

Public Town Hall 2012 Physician Quality Reporting System (Physician Quality Reporting)

CMS Auditorium or via
Teleconference/WebEx

February 9, 2011

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Agenda



- 10:00-10:15 Welcome and Opening Remarks-**Michael Rapp, MD/Aucha Prachanronarong**
- 10:15-10:35 Individual Physician Quality Reporting System Measure Suggestions Submitted
Measures Groups Suggestions Submitted
Physician Quality Reporting System Measure Work
Timeline Process for Measure Developers-**Jacquelyn Kosh-Suber**
- 10:35-12:00 **Public Comment**
- 12:00-1:00 Lunch Break
- 1:00-1:15 Reporting Options for Individual Eligible Professionals
Electronic Prescribing (eRx) Overview-**Daniel Green, MD**
GPRO I & II Reporting-**Regina Reymann Chell**
- 1:15-2:15 **Public Comment**
- 2:15-2:30 Break
- 2:30-2:35 Maintenance of Certification Program Incentive-**Molly MacHarris**
- 2:35-2:40 Feedback-**Christine Estella**
- 2:40-2:45 Informal Review Process-**Christine Estella**
- 2:45-2:50 Physician Quality Reporting System Beyond 2012 (payment adjustment, aligning with other physician quality initiatives, value-based modifier and Physician Compare)-**Aucha Prachanronarong**
- 2:50-3:50 **Public Comment**
- 3:50-4:00 Closing Remarks- **Aucha Prachanronarong**
- 4:00 Adjourn

Michael Rapp, MD/Aucha Prachanronarong

Welcome and Opening Remarks

Session Purpose



- ◆ CMS continues to seek ways to improve the Physician Quality Reporting System
- ◆ Receive input on suggestions for Individual Quality Measures or Measures Groups (includes creation of new Measures Groups from existing measures)
- ◆ Receive insights from stakeholders for key components of the design of the Physician Quality Reporting System program
- ◆ All feedback from this Town Hall will be considered, and may be incorporated into the 2012 Medicare Physician Fee Schedule Proposed Rule

Program Background



- ◆ Physician Quality Reporting is a reporting program that began in 2007 with 74 quality measures (formerly PQRI)
- ◆ Over time, the program has expanded the number of measures and reporting options to facilitate quality reporting by a broad array of eligible professionals
 - ◆ Currently more than twice the quality measures available than at inception of program
 - ◆ Eligible professionals may report quality measures via:
 - ◆ Claims
 - ◆ Qualified Registry
 - ◆ Qualified EHR

Program Background



- ◆ Eligible professionals (or group practices) who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B beneficiaries will qualify to earn 2012 incentive payment of 0.5%
 - ◆ Incentive is a percentage of the eligible professional's (or group's) estimated total Medicare Part B PFS allowed charges

2012 Goals for Physician Quality Reporting System



- ◆ Increase participation
- ◆ Leverage the benefits of alternative reporting
- ◆ Encourage the adoption and use of electronic prescribing
- ◆ Further alignment with other initiatives

Jacquelyn Kosh-Suber

**Individual Physician Quality Reporting System
Measure Suggestions Submitted**

Measure Group Suggestions Submitted

**Physician Quality Reporting System Measure Work
Timeline Process for Measure Developers**

Individual Physician Quality Reporting System Measure Suggestions Submitted



- ◆ Received suggestions from 17 requestors
 - ◆ Total of 91 measures requested for 2012 Call for Measures
 - ◆ 8 measures NQF endorsed
 - ◆ 30 Individual measures are in NQF process
 - ◆ 53 measures not NQF endorsed

- ◆ Suggested topics are varied and may potentially impact a large number of Medicare participants

Individual Physician Quality Reporting System Measure Suggestions Submitted (cont.)



