Physician Quality Reporting Program
Changes under the CY 2015 Physician Fee Schedule
Prepared for the American Society of Retina Specialists
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PQRS Requirements for Individuals to Avoid the 2017 Payment Penalty

Eligible professionals who do not satisfactorily report data on PQRS quality measures during the 2015 performance year will receive a -2.0% payment adjustment in 2017 on the fee schedule amount for services furnished by the eligible professional during the year. For 2015 reporting, individual eligible professionals may participate in PQRS using the following available reporting mechanisms: claims, registry, electronic health record (EHR), and through a Qualified Clinical Data Registry (QCDR). The following are the reporting options and criteria for individual eligible professionals.

Criteria: Reporting **Individual** Quality Measures via **Claims or Registry**

- For the 12-month reporting period, individual eligible professionals using claims and traditional PQRS registries must report at least 9 measures covering at least 3 of the National Quality Strategy Domains: 1) Person and Caregiver-Centered Experience and Outcomes; 2) Patient Safety; 3) Communication and Care Coordination; 4) Community/Population Health; 5) Efficiency and Cost Reduction; 6) Effective Clinical Care.
- Eligible professionals must report each measure on at least 50% of the Medicare Part B fee-for-service (FFS) patients seen during the reporting period to which the measure applies.
- Of the 9 measures reported, if the eligible professional sees at least 1 Medicare patient in a face-to-face encounter, the eligible professional must report at least one of 19 CMS-specified cross-cutting measures. (See Table 52 of final rule.)
- If less than 9 measures apply to the eligible professional, the eligible professional can report on 1 to 8 measures, and report each measure for at least 50% of Part B FFS patients. The Centers for Medicare & Medicaid Services (CMS) will use the measure application validation (MAV) process to determine whether an eligible professional should have reported quality data codes for additional measures. CMS will also use the MAV process for the cross-cutting measure requirement.
- Measures with 0 performance will not be counted.
- Traditional PQRS registries must be capable of collecting all required data elements and transmitting the data to CMS at the TIN/NPI level for at least one cross-cutting measure specified in Table 52 for the CY 2015 MPFS final rule.

Criteria: Reporting **Individual** Quality Measures via **Electronic Health Record**

- Individual eligible professionals using an EHR must report at least 9 measures covering at least 3 domains.
- Eligible professionals can report via a direct EHR that is Certified Electronic Health Record Technology (CEHRT) or via a direct EHR data submission vendor that is CEHRT.
- If an eligible professional's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional would be required to report all of the measures for which there is Medicare patient data.
- An eligible professional would be required to report on at least 1 measure for which there is Medicare patient data.

Criteria: Reporting of **Measures Groups** via **Registry**

- A registry is the only method for an eligible professional to report a measures group.
- For the 12-month reporting period, the eligible professional must report at least one measures group and report each measures group for at least 20 patients, of which a majority (11 patients) would be required to be Medicare Part B FFS patients.

Proposed Criteria: Participation in a **Qualified Clinical Data Registry**

- For the 12-month reporting period, eligible professionals must report at least 9 measures available for reporting under a QCDR covering at least 3 quality domains.
- Eligible professionals must report each measure on at least 50% of patients (Medicare and non-Medicare) seen during the reporting period to which the measure applies.
- Of the 9 measures, at least 2 must be outcome measures, or, if 2 outcomes measures are not available, the eligible professional can report on at least 1 outcome measure and at least 1 of the following types of measures: resource use, patient experience of care, efficiency/appropriate use, or patient safety.
- The American Academy of Ophthalmology's IRIS Registry was a QCDR for the 2014 performance year. CMS will list thequalified registries for the 2015 performance year in early 2015.

PQRS Requirements for Group Practices to Avoid the 2017 Payment Penalty

As previously established, a group practice for the purpose of the Group Practice Reporting Option (GPRO) is defined as 2 or more eligible professionals. For a group practice to participate in the PQRS GPRO in lieu of participating as individual eligible professionals, a group practice must register to participate in the GPRO by June 30 of the reporting period (i.e., June 30, 2015 for the 2015 performance year). For 2015 reporting, group practices may participate in PQRS using the following available reporting mechanisms: Web Interface (groups of 25+ eligible professionals only), registry, and EHR. The following are the reporting options and criteria for group practices.

Criteria: Reporting using the **GPRO Web Interface (groups 25+ eligible professionals)**

- For the 12-month reporting period, group practices with **25-99 eligible professionals** must 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 the group practice must report on 100% of assigned beneficiaries.
- For group practices with **100 or more eligible professionals**, the group must report all Clinicians & Groups Consumer Assessment of Healthcare Providers and Systems Survey (CG-CAHPS) measures via a certified survey vendor. Additionally, the group must 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 the group practice must report on 100% of assigned beneficiaries.
- A group practice is required to report on at least one measure for which there is Medicare patient data. If a group has no Medicare patients for which any of the GPRO measures are applicable, the group will not meet the criteria for satisfactory reporting using the GPRO Web Interface.
- Beneficiaries will be attributed to a group practice using the same attribution methodology used for the value-based modifier program.

Criteria: Reporting Individual Quality Measures for Group Practices via **Registry (groups 2-99 eligible professionals)**

- For the 12-month reporting period, group practices with **2-99 eligible professionals** using registries must report at least 9 measures covering at least 3 of the domains.
- Groups must report each measure on at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies.
- Of the 9 measures, if the group sees at least 1 Medicare patient in a face-to-face encounter, the group must report on at least 1 of 19 CMS-specified cross-cutting measures. (See Table 52 of the final rule.)
- If less than 9 measures apply to the eligible professional, the eligible professional can report on 1 to 8 measures, and report each measure for at least 50% of Part B FFS patients. CMS will use the MAV process to determine whether an eligible professional should have reported quality data codes for additional measures. Measures with 0 performance will not be counted.

