

# Medicare Quality Reporting for Rural Health Providers Webinar Transcript

April 18, 2016

Laurie: The Quality Insights Quality Innovation Network team welcomes you to today's webinar, Medicare Quality Reporting for Rural Health Providers. My name is Laurie Fink and I would like to take a moment to review a few items.

First, all participant lines have been muted and will remain in a listen-only mode during the presentation. There will be a question-and-answer session following the presentation. If a question comes to mind at any time, please feel free to type it in the chat window on the right of your screen and we will address it during the Q and A session.

Note that as time permits we will unmute phone lines during the Q and A session so that you make ask a question. Please note that this webinar is being recorded. The slide deck was emailed to all participants earlier today and it is also posted on the Quality Insights website under the events pad as an archived event.

Now I would like to introduce today's presenters. Dr. Barbara Connors serves as the chief medical officer at the Centers for Medicare and Medicaid Services, Region 3, and has served as the acting associate regional administrator for the Division of Survey and Certification in CMS Northeast Consortium, Regions 1, 2, and 3. As a chief medical officer, she is responsible for ensuring the provider community is cognizant of the CMS healthcare quality improvement initiatives, including current legislative issues that impact the provider community.

Dr. Connors graduated from the New York College of Osteopathic Medicine and received her masters of public health from the Medical College of Wisconsin. Dr. Connors is board certified by the American Board of Internal Medicine and the American Board of Preventive Medicine.

Patrick Hamilton, also one of today's presenters, is a health insurance specialist for the Centers for Medicare and Medicaid Services. Patrick has been with the Philadelphia regional office since October of 1998. He has worked in the area of provider outreach for the past 13 years where he has served as the outreach specialist for providers in Delaware, Maryland, Pennsylvania, Virginia, West Virginia, and the District of the Columbia.

In addition to his outreach responsibilities, Patrick works closely with providers, beneficiaries, and congressional offices in resolving inquiries dealing with Part A and Part B issues. Patrick currently is a regional point of contact for the Medicare quality programs, including the physician quality reporting system and high tech meaningful use for the Philadelphia regional office, as well as the national regional

office lead for the new merit-based incentive payment system, also known as MIPS, and alternative payment models.

Patrick received a bachelor of arts in political science from St. Joseph's University in Philadelphia in 1996 and a masters in public administration from Villanova University in 1999.

Patrick and Dr. Connors, thank you so much for joining us today. I will now turn the presentation over to you.

Patrick: Thank you, Laurie. Thank everyone for joining us today.

I am Patrick and I'm here with Dr. Connors here in the Philadelphia regional office. The purpose of the presentation that we put together for you today is to give you really kind of a 101 background understanding of the physician quality reporting system, or PQRS. What we're going to do is we are going to start with just a little bit of the legislative history. Where did PQRS come from, what exactly is it, what does CMS hope to achieve with quality reporting, who is eligible? What are some of the new rules for those providers who are in critical access hospitals who originally were not part of those providers who weren't eligible for the program but now are, and what that means in terms of avoiding payment adjustments?

We're also going to go into the reporting methods and we have some interactive decision trees that will help you decide what type of method best suites your situation in terms of your practice and your setting. Also the measures how you go about to select the actual measures that you would be reporting, what you need to do to avoid payment adjustments specific for the 2018 payment adjustment year for PQRS. Then we'll also talk about the relationship with PQRS with the other current Medicare quality reporting programs.

We will touch briefly, although we won't be talking about it in too much detail, about the upcoming changes to quality reporting in general; namely, the new merit-based incentive payment system and alternative payment models. The first proposed rules for those programs are set to be released pretty soon and that's really going to change the way the quality reporting is done, and that you are paid for quality reporting starting in 2019. Then if we have time, we will do some questions and answers.

Let's start with a very quick Cliffs Notes version of the legislative history of PQRS. There are a number of major pieces of legislation going all the way back to 2006 that the physician quality of reporting system or the physician voluntary reporting program as it was originally known back in 2006, there's a number of pieces of legislation that actually play into this. It was originally created in 2006 under the Tax Relief and Healthcare Act, or the TRHCA, and at that point it was just a strictly voluntary reporting program. You could have registered your intent to participate or you simply could have just submitted your codes on your claims.

When this program began in 2006 there were 16 measures, a 16-measure set that physicians would report on, basically primary-care focused, but we always had the intention, and we have followed through on this intention, of expanding those quality codes to include a broader range of specialists, and we'll talk about how we've done that over the course of the presentation.

The next piece of legislation was MIPPA, or the Medicare Improvements for Patients and Providers Act of 2008. That authorized actual incentive payments. Though when TRHCA created the PVRP, or the Physician Voluntary Reporting Program, it was basically to try to encourage physicians to submit quality data to CMS. The MIPPA Act of 2008 was the first time that Congress actually allocated resources to pay incentives for actually doing so. The Affordable Care Act, which was passed in 2010, of course, extended those incentive payments through 2014. Just as importantly, it also instituted for the first time payment adjustments for failing to report quality codes. Those first payment adjustments started in 2015. They were 1-1/2% last year. Payment adjustments are 2% for 2016 and remain at 2% for 2017 and 2018.

