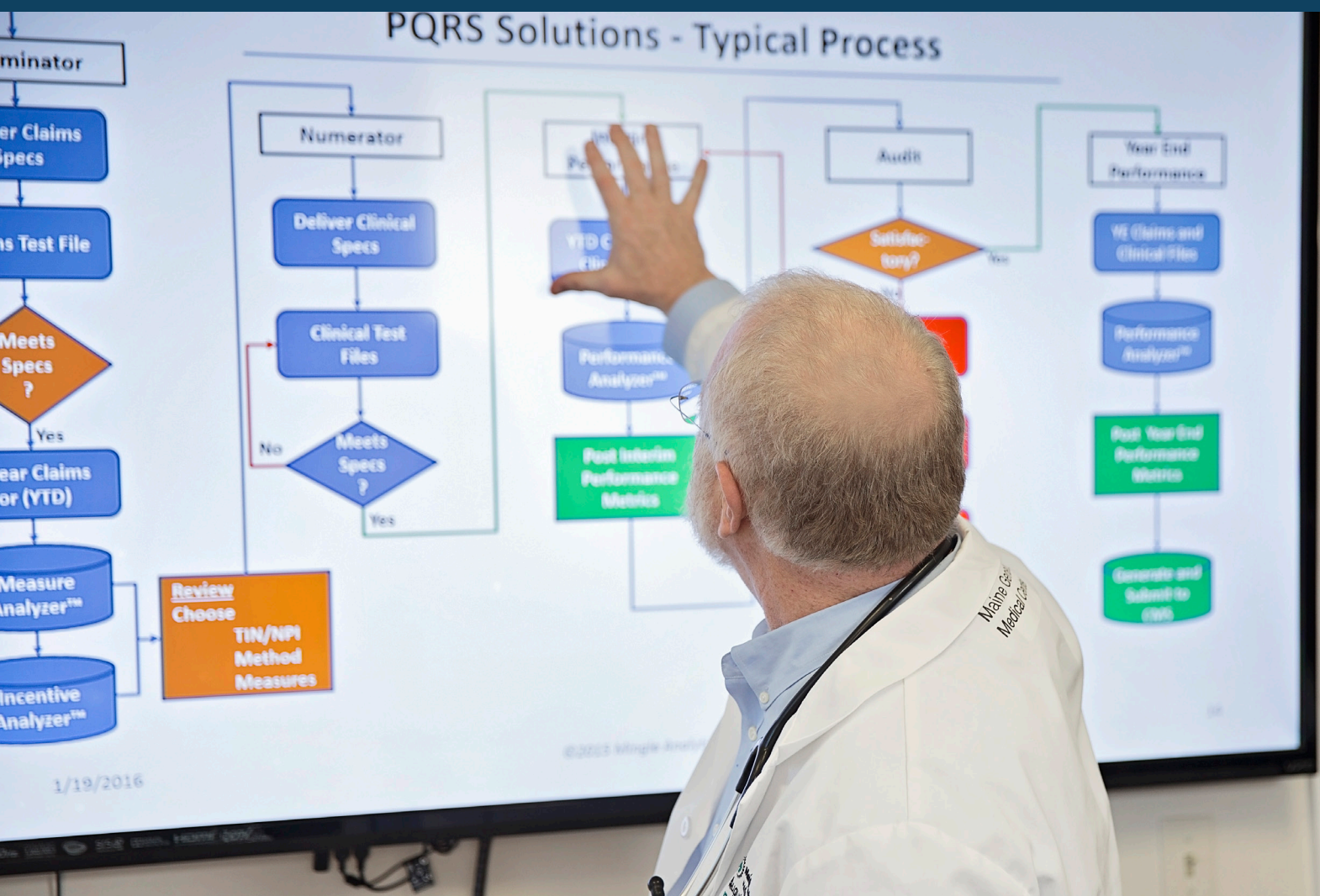




Medicare PQRS Reporting for 2016

WEBINAR RECAP



Why should your practice participate in PQRS in 2016?

Because there's money on the line for 2018! You can incur a penalty for not submitting, which will affect your payments from Medicare. In a recent webinar, Dr. Dan Mingle reviewed what's at risk, what can be gained and how PQRS submissions generally work. Here's a recap of the important highlights.



PQRS 2016 Risks

Money to be Lost

Failing to make a qualifying submission for PQRS in 2016 will result in a 2% downward adjustment to all of your Medicare payments in 2018. If you're an MD or DO, the penalty represents, on average, about \$2,000 per provider. The loss has been as high as \$335,000 – it all depends on your Medicare Part B billings. Non-MDs or DOs who don't participate in PQRS have an average loss of \$650, with the maximum penalty potentially reaching \$40,000.

