST

  Phone: 888-734-6433, press option 3

  Email: pvhelpdesk@cms.hhs.gov

- **ACO Help Desk via the CMS Information Center:**

  888-734-6433 Option 2 or cmsaco@cms.hhs.gov

- **Physician Compare Help Desk:**

  E-mail: PhysicianCompare@Westat.com

Resources

MACRA: MIPS & APMs
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

2016 MPFS Final Rule
https://www.federalregister.gov/articles/2015/11/16/2015-28005/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions

PQRS Website
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS

PQRS Payment Adjustment Information
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html

PFS Federal Regulation Notices
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html

Medicare Electronic Health Record (EHR) Incentive Program
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

Medicare EHR Incentive Program Payment Adjustments & Hardship Exceptions
https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/paymentadj_hardship.html

Medicare Shared Savings Program
http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/_Quality_Measures_Standards.html

Value-based Payment Modifier (VM) Website
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

Comprehensive Primary Care Initiative
http://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/

Physician Compare
http://www.medicare.gov/physiciancompare/search.html

Frequently Asked Questions (FAQs)
https://questions.cms.gov/

MLN Connects™ Provider eNews
http://cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Index.html

PQRS Listserv
https://public-dc2.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_520

Acronyms

Eligible Professional (EP) Hardship Exception Application for 2015 MU

- **Eligible Professional (EP) Hardship Exception Application:**

The deadline for Eligible Professionals to submit hardship applications for the 2017 payment adjustment, based on the 2015 EHR reporting period is July 1st, 2016. For more information see the EP tip sheet.

Questions?

James R. Christina, DPM
jrchristina@apma.org
301-581-9265