The Medicare Quality Reporting Programs:
What Eligible Professionals Need to Know in 2016
Modules

• Module 1: Medicare Access and CHIP Reauthorization Act (MACRA) Preview
• Module 2: 2016 Incentive Payments and 2018 Payment Adjustments
• Module 3: 2016 PQRS Updates
• Module 4: 2018 Value-based Payment Modifier (VM) Policies
• Module 5: Physician Compare Updates for 2016
• Module 6: Meaningful Use of CEHRT in 2016
Module 1: Medicare Access and CHIP Reauthorization Act (MACRA) Preview
Medicare Access and CHIP Reauthorization Act (MACRA) Preview

• Separate application of payment adjustments under PQRS, VM, and EHR-MU will sunset Dec. 31, 2018
• January 1, 2019 – Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) incentive payments begin
• EPs can participate in MIPS or meet requirements to be qualifying APM participant
• MIPS – Can receive positive, negative or zero payment adjustment
• APM Participant – If criteria are met, can receive 5 percent incentive payment for 6 years
Medicare Access and CHIP Reauthorization Act (MACRA) Preview: MIPS

• Applies to individual EPs, groups of EPs or virtual groups
• 2019 & 2020 (First two years)
  – Physicians, PAs
  – Certified Registered Nurse Anesthetists
  – NPs, Clinical Nurse Specialists
  – Groups that include such professionals
• 2021 onward
  – Secretary can add EPs (described in 1848(k)(3)(B)) to MIPS
• Excluded EPs
  – Qualifying APM participants (QP)
  – Partial Qualifying APM Participants
  – Low volume threshold exclusions
Medicare Access and CHIP Reauthorization Act (MACRA) Preview: MIPS

<table>
<thead>
<tr>
<th>Year</th>
<th>Quality Measures</th>
<th>Resource Use</th>
<th>Clinical Improvement Activities</th>
<th>Meaningful Use of Certified EHR Technology</th>
<th>MIPS Adjustment Factor (+/-)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>50%</td>
<td>10%</td>
<td>15%</td>
<td>25%</td>
<td>+/- 4%</td>
</tr>
<tr>
<td>2020</td>
<td>45%</td>
<td>15%</td>
<td>15%</td>
<td>25%</td>
<td>+/- 5%</td>
</tr>
<tr>
<td>2021</td>
<td>30%</td>
<td>30%</td>
<td>15%</td>
<td>25%</td>
<td>+/- 7%</td>
</tr>
<tr>
<td>2022 and beyond</td>
<td>30%</td>
<td>30%</td>
<td>15%</td>
<td>25%</td>
<td>+/- 9%</td>
</tr>
</tbody>
</table>

- The composite performance score will range from 0 – 100
- Statute establishes formula for calculating payment adjustment factors relative to performance threshold and established “applicable percent” amounts.
- EPs receive a positive adjustment factor if score is above the performance threshold and a negative adjustment factor if score is below threshold.
Medicare Access and CHIP Reauthorization Act (MACRA) Preview: APMs

• Beginning in 2019 and for 6 years 5% incentive payment for:
  – EPs or groups of EPs who participate in certain types of APMs and who meet specified payment amount or patient count thresholds.
  – Payment is made in a lump sum on an annual basis.
  – EPs or groups of EPs meeting criteria to receive APM incentive payment are excluded from the requirements of MIPS.

• To earn the incentive payment, an EP must participate in an APM that meets the following criteria:
  – Requires participants to use certified EHR technology
  – Provides payment for covered professional services based on quality measures “comparable to” MIPS quality measures; AND
  – Either:
    (a) Entities participating in the APM bear financial risk for monetary losses that are in excess of a nominal amount; OR
    (b) APM is a medical home model expanded under section 1115A(c) of the SSA.
Module 2: 2016 Incentive Payments and 2018 Payment Adjustments
## 2016 Incentive Payments and 2018 Payment Adjustments

<table>
<thead>
<tr>
<th>PQRS</th>
<th>Value Modifier</th>
<th>EHR Incentive Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Solo Practitioners</td>
<td>Medicaid Inc. (2016)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total Medicare Payment Adjustments at Risk for Non-participation in PQRS and Meaningful Use in 2018</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PQRS-Reporting (Up or Neutral Adj) (2018)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-PQRS Reporting (2018)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PQRS-Reporting (Down Adj) (2018)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-PQRS Reporting (Down Adj) (2018)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Inc. (2016)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid Inc. (2016)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Pay Adj (2018)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Physicians

<table>
<thead>
<tr>
<th>MD &amp; DO</th>
<th>PQRS-Reporting (Up or Neutral Adj) (2018)</th>
<th>Medicare Inc. (2016)</th>
<th>$8,500 or $21,250 (based on when EP did A/I/U)</th>
<th>-3.0% of MPFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DDM</td>
<td>PQRS-Reporting (Up or Neutral Adj) (2018)</td>
<td>Medicare Inc. (2016)</td>
<td>$2,000-$4,000 (based on when EP did A/I/U)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

- **MD & DO**: Medically Doctor of Osteopathy
- **DDM**: Doctor of Dental Medicine
- **Opt.**: Optometrist
- **Chiro.**: Chiropractors

- **PQRS Reporting**: Reporting on PQRS
- **Non-PQRS Reporting**: Not reporting on PQRS

- **Pay Adj (2018)**: Payment Adjustment in 2018
- **Meaningful Use in 2018**: Meaningful Use in 2018

- **MPFS**: Medicare Payment (2016)

- **+2.0 (x), +1.0 (x), or neutral**: Increase of 2.0% or 1.0% or neutral

- **-2.0% of MPFS**: Decrease of 2.0% of MPFS

- **+4.0 (x), +2.0 (x), or neutral**: Increase of 4.0% or 2.0% or neutral

- **-2.0% or -4.0% of MPFS**: Decrease of 2.0% or 4.0% of MPFS

- **-4.0% of MPFS**: Decrease of 4.0% of MPFS

- **$2,000-$4,000 (based on when EP did A/I/U)**: Payment range based on meaningful use"
## 2016 Incentive Payments and 2018 Payment Adjustments