The **Value Modifier (VM)** program adds to the penalty. Groups of fewer than 10 providers who fail to submit under the **Group Practice Reporting Option (GPRO)** or groups in which at least half of the providers don't submit individually, will have an additional penalty. For example, on top of the PQRS penalty, groups with fewer than 10 providers where more than half didn't submit will average an additional \$2,000 loss per MD/DO provider and \$650 per other providers. Groups with more than 10 providers where half didn't submit PQRS will average a \$4,000 loss per MD/DO provider and \$1,300 per other providers.

	PQRS Adjustment (-2%)		Value Modifier (VM) Adjustment (-2%)	Value Modifier (VM) Adjustment (-4%)
Based On	Failure to make a qualifying PQRS Submission		Groups < 10 Providers where ≥ half did not submit PQRS	Groups ≥ 10 Providers where ≥ half did not submit PQRS
	Average	Max	Average	Average
MD/DO	\$2,000	\$335,000	\$2,000/Provider	\$4,000/Provider
Other Provider	\$650	\$40,000	\$650/Provider	\$1,300/Provider

Money to be Made

Quality Tiering under VM has the potential for at least a 1-2% negative adjustment and potentially much higher positive payment adjustments throughout 2018 for high quality and low cost care. There is also a Maintenance of Certification (MOC) program in place through some specialty societies that offers an additional 0.5% lump sum incentive in 2017 if you participate in PQRS in 2016 and meet their other requirements. This may not be available under the Merit-Based Incentive Payment System (MIPS).

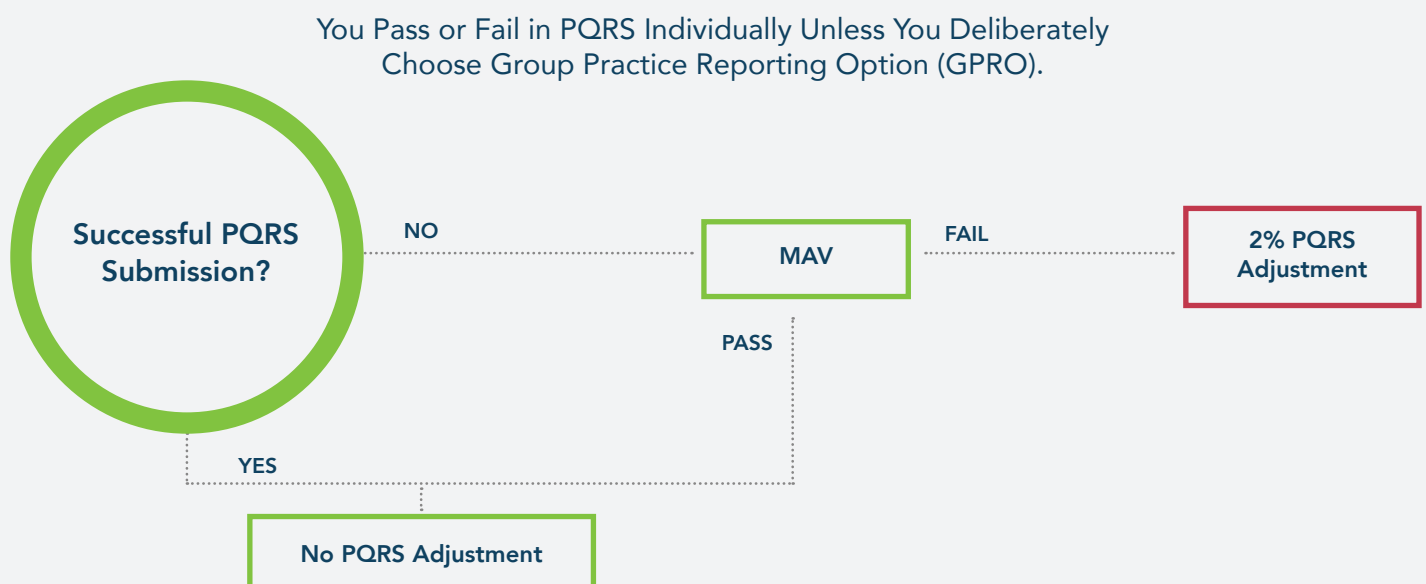
Under MIPS and the Quality Payment Program, the amount of money on the line will only increase. By 2022, according to the 2017 Proposed Rule, the potential incentives and penalties under MIPS will +/-9%

Visualize This System as 3 Checkpoints:

CHECKPOINT ONE

PQRS is the first checkpoint. You either submit or you don't and the responsibility is the individual provider's unless you choose GPRO. The penalty you receive for not submitting or receiving a failing score in this category will result in a 2% cut to every Medicare reimbursement check in 2018.