Topic examples suggested for individual measures:

- ◆ Otitis Media with Effusion
- ◆ Inflammatory
- ◆ Chronic Wound Care
- ◆ Endoscopy and Polyp Surveillance
- ◆ Oncology
- ◆ Substance Use Disorders
- ◆ Coronary Artery Disease
- ◆ Irritable Bowel Syndrome
- ◆ Chronic Obstructive Pulmonary Disease
- ◆ Abdominal Aortic Aneurysm
- ◆ Colon Cancer Screening
- ◆ Atrial Fibrillation
- ◆ Hypertension
- ◆ Dementia
- ◆ Depression
- ◆ Barrett's Esophagus
- ◆ Cytopathology
- ◆ Immunohistochemical Evaluation
- ◆ Anticoagulation for Pulmonary Emboli
- ◆ Sleep Apnea
- ◆ Biopsy
- ◆ Cataract

Physician Quality Reporting System Measures Group Suggestions Submitted



Summary of Measures Groups analysis:

- ◆ Received suggestions from 6 requestors
- ◆ 8 measures groups suggested for 2012 Physician Quality Reporting
- ◆ New clinical topics:
 - ◆ Cataracts
 - ◆ Pulmonary Rehabilitation
 - ◆ Chronic Obstructive Pulmonary Disease
 - ◆ Irritable Bowel Syndrome
 - ◆ Colon Cancer Screening
 - ◆ Dementia

Lists for Individual Measures and Measures Groups



- ◆ List of these measures are posted on CMS Sponsored Calls section of CMS Physician Quality Reporting website
 - ◆ <http://www.cms.gov/pqri> > CMS Sponsored Calls > Downloads

Physician Quality Reporting System Measure Work Timeline Process for Measure Developers



- ◆ Measure development process
 - ◆ Approximately 12-18 months at a minimum for measure development
 - ◆ Measure and/or measures groups submission
 - ◆ Verification of NQF status
 - ◆ Collaboration between Measure Owner and CMS for measure specification development/refinement
 - ◆ Implementation of measure and/or measures groups
- ◆ Regulatory process
 - ◆ Proposed Rule and public comment period
 - ◆ Final Rule
- ◆ CMS prefers NQF-endorsed measures

Physician Quality Reporting System Measure Work Timeline Process for Measure Developers (cont.)



- ◆ CMS invites stakeholders to provide input on the following issues:
 - ◆ How can individual quality measures and measures groups be expanded to be collected through qualified* EHR
 - ◆ Can quality-data codes, instructions, and specifications for new measures and revised measures be completed to meet CMS deadlines
 - ◆ What are suggestions for considering retirement of quality measures
 - ◆ What activities can CMS and stakeholders undertake to improve education and outreach for participants
 - ◆ Suggestions for measures not particularly relevant to quality improvement (by not addressing improvement in outcomes, patient safety or health results)
 - ◆ Which broadly applicable measures should CMS consider including in a core measure set
 - ◆ Which specialties, if any, lack relevant measures
 - ◆ Should CMS also consider grouping measures by relevance to a particular specialty
 - ◆ Incorporation of ICD-10-CM codes

* *EHR vendors must successfully complete a vetting process in order to be considered CMS "qualified" for 2011 Physician Quality Reporting*

Physician Quality Reporting System Measure Work Timeline Process for Measure Developers (cont.)



◆ Transition to ICD-10-CM for Physician Quality Reporting

◆ ICD-9-CM

- ◆ ICD-9-CM code set is outdated
- ◆ ICD-9-CM codes cannot reflect current medical technologies
- ◆ Many code chapters are full, resulting in code placement in non-related chapters
- ◆ Current codes are often not descriptive enough

◆ ICD-10-CM

- ◆ More codes, greater specificity
- ◆ Greater flexibility to add new codes
- ◆ Reflects current use of medical technology

Physician Quality Reporting System Measure Work Timeline Process for Measure Developers (cont.)



