



# Medicare Quality Reporting for Rural Health



## WVMI & Quality Insights/ PA Office of Rural Health

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# Agenda

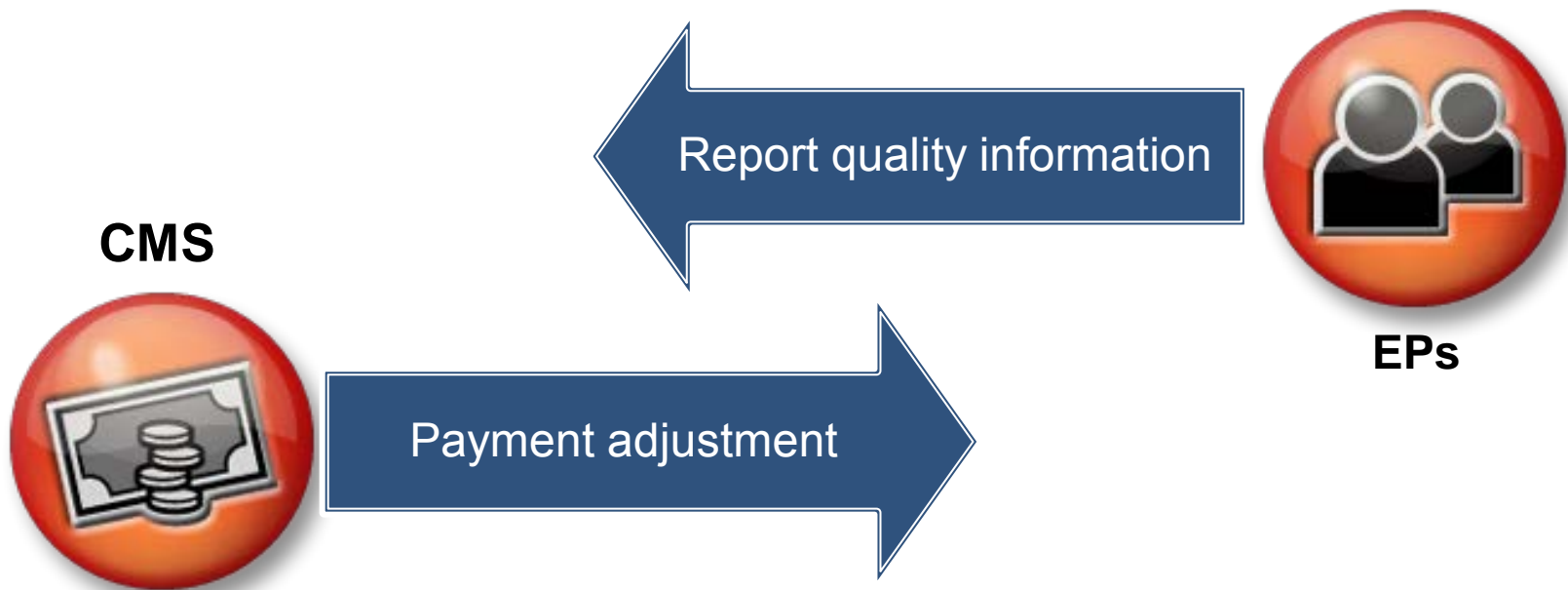
- PQRS Legislative History
- What is PQRS?
- Eligibility
- Choosing a Reporting Method
- Selecting Measures
- 2018 Payment Adjustments
- Relationship with other Reporting Programs
- Resources

# PQRS Legislative History

- Originally created under the Tax Relief and Health Care Act of 2006 as a voluntary reporting program
- The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008
  - Authorized incentive payments through 2010
- Patient Protection and Affordable Care Act
  - Extended incentive payments through 2014
  - Established payment adjustment for not reporting beginning in 2015
- Medicare Access and CHIP Reauthorization Act (MACRA) of 2015
  - PQRS ends in 2018, certain aspects of the program may be incorporated under the new incentive program

# What is PQRS?

**PQRS** is a reporting program that promotes the reporting of quality information by individual eligible professionals (EPs) or group practices participating via group practice reporting option (GPRO).



Resource: See the CMS [PQRS website](#) for additional information.