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Groups with Non-Physician EPs only and Solo Practitioners</td>
<td>Groups with Physicians + PAs, NPs, CNSs, &amp; CRNAs</td>
<td>Value Modifier</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAs</td>
<td>NPs</td>
<td>CNSs</td>
<td>CRNAs</td>
<td>Practitioners</td>
<td>N/A</td>
</tr>
<tr>
<td>-2.0% of MPFS</td>
<td>+2.0 (x), +1.0(x), or neutral</td>
<td>-2% of MPFS</td>
<td>-2% of MPFS</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>NPs</td>
<td>CNSs</td>
<td>CRNAs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-2% of MPFS</td>
<td>-1% or -2% of MPFS</td>
<td>-2% of MPFS</td>
<td>-2% of MPFS</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>CRNAs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 2016 Incentive Payments and 2018 Payment Adjustments

<table>
<thead>
<tr>
<th>Practitioners</th>
<th>PQRS Pay Adj. (2018)</th>
<th>Value Modifier</th>
<th>EHR Incentive Program</th>
<th>Total Medicare Payment Adjustments at Risk for Non-Participation in PQRS and Meaningful Use in 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certified Nurse Midwife</td>
<td>-2.0% of MPFS</td>
<td>N/A</td>
<td>Medicare Inc.</td>
<td>$8,500 or $21,250 (based on when EP did A/I/U)</td>
</tr>
<tr>
<td>Clinical Social Worker</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>-2.0% of MPFS</td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>-2.0% of MPFS</td>
</tr>
<tr>
<td>Registered Dietician</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>-2.0% of MPFS</td>
</tr>
<tr>
<td>Nutrition Professional</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>-2.0% of MPFS</td>
</tr>
<tr>
<td>Audiologits</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>-2.0% of MPFS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Therapists</th>
<th>PQRS Pay Adj. (2018)</th>
<th>Value Modifier</th>
<th>EHR Incentive Program</th>
<th>Total Medicare Payment Adjustments at Risk for Non-Participation in PQRS and Meaningful Use in 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapist</td>
<td>-2.0% of MPFS</td>
<td>N/A</td>
<td>Medicare Inc.</td>
<td>$8,500 or $21,250 (based on when EP did A/I/U)</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>-2.0% of MPFS</td>
</tr>
<tr>
<td>Qualified Speech-Language Therapist</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>-2.0% of MPFS</td>
</tr>
</tbody>
</table>
Module 3: 2016 PQRS Updates
2016 PQRS Updates

• In 2016, 281 measures in the PQRS measure set and 18 measures in the GPRO Web Interface; 23 cross-cutting measures

• Added 3 new measures groups: Multiple Chronic Conditions; Cardiovascular Prevention (Million Hearts); and Diabetic Retinopathy

• Adding the Qualified Clinical Data Registry (QCDR) reporting option for groups in 2016

• 2018 PQRS payment adjustment is the last adjustment that will be issued under PQRS
  – Starting in 2019, adjustments to payment for quality reporting will be made under the Merit-Based Incentive Payment System (MIPS)
**2016 PQRS: Reporting Via Claims**

- Requirement is to report 9 measures covering at least 3 National Quality Strategy (NQS) domains
  1. Patient Safety
  2. Person and Caregiver-Centered Experience and Outcomes
  3. Communication and Care Coordination
  4. Effective Clinical Care
  5. Community/Population Health
  6. Efficiency and Cost Reduction

- Required to report one “cross-cutting” measure if at least one Medicare face-to-face encounter

- Measure-applicability validation (MAV) process will be used to determine if EP could have reported 9 measures covering at least 3 domains
If EP sees at least 1 Medicare patient in a face-to-face encounter, must report on at least 1 cross-cutting measure AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. (Subject to MAV)
<table>
<thead>
<tr>
<th>NQS Domain</th>
<th>Measure Title</th>
<th>Claims</th>
<th>CSV</th>
<th>Registry</th>
<th>EHR</th>
<th>GRPO Web Interface</th>
<th>Measures Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community/Population Health</td>
<td>Tobacco Use and Help with Quitting Among Adolescents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Effective Clinical Care</td>
<td>Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Communication and Care Coordination</td>
<td>Medication Reconciliation Post Discharge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication and Care Coordination</td>
<td>Care Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Community/Population Health</td>
<td>Preventive Care and Screening: Influenza Immunization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community/Population Health</td>
<td>Pneumonia Vaccination Status for Older Adults</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective Clinical Care</td>
<td>Diabetes: Hemoglobin A1c Poor Control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 2016 PQRS Cross-Cutting Measures

<table>
<thead>
<tr>
<th>NQS Domain</th>
<th>Measure Title</th>
<th>Claims</th>
<th>CSV</th>
<th>Registry</th>
<th>EHR</th>
<th>GRPO Web Interface</th>
<th>Measures Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community/Population Health</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Documentation of Current Medications in the Medical Record</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Communication and Care Coordination</td>
<td>Pain Assessment and Follow-Up</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Community/Population Health</td>
<td>Preventive Care and Screening for Clinical Depression and Follow-Up Plan</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Communication and Care Coordination</td>
<td>Functional Outcome Assessment</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community/Population Health</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
# 2016 PQRS Cross-Cutting Measures

<table>
<thead>
<tr>
<th>NQS Domain</th>
<th>Measure Title</th>
<th>Claims</th>
<th>CSV</th>
<th>Registry</th>
<th>EHR</th>
<th>GRPO Web Interface</th>
<th>Measures Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Clinical Care</td>
<td>Controlling High Blood Pressure</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Community/Population Health</td>
<td>Childhood Immunization Status</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community/Population Health</td>
<td>Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Falls: Screening for Fall Risk</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Person and Caregiver Experience and Outcomes</td>
<td>CAHPS for PQRS Clinician/Group Survey</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication and Care Coordination</td>
<td>Closing the Loop: Receipt of Specialist Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 2016 PQRS Cross-Cutting Measures

<table>
<thead>
<tr>
<th>NQS Domain</th>
<th>Measure Title</th>
<th>Claims</th>
<th>CSV</th>
<th>Registry</th>
<th>EHR</th>
<th>GRPO Web Interface</th>
<th>Measures Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community/Population Health</td>
<td>Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Effective Clinical Care</td>
<td>Breast Cancer Screening</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Communication and Care Coordination</td>
<td>Falls: Plan of Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Falls: Risk Assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Can report either individual measures (9 measures covering 3 quality domains) or measures groups

Requirement to report on at least one cross-cutting measure if the EP has at least one Medicare face-to-face encounter

Registries may now attest that quality measure results and all associated data are accurate via web (in lieu of written attestation statement)

Registries have until January 31, 2016 to self-nominate for participation in the 2016 PQRS
Individual Reporting Criteria for the 2018 PQRS Payment Adjustment

Qualified Registry

Individual Measures

Can you report at least 9 measures covering 3 domains?