◆ ICD-10-CM implementation

- ◆ Reach extends into policies, business process, and systems
- ◆ Requires broad business and systems focus

◆ Consideration points for implementation of ICD-10-CM

- ◆ Possible quality measure freeze
- ◆ Possible changes to measure denominator/numerator
- ◆ Possible effects to quality measure analytics
- ◆ Possible effects to feedback reports for eligible professionals

2012 Physician Quality Reporting Measure Work Timeline



- ◆ **July 2011**
PFS Proposed Rule published for Public Comments on 2011 Physician Quality Reporting & eRx
- ◆ **October 2011**
Measure specifications review meeting
- ◆ **October 29, 2011**
2011 HCPCS tape published (all codes due as stated above)
- ◆ **November 2011**
PFS Physician Quality Reporting & Electronic Prescribing (eRx) Final Rule is published
- ◆ **November 2011**
Web posting of final 2012 Physician Quality Reporting & eRx measure specifications and supporting documents

Public Comment

Lunch

Daniel Green, MD

Physician Quality Reporting Options for Individual Eligible Professionals

Physician Quality Reporting: Options



- ◆ 2011 has two reporting periods:
 - ◆ 12-month (January 1-December 31)
 - ◆ 6-month (July 1-December 31)-this option is not available for EHR reporting
- ◆ 2011 reporting options available:
 - ◆ Claims-based
 - ◆ Registry-based
 - ◆ EHR-based
 - ◆ GPRO I and II (GPRO II is new for 2011)
- ◆ See *2011 Physician Quality Reporting Decision Tree* in *2011 Physician Quality Reporting Implementation Guide* for complete list

Reporting Criteria Individual Measures



Reporting Mechanism(s)	Reporting Period(s)	Criteria for Satisfactory Reporting of Individual Measures
Claims	Jan 1, 2011- Dec 31, 2011 or July 1, 2011- Dec 31, 2011	Report at least 3 Physician Quality Reporting System measures, (or 1-2 measures if fewer than 3 apply*); and Report each measure for at least 50% of applicable Medicare Part B FFS patients seen during the reporting period (revised)

*Eligible professionals who report on fewer than 3 measures may be subject to the Measure-Applicability Validation process.

Reporting Criteria Individual Measures (cont.)



Reporting Mechanism(s)	Reporting Period(s)	Criteria for Satisfactory Reporting of Individual Measures
Registry	Jan 1, 2011 - Dec 31, 2011 or July 1, 2011- Dec 31, 2011	Report at least 3 Physician Quality Reporting System measures*; and Report each measure for at least 80% of applicable Medicare Part B FFS patients seen during the reporting period
EHR	Jan 1, 2011- Dec 31, 2011	Report at least 3 Physician Quality Reporting System EHR measures*; and Report each measure for at least 80% of applicable Medicare Part B FFS patients seen during the reporting period

*Measures with a 0% performance rate will not be counted (**new**)

Reporting Criteria Measures Groups (cont.)



Reporting Mechanism(s)	Reporting Period(s)	Criteria for Satisfactory Reporting of Measures Groups
Claims or Registry	Jan 1, 2011- Dec 31, 2011	Report at least 1 Physician Quality Reporting System measures group*; and Report each measures group for at least 30 <i>unique</i> Medicare FFS patients seen during the reporting period**

*For registry-based reporting, measures groups with a 0% performance rate will not be counted **(new)**

Eligible professionals reporting measures groups using the registry-based reporting mechanism will no longer be able to report on non-Medicare FFS patients **(new)

Reporting Criteria Measures Groups (cont.)



Reporting Mechanism(s)	Reporting Period	Criteria for Satisfactory Reporting of Measures Groups
Claims	Jan 1, 2011- Dec 31, 2011	<p>Report at least 1 Physician Quality Reporting System measures group;</p> <p>Report each measures group for at least 50% of applicable Medicare Part B FFS patients seen during the reporting period (revised); and</p> <p>Report each measures group for at least 15 Medicare Part B FFS patients seen during the reporting period</p>

Reporting Criteria Measures Groups (cont.)