# What is PQRS?

- Health care providers report quality measures to CMS about health care services provided to Medicare beneficiaries
- Quality measures are tools that help CMS assess various aspects of care such as health outcomes, patient perceptions, and organizational structure
- The measures reported by health care professionals are associated with the ability to provide high-quality health care and relate to the goal of effective, safe, efficient, patient-centered, equitable, and timely care

# What is PQRS?

- By reporting quality measures, clinicians can:
  - Assess the quality of care they provide to their patients
  - Quantify how often they are meeting a particular quality metric
  - View their published quality metrics alongside that of their peers on the Physician Compare website
  - Avoid Physician Quality Reporting System (PQRS) negative payment adjustments
  - Receive Medicare Electronic Health Record (EHR) Incentive Program incentive payments and avoid the program's payment adjustments
  - Avoid the Value-Based Payment Modifier (Value Modifier) downward payment adjustment

# What is PQRS?

- PQRS covers professional and institutional services paid under or based on Part B MPFS submitted via CMS-1500 and CMS-1450 claim form, or the electronic equivalents 837P and 837I
  - Only EPs who render denominator-eligible, Part B MPFS professional and/or institutional services are considered *able* to participate in PQRS and will be analyzed for future PQRS negative payment adjustments
  - There is no threshold to participate in PQRS so all Part B MPFS services, even if minimally billed, count
- Technical services are not eligible for PQRS



# Eligibility

- Identify which providers render Part B MPFS services and are eligible for PQRS

## Medicare Physicians

- Doctor of Medicine
- Doctor of Osteopathy
- Doctor of Podiatric Medicine
- Doctor of Optometry
- Doctor of Oral Surgery
- Doctor of Dental Medicine
- Doctor of Chiropractic

## Practitioners

- Physician Assistant
- Nurse Practitioner\*
- Clinical Nurse Specialist\*
- Certified Registered Nurse Anesthetist\* (and Anesthesiologist Assistant)
- Certified Nurse Midwife\*
- Clinical Social Worker
- Clinical Psychologist
- Registered Dietician
- Nutrition Professional
- Audiologists

## Therapists

- Physical Therapist
- Occupational Therapist
- Qualified Speech-Language Therapist

\* Includes Advanced Practice Registered Nurse (APRN)

Resource: A list of PQRS EPs is available on the [PQRS How to Get Started webpage](#).

# Eligibility

- EPs working in CAHs who bill Method II are eligible to participate
- Method II:
  - The CAH bills for facility services
  - If a physician/practitioner has reassigned his/her benefits to the CAH, the CAH bills for that particular physician's/practitioner's professional service
  - If a CAH has elected Method II, the physician/practitioner is not required to reassign his or her benefits to the CAH. For those physicians/practitioners who do not reassign their benefits to the CAH, the CAH only bills for facility services and the physicians/practitioners separately bill for their professional services (similar to Method I)
- Beginning in 2014 EPs at CAHs who bill Medicare Part B using Method II can participate in PQRS (and the EHR Incentive Program) if they add their Individual NPI on the **CMS-1450 Institutional Claim form** (NOT the CMS-1500 form)
  - For the 5010 version of the 837 I, Fiscal Intermediary Shared System (FISS) shall accept rendering physician/practitioner information at the line level (loop 2420A) or at the claim level if the rendering physician/practitioner is different than the attending physician/practitioner (loop 2310D)

# Eligibility

- Sharing a TIN with a CAH does **not** change a provider's eligibility to participate in PQRS
  - PQRS EPs under CAH Method II who render **Part B MPFS professional or institutional services** are still eligible to participate in PQRS and to receive a future PQRS payment adjustments if they do not satisfactorily report
  - PQRS EPs should see the [PQRS How to Get Started webpage](#)

**Note:** Providers who are eligible for PQRS may also be eligible for the [Value-based Payment Modifier](#) and to participate **as a professional** in the Medicare [EHR Incentive Program](#). PQRS EPs are encouraged to review the information on the applicable websites to determine whether they are eligible to participate in other Medicare programs.