Yes

Report at least 9 measures covering at least 3 NQS domains

No

Report 1—8 measures covering 1—3 NQS domains

What Measure Type?

Measures Groups

Report at least 1 measures group, AND report each measures group for at least 20 patients, a majority (11 patients, if 20 submitted) of which much be Medicare Part B FFS patients. Measures groups containing a measure with a 0 percent performance rate will not be counted.

If EP sees at least 1 Medicare patient in a face-to-face encounter, must report on at least 1 cross-cutting measure AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.

Yes

No

(Subject to MAV)
2016 PQRS Measures Groups

- In 2016, a measure group is defined as a subset of 6 or more PQRS measures that have a particular clinical condition or focus in common.

- All applicable measures within the group must be reported for all patients in the sample seen by the EP during the reporting period.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
<th>Condition</th>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Chronic Kidney Disease</td>
<td>Preventive Care</td>
<td>Coronary Artery Bypass Graft</td>
<td>Rheumatoid Arthritis</td>
</tr>
<tr>
<td>Acute Otitis Externa (AOE)</td>
<td>Cataracts</td>
<td>Hepatitis C</td>
<td>Heart Failure</td>
<td>Coronary Artery Disease</td>
</tr>
<tr>
<td>Optimizing Patient Exposure to Ionizing Radiation</td>
<td>HIV/AIDS</td>
<td>Asthma</td>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>Inflammatory Bowel Disease</td>
</tr>
<tr>
<td>Sleep Apnea</td>
<td>Dementia</td>
<td>Parkinson’s Disease</td>
<td>Sinusitis</td>
<td>Multiple Chronic Conditions</td>
</tr>
<tr>
<td>Cardiovascular Prevention (Million Hearts)</td>
<td>Oncology</td>
<td>Total Knee Replacement</td>
<td>General Surgery</td>
<td>Diabetic Retinopathy</td>
</tr>
</tbody>
</table>
Specialty Measure Sets

- CMS is collaborating with specialty societies to ensure that the measures represented within Specialty Measure Sets accurately illustrate measures associated within a particular clinical area (suggested, NOT required); the following were established in 2015:

1. Cardiology
2. Emergency Medicine
3. Gastroenterology
4. General Practice/Family
5. Internal Medicine
6. Multiple Chronic Conditions
7. Obstetrics/Gynecology
8. Oncology/Hematology
9. Ophthalmology
10. Pathology
11. Radiology
12. Surgery

- CMS is adding the following specialty measure sets in 2016:

1. Dermatology
2. Physical Therapy/Occupational Therapy
3. Mental Health
4. Hospitalist
5. Urology
Individual Reporting Criteria for the 2018 PQRS Payment Adjustment

Direct EHR product that is CEHRT

- OR -

EHR data

Submission vendor that is CEHRT

What Measure Type?

Individual Measures

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.
Individual Reporting Criteria for the 2018 PQRS Payment Adjustment

Qualified Clinical Data Registry

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

What Measure Type?

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.
2016 PQRS: Group Practice Reporting Option (GPRO)

• Group practices will be able to register for the PQRS GPRO between April 1, 2016 and June 30, 2016

• Size of the group will determine the GPRO options
  ▪ GPRO Web Interface available for groups of 25+ EPs

• In 2016, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS continues to be mandatory for groups of 100+ EPs, optional for other groups

• Groups can now choose to report using a QCDR
GPRO Reporting Criteria for the 2018 Payment Adjustment

Qualified Registry

Group Practice Size?

2-99 EPs; 100+ EPs if CAHPS for PQRS does not apply

Can the group report at least 9 measures covering at least 3 domains?

Yes

Report at least 9 measures covering at least 3 NQS domains

No

Report 1-8 measures covering 1-3 NQS domains (Subject to MAV)

If group practice sees at least 1 Medicare patient in a face-to-face encounter, must report on at least 1 cross-cutting measure AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.
GPRO Reporting Criteria for the 2018 Payment Adjustment

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

2-99 EPs; 100+ EPs if CAHPS for PQRS does not apply

Report 9 measures covering at least 3 of the NQS domains. If a group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.
Beneficiary sample size remains 248 beneficiaries for groups of all sizes.

If there are less than 248 patients in the group practice, group would report on 100 percent of assigned beneficiaries.

If group does not have any Medicare patients for any of the GPRO measure in the Web Interface, another reporting option must be chosen.
GPRO Reporting Criteria for the 2018 Payment Adjustment

GPRO Web Interface

Group Practice Size?

25+ EPs

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.
2016 GPRO Web Interface Measures

- Falls: Screening for Future Fall Risk
- Documentation of Current Medications in the Medical Record
- Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor (ARB) Therapy - Diabetes or left Ventricular Systolic Dysfunction (LVEF <40%)
- Composite (All or Nothing): Diabetes: Hemoglobin A1c Poor Control
- Composite (All or Nothing): Diabetes: Eye Exam
- Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- Controlling High Blood Pressure
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
- Depression Remission at Twelve Months
2016 GPRO Web Interface Measures

- Breast Cancer Screening
- Colorectal Cancer Screening
- Preventive Care and Screening: Influenza Immunization
- Pneumonia Vaccination Status for Older Adults
- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
- Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
Section 101(d)(1)(B) of MACRA created the QCDR option for EPs participating in the GPRO starting in 2016.

- Reporting period is 12 months (i.e.; January 1-December 31, 2016)

- Same criteria for group practices to report via QCDR as individual EPs
GPRO Reporting Criteria for the 2018 PQRS Payment Adjustment

Qualified Clinical Data Registry

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

What Measure Type?