Reporting Mechanism(s)	Reporting Period	Criteria for Satisfactory Reporting of Measures Groups
Claims	<u>July 1, 2011-</u> Dec 31, 2011	Report at least 1 Physician Quality Reporting System measures group; Report each measures group for at least 50% of applicable Medicare Part B FFS patients seen during the reporting period (revised); and Report each measures group for at least 8 Medicare Part B FFS patients seen during the reporting period

Reporting Criteria Measures Groups (cont.)



Reporting Mechanism(s)	Reporting Period(s)	Criteria for Satisfactory Reporting of Measures Groups
Registry	Jan 1, 2011- Dec 31, 2011	<p>Report at least 1 Physician Quality Reporting System measures group*;</p> <p>Report each measures group for at least 80% of applicable Medicare Part B FFS patients seen during the reporting period; and</p> <p>Report each measures group for at least 15 Medicare Part B FFS patients seen during the reporting period</p>

*Measures groups with a 0% performance rate will not be counted (**new**)

Reporting Criteria Measures Groups (cont.)



Reporting Mechanism(s)	Reporting Period(s)	Criteria for Satisfactory Reporting of Measures Groups
Registry	<u>July 1, 2011-</u> Dec 31, 2011	<p>Report at least 1 Physician Quality Reporting System measures group*;</p> <p>Report each measures group for at least 80% of applicable Medicare Part B FFS patients seen during the reporting period; and</p> <p>Report each measures group for at least 8 Medicare Part B FFS patients seen during the reporting period</p>

*Measures groups with a 0% performance rate will not be counted (**new**)

Physician Quality Reporting



- ◆ CMS invites stakeholders to provide input on the following issues:
 - ◆ Advantages/disadvantages of the various reporting mechanisms (e.g., claims, registries, EHRs)
 - ◆ Advantages/disadvantages of continuing claims-based reporting mechanism availability in light of other reporting options
 - ◆ How can CMS begin to phase-out claims based reporting without creating unintended barriers to participation
 - ◆ Are current reporting periods adequate
 - ◆ Are three measures appropriate for eligible professional individual reporting
 - ◆ Consider impact to eligible professionals if the expectation to report on all denominator eligible cases is implemented
 - ◆ Should CMS identify relevant measures and/or measures groups for specialty eligible professionals based on claims data
 - ◆ How should CMS ensure an eligible professionals' self-designated specialty information is accurate
 - ◆ Implications if a set of broadly applicable measures are applied regardless of specialty
 - ◆ Implications if CMS requires reporting on one measures groups, unless no measures groups are applicable

Daniel Green, MD

Electronic Prescribing (eRx)

Physician Quality Reporting: Electronic Prescribing (eRx)



- ◆ eRx is the transmission of prescriptions or prescription-related information through electronic media
- ◆ eRx takes place between a prescriber, dispenser, pharmacy benefit manager, or health plan
 - ◆ Can take place directly or through an intermediary (eRx network)
- ◆ No registration required for eRx program:
 - ◆ Individual eligible professionals begin by reporting G-Code when appropriate
 - ◆ Groups self-nominating for 2011 GPRO I or II must indicate whether they intend to report on the eRx measure as a group practice or individually

Physician Quality Reporting: eRx (cont.)



- ◆ The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized the Medicare eRx Incentive Program beginning in 2009 to promote adoption/use of eRx systems
- ◆ Provides a combination of incentive and payment adjustment for individual eligible professionals and group practices who electronically prescribe
- ◆ See <http://www.cms.gov/ERXincentive>

Physician Quality Reporting: eRx (cont.)



- ◆ A “successful electronic prescriber”, eligible to receive an incentive payment, must generate and report one or more electronic prescriptions associated with a patient visit
 - ◆ A minimum of 25 unique visits per year is required for individual and varies for selected group practices based on group size (75-2500 unique visits)
 - ◆ Each visit must be accompanied by the eRx G-code attesting that during the patient visit at least one prescription was electronically prescribed
 - ◆ Electronically generated refills do not count (unless associated with patient encounter) and faxes do not qualify as eRx prescriptions
 - ◆ New prescriptions not associated with a code in the denominator of the measure specification are not accepted as an eligible patient visit and do not count towards the minimum unique eRx events

Physician Quality Reporting: eRx (cont.)