# Choosing a Reporting Method

- Individual reporting vs. Group Practice Reporting Option (GPRO)

Individual Reporting	GPRO
<p><b>Individual EPs</b> are identified on claims by their individual National Provider Identifier (NPI) and Tax Identification Number (TIN)</p>	<p>A <b>group practice</b> under 2016 PQRS is defined as a single Tax Identification Number (TIN) with 2 or more individual EPs who have reassigned their billing rights to the TIN. Group practices can register to participate in PQRS via the group practice reporting option (GPRO) to be analyzed at the group (TIN) level. Note that group practices participating via GPRO are referred to as PQRS group practices.</p>

- Available reporting methods based on whether you report individually or via GPRO

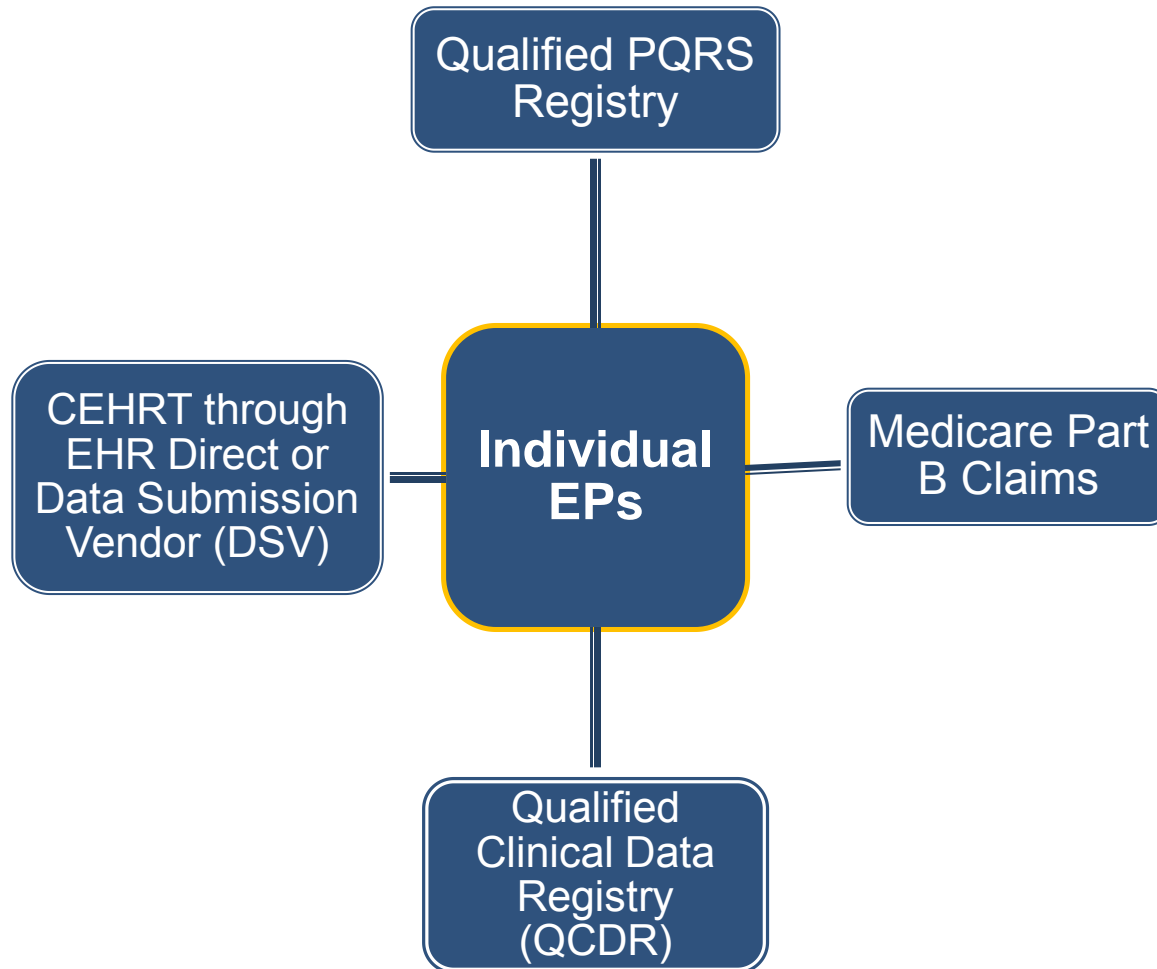
# Choosing a Reporting Method

- **Participating as individual EPs:** Analysis is based on data submitted by the individual/rendering National Provider Identifier (NPI) within a Taxpayer Identification Number (TIN), or at the unique TIN/NPI combination level
- **Participating as group practice via GPRO:** Analysis is based on data submitted by the TIN, or at the TIN-level
- To determine if a provider is eligible to participate in PQRS, CMS will analyze claims (for a unique TIN) to identify those EPs (by NPI) who render Part B MPFS services and to determine if those EPs provide services that fall within the PQRS measures' denominators.
  - These EPs are considered eligible and able to participate in PQRS and they should participate to avoid future PQRS negative payment adjustments.