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

Of the measures reported via a qualified clinical data registry, the group 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.
2016 PQRS: CAHPS for PQRS Survey

- Starting in 2015, CAHPS is mandatory for groups of 100+ EPs (in addition to other reporting methods)

- Optional for groups of 2-99 EPs

- Group practices required to contract with a CMS certified vendor and bear administrative costs for the CAHPS survey

- The CMS-certified survey vendor will administer and collect 12 summary survey modules on behalf of the group practice’s patients

- 12 survey modules are the same as the survey from previous years
1. Getting timely care, appointments and information
2. How well your providers communicate
3. Patient’s rating of provider
4. Access to specialists
5. Health promotion and education
6. Shared decision making
7. Health status and financial status
8. Courteous and helpful office staff
9. Care coordination
10. Between visit communication
11. Helping you take medications as directed
12. Stewardship of patient resources
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.
Module 4: 2018 Value-Based Payment Modifier (VM) Policies
Policies for the 2018 VM

• 2016 is the performance year for application of the 2018 VM

• Applies to all physicians and also to physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs) and certified registered nurse anesthetists (CRNAs) in groups of 2+ EPs and those who are solo practitioners, as identified by their Taxpayer Identification Number (TIN)

• Quality-tiering is mandatory; TINs consisting of non-physician EPs only will be held harmless from downward adjustments; all other TINs will be subject to upward, downward or neutral adjustments
  – TINs are determined to be consisting of non-physician EPs only if either the PECOS-generated list or our analysis of the claims data shows that the TIN contains no physicians or that no physicians billed under the Medicare PFS during the performance period for the 2018 VM.
  – The 2018 VM will not be applied to TINs if either the PECOS-generated list or claims analysis shows that the TIN consists only of non-physician EPs who are not PAs, NPs, CNSs, or CRNAs.

• 2018 is the final year for the VM
Quality Measures used to Calculate the 2018 VM

- Groups with 2+ EPs: Measures reported through the PQRS Group Practice Reporting Option (GPRO) OR individual PQRS measures reported by at least 50% of the EPs in the group (50% threshold option)

- Solo practitioners: Individual PQRS measures reported by the solo practitioner

- Three claims-based outcome measures: All-Cause Hospital Readmissions, Composite of Preventable Hospitalizations for Acute Conditions, and Composite of Preventable Hospitalizations for Chronic Conditions

- CAHPS for PQRS survey measures (applicable only for groups that elect to use their 2016 CAHPS for PQRS survey results in the calculation of their 2018 VM)
Cost Measures used to Calculate the 2018 VM

- Total per capita costs measure (Parts A & B)
- Total per capita costs for beneficiaries with 4 chronic conditions (COPD, Heart Failure, Coronary Artery Disease, and Diabetes)
- Medicare Spending Per Beneficiary (MSPB) measure (3 days before and 30 days after an inpatient hospitalization)
- All cost measures are payment-standardized, risk-adjusted, and adjusted for the specialty mix of the EPs in the group
Quality-Tiering Approach for 2018 VM (Based on 2016 Performance): Physicians, PAs, NPs, CNSs, & CRNAs in Groups of Physicians with 10+ EPs

- Maintaining the 2017 VM payment adjustment levels

- An automatic -4.0% VM downward adjustment will be applied for not meeting the satisfactory reporting criteria to avoid the 2018 PQRS payment adjustment.

- Under quality-tiering, the maximum upward adjustment is up to +4.0x (‘x’ represents the upward VM payment adjustment factor), and the maximum downward adjustment is -4.0%.

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>+0.0%</td>
<td>+2.0x*</td>
<td>+4.0x*</td>
</tr>
<tr>
<td>Average Cost</td>
<td>-2.0%</td>
<td>+0.0%</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>High Cost</td>
<td>-4.0%</td>
<td>-2.0%</td>
<td>+0.0%</td>
</tr>
</tbody>
</table>

* Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores
Quality-Tiering Approach for 2018 VM (Based on 2016 Performance): Physicians, PAs, NPs, CNSs, & CRNAs in Groups of Physicians with 2-9 EPs & Physician Solo Practitioners

- Maintaining the 2017 VM payment adjustment levels, but applying both upward and downward adjustments under quality-tiering

- An automatic -2.0% VM downward adjustment will be applied for not meeting the satisfactory reporting criteria to avoid the 2018 PQRS payment adjustment.

- Under quality-tiering, the maximum upward adjustment is up to +2.0x (‘x’ represents the upward VM payment adjustment factor), and the maximum downward adjustment is -2.0%.

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>+0.0%</td>
<td>+1.0x*</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>Average Cost</td>
<td>-1.0%</td>
<td>+0.0%</td>
<td>+1.0x*</td>
</tr>
<tr>
<td>High Cost</td>
<td>-2.0%</td>
<td>-1.0%</td>
<td>+0.0%</td>
</tr>
</tbody>
</table>

* Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores.
Quality-Tiering Approach for 2018 VM (Based on 2016 Performance): PAs, NPs, CNSs, & CRNAs who are Solo Practitioners or in Groups Consisting of Non-Physician EPs only

- An automatic -2.0% VM downward adjustment will be applied for not meeting the satisfactorily reporting criteria to avoid the 2018 PQRS payment adjustment.

- Under quality-tiering, the maximum upward adjustment is up to +2.0x (‘x’ represents the upward VM payment adjustment factor) and held harmless from any downward adjustments for poor performance.

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>+0.0%</td>
<td>+1.0x*</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>Average Cost</td>
<td>+0.0%</td>
<td>+0.0%</td>
<td>+1.0x*</td>
</tr>
<tr>
<td>High Cost</td>
<td>+0.0%</td>
<td>+0.0%</td>
<td>+0.0%</td>
</tr>
</tbody>
</table>

* Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores.
Groups and solo practitioners participating in an ACO under the Shared Savings Program in the 2016 performance period will have their Value Modifier calculated as follows for the 2018 VM:

- **Cost Composite**: Average
- **Quality Composite**: Based on ACO’s quality data submitted through the GPRO web interface and the ACO all-cause hospital readmissions measure as calculated under the Shared Savings Program
  - Include the CAHPS for ACOs Survey in the quality composite of the 2018 VM for TINs participating in ACOs in the Shared Shaving Program in 2016

If the ACO does not successfully report quality data as required by the Shared Savings Program, then all groups and solo practitioners participating in the ACO will fall in Category 2 for the VM and be subject to the automatic downward adjustment.
In 2018, the application of the VM is waived for groups and solo practitioners, as identified by their TIN, if at least one EP who billed for PFS items and services under the TIN during 2016 participated in the Pioneer ACO Model, CPC Initiative, or other similar Innovation Center models (e.g., the Next Generation ACO Model, Oncology Care Model, Comprehensive ESRD Care Model).
How Does 2016 PQRS Participation Affect the VM in 2018?