The latest piece of legislation and the one that you'll be hearing about a lot more in the coming weeks is MACRA, or the Medicare Access and CHIP Reauthorization Act. In addition to repealing the SGR which on the Part B side was that Doc Fix that Congress had to go through every year in order to avoid those drastic Medicare cuts on the Medicare Part B physician fee schedule side, it did away with the SGR and instituted modest steady increases in the physician fee schedule rates on the B side. It also created this new merit incentive-based payment system and eligible alternative payment models and incentives and payment adjustments for incentives if you are successful in reporting in the program payment adjustments if you fail to meet the criteria.

What that does it ends or it sunsets the individual payment adjustments that are still in place or will still be in place for PQRS for the value-based payment modifier and also for the EHR incentive program for Medicare physicians. Now for critical access hospitals of which there are many that are on the call today, for other hospitals, and for Medicaid providers. The current EHR incentive program, will continue as is. When we talk about MIPPS and APMs, we talk about the payment adjustments specific for Medicare Part B providers that will sunset, but the hospital programs will continue so just keep that in mind.

What is PQRS? Again, it stands for the Physician Quality Reporting System. It is a reporting program that promotes the reporting of quality information by individual EPs or by group practices that choose to participate through the group practice reporting option or GPRO. You'll hearing a lot about GPRO. When it started in 2006, it was really the beginning of Medicare taking those first steps, and albeit they were very small steps in the beginning, to transitioning from paying for the quantity of care that providers were providing their Medicare patients to providing the quality of care.

Now, we're not there yet, but in 2006 with the first iteration of PVRP, that was really the first time that Medicare was starting to think about incentivizing for quality, not simply for the volume of services that providers are providing to Medicare patients. We won't go into detail on this call, but you will be on call in the very near future when we're talking about MIPS and EPDs and you're going to hear a lot about quality over quantity, value based purchasing, things of that nature. This is really the very, very early stages of that, of really looking at quality and figuring out how do we incentivize, how do we reward doctors for providing high-quality service to their patients?

Healthcare providers report quality measures to us, to CMS, about the services that they're providing to their patients, the measures we think are tools that are going to help us assess various aspects such as health outcomes, patient perceptions, and also organizational structure of the individual practices. The measures and there are upwards of 240 measures or 280 measures, in PQRS just this year alone, we go through a process every year on the Medicare Part B fee schedule side of retiring quality measures that we feel no longer have value to the provider community or to CMS. We're also always constantly introducing new measures into the program.

The measures are reported by healthcare professionals and they're associated with the ability to provide high-quality healthcare and relate to specific goals. If you look at the measure sets or the listing of measures, they fall under 6 what we call quality domains. These are domains that were established in conjunction with the National Quality Forum or NQF, and those 6 domains are effective clinical care, patient safety, communication and care coordination, community and population health, efficiency and cost reduction, and person and caregiver centered experience.

When you ask what exactly is CMS trying to measure? What information are we trying to get? What are we trying to determine outcomes for? They fall under one of those 6 specific categories. It's important to note that the measures and the domains were done in partnership with outside entities. It was not strictly CMS who was coming up with these measure sets and with these quality domains. They were done in conjunction with the National Quality Forum.

If a provider successfully reports to PQRS, then as a clinician you will be able to assess the quality of care that you provide to your patients. You can quantify how often that you are meeting particular quality metrics. You can also view their published quality metrics alongside that of their peers on a physician compare website. Every year, a physician compare website, if you're not familiar with it, it's a website that was instituted by CMS a few years back that is publicly available information that consumers can go on to make informed decisions about who they want to see to provide their care.

Little by little we had added, and this is actually through the rule-making process, specific information or specific data from the various programs, such as PQRS, the value-based modifier, EHR, and other quality programs, we put that information on the physician compare website for consumer consumption.

Also it's very important that when you start participating in PQRS, that you avail yourselves of the feedback reports that are made available to you usually it's in September, every fall, and they're called your QRUR reports, which stand for Quality and Resource Use Reports. These are basically your report cards of how you fared with the reporting of your quality codes. It will give you specific percentages in terms of where you fell with your numerators and your denominators. It will give you an idea of where you fall in terms of the value-based payment modifier to determine if you're going to get an upward, downward, or neutral adjustment. It's very important each September that you get your QRUR reports when they are made available to you.

Also by participating in PQRS, and we're going to talk about this a little bit when we talk about the relationship with other programs, if you successfully report then, obviously, you'll avoid the 2% payment adjustment that I talked about. You'll also have the opportunity to align the reporting if you are not reporting as part of the critical access hospital. If you're reporting EHR as an individual provider on the Medicare side, then there is the opportunity to align the reporting that you do with PQRS with the EHR program.