*Resource: See [FAQ 12588](#) for additional information on who is eligible under CAH Method II.*

# 2016 Reporting Mechanisms

## Individual EPs



# 2016 Reporting Mechanisms

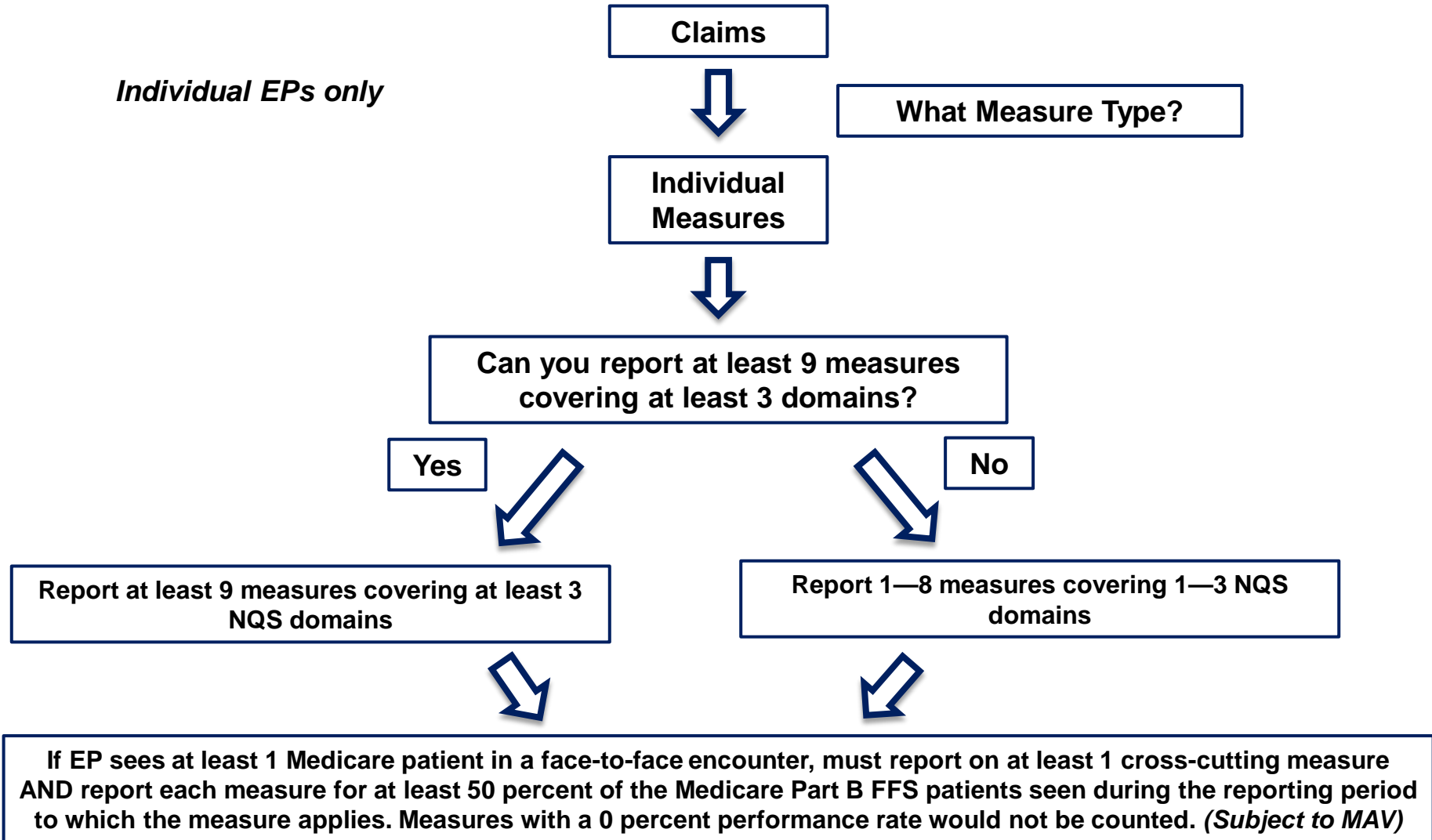
## PQRS Group Practices



*\*CAHPS is required for groups of 100+ EPs reporting via GPRO*

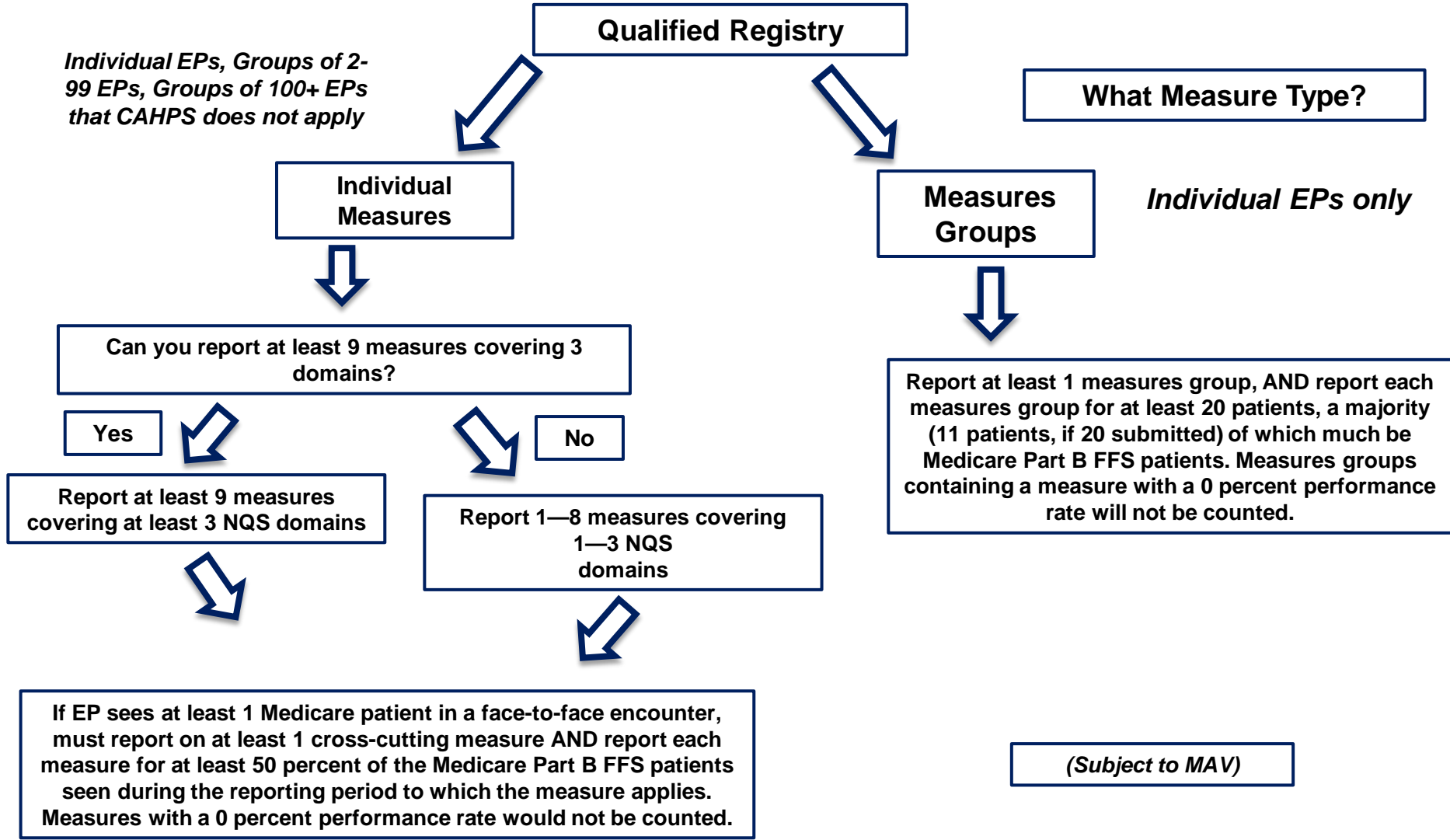
# Reporting Criteria for the 2018 PQRS Payment Adjustment

*Individual EPs only*





# Reporting Criteria for the 2018 PQRS Payment Adjustment



# Individual Reporting Criteria for the 2018 PQRS Payment Adjustment

*Individual EPs, Groups of 2-99 EPs, Groups of 100+ EPs that CAHPS does not apply*

Direct EHR product that is CEHRT  
-OR-  
EHR data  
Submission vendor that is CEHRT



Individual  
Measures



What Measure Type?