Do you plan to satisfactorily report for PQRS in 2016?  
No

Are you a solo practitioner or part of a group?  
Solo

- Will be subject to 2018 VM Downward adjustment of -2.0%
- Will be subject to 2018 PQRS payment adjustment of -2.0%

Are there physicians in the group?  
Only non-physicians in group

- Will be subject to 2018 VM Downward adjustment of -2.0%

Group

- Will be subject to 2018 PQRS payment adjustment of -2.0%

Are you a physician, PA, NP, CNS or CRNA?  
Yes

- Will be subject to 2018 PQRS payment adjustment of -2.0%

No

Are there physicians in the group?  
Physicians in group

- Will be subject to the 2018 PQRS payment adjustment of -2.0%

- VM does not apply to EPs who are not physicians, PAs, NPs, CNSs or CRNAs in 2018

2-9 EPs

What is the size of the group?  
10+ EPs

- Will be subject to the 2018 PQRS payment adjustment of -4.0%

- Will be subject to 2018 VM downward adjustment of -4.0%
How Does 2016 PQRS Participation Affect the VM in 2018?

- **Do you plan to satisfactorily report for PQRS in 2016?**
  - **Yes**
  - **Are you a physician, PA, NP, CNS or CRNA?**
    - **Yes**
    - Are you a solo practitioner or part of a group?
      - **Solo**
        - Physician
          - Will avoid 2018 PQRS payment adjustment of -2.0%
          - Upward, neutral, or downward VM adjustment in 2018 from -2.0% to +2.0(x) based on quality-tiering
        - PA, NP, CNS, or CRNA
          - Will avoid 2018 PQRS payment adjustment of -2.0%
          - Upward, neutral, or downward VM adjustment in 2018 from -2.0% to +2.0(x) based on quality-tiering
    - **Group**
      - **Physicians in group**
        - Will avoid 2018 PQRS payment adjustment of -2.0%
        - Upward or neutral VM adjustment in 2018 from +0.0% to +2.0(x) based on quality-tiering
      - **Only non-physicians in group**
        - Will avoid 2018 PQRS payment adjustment of -2.0%
        - Upward or neutral VM adjustment in 2018 from +0.0% to +2.0(x) based on quality-tiering

- **No**
  - Are there physicians in the group?
    - **Yes**
      - Will avoid 2018 PQRS payment adjustment of -2.0%
      - Upward, neutral, or downward VM adjustment in 2018 from +4.0(x) to -4.0% based on quality-tiering
    - **No**
      - What is the size of the group?
        - **2-9 EPs**
          - Held harmless from downward adjustment for poor performance
        - **10+ EPs**
          - Held harmless from downward adjustment for poor performance

**Group can report through the PQRS GPRO option or meet the 50% threshold option

**Held harmless from downward adjustment for poor performance
## VM Policies for 2016 - 2018

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performance Year</strong></td>
<td>2014</td>
<td>2015</td>
<td>2016</td>
</tr>
<tr>
<td><strong>Group Size</strong></td>
<td>Physicians in groups with 10+ EPs</td>
<td>Physicians in groups with 2+ EPs and physician solo practitioners</td>
<td>Physicians, PAs, NPs, CNSs, and CRNAs in groups with 2+ EPs and those who are solo practitioners</td>
</tr>
<tr>
<td><strong>Maximum Payment at Risk</strong></td>
<td>-2.0%</td>
<td>-2.0% (Physicians in groups of physicians with 2-9 EPs and physician solo practitioners)</td>
<td>-2.0% (Physicians in groups of physicians with 2-9 EPs and physician solo practitioners)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-4.0% (Physicians in groups of physicians with 10+ EPs)</td>
<td>-4.0% (Physicians in groups of physicians with 10+ EPs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-2.0% (PAs, NPs, CNSs, CRNAs in groups with non-physician EPs only and PAs, NPs, CNSs and CRNAs who are solo practitioners)</td>
</tr>
<tr>
<td><strong>Available PQRS Reporting Mechanisms</strong></td>
<td>GPRO Web Interface, Qualified PQRS Registry, or EHR; or 50% of EPs report under the PQRS as individuals</td>
<td>Same as 2016</td>
<td>GPRO Web Interface, Qualified PQRS Registry, EHR, or QCDR, or 50% of EPs report under the PQRS as individuals</td>
</tr>
</tbody>
</table>
### VM Policies for 2016 - 2018

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome Measures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOTE: A TIN’s performance on the measures reported through the PQRS reporting mechanisms, CAHPS measures (if applicable), and outcome measures will be used to calculate its quality composite score under the VM.</td>
<td>• All-Cause Hospital Readmissions</td>
<td>Same as 2016, except the all-cause hospital readmissions measure will not be applied to groups with 2-9 EPs and solo practitioners</td>
<td>Same as 2017</td>
</tr>
<tr>
<td></td>
<td>• Composite of Acute Prevention Quality Indicators: (bacterial pneumonia, urinary tract infection, dehydration)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Composite of Chronic Prevention Quality Indicators: (chronic obstructive pulmonary disease (COPD), heart failure, diabetes)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Experience Care Measures</strong></td>
<td>CAHPS for PQRS: Optional for groups with 25+ EPs; required for all groups with 100+ EPs Groups may elect to include their CAHPS results in the calculation of the 2016 VM</td>
<td>CAHPS for PQRS: Optional for groups with 2-99 EPs; required for all groups with 100+ EPs Groups may elect to include their CAHPS results in the calculation of the 2017 VM</td>
<td>CAHPS for PQRS: Optional for groups with 2-99 EPs; required for all groups with 100+ EPs Groups may elect to include their 2016 CAHPS results in the calculation of the 2018 VM. Include the CAHPS for ACOs Survey in the quality composite of the 2018 VM for TINs participating in ACOs in the Shared Shaving Program in 2016</td>
</tr>
</tbody>
</table>
### VM Policies for 2016 - 2018