Also the value modifier, and if you're not familiar with the value modifier, we can have that discussion at a later time, but there is a component of the value modifier that states that if you do not successfully report your PQRS data, then you get an additional automatic downward adjustment for the value modifier. As you can see if you weren't aware, now it is very important that you are reporting your PQRS data.

Specifically, PQRS covers professional and institutional services that are paid under or based on the Medicare Part B physician fee schedule submitted via CMS 1500 and CMS 1450 claim forms or the electronic equivalent. Technical services are not eligible for PQRS and anything else that is paid through another payment methodology, such as another fee schedule. Radiology, I believe, has its own fee schedule; anesthesiology, they're not eligible. Also rural health clinic and FQH services that are billed under those specific methodologies also are not eligible.

Starting in, I think, it was 2014, Method II and we're going to go into this in a few slides, Method II CAH providers were eligible to participate and this year is the first year you can actually do so through your claims and we'll talk about that in a second.

The eligibility that was established in the legislation, and this goes to the provider types, not necessarily the setting in which the provider is practicing, but it's the provider type. All Medicare physicians that are listed on this slide, the non-physician practitioners and therapists, and again this is how we define Medicare providers generally. According to the Social Security Act, we use that definition in the Social Security Act when we make changes to the programs and the various pieces of legislation that I mentioned earlier.

Eligible professionals includes physicians, nurse practitioners, clinical nurse specialists, physician assistants, physical therapists, and many other healthcare professionals. In 2016 professionals who reassigned benefits to a critical access hospital that bills professional services at a facility level, such as CAH Method II billing, can now participate in all reporting methods. I'll explain what that means in a second. Depending on if you're reporting as an individual or as a group, you have different methods that you can choose to report. For these providers who were in CAH Method II billing situations, until this year they were not able to do claims-based reporting because we do not have the capability on our end system-wise to accept those quality data. We are able now to do that, so that's what that means that you can report using all methods.

In order to do so, the CAH must include the individual provider NPI on their institutional FI claims.

Barbara Connors: The operative word is any provider that bills under Medicare Part B, as in boy, including those that are under the CAH this year that can bill under claims, although the CAH, it jumped into effect in ...

Patrick: 2014.

Barbara Connors: ... 2014.

Patrick: 2014 was the first year that CAHs could do so, 2016 is the first time you can do so via your claims.

Barbara Connors: Claims, but anesthesia does bill under Medicare Part B, so anesthesia, even though they bill differently, they bill in units of time. They are behold to the PQRS.

Patrick: Okay.

As I mentioned, EPs working in CAHs to bill Method II are eligible to participate. You all, I'm sure, are familiar with Method II to CAH bill for facility services if the physician or practitioner reassigns benefits to the CAH, the the CAH bills for that particular physician's professional services. If they've elected Method II, the physician or practitioner is not required to reassign his or her benefits to the CAH. For those who do not do the reassignment, then the facility, the hospital, only bills for the facility services and then the practitioner would bill separately for their professional services. We just mentioned this starting in 2015, EPs and CAHs were able to start participating.

If you happen to share a tax identification number with a critical access hospital that does not change the individual provider's eligibility to participate in PQRS. With PQRS always have this in mind. We are looking at the TIN/NPI combination of the provider, TIN/NPI combination of the provider. PQRS EPs under CAH Method II will render Part B Medicare physician fee service, professional or institutional

services are still eligible to participate and receive future payment adjustments if they don't satisfactorily report. There is a very good PQRS how to get started web page. If you have this presentation electronically, you should be able to click on the link. If not, you can simply just google CMS PQRS Get Started and it will take you right to that page.

There are 2 ways that one can participate in PQRS. You can either elect to participate as an individual or via the GPRO, the group practice reporting option. There is no requirement that any group, whether they're a hospital-based group, if they are just a stand-alone group of X number of practitioners, there's no requirement that if you are identified in PECOS as a group that you have to do the group reporting option. You can have 300 providers in your group and you can choose for all 300 of those providers to participate as individuals.

Now if we were going to have a more in-depth discussion about the value-based payment modifier, we would talk about why that may or may not be a good idea. The takeaway here is that an individual can choose to either report as an individual or if the group as a whole chooses to report as a group they can do so. Then the reporting methods, as I mentioned, differ between whether or not you choose to report as an individual or as a group.

If you participate as an individual, then the analysis that is done is based on data submitted by the individual rendering NPI within a tax identification number, again, the combination of TIN and NPI. If you're participating via the GPRO, then the analysis is based on the data submitted by the TIN at the TIN level. In order to make the determination if an individual provider is eligible in PQRS, then we will analyze the claims for a unique TIN, either if they are part of a group or that individual NPI/TIN number. We'll identify the NPIs that are under that TIN who render Medicare Part B for services, physician B scheduled services, to determine if those EPs provide services that fall within the PQRS measures denominators.