2012 Payment Adjustment

- ◆ Reporting Period: January 1–June 30, 2011
- ◆ Reporting Mechanism: Claims
 - ◆ Payment adjustment does not apply if <10% of an eligible professional's (or group practice's) allowed charges for the January 1–June 30, 2011 reporting period are comprised of codes in the denominator of 2011 eRx measure **or** do not have 100 events based on same codes
- ◆ Earning an eRx incentive (25 unique eRx events for between January 1 and December 31, 2011) for 2011 will **not** exempt an eligible professional or group practice from the payment adjustment (must submit 10 unique eRx events via claims between January 1 and June 30, 2011)
- ◆ Is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of June 30, 2011 based on primary taxonomy code in NPPES

2013 Payment Adjustment

- ◆ Reporting Period: January 1–December 31, 2011
- ◆ Reporting Mechanism: Claims, Registry, EHR
 - ◆ Payment adjustment does not apply if <10% of an eligible professional's (or group practice's) allowed charges for the January 1–December 31, 2011 reporting period are comprised of codes in the denominator of 2011 eRx measure
- ◆ Earning an eRx incentive (25 unique eRx events via one method between January 1 and December 31, 2011) for 2011 **will** exempt an eligible professional or group practice from the payment adjustment
- ◆ Is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of June 30, 2011 based on primary taxonomy code in NPPES

Physician Quality Reporting:

eRx (cont.)



- ◆ CMS may, on a case-by-case basis, exempt an eligible professional from the application of the eRx payment adjustment if compliance with the requirement for being a “successful electronic prescriber” would result in a significant hardship
- ◆ This exemption is subject to annual renewal
- ◆ For the 2012 eRx payment adjustment, the following circumstances would constitute a hardship:
 - ◆ The eligible professional practices in rural area with limited high-speed internet access (G8642)
 - ◆ The eligible professional practices in an area with limited available pharmacies that can receive electronic prescriptions (G8643)

Physician Quality Reporting: eRx (cont.)



- ◆ CMS invites stakeholders to provide input on the following issues:
 - ◆ Are reporting thresholds appropriate for eRx incentive payment
 - ◆ Are reporting thresholds appropriate for eRx 2012 payment adjustment
 - ◆ Additional eRx hardship circumstances
 - ◆ Possible changes to 2011 eRx measures
 - ◆ Advantages/disadvantages of switching to Part D data for incentive/payment adjustment
 - ◇ Appropriate number/threshold of eRx Part D prescriptions for incentive/payment adjustment eligibility for individual eligible professionals and group practice
 - ◆ Alignment of eRx incentive program with EHR incentive program

Regina Reymann Chell

Group Practice Reporting Option (GPRO) I & II

How to Participate in GPRO for 2011



- ◆ To be eligible for 2011 GPRO, potential participants must:
 - ◆ Meet “group practice” definition: 2 or more eligible professionals under a single Tax Identifier Number (TIN)
 - ◆ Have billed Medicare Part B on or after January 1, 2010 and prior to October 29, 2010
 - ◆ Must have self-nominated by January 31, 2011
 - ◆ For 2011 GPRO I, current 2010 GPRO participants must have notified CMS via e-mail of plans for continued participation
 - ◆ Provided group practice’s TIN
 - ◆ Agreed to attend/participate in mandatory training sessions and kick-off meeting
 - ◆ Met certain technical and/or other requirements
 - ◆ Be selected by CMS to participate

2011 GPRO I



- ◆◆ GPRO I: self-nominated group practices with 200 or more eligible professionals
 - ◆ Complete pre-populated 2011 Group Practice I Reporting Tool for an assigned set of Medicare beneficiaries
 - ◆ 26 total measures (4 disease modules + 4 individual preventive care measures)
 - ◆ Access to tool no later than first quarter of 2012
 - ◆ Data for the 2011 reporting period will be submitted in 2012