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost Measures</strong></td>
<td>Same as 2015 and:</td>
<td>Same as 2016</td>
<td>Same as 2016</td>
</tr>
<tr>
<td></td>
<td>Medicare Spending Per Beneficiary measure (includes Part A and B costs during the 3 days before and 30 days after an inpatient hospitalization)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Benchmarks (Measure Level)</strong></td>
<td><strong>Quality Measures:</strong> The peer group for all quality measures is defined as all TINs nationwide that had at least 20 eligible cases for each measure.</td>
<td><strong>Quality Measures:</strong> The peer group for the All-Cause Hospital Readmissions measure is defined as all TINs nationwide with 10+ EPs that had at least 200 eligible cases. The peer group for all other quality measures is defined as all TINs nationwide that had at least 20 eligible cases for each measure.</td>
<td><strong>Quality Measures:</strong> Same as 2017 Create separate eCQM benchmarks, based on the CMS eMeasure ID and exclude eCQM measures from the overall benchmark for a given measure.</td>
</tr>
<tr>
<td></td>
<td><strong>Cost Measures:</strong> The peer group for all cost measures is defined as all TINs nationwide that had at least 20 eligible cases for each measure.</td>
<td><strong>Cost Measures:</strong> The peer group for the MSPB measure is defined as all TINs nationwide that had at least 125 eligible episodes. The peer group for all other cost measures is defined as all TINs nationwide that had at least 20 eligible cases for each measure.</td>
<td><strong>Cost Measures:</strong> Same as 2017</td>
</tr>
</tbody>
</table>

**Value Modifier Components**

- **2016 Finalized Policies:**
  - Medicare Spending Per Beneficiary measure (includes Part A and B costs during the 3 days before and 30 days after an inpatient hospitalization)

- **2017 Finalized Policies:**
  - Medicare Spending Per Beneficiary measure (includes Part A and B costs during the 3 days before and 30 days after an inpatient hospitalization)

- **2018 Finalized Policies:**
  - Medicare Spending Per Beneficiary measure (includes Part A and B costs during the 3 days before and 30 days after an inpatient hospitalization)
### VM Policies for 2016 - 2018

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality-Tiering</strong></td>
<td><strong>Mandatory:</strong> Physicians in groups of physicians with 10-99 EPs receive only the upward or neutral VM adjustment (no downward adjustment). Physicians in groups of physicians with 100+ EPs can receive upward, neutral, or downward VM adjustment.</td>
<td><strong>Mandatory:</strong> Physicians in groups of physicians with 2-9 EPs and physician solo practitioners receive only the upward or neutral VM adjustment (no downward adjustment). Physicians in groups of physicians with 10+ EPs can receive upward, neutral, or downward VM adjustment.</td>
<td><strong>Mandatory:</strong> PAs, NPs, CNSs, and CRNAs in groups consisting of non-physician EPs only and those who are solo practitioners receive only the upward or neutral VM adjustment (no downward adjustment). Physicians, NPs, PAs, CNSs, and CRNAs in groups of physicians with 2+ EPs and physician solo practitioners can receive upward, neutral, or downward VM adjustment.</td>
</tr>
<tr>
<td><strong>Application of the VM to Participants of the Shared Savings Program, Pioneer ACO Model, CPC Initiative, or other Similar Innovation Center Models</strong></td>
<td>Not applicable</td>
<td>Shared Savings Program: VM based on the ACO’s quality data and average cost. Pioneer ACO Model, CPC Initiative, or other similar Innovation Center Models: VM waived</td>
<td>Shared Savings Program: VM based on the ACO’s quality and CAHPS data, and average cost. Pioneer ACO Model, CPC Initiative, or other similar Innovation Center Models: VM waived</td>
</tr>
</tbody>
</table>
## VM Policies for 2016 - 2018

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VM Informal Review Process: Timeline</strong></td>
<td>Deadline of February 28, 2015 for a group to request correction of a perceived error made by CMS in the 2015 VM payment adjustment.</td>
<td>Establish a 60 day period that would start after the release of the QRURs for the applicable reporting period for a group or solo practitioner (as applicable) to request correction of a perceived error made by CMS in the determination of the group or solo practitioner’s VM for that payment adjustment period.</td>
<td>The Informal Review submission period will occur during the 60 days following the release of the QRURs for the 2016 VM and subsequent years</td>
</tr>
</tbody>
</table>
| **VM Informal Review Process: If a third party or CMS made an error** | • Classify a TIN as “average quality” in the event we determine that CMS made an error in the calculation of quality composite.  
• Recompute a TIN’s cost composite if CMS made an error in its calculation.  
• Adjust a TIN’s quality tier. | • Recompute a TIN’s quality composite in the event we determine a third party error was made or CMS made an error in the calculation of quality composite.  
• Otherwise, the same as 2015. | Same as 2016, 2017 and: Reclassify a TIN as Category 1 when PQRS determines on informal review that at least 50 percent of the TIN’s EPs meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the relevant CY PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS QCDR for the relevant CY PQRS payment adjustment. |
Actions for Groups with 2+ EPs and Solo Practitioners in 2016 for the 2018 VM

- Be sure to satisfactorily report quality data under the PQRS for 2015

- Choose a PQRS reporting mechanism and become familiar with the measures AND data submission timeframes

- Decide whether and how to participate in the PQRS in 2016
  - Group reporting - Register for the 2016 PQRS GPRO between April 1, 2016 and June 30, 2016
    - [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html)
  - Individual reporting – No registration necessary

  - [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html)

- Watch for announcements about availability of the 2015 Mid-Year QRUR and 2015 Annual QRUR to understand your TIN’s current quality and cost performance

- Review quality measure benchmarks under the VM; understand what is required for above average performance; and identify measures for distinguishing your performance
  - [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html)
Module 5: Physician Compare Updates in 2016
Physician Compare Updates in 2016

• The following 2016 measures are available for public reporting on Physician Compare in late 2017:
  – All PQRS measures for individual EPs and group practices.
  – All CAHPS for PQRS measures for groups of 2 or more EPs who meet the specified sample size requirements and collect data via a CMS-specified certified CAHPS vendor.
  – All ACO measures, including CAHPS for ACOs.

• Physician Compare will include an indicator on profile pages for individual EPs who satisfactorily report the 2016 PQRS Cardiovascular Prevention measures group in support of Million Hearts.
Physician Compare Updates in 2016

• All individual and group-level QCDR measures, including PQRS and non-PQRS measures are available for public reporting in late 2017.