What does that mean? All of the quality measures have numerators and denominators. The denominator which, if you remember from 5th grade math, that's the number that's at the bottom of the fraction. The denominator would represent all of the possible patients that you would have in your universe, in your office setting, in your practice, that could have services that pertain to a particular quality code or particular quality measure. That would be the denominator. The numerator is for how many of those patients do you actually do the reporting.

To determine providers' eligibility, that's what we mean when we say that we'll analyze the claims to identify the EPs by their NPIs on their claim under the TIN and we look at the codes of the services that are provided and we are able to say, all right, for these types of services, these quality measures that are currently part of PQRS could have been reported for these patients that have that NPI/TIN combination. That's how eligibility is determined. Again, Medicare patients, this is Medicare Part B patients, so if you have Medicare Advantage patients, they do not fall under this program.

We're going to look at first the methods that are available for individual EPs to report. We talked about claims and if you need a tutorial about how to do that, you can go onto the PQRS website, you can go to claims reporting option, and they will go through a very thorough detailed explanation of how the claims form should be filled out, where do the codes go, how many codes you can put on a claim, et cetera, et cetera. I'm going to hold off my spiel about the claims stuff, because claims will be continuing.

Let's now talk about the other reporting mechanisms. Qualified PQRS registry. What is a qualified registry? A registry is an entity that will capture and store clinically-related data and then submits the data to CMS on behalf of the providers or the groups that contract with them. The registry actually provides calculated reporting and performance rates directly to CMS. The data that the registry will submit to CMS would be submitted by the registry in defined XML specifications, which is just a lot of technical speak about how the data must be delivered electronically to CMS.

The registry will take patient data that either comes from the practices or the individuals' EHR or from their paper charts from submitted Part B claims. The providers then submit the data to the registry via a secured web portal, and the registry itself will set up their own portal and you contract with the registry and to make sure that the information is securely sent. Then the registries validate the data, they do any formatting of the data that needs to be done, and it's submitted to CMS prior to the deadline.

CMS establishes deadlines that the registries have to submit data to us. When you enter into a contract with the registry, you will see that the deadlines for you to submit your data to the registry will be ahead of the CMS deadline. For example, I think the deadline this year was March 31st. March 31st is the deadline for all the registries that were participating in the 2015 program to get the data to CMS. If I'm a registry, I could say your deadline provider is to get your data to me, the registry, by let's say February 15th. That gives me time to do the formatting and the submitting and the reporting that needs to be done.

Sometimes we get questions because people will hear, well, March 31st is the deadline, but my registry is telling me February 15th. That's because the only deadline CMS establishes is for the registries. The registries then will establish their own deadlines to make sure that they have time to get the data from you that they need.

If you have a certified electronic health record system in your practice that you can directly submit your quality data through your EHR system, or if you want to just contract with a data submission vendor, you may do that as well. Then starting 2 years ago, we instituted a qualified clinical data registry. That sounds a lot like the qualified registries we talked about, and in a lot of respects they are. The major difference with the QCDR, or qualified clinical data registry, is that the QCDR is not

limited to just measures that are contained or were created for PQRS purposes.

You may find it that it's in your best interest or you may other programs with other payers, for example, that are using a QCDR, and even though they are not fully PQRS only measures, CMS is now allowing those to be included. Now there are some specifications in terms of the minimum amount of PQRS measures that must be included in the QCDR, but we are allowing for the opportunity to report on measures that are outside of PQRS if you opt for an approved QCDR.

Moving over to the group practice reporting options, or GPRO, you will see that the claims reporting option is not available for groups. This is one of the main reasons why groups that have any number of providers within the group opt to report as individuals because a lot of providers and a lot of groups still like to report via their claims. That's not an option at the group level.

The options that are available, we talked about the qualified registry, we talked about the QCDR, we talked about EHR. There is something called the CAHPs for PQRS CMS certified survey vendor. What that is is a 12-point patient-based survey. Basically it's a satisfaction survey, that asks patients to rate the experience of care that they're getting from their providers. Some of the things, and I'm not going to list all of them, but some of the things that that the CAHPs for PQRS survey including are getting timely care appointments and information, access to specialists, shared decision-making between visit communication, et cetera, et cetera.

I will go through when we go through the different reporting options and the requirements for each. There are certain providers and certain groups for which this is going to be mandatory they report the cap survey. For others it is optional. If you do opt for this, some of the additional reporting requirements are a little bit different for you.

Groups also have the opportunity to report using the GPRO web interface which is a repository of 18 measures and you must be able to report on all 18 measures. The group as a whole must be able to report on all 18 measures in order to use that option.