2011 GPRO II



- ◆ GPRO II: group practices with 2-199 eligible professionals (new for 2011)
 - ◆ CMS will select approximately 500 groups meeting eligibility requirements
 - ◆ No data collection tool; will use:
 - ◇ *2011 Physician Quality Reporting System Individual Measure Specifications for Claims and Registry*
 - AND
 - ◇ *2011 Physician Quality Reporting System Measures Groups Specifications Manual*

2011 GPRO II (cont.)



- ◆ Reported via claims, unless the only applicable measures group(s) is registry-only
- ◆ Groups intending to submit 2011 data through a Qualified Registry
 - ◆ Qualified EHR and registries will be posted on the CMS website in the summer of 2011

Group Practice Reporting Option



- ◆ CMS invites stakeholders to provide input on the following issues:
 - ◆ How should CMS expand GPRO I measures to facilitate participation in GPRO I by specialty practices
 - ◇ Should there be specialty-specific measure sets
 - ◆ Definition of “group practice” to accurately reflect how group practices conduct business and/or operate
 - ◇ Methods for associating an individual eligible professional with a group practice
 - ◆ Consideration for expanding GPRO I to smaller group practices
 - ◇ If expanded, should reporting requirements be revised
 - ◆ Consideration for expanding GPRO II to larger group practices
 - ◇ If expanded, should reporting requirements be revised

Public Comment

Break

Molly MacHarris

Maintenance of Certification Program Incentive – Reporting Requirements

2011 Maintenance of Certification Program Incentive



- ◆ Beginning in 2011, physicians can receive an additional 0.5% incentive payment. In order to qualify for the incentive payment, physicians will need to complete the following:
 - ◆ Satisfactorily submit data, without regard to method, on quality measures under Physician Quality Reporting, for a 12-month reporting period either as an individual physician or as a member of a selected group practice

AND

- ◆ “More frequently” than is required to qualify for, or maintain board certification:
 - ◆ Participate in a Maintenance of Certification Program, and
 - ◆ Successfully complete a qualified Maintenance of Certification Program practice assessment

2011 Maintenance of Certification Program Incentive (cont.)



- ◆ A “Maintenance of Certification Program” is a continuous assessment program that advances quality and the life-long learning and self-assessment of board-certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills, and professionalism. Such a program shall require a physician to do the following:
 - ◆ Maintain a valid, unrestricted medical license in the United States
 - ◆ Participate in educational and self-assessment programs that require an assessment of what was learned
 - ◆ Demonstrate through a formalized, secure examination that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty
 - ◆ Successfully complete a qualified Maintenance of Certification program practice assessment, including patient experience survey

2011 Maintenance of Certification Program Incentive (cont.)



- ◆ Maintenance of Certification vendors/registries/entities will manage the program for physicians
- ◆ Any organization may self-nominate provided:
 - ◆ The entity can demonstrate how the Maintenance of Certification Program meets definition
 - ◆ Define “more frequently” the activities for practice assessment physician participation
 - ◆ Define “more frequently” for completion of practice assessment
- ◆ A listing of the conditionally qualified entities will be posted on the CMS website Spring 2011
- ◆ Individual physicians do not need to self-nominate
 - ◆ Physicians will need to work directly with the entity to complete the Maintenance of Certification required activities during 2011
- ◆ The qualified entity will submit 2011 information during the February-March 2012 submission period on behalf of physicians

2011 Maintenance of Certification Program Incentive (cont.)



- ◆ Potential 0.5% incentive only applies to those physicians who qualify for a 2011 Physician Quality Reporting incentive
 - ◆ Incentive for physicians only
- ◆ Incentive will be paid at the same time as the 2011 Physician Quality Reporting incentive for those physicians who qualify
 - ◆ Identified separately on the 2011 feedback report
- ◆ Physicians cannot receive more than one additional 0.5% incentive even if they complete a Maintenance of Certification Program in more than one specialty