**Report 9 measures covering at least 3 of the NQS domains. If an EP's CEHRT or EHR data submission vendor does not contain patient data for at least 9 measures covering at least 3 domains, then the EP must report the measures for which there is Medicare patient data.**

**An EP must report on at least 1 measure for which there is Medicare patient data.**

# Reporting Criteria for the 2018 PQRS Payment Adjustment

Qualified Clinical Data  
Registry

*Individual EPs, Groups of 2-99 EPs, Groups of 100+ EPs that CAHPS does not apply*



What Measure Type?

Individual PQRS measures  
and/or non-PQRS measures  
reportable via a QCDR



**Report at least 9 measures covering at least 3 NQS domains AND report each measure for at least 50 percent of the EP's applicable patients seen during the reporting period to which the measure applies.**

**Of the measures reported via a qualified clinical data registry, the EP must 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 of the following: resource use, patient experience of care, efficiency/appropriate use, or patient safety**

# GPRO Reporting Criteria for the 2018 Payment Adjustment

GPRO Web Interface



25+ EPs

Group Practice Size?

Report on all measures included in the web interface; AND  
Populate data fields for the first 248 consecutively ranked and  
assigned beneficiaries in the order in which they appear in the  
group's sample for each module or preventive care measure.  
If the pool of eligible assigned beneficiaries is less than 248,  
then report on 100 percent of assigned beneficiaries.

***Groups of 100+ EPs: In addition, the group practice must report  
all CG CAHPS survey measures via certified survey vendor.***

# GPRO Reporting Criteria for the 2018 Payment Adjustment

**Groups of 2-99 EPs: Optional Methods Below**

**Groups of 100+ EPs (if CAHPS applies to the group): MANDATORY...MUST CHOOSE ONE OF THESE OPTIONS**

Report all CAHPS for PQRS survey measures via a CMS-certified survey vendor PLUS one of:

Qualified Registry

GPRO Web Interface (25+ EPs only)

Direct EHR product that is CEHRT -OR- EHR data submission vendor that is CEHRT

Qualified Clinical Data Registry (QCDR)

Report at least 6 additional measures outside of CAHPS for PQRS, covering at least 2 NGS domains; if less than 6 apply to group, report up to 5 measures.  
If EP in group sees at least 1 Medicare patient in face-to-face encounter, must report at least 1 cross-cutting measure

Report on all measures included on web interface; AND populate data fields for first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then report on 100 percent of assigned beneficiaries

Report at least 6 additional measures outside of CAHPS for PQRS, covering at least 2 NGS domains; if less than 6 apply to group, report up to 5 measures.  
Group practice required to report on at least 1 measure for which there is Medicare patient data

Report at least 6 additional measures covering at least 2 NGS domains using the QCDR; of the additional measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, at least 1 measure must be an outcome measure

# Choosing a Reporting Method

- Implement the chosen reporting mechanism
  - **Qualified registry:** Work directly with selected vendor for PQRS data submission
  - **QCDR:** Work directly with selected vendor for PQRS data submission
  - **Claims-based reporting:** Establish an office workflow to allow each chosen measure's denominator-eligible patient to be accurately identified on the Medicare Part B claim
  - **Electronic Reporting using an EHR:**
    - Direct EHR Vendor (EHR Direct) – submit PQRS quality measure data from CEHRT
    - EHR Data Submission Vendor (DSV) – work directly with selected vendor for PQRS data submission
  - **GPRO Web Interface (for PQRS group practices only):** Work with your internal IT departments to determine how best to support this mechanism
  - **CAHPS for PQRS (for PQRS group practices only):** Work directly with a CMS-certified survey vendor to administer and collect the CAHPS for PQRS survey measure data