I did not animate these trees because that usually takes a lot of time and I want to make sure that we have time for questions at the end. If you take a look at this, if you follow the arrows, what I've done here is I've started with ... actually, no. I merged the trees here, but if you look at the upper left-hand corner you'll see for whom each of these options pertains. As I mentioned, for the claims option it's available only to individual EPs. You are able to report just on individual measures as opposed to measures groups and we'll talk about that on the next slide.

Now we're going to talk about the actual requirements. You must report on at least 9 measures coming from the 3 domains. I listed what the 6 quality domains were a little bit earlier. What you must do is from 3 of those domains choose at least 9

measures. If you are able to do that, if you are any practice that you can pick 9 measures from 3 domains, that is what you would report. If you see at least 1 Medicare patient face-to-face, telehealth does not count, then you must report on at least 1 cross-cutting measure and report each measure for at least 50% of your Medicare Part B fee-for-service patients during the reporting period, which is the entire year. Reporting period in 2016 is the entire 12-month period. Anything that has a zero performance rate doesn't count, so you can't pick 6 measures, for example, that have zeros and think that's going to count for 6 measures. That does not count.

What if you were in a practice or what if you are a provider and you can't pick 9 measures or you can't find 9 measures that come from 3 domains? Then we do allow reporting on either 1 through 8 measures coming from 1 through 3 of the domains, but there's something called the measure's applicability validation process. We just call it validation. Without going into too much detail, there's a 2-step process by which Medicare can analyze your claims to determine whether or not additional measures could have been reported by a particular NPI/TIN combination. It is not on the onus of the provider to report any additional information on the validation process. That is done strictly through administrative means on claims data.

Now we're going to talk about the qualified registry. This gets a little bit confusing, but if you bear with me, hopefully, we'll be able to walk you through this. There are 2 different types of measures that can be reported through the qualified registry; either individual measures, and that's when you look at the list of the 280-something measures and you try to pick 9 from your 3, or you can report what are known as measures groups. Measures groups, I think, there are 25 groups that are part of the program this year and they all relate around specific conditions. I think there is a diabetes measures group. There is a [million hearts 00:32:54]. Acute or [inaudible 00:32:58], HIV, there's 25 groups. Within each of those measures groups are at least 6 quality measures that make up that group. Some of them have a little bit more, but they all have at least 6.

Only individual EPs, groups cannot report on the measures groups, but if you are an individual EP reporting on your own and you find a measures group that pertains to your scope of practice and you want to report on that measures groups you may do so only through the qualified registry. Measures groups can only be reported by EPs if they're using a registry.

For everybody else who's using a registry it would be individual measures, and we're talking about individual EPs and groups that are 2 to 99 EPs and groups of 100 or more that the CAHP survey does not apply to, and I will explain what that means when we get to the CAHPs slide. The requirement is the same as the claims requirement, 9 measures covering 3 domains. Again, if you don't have 9 measures to report, then that validation process that I talked about would kick in. As you can see, the requirements and the footnotes are the same for both claims and registry. It would be basically reporting the same claims, but you'd be contracting with the

registry to submit the data, validate it, format it, and send it in.

If you were going to use your EHR product or if you're going to use an EHR data submission vendor, then again for individual EPs or for groups of 2 to 99 or groups of 100 or more that cannot do the CAHPs, then you do it directly through your system. It's 9 measures covering at least 3 of the domains. Now the footnote here is slightly different. If your cert does not have patient data for at least 9 measures covering at least 3 domains, then instead of that validation process that I talked about, then what you must report on are the measures for which there is actual Medicare Part B patient data and the EP or the group must report on at least 1 measure for which there is Medicare Part B patient data.

The QCVR, again, the big difference here is PQRS and non-PQRS measures. The same reporting requirement, 9 measures from 3 domains. This footnote is also slightly different of the measures reported via QCVR, that you must report on at least 2 outcome measures, and we have what the specific outcome measures are listed on the website. If 2 outcome measures are not available because they do not pertain to your scope of practice, then you report on at least 1 outcome measure and at least an additional 1 measure from one of the 4 domains that are listed there; patient resource use, patient experience of care, efficiency, or patient safety.

For the GPRO web interface, this pertains only to practices of 25 or more EPs. That is a specific criteria for this reporting method. What you, again, need to do is report on all 18 measures that are included in the GPRO web interface and you also have to populate the data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group sample for each module or preventive care measure. If you don't have 248 beneficiaries, then you report on 100% of your beneficiaries.

I mentioned this CAHPs for survey and I mentioned that for certain group sizes it is mandatory. That started last year, I believe, the mandatory reporting and it continues this year. For groups of 100 or more EPs and when we say 100 or more EPs, EPs are all those provider types that were in those 3 boxes in the slide earlier; so the physicians, the practitioners, and the therapists. If your group is participating, and that means that you registered for the GPRO because you do go through a registration process, by the way, if you elect to do the GPRO option. If you have more than 100 NPIs under you TIN, then you are required to report the CAHPs for PQRS survey.