• Physician Compare plans to publicly report an item-level benchmark for group practice and individual EP PQRS measures using the Achievable Benchmark of Care (ABC) methodology in late 2017
  ◦ We will stratify the benchmark by reporting mechanism to ensure comparability and reduce the interpretation burden for consumers.
  ◦ We will use this methodology to systematically assign stars for the Physician Compare 5 star rating.
Physician Compare Updates in 2016

• Physician Compare public reporting standards:
  ◦ All data must meet the public reporting standards – measures must be statistically accurate, valid, reliable, and comparable and must resonate with consumers.
  ◦ CMS can publicly report all measures submitted, reviewed, and deemed valid and reliable in the Physician Compare downloadable file.
  ◦ Not all measures will be included on the Physician Compare profile pages.
Physician Compare Updates in 2016

• As required by MACRA, we are publicly reporting utilization data in the downloadable database in late 2017.

• Physician Compare plans to add the following 2016 VM information to the downloadable database in 2018:
  ◦ Quality tiers for cost and quality noting if the group practice or EP is high, low, or neutral on cost and quality per the VM.
  ◦ A notation of the payment adjustment received based on the cost and quality tiers.
  ◦ An indication if the individual EP or group practice was eligible to but did not report quality measures to CMS.
Module 6: Meaningful Use of CERHT in 2016
Meaningful Use of CERHT in 2016

• Restructured Stage 1 and Stage 2 objectives and measures to align with Stage 3
  – 10 objectives for EPs, including one consolidated public health reporting objective with measure options

• Streamlined the program by removing redundant, duplicative and topped out measures

• Starting in 2015, the EHR reporting period aligns with the calendar year for all providers (EPs and EHs/CAHs)

• Modified Stage 2 patient engagement objectives that require “patient action”

• CQM reporting for EPs and EHs/CAHs remains as previously finalized
Meaningful Use of CERHT in 2016

• Beginning in 2016, the EHR reporting period must be completed within January 1 and December 31 of the calendar year

• EPs/EHs/CAHs that are new to the program in 2016 will have an EHR reporting period of any continuous 90-day period in CY 2016

• All returning participants have a 2016 reporting period of the entire calendar year

• For 2016, all providers previously scheduled to be in Stage 1 may claim alternate exclusion for the CPOE objective measure 2 (laboratory orders) and measure 3 (radiology orders)
Patient Engagement Measures

1. Patient Electronic Access:
   - 2016: requires that at least 1 patient seen by EP views, downloads or transmits to a third party
   - 2017 (Stage 2): More than 5 percent of unique patients seen by EP views, downloads or transmits to a third party

2. Secure Messaging (EPs only):
   - 2016: for at least 1 patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient or in response to a secure message sent by the patient
   - 2017 (Stage 2): for more than 5 percent of unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient or in response to a secure message sent by the patient
## Meaningful Use Objectives and Measures for 2016

### Objective 1: Protect Patient Health Information

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measures for 2016</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.</td>
<td>Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP, eligible hospital, or CAH's risk management process.</td>
<td>NONE</td>
</tr>
</tbody>
</table>

### Objective 2: Clinical Decision Support

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measures for 2016</th>
<th>Exclusions</th>
</tr>
</thead>
</table>
| Use clinical decision support to improve performance on high-priority health conditions. | **Measure 1**: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP, eligible hospital's or CAH's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.  
**Measure 2**: The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period. | **EP Exclusion for Measure 2**: Any EP who writes fewer than 100 medication orders during the EHR reporting period. |
## Meaningful Use Objectives and Measures for 2016

### Objective 3: Computerized Provider Order Entry (CPOE)

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measures for 2016</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Use CPOE for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.</strong></td>
<td><strong>Measure 1:</strong> More than 60 percent of medication orders created by the EP or by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry. <strong>Measure 2:</strong> More than 30 percent of laboratory orders created by the EP or by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry. <strong>Measure 3:</strong> More than 30 percent of radiology orders created by the EP or by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.</td>
<td><strong>EP Exclusion for Measure 1:</strong> Any EP who writes fewer than 100 medication orders during the EHR reporting period. <strong>EP Exclusion for Measure 2:</strong> Any EP who writes fewer than 100 laboratory orders during the EHR reporting period. <strong>Alternate Exclusion for Measure 2:</strong> Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for measure 2 (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016. <strong>EP Exclusion for Measure 3:</strong> Any EP who writes fewer than 100 radiology orders during the EHR reporting period. <strong>Alternate Exclusion for Measure 3:</strong> Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for measure 3 (radiology orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016.</td>
</tr>
</tbody>
</table>
### Objective 4: Electronic Prescribing

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measures for 2016</th>
<th>Exclusions</th>
</tr>
</thead>
</table>
| **EP**: Generate and transmit permissible prescriptions electronically (eRx). | **EP Measure**: More than 50 percent of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT. **Eligible Hospital/CAH Measure**: More than 10 percent of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT. | **EP Exclusion**: Any EP who:  
- Writes fewer than 100 permissible prescriptions during the EHR reporting period; or  
- Does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP’s practice location at the start of his or her EHR reporting period.  
**EH/CAH Exclusion**: Any eligible hospital or CAH that does not have an internal pharmacy that can accept electronic prescriptions and is not located within 10 miles of any pharmacy that accepts electronic prescriptions at the start of their EHR reporting period.  
**EH/CAH Alternate Exclusion**: Eligible hospital or CAH may claim an exclusion for the eRx objective and measure for an EHR reporting period in 2016 if they were either scheduled to demonstrate Stage 1 in 2016 or if they are scheduled to demonstrate Stage 2 but did not intend to select the Stage 2 eRx objective for an EHR reporting period in 2016. |

### Objective 5: Health Information Exchange

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measures for 2016</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>The EP, eligible hospital, or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.</td>
<td>The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care must: (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.</td>
<td><strong>EP Exclusion</strong>: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.</td>
</tr>
</tbody>
</table>
## Objective 6: Patient-Specific Education

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measures for 2016</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.</td>
<td><strong>EP Measure:</strong> Patient-specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period. <strong>Eligible Hospital/CAH Measure:</strong> More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources identified by CEHRT.</td>
<td><strong>EP Exclusion:</strong> Any EP who has no office visits during the EHR reporting period.</td>
</tr>
</tbody>
</table>