MAV is the Measure Applicability Validation test. For practices that don't have the eligibility to report nine measures, a single measure submission can qualify you for PQRS and help you avoid the adjustment under MAV. If you fail MAV, you will be subject to the negative PQRS adjustment and 2% will be taken out of every reimbursement check in 2018.



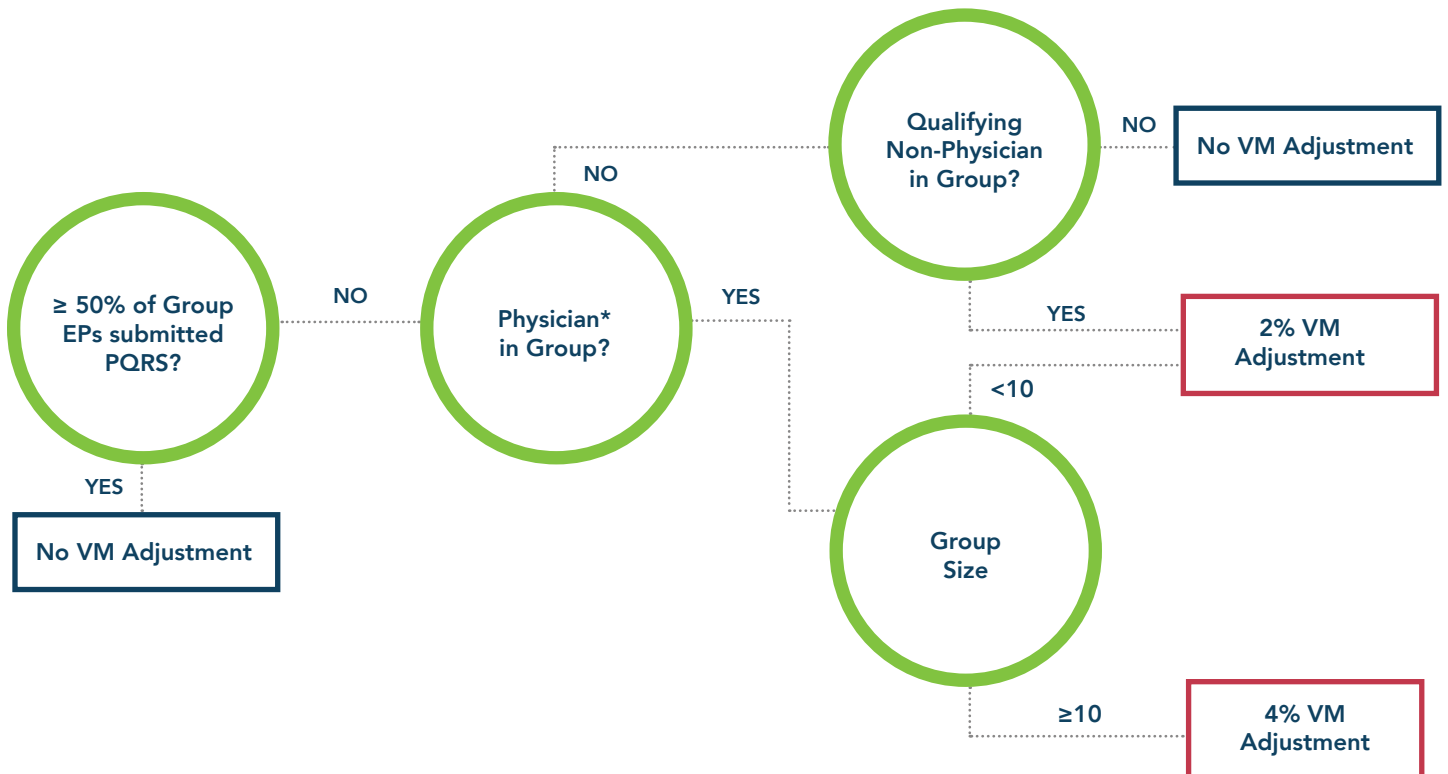


CHECKPOINT TWO

Under VM, you will pass if you participate in PQRS. But if you don't make a PQRS submission, you will incur an additional penalty. Non-physicians have been exempt from VM up until this year.