There are going to be certain groups and CMS has this data that this survey will not pertain to either because of the scope of practice or because of the low volume of beneficiaries to whom the items in the survey would pertain. That's when I said in the earlier slide groups of 2 to 99 EPs or groups of 100 or more that the CAHP survey doesn't apply to. That's what we mean here. For all the other groups of 100 or more EPs, you have to submit the 12-point survey plus do one of these 4 options. Again, it's the same 4 options for their groups; qualified registry, GPRO web interface, direct EHR or data submission vendor, or the QCDR.

Note though, however, with the exception of the GPRO web interface, if you're doing the web interface, you still have to do all 18 of the measures that are on the interface. For the registry, for EHR, and for QCDR, the requirement is reduced to 6 measures from 2 of the domains. You have to make sure that the measures that you are choosing are measures that are not duplicated in the CAHP survey.

Once you choose your reporting method, what's the next step or how do I go through this process? For the qualified registry you're going to work directly with the selected vendor for the PQRS data submission. They will set up the web portal, they will set up the parameters by which you will submit the data. They will give you the deadlines, they will ensure that they will do the formatting and the reporting as we specified. The same thing with the QCDR. You work with the selected [inaudible 00:39:42].

Keep in mind, these qualified registries, they all go through an approval process with PQRS. Like Joe Smith off the street can't decide he wants to be a qualified registry for PQRS. They go through a validation process with us so that we can be assured that they know what they're doing. If you're doing claims-based reporting, then our advice would be to establish an office workflow to allow each chosen measures denominator eligible patient to be accurately identified on the Medicare Part B claim. Again, there are claim samples under the claims reporting section on the website that will tell you exactly where on the claims those codes need to go.

If you're using your EHR, work with your vendor to make sure that your systems are set up and also certified to report PQRS data. With the GPRO web interface, you would work with your internal IT departments because it is a web-based tool. This is not something that have to sign up with a third party or another registry in order to do that, so you would work with your internal IT departments to ensure that you are fulfilling your requirements for web-based reporting. Then the CAHPs for PQRS survey, you would contract with a certified vendor and, again, they go through an approval process to administer and to collect the data for your survey.

As I mentioned, there are probably about 280 measures. How do you actually go about and select the measures? The best tool that we have right now is the PQRS measures codes webpage which you should be able to link from the electronic version of this slide deck. The way that the measures list is set up, there's also a web-based tool that you can do a search. They have filters that allow you to search by the actual codes, either ICD-10 codes, CPT, or HCPCS codes across all measures and for all reporting mechanisms.

You also need to keep in mind that even though we have 280-some-odd measures, not all 280 measures can be reported using all of the methods. For example, I'm pretty sure that for EHR, I still think there's 64 because with the EHR reporting system, for those of you who are familiar with that on the provider side, there is a set of 64 clinical quality measures, the CQM part. Those are the same measures that are part of PQRS.

Once you decide the reporting mechanism that you're going to use and the reporting method, you have to be sure or maybe you'd do this conversely, you'd figure out the codes that you can report is probably the better way to do it. Figure out what codes pertain to your scope of practice and then look at to see what methods are available for reporting those particular codes because all 280 are not available for all of the methods that we talked about.

I also mentioned our expansion of codes as it pertains to specialties. About a year or 2 ago we started working with National Specialty Societies across the country to try to develop what we call a suggested or recommended list of measures that pertain to specific specialties. We had 12, I think, last year when we published our first list and we added 5 for this year. There's currently 17 specialties that have documents on our website that say if you are in hematology, for example, or if you are an obstetrician or cardiology, these are measures that most likely would pertain to your scope of practice. These are by no means required. They are just suggestions.

Maybe there's a measure in there that you didn't see or you didn't think of actually pertaining to your practice. If you do fall into a specialty that's outside of a family practice or general practitioners, it's a good idea to take a look at those specialty measures.

Some of the things that you should take into consideration when you decide on the measures, what are the clinical conditions that you are treating? When your patients come in, what are you treating them for and then review diagnosis coding and the measures denominator. I explained what the denominator is, if it's applicable. Also the setting where care is usually delivered; the office, the emergency department, the surgical suite. That will determine the measures that you can report. When we talked about eligibility in terms of what the law and what the statute says the provider types that are eligible for, we said that the place of service didn't really matter in terms of eligibility. It will come into play when you go to select your measures.

Payment adjustments, so we talked a little bit about payment adjustments and, again, these are specific to the Medicare Part B. Now for critical access hospitals and hospitals, some of these adjustments are a little bit different, but each of these programs and, again, this is Medicare Part B because we actually look at the cost reports for the given year to determine the adjustments. For the Medicare Part B when we're talking the Medicare Part B physician, we always had this idea of a 2-year look back period. That means for a year that a payment adjustment would have to be applied, we look back 2 years to the activity to determine if a payment adjustment is going to take effect.