## Objective 7: Medication Reconciliation

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measures for 2016</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>The EP, eligible hospital, or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.</td>
<td>The EP, eligible hospital or CAH performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).</td>
<td><strong>EP Exclusion:</strong> Any EP who was not the recipient of any transitions of care during the EHR reporting period.</td>
</tr>
</tbody>
</table>
# Meaningful Use Objectives and Measures for 2016

## Objective 8: Patient Electronic Access

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measures for 2016</th>
<th>Exclusions</th>
</tr>
</thead>
</table>
| **EP Objective:** Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP. | **EP Measure 1:** More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information. | **EP Exclusion for Measure 2:** Any EP who--
  - Neither orders nor creates any of the information listed for inclusion as part of the measures; or
  - Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period. |
| **EP Measure 2:** For an EHR reporting period in 2016, at least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits his or her health information to a third party during the EHR reporting period. | **EP Measure 1:** More than 50 percent of all unique patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH are provided timely access to view online, download and transmit to a third party their health information. | **EH/CAH Exclusion for Measure 2:** Any eligible hospital or CAH that is located in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period. |
| **Measure 2:** For an EHR reporting period in 2016, at least 1 patient who is discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH (or patient-authorized representative) views, downloads or transmits to a third party his or her information during the EHR reporting period. | |

**Eligible Hospital/CAH Objective:** Provide patients the ability to view online, download, and transmit their health information within 36 hours of hospital discharge.
### Objective 9: Secure Messaging (EPs only)

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measures for 2016</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use secure electronic messaging to communicate with patients on relevant health information.</td>
<td><strong>Measure</strong>: For an EHR reporting period in 2016, for at least 1 patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative).</td>
<td>Any EP who has no office visits during the EHR reporting period, or any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.</td>
</tr>
</tbody>
</table>
## Objective 10: Public Health

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measures for 2016</th>
<th>Exclusions</th>
</tr>
</thead>
</table>
| The EP, eligible hospital or CAH is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice. | **EPs must meet 2 of 3 measures; eligible hospitals/CAHs must meet 3 of 4 measures**

**Measure 1 – Immunization Registry Reporting:** The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit immunization data. | Any EP, eligible hospital, or CAH meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP, eligible hospital, or CAH:

- Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction’s immunization registry or immunization information system during the EHR reporting period;
- Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
- Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP, eligible hospital, or CAH at the start of the EHR reporting period. |
### Objective 10: Public Health

The EP, eligible hospital or CAH is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.

**EPs must meet 2 of 3 measures; eligible hospitals/CAHs must meet 3 of 4 measures**

**Measure 2 – Syndromic Surveillance Reporting:** The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit syndromic surveillance data.

- **Exclusion for EPs:** Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP:
  - Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system;
  - Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
  - Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period.

- **Exclusion for eligible hospitals/CAHs:** Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the eligible hospital or CAH:
  - Does not have an emergency or urgent care department;
  - Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from eligible hospitals or CAHs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
  - Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from eligible hospitals or CAHs at the start of the EHR reporting period.
### Objective 10: Public Health

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measures for 2016</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>The EP, eligible hospital or CAH is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.</td>
<td><strong>EPs must meet 2 of 3 measures; eligible hospitals/CAHs must meet 3 of 4 measures</strong>&lt;br&gt;<strong>Measure 3</strong> – Specialized Registry Reporting: The EP, eligible hospital, or CAH is in active engagement to submit data to a specialized registry.</td>
<td>Any EP, eligible hospital, or CAH meeting at least one of the following criteria may be excluded from the specialized registry reporting measure if the EP, eligible hospital, or CAH:&lt;br&gt;• Does not diagnose or treat any disease or condition associated with or collect relevant data that is required by a specialized registry in their jurisdiction during the EHR reporting period;&lt;br&gt;• Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or&lt;br&gt;• Operates in a jurisdiction where no specialized registry for which the EP, eligible hospital, or CAH is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.</td>
</tr>
</tbody>
</table>
## Objective 10: Public Health

The EP, eligible hospital or CAH is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measures for 2016</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EPs must meet 2 of 3 measures; eligible hospitals/CAHs must meet 3 of 4 measures</strong></td>
<td></td>
<td>Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the electronic reportable laboratory result reporting measure if the eligible hospital or CAH:</td>
</tr>
<tr>
<td>Measure 4 (EHs/CAHs only) – Electronic Reportable Laboratory Result Reporting: The eligible hospital or CAH is in active engagement with a public health agency to submit electronic reportable laboratory (ELR) results.</td>
<td></td>
<td>• Does not perform or order laboratory tests that are reportable in their jurisdiction during the EHR reporting period;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Operates in a jurisdiction for which no public health agency is capable of accepting the specific ELR standards required to meet the CEHRT definition at the start of the EHR reporting period; or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Operates in a jurisdiction where no public health agency has declared readiness to receive electronic reportable laboratory results from eligible hospitals or CAHs at the start of the EHR reporting period.</td>
</tr>
</tbody>
</table>
Meaningful Use of CERHT in 2016

• Clinical Quality Measures (CQMs) remain in tact as previously finalized

• Continue to align reporting requirements with Physician Quality Reporting System (PQRS)

• Use 2014 electronic specifications for CQMs
Who to Call for Help

• **QualityNet Help Desk:**
  866-288-8912 (TTY 877-715-6222)
  7:00 a.m. – 7:00 p.m. CST M-F or qnetsupport@hcqis.org
  You will be asked to provide basic information such as name, practice, address, phone, and e-mail

• **Provider Contact Center:**
  Questions on status of 2013 PQRS/eRx Incentive Program incentive payment (during distribution timeframe)

• **Physician Value Help Desk (for VM or QRUR questions)**
  Monday – Friday: 8:00 am – 8:00 pm EST
  Phone: 888-734-6433, press option 3
  Email: pvhelpdesk@cms.hhs.gov

• **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

• **Physician Compare Help Desk:**
  E-mail: PhysicianCompare@Westat.com
Resources

MACRA: MIPS & APMs

2016 MPFS Final Rule

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

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

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

Medicare Electronic Health Record (EHR) Incentive Program

Medicare EHR Incentive Program Payment Adjustments & Hardship Exceptions

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

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

Comprehensive Primary Care Initiative

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

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

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

PQRS Listserv