2011 Maintenance of Certification Program Incentive (cont.)



- ◆ Please refer to <http://www.cms.gov/pqri> > Spotlight
 - ◆ See *Requirements of Self-Nomination for 2011*
- ◆ CMS has issued additional guidance on the “more frequently” requirement for the Maintenance of Certification Program Incentive
 - ◆ See <http://www.cms.gov/pqri/> > Overview > Downloads
- ◆ Maintenance of Certification Program Incentive self-nomination letters must have been received by January 31, 2011
 - Please refer to <http://www.cms.gov/pqri> > Spotlight
 - ◆ See *Requirements of Self-Nomination for 2011*

2011 Maintenance of Certification Program Incentive (cont.)



- ◆ CMS invites stakeholders to provide input on the following issues:
 - ◆ Should CMS consider collecting patient experience survey results in the future:
 - ◆ Level of information used and collected
 - ◆ Should type/format limitations be considered
 - ◆ Should physicians who satisfactorily report Physician Quality Reporting for 6 months be eligible for Maintenance of Certification Incentive
 - ◆ Expanding incentive to include all eligible professionals
 - ◆ Ways CMS can apply the “more frequently” requirement to increase provider participation in Maintenance of Certification Incentive Program

Christine Estella

Timely Feedback

Feedback Reports



- ◆ The Affordable Care Act requires CMS to provide timely feedback to eligible professionals
- ◆ Feedback report evolution
 - ◆ Since the inception of the Physician Quality Reporting System (formerly known as PQRI) in 2007, the program has provided feedback reports at the TIN/NPI level to eligible professionals who participated
 - ◆ Feedback reports provide reporting and performance information
 - ◆ For 2011, CMS will continue to provide feedback reports on or about the time of incentive payment distribution
 - ◆ For 2012, CMS anticipates providing additional interim feedback reports

Feedback Reports (cont.)



- ◆ CMS invites stakeholders to provide input on the following issues:
 - ◆ Frequency of feedback reports
 - ◆ Beneficial information for inclusion in annual feedback reports
 - ◆ Beneficial information for inclusion in interim feedback reports

Christine Estella

2011 Informal Review Process

2011 Informal Review Process



- ◆ CMS is implementing an Informal Review Process for the program year 2011 Physician Quality Reporting System
- ◆ Will provide eligible professionals who were not incentive eligible for 2011 the opportunity to request a review of that determination

2011 Informal Review Process (cont.)



◆ Time Limitations

- ◆ An eligible professional must request an informal review within 90 days of the release of his/her feedback report

◆ Method of Informal Review Request

- ◆ Eligible professional may request informal review by notifying the QualityNet Help Desk via email at qnetsupport@sdps.org
- ◆ The request for review must state:
 - ◆ Concern(s) of the eligible professional
 - ◆ Reason(s) for requesting an informal review

2011 Informal Review Process (cont.)



- ◆ Submission of Evidence (optional)
 - ◆ The eligible professional may, but is not required to, submit information to assist in the review
 - ◆ However, please note there will be no evidential hearing on the information the eligible professional provides

2011 Informal Review Process (cont.)



◆ CMS Response

- ◆ CMS will provide written response via e-mail to the informal review requestor
- ◆ Where the eligible professional did satisfactorily report, the applicable incentive payment will be provided
- ◆ CMS must provide a written response within 60 days of receipt of original request

2011 Informal Review Process (cont.)



- ◆ Finality of Decision on Informal Review
 - ◆ Decisions are **final**, and there will be no further review

2011 Informal Review Process (cont.)



- ◆ CMS invites stakeholders to provide input on the following issues:
 - ◆ How should CMS improve the informal review process that was implemented for the 2011 Physician Quality Reporting System