This year, 2016, is the year that we're looking at for the 2018 payment adjustment. This is the slide that's supposed, I guess, scare you into really considering doing these programs if you've not done so. For not doing PQRS, if you are eligible and if

you're in a Method II CAH and you're now eligible, it's a 2% reduction of Medicare fee-for-service claims for 2018. Anything that's billed directly to the hospital would not be affected.

The same thing for EHR. The Medicare EHR incentive program, it's a 3% payment adjustment for not doing meaningful use in 2016. I'm not going to go into detail because I'd say we're running short on time, but the value-based payment modifier, that is an entirely separate presentation that if need be, we could do in the future. There are additional reductions in 2018.

The takeaway from all this is that 2018, as I mentioned, is the last year that those particular payment adjustments will be in effect because the [inaudible 00:46:48] legislation that I mentioned earlier sunsets those 3 payment adjustments, those 3 programs for Medicare Part B providers in anticipation for the beginning of MIPPS and APMs.

I'm just going to quickly go through these relationships with other quality reporting programs. You can go through this and I think we touched on this. With the EHR program there's the opportunity to align the reporting requirements for both programs if you're using your EHR system and to avoid the payment adjustments for each. The value-based payment modifier, as I mentioned, if you don't report PQRS and you are eligible for PQRS, then not only is it the 2% payment adjustment but if you are a certain provider type in a group of a certain size, you could get additional downward adjustments for the value modifier. I mentioned that information on PQRS will be made available on the physician compare website.

I'm going to finish up with a few FAQs and we basically, I think, answered all of these questions throughout our discussion, but I wanted to have them here just for your viewing. If you furnish professional Medicare Part B services only at a rural health clinic or a federally qualified health center, are those services eligible for PQRS? The answer is no if the Part B professional services only at the RHC are the only services that you are billing and they are being billed under the RHC or FQHC methodologies.

If you're an EP and you furnish Medicare Part B services at an RHC or FQHC and also furnish services at a non-RHC/FQHC setting, are the non-RHC/FQHC services eligible for the payment adjustment? The answer is?

Barbara Connors: Yes.

Patrick: Yes, and you can go through and basically read the answer there. Again, it goes back to anything billed outside of the RHC/FQHC payment methodology that is then billed to Medicare Part B per the NPI/TIN combination. Those are the 3 takeaways.

Under what circumstances are professional Medicare B services furnished by an EP at a setting outside the RHC/FQHC setting subject to the payment adjustment?

Then there are 2 circumstances. Either the non-RHC/FQHC services furnished by the EP are billed under his or her own TIN/NPI combination, again, as reported in PECOS and they didn't do the reporting.

Keep in mind that even if the services were physically done in the clinic but were billed to Medicare Part B, the payment adjustment goes to the provider at the clinic as an entity is not held responsible. There is some confusion because letters to individual EPs who work at the clinics were sent to the clinic's address and when whoever opened the letter read this, they thought that the clinic was getting penalized. That's not the case. It just happens that on file we only have the address for these individual EPs working at the clinic. Then also the second circumstance in which there could be a payment adjustment assessed is if the EP furnished their bill under a group practice's TIN that registered to participate in PQRS but did not submit the appropriate data.

We talked about EPs who furnished professional Medicare B services at a CAH, and the CAH is Method II, are they eligible. The answer again should be yes. Any EP who furnishes Medicare B services at a CAH and the CAH is paid under Method II may be eligible for PQRS beginning in 2014. That was for the incentive payment because there was an incentive payment that was available up to 2014. Then the 2016 PQRS negative payment adjustment if they did not report. Again, those adjustments would continue through 2018.

If you are a CAH provider paid under Method II, am I required to report line item rendering NPI information? You would be required if it is different than the rendering NPI at the claim level.

These are the resources that you want to go to for all the programs that I talked about, so not only PQRS, but also EHR, value modifier physician compare. Again, if you're looking quickly to get to PQRS, just type in CMS PQRS and google. It will take you right there. The menu on the left-hand side of the page is very helpful. If this is completely new to you, I strongly suggest that you look at the how to get started page. There are some very, I think, reader-friendly documentation. It's not all legislative and administrative gobbledygook. I think we've got a little bit better in trying to make this a little bit more comprehensible for you.

With that, we have about 10 minutes ... and our contact information, of course. If we can't answer your questions then I think that if you want to just contact us directly off line. We get into a little bit of a thing about trying. There was a question about whether or not we can have an FAQ answer sheet and anything that we would officially release. FAQ has to go through a clearance process, so if you have questions, it's just best to send us an email afterwards.

Laurie, if you want to open the phones and see if we can answer a few?