# Selecting Measures

- Resources for selecting PQRS measures to report can be found on the [PQRS Measures Codes webpage](#), including:
  - 2016 PQRS Measures List and web-based tool, 2016 PQRS Single Source Code Master allows you to filter or search by codes (ICD, CPT, and HCPCS) across all measures for all reporting mechanisms
  - Measure specifications for a specific reporting mechanism can be found on the applicable PQRS webpage (i.e., Electronic Reporting Using an Electronic Health Record [EHR]).
- Contact the QualityNet Help Desk for assistance in identifying applicable measures

# Selecting Measures

The following factors should be considered when deciding which measures to select for PQRS reporting:

- Clinical condition usually treated
  - Review diagnosis coding in the measure's denominator, if applicable
- Settings where care is usually delivered (e.g., office, emergency department [ED], surgical suite)
  - Review coding in the measure's denominator
- Quality action (Numerator) intended to be captured by the measure



# 2018 Payment Adjustments

Program	Applicable to	Adjustment Amount	Based on PY
PQRS	All EPs	-2.0% of Medicare Physician Fee Schedule (MPFS)	2016
Medicare EHR Incentive Program	Medicare physicians (if not a meaningful user)	-3.0% of MPFS	2016
Value-based Payment Modifier	All physicians in groups with 2+ EPs and physicians who are solo practitioners, and physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists	<p><b>Mandatory Quality-Tiering for PQRS reporters:</b></p> <ul style="list-style-type: none"> <li><b>Groups with 2-9 EPs and solo practitioners:</b> Upward or neutral, or downward VM adjustment only based on quality-tiering (-2.0% to +2.0x of MPFS)</li> <li><b>Groups with 10+ EPs:</b> Upward, neutral, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x of MPFS)</li> </ul> <p>Groups and solo practitioners receiving an upward adjustment are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25% of all beneficiary risk scores nationwide.</p> <p><b>Non-PQRS reporters:</b></p> <ul style="list-style-type: none"> <li><b>Groups with 2-9 EPs and solo practitioners:</b> automatic -2.0% of MPFS downward adjustment</li> <li><b>Groups with 10+ EPs:</b> Automatic -4.0% of MPFS downward adjustment</li> </ul>	2016

# Relationship with other Quality Reporting Programs

## Electronic Health Records Incentive Program:

- PQRS data are used as part of the Medicare EHR Incentive Program
- The Medicare EHR Incentive Program provides incentive payments to individual EPs, eligible hospitals, and critical access hospitals (CAHs) who adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology (CEHRT)
- The Medicare EHR Incentive Program asks providers to demonstrate meaningful use of the capabilities of their EHRs to achieve benchmarks that can lead to improved patient care
- EPs can use their CEHRT to submit quality data codes once and receive credit for both programs

# Relationship with other Quality Reporting Programs

## Value-Based Payment Modifier:

- PQRS data are used to calculate a physician's Value Modifier.
- The Value Modifier is calculated using quality of care and cost data. All physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists who participate in Fee-for-Service Medicare in 2016 will be affected by the Value Modifier starting in 2018
- In order to be eligible for upward, downward, or neutral payment adjustments under the Value Modifier quality-tiering methodology, and to avoid an automatic negative Value Modifier payment adjustment in 2018, EPs in groups and solo practitioners MUST participate in PQRS and satisfy reporting requirements as a group or as an individual in 2016
- Failure to report will result in a PQRS payment adjustment of -2.0 percent, as well as an additional automatic VM downward adjustment between -2.0 and -4.0 percent

# Relationship with other Quality Reporting Programs

## Physician Compare:

- Several PQRS measures are housed in Physician Compare, a website that displays information about individual EPs and group practices who satisfactorily participated in CMS quality programs
- With Physician Compare, individual EPs and group practices can compare their performance on pre-determined measures with the performance of their peers
- This website enables individual EPs and group practices to track their performance against established metrics, and allows consumers to make informed choices about the health care they receive

# Frequently Asked Questions

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Question:

If I furnish professional Medicare Part B services **only** at an RHC or an FQHC, are the services eligible for PQRS?

# Frequently Asked Questions

Answer:

No, if you furnish Medicare Part B professional services **only** at an RHC or an FQHC, such services are not eligible for either the PQRS incentive payment or for the PQRS negative payment adjustment.