Criteria: Reporting Individual Quality Measures for Group Practices via **EHR (groups 2-99 eligible professionals)**

- Using a direct EHR that is CHERT or an EHR data submission vendor that is CEHRT, the group must report 9 measures covering at least 3 domains.
- If the CHERT does not contain patient data for at least 9 measures covering at least 3 domains, then the group would be required to report all of the measures for which there is patient data.
- A group would be required to report on at least 1 measure for which there is Medicare patient data.

Criteria: **CMS-Certified Survey Vendor**

- CMS gives the *option* for group practices of 25 or more eligible professionals to report the CG-CAHPS measures via a Certified Survey Vendor.
- CMS *requires* group practices with 100 or more eligible professionals that participate in the PQRS GPRO to report the CG-CAHPS measures.
- Group practices that report the CG-CAHPS measures must also report on additional PQRS measures using a registry, EHR or GPRO Web Interface.
- For reporting CG-CAHPS measures, CMS requires group practices to select one of the following three options:
    - #1 – Registry: A group (2+ eligible professionals) reports all CG-CAHPS measures via certified vendor and 6 additional PQRS measures covering at least 2 domains. If less than 6 measures apply, the practice can report on less than 6 but would be subject to the MAV process. Of the additional 6 measures that must be reported, if any eligible professional in a group practice sees at least 1 Medicare patient face-to-face, the group practice would be required to report on at least 1 CMS-specified cross-cutting measure.
    - #2 – EHR: The group (2+ eligible professionals) reports all CG-CAHPS measures via certified vendor and 6 additional PQRS measures covering at least 2 domains. If less than 6 measures apply, the practice must report on all applicable measures. The group practice will be required to report on at least 1 measure for which there is Medicare patient data.
    - #3 – Web Interface: The group (25+ eligible professionals) reports all CG-CAHPS measures via a certified vendor and reports on all measures in the GPRO Web Interface, and populates 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, the practice must report on 100% of assigned beneficiaries. A group practice would be required to report on at least 1 measure for which there is Medicare patient data.

- Beneficiaries will be assigned, for the purpose of the survey, using the same assignment methodology used for the GPRO Web Interface – assigning beneficiaries to a group based on whether the group provided the plurality of primary care services. Because beneficiaries will be assigned based on this methodology, the CG-CAHPS will not be an appropriate reporting option for groups of physicians who do not provide primary care services.
- The survey will be administered by a certified survey vendor on behalf of the group practice for a sample of a group's assigned beneficiaries. CMS will no longer bear the cost of practices that report the CAHPS for PQRS survey measures.

PQRS INDIVIDUAL MEASURES

- CMS finalized 20 new measures in PQRS beginning with the 2015 performance period. New measures can be found in Table 53 of the final rule.
    - NQF #384 – Adult Primary Rhegmatogenous Retinal Detachment Repair Success Rate *(registry reporting only)*
    - NQF #385 – Adult Primary Rhegmatogenous Retinal Detachment Surgery Success Rate (*registry reporting only)*

- CMS finalized changes the National Quality Strategy domain for 23 measures, which can be found in Table 54 of the final rule. Domain changes of note include:
    - PQRS #46 – Medication Reconciliation: New domain is Communication and Care Coordination. *(Previous domain was Patient Safety.)*
    - PQRS #111 – Pneumonia Vaccination Status for Older Adults: New domain is Community/Population Health. *(Previous domain was Effective Clinical Care.)*
    - PQRS #321 – CAHPS: New domain is Person and Caregiver Experience and Outcomes. *(Previous domain was Communication and Care Coordination.)*

- CMS has finalized removing 50 of 73 proposed measures, effective the 2015 performance year. These measures can be found in Table 55 of the final rule. **CMS decided <u>against</u> removing the following measures for 2015**, but notes that these measures may be considered for removal in <u>future years</u>.
    - PQRS #14 – Age-Related Macular Degeneration: Dilated Macular Examination
    - PQRS #140 – Age-Related Macular Degeneration: Counseling on Antioxidant Supplement

- CMS finalized changes to reporting mechanisms for 28 measures. These measures can be found in Table 56 of the final rule. Changes of note include:
    - PQRS #18 – Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy. *(EHR reporting only.)*
    - PQRS #238 – Use of High-Risk Medications in the Elderly. *(Registry reporting option added, in addition to EHR reporting.)*

  CMS decided <u>against</u> removing claims reporting for the following measures:

    - PQRS #19 – Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care. *(Claims, registry and EHR reporting available.)*
    - PQRS #117 – Diabetes: Eye Exam. *(Claims, registry, EHR, GPRO Web Interface, measure group reporting available.)*

- PQRS #46 – Medication Reconciliation. *(Claims and registry reporting available.)*

PQRS MEASURES GROUPS

- CMS finalized increasing the minimum number of measures included in a PQRS measures group from 4 or more to 6 or more. Consequently, CMS is adding additional measures to groups that previously contained less than 6 measures. Many of the measures newly added to groups are cross-cutting measures contained in Table 52 of the final rule.

- CMS is finalizing two additional measures groups: Sinusitis and Acute Otits Externa.

Note: Measure tables referenced in this document can be accessed in the Medicare Physician Fee Schedule final rule.