Aucha Prachanronarong

Physician Quality Reporting System Beyond 2012

Physician Quality Reporting System Beyond 2012



- ◆ “Physician Quality Reporting System incentives, including the additional 0.5% Maintenance of Certification Program incentive, continue through 2014” and provide incentive amounts for 2013 and 2014
- ◆ Beginning 2015, a payment adjustment will apply under the Physician Quality Reporting System
 - ◆ If eligible professionals do not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year, the fee schedule amount for services furnished by such professionals during the year shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services
 - ◆ 2015 is 98.5 percent
 - ◆ 2016 and subsequent years 98.0 percent

Physician Quality Reporting System Beyond 2012 (cont.)



- ◆ Physician Quality Reporting and integration of EHR reporting
 - ◆ No later than January 1, 2012, CMS is required to move toward integration of EHR measures with respect to the Physician Quality Reporting System measures
- ◆ Such integration shall consist of the following:
 - ◆ In the selection of measures the reporting would demonstrate
 - ◆ Meaningful use of an EHR for purposes of the EHR incentive program
 - ◆ Quality of care furnished to an individual; and
 - ◆ Such other activities as specified by the Secretary

Physician Quality Reporting System Beyond 2012 (cont.)



- ◆ The Affordable Care Act includes a number of provisions related to physician and other eligible professionals quality that could impact the Physician Quality Reporting System and/or eRx Incentive Program beginning in 2012
 - ◆ The Physician Compare Website
 - ◆ Value-based payment modifier
 - ◆ Physician Feedback Program

Physician Quality Reporting System Beyond 2012 (cont.)



- ◆ CMS announced the release of a Physician Compare Website on December 30, 2010. The Physician Compare Website contains information on eligible professionals enrolled in the Medicare program, including whether the professional satisfactorily reported for the 2009 Physician Quality Reporting System
 - ◆ Currently, there is no performance information posted on the Physician Compare Website

- ◆ By January 1, 2013, CMS is required to implement a plan for posting performance information on the Physician Compare Website for reporting periods beginning no earlier than January 1, 2012
 - ◆ To the extent practicable, the performance information should include information on Physician Quality Reporting System measures among other types of measures

Physician Quality Reporting System Beyond 2012 (cont.)



- ◆ The value-based payment modifier is a differential payment under the fee schedule to a physician or groups of physicians based upon the relative quality and cost of care
 - ◆ Phased in beginning January 1, 2015
 - ◆ CMS may also include information on the quality of care furnished to Medicare beneficiaries by the physician (or a group of physicians) on the confidential reports that are provided under the Physician Feedback Program

Physician Quality Reporting System Beyond 2012 (cont.)



◆ Summary:

- ◆ Additional incentives: Maintenance of Certification Program Incentive
- ◆ Establishment of informal appeals process
- ◆ Incentive payments authorized through 2014
- ◆ Payment adjustment beginning in 2015 for eligible professionals who do not satisfactorily report
- ◆ Develop plan to integrate reporting on quality measures relating to meaningful use of electronic health records (EHRs)
- ◆ Requirement of timely feedback to participants for value-based modifier
- ◆ Establishment of Physician Compare Web site

Physician Quality Reporting System Beyond 2012 (cont.)



- ◆ CMS invites stakeholders to provide input on the following issues:
 - ◆ What reporting period(s) should CMS consider to prospectively determine 2015 payment adjustment?
 - ◆ What criteria should CMS consider to prospectively determine 2015 payment adjustment?
 - ◆ How should Physician Quality Reporting System performance information reported by participating eligible professionals be used on the Physician Compare Web site?
 - ◆ What steps can CMS take to better align the various CMS initiatives?

PUBLIC COMMENT

◆ Resources

Program and measure-specific questions:

QualityNet Help Desk 866-288-8912

(7:00 a.m. – 7:00 p.m. CST M-F)

or qnetsupport@sdps.org

(TTY 877-715-6222)

ICD-10-CM: <http://www.cms.gov/ICD10/>

Adjourn