# Frequently Asked Questions

Question:

I'm an Eligible Professional (EP) and I furnish professional Medicare Part B services at an RHC/FQHC and also furnish services at a non-RHC/FQHC setting. Are the non-RHC/FQHC services eligible for the 2016 PQRS negative payment adjustment?

# Frequently Asked Questions

Answer:

Yes, for an EP who furnishes professional Medicare Part B services at an RHC/FQHC and also furnishes services at a non-RHC/FQHC setting, the non-RHC/FQHC services may be eligible for the PQRS negative payment adjustment. The PQRS program applies a negative payment adjustment to practices with EPs, identified on claims by their individual National Provider Identifier (NPI) and Tax Identification Number (TIN), or group practices participating via the Group Practice Reporting Option (GPRO) (referred to as PQRS group practices) who do **not** satisfactorily report data on quality measures for covered Medicare Physician Fee Schedule services furnished to Medicare Part B Fee-For-Service beneficiaries.



# Frequently Asked Questions

Question:

Under what circumstances are professional Medicare Part B services furnished by an EP at a setting outside an RHC/FQHC subject to the 2016 PQRS 2.0 percent negative payment adjustment if he or she has not satisfactorily reported 2014 PQRS quality measures?

# Frequently Asked Questions

Answer:

There are two circumstances under which professional Medicare Part B services furnished by an EP at a setting outside an RHC/FQHC may be subject to the 2016 PQRS negative payment adjustment if he or she has not satisfactorily reported 2014 PQRS quality measures:

1. The non-RHC/FQHC services furnished by the EP are billed under his or her own TIN/NPI combination as reported via Provider Enrollment, Chain, and Ownership System (PECOS). The 2016 PQRS payment adjustment applies to the EP as an individual, **not** to the clinic or the facility; and
2. The non-RHC/FQHC services an EP furnished are billed under a group practice's TIN, which may be registered to participate in the 2014 PQRS under the GPRO registration or self-nomination. The 2016 PQRS payment adjustment applies to the EP under the group practice's TIN, which applies to the entire group practice.

# Frequently Asked Questions

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Question:

I'm an EP who furnishes professional Medicare Part B services at a CAH and the CAH is paid under the Optional Payment Method (Method II). Are my services eligible for PQRS?

# Frequently Asked Questions

Answer:

An EP who furnishes Medicare Part B services at a CAH and the CAH is paid under Method II may be eligible for PQRS beginning in 2014 for the 2014 PQRS incentive payment (2014 was the final year for PQRS incentive payments) and will be subject to the 2016 PQRS negative adjustment payment if he or she does not report by the deadline specified for each reporting method. Any physician-reported NPI, at either the claim level or the line level of a UB-04 claim, is considered eligible to participate in PQRS.

# Frequently Asked Questions

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Question:

I'm a CAH provider paid under Method II. Am I required to report line item rendering NPI information?

# Frequently Asked Questions

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Answer:

Yes, a CAH provider paid under Method II is required to report the rendering NPI at the line level **if** it is different than the rendering NPI at the claim level.

# Resources

- **CMS PQRS Website**  
<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS>
- **Medicare and Medicaid EHR Incentive Programs**  
<http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms>
- **CMS Value-based Payment Modifier (Value Modifier) Website**  
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>
- **Physician Compare**  
<http://www.medicare.gov/physiciancompare/search.html>
- **Frequently Asked Questions (FAQs)**  
<https://questions.cms.gov/>
- **PQRS Listserv**  
[https://public-dc2.govdelivery.com/accounts/USCMS/subscriber/new?topic\\_id=USCMS\\_520](https://public-dc2.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_520)

# Where 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 [gnetsupport@hcqis.org](mailto:gnetsupport@hcqis.org)

You will be asked to provide basic information such as name, practice, address, phone, and e-mail

- **Provider Contact Center:**

Questions on Method II billing, Remittance Advice codes, PQRS incentive payment (during distribution timeframe)

See the [MAC Jurisdiction](#) website

- **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, or [cmsaco@cms.hhs.gov](mailto:cmsaco@cms.hhs.gov)

- **Comprehensive Primary Care (CPC) Initiative Help Desk:**

800-381-4724 or [cpcisupport@telligen.org](mailto:cpcisupport@telligen.org)

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

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

Phone: 888-734-6433, press option 3



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