Laurie : Yeah, actually we're going to start with some of the questions that were submitted via the chat and once we've gone through all those, I'll go ahead and open up the

phone lines.

Here's our first question for today. We are a critical access hospital with ER Part B billing only. In 2015 we had 19 [inaudible 00:53:03] but did not sign up for GPRO in time. We did individual data submission. Could we do GPRO in 2016, but would we have to do the CAHPs PQRS?

Patrick: Okay, so I believe that you have until June 30th to register your intent to participate in GPRO, so there is a deadline. You still have time to do that. The process to do that, you can again look at the how to get started page and look at GPRO reporting options. They'll actually take you to the link where you would sign up to do that. I think that has to be done by June 30th.

Also if you only have 19 providers in your practice, you are not required to do the CAHP survey. The mandatory requirement is only for groups that have more than 100. However, if you do want to do the survey, that is an option if you signed up for GPRO. Then in addition, you just go back and have to do one of those additional 4 reporting methods. If you do a registry, if you do EHR, or if you do the QCDR, it's just 6 additional measures from at least 2 of the quality domains. If you're going to use the web interface, you have to do all 18 measures, and that would be in addition to the 12-point survey that you're reporting.

Barbara Connors: We have a lot of information on our website for your particular scenario with 19 providers to report the CAHPs measures as well, the benefits to doing so.

Okay, next one.

Laurie : Yes, the next question asks what makes critical access hospitals different from meaningful use objectives and reporting purposes?

Patrick: Well, that's actually in the regulations. I'm assuming you mean for EHR for the meaningful use program?

Laurie : I believe so.

Patrick: Yeah, that was actually set up in the regulations. The reporting requirements for individual EPs, Medicare and actually Medicaid EPs are slightly different than for hospitals that are not critical access hospitals, IPPS, or OPSS hospitals, and critical access hospitals. The major difference is you have 2 things that you have that make up meaningful use. You have the meaningful use objectives and measures and you have the clinical quality measures.

Now the reporting of the objectives, we streamlined the reporting of the objectives and measures last year. We are down to, I believe, I think it was 10 on the provider side and 9 on the hospital side. There was 1 less. You don't have to do secure messaging. For the CQMs I believe and I have to look at this again because it's been a while, but I know the Medicare providers report on 9 measures. Hospitals report,

I think, on 15. There have been no changes to the reporting of the quality measures for meaningful use. There were some changes to the objectives and measures. Those are really the main differences.

You now have 1 less objective to report on. You have a few more quality measures to report on, but that's been the case since the program started in 2011.

Barbara Connors: There's one other caveat. If you are reporting CQMs through your EHR to satisfy the PQRS reporting requirements, and only part of the group is reporting the CQMs, you will not get credit for every NPI in the group for the CQM reporting portion for EHR. I know it sounds as clear as mud, but keep in mind that if you are choosing to report through your EHR, choosing from the 64 CQMs, yes, it does satisfy the EHR reporting CQM requirements, but only for those NPIs that are reporting the PQRS within the group.

Patrick: Yeah, this is where the confusion really sets in because how many times did I say with PQRS, it's TIN/NPI driven. With meaningful use on the provider side, it's just NPI and your meaningful use activity follows you. Not necessarily the case with PQRS.

Barbara Connors: Any other questions in the queue?

Laurie : Yes, we have 1 more question. Messaging is a challenge in many parts of Pennsylvania. What should the rural areas do to meet this objective since they have a smaller network?

Patrick: You mean direct messaging for EHR?

Laurie : Yes.

Barbara Connors: Is it out of the hospital or a practice site?

Patrick: Yeah, because for a hospital direct messaging is not one of the objectives. If you're talking about the direct messaging requirement for individual EPs on the Medicare side, we talked about the streamlining of the measures and the requirements were greatly reduced for last year and this year. For 2016, the requirements for direct secure messaging is just 1 patient send or receive a message via the certified EHR.

As of right now the requirement does go back to 5% next year and I'm not sure when we move into MIPPS for 2019 what the requirement's going to be. At least for 2016 the requirement for secure messaging is just 1 patient.

Barbara Connors: Practices have become very creative, especially in the more rural areas where some practices have actually put a computer in the waiting room and given the temporary password to patients where they actually encourage the patients to sign up for the direct messaging. You'd be surprised at how many of your veterans are using the VA portal and they're actually quite savvy in communicating back and

forth with the VA. That's just something to keep in mind.

Do we have any more? No?

Laurie :

We are nearing the top of the hour and the webinar will conclude in a few moments, so if there are any additional questions that we may not have had time to address today, please email our presenters and you'll see their contact information is displayed on the screen.

At this time I would like to thank Patrick and Dr. Connors for sharing such an informative presentation with us today, and many thanks to everyone for joining us. In a few moments you will receive an evaluation. Please take a minute to complete it. Your input helps us plan future programs.

Thanks again for joining us, and have a great day. The session has now concluded.