Value Modifier 2016

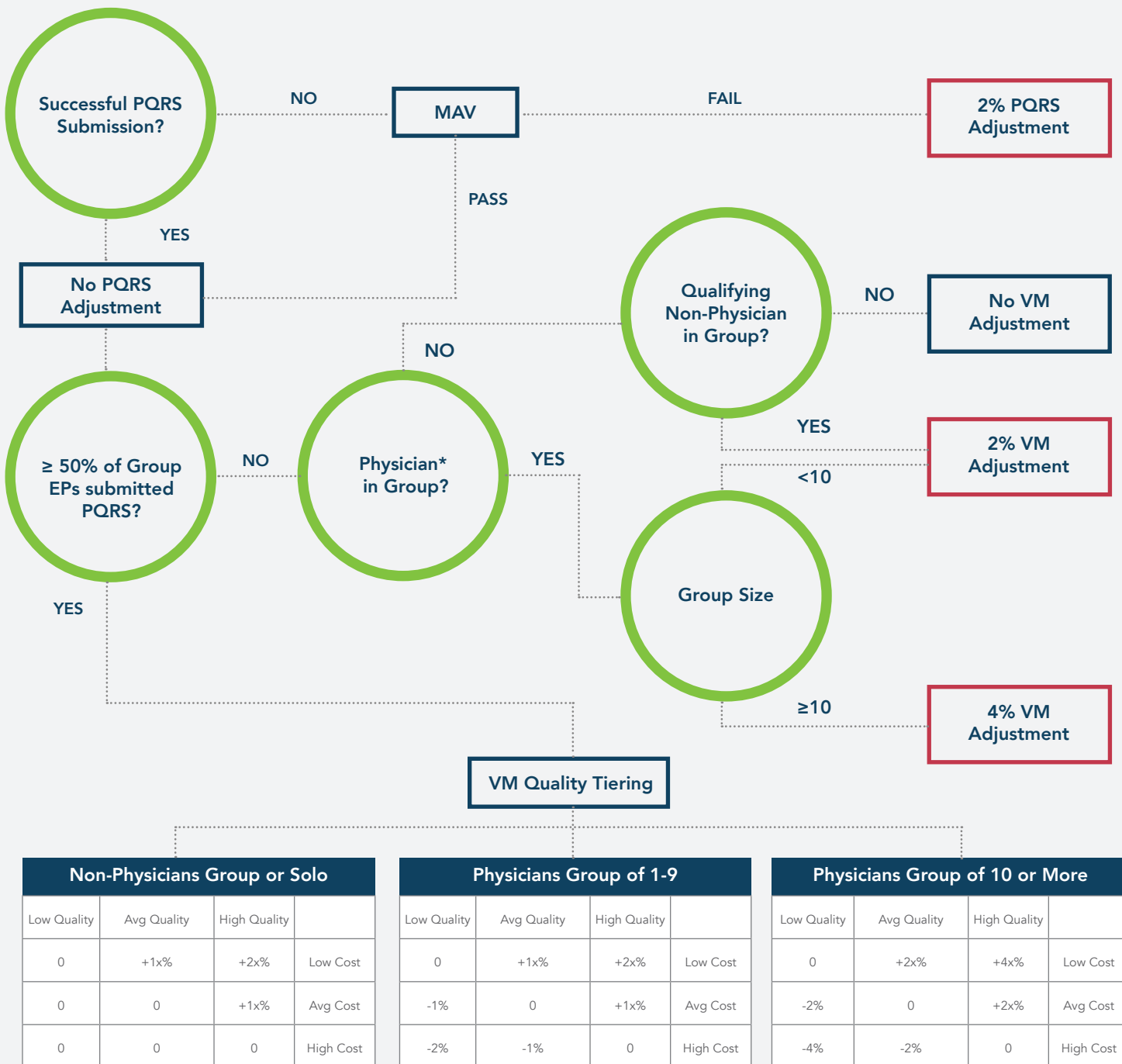
You Pass or Fail in VM as a Group



CHECKPOINT THREE

If you passed PQRS and VM, next you'll be evaluated under Quality Tiering, where you'll gain or lose based on the cost and quality of care you deliver as compared to other Medicare providers. You'll be scored on cost and quality as average, below average or above average. You gain and lose for a score above or below average, respectively.

Then There's Quality Tiering





Who is Subject to PQRS in 2016?

Any provider who generates a bill to Medicare Part B that is covered by the Physician Fee Schedule is subject to a penalty if they don't participate in PQRS. If a Critical Access Hospital (CAH) provider assigns their benefit to the CAH, the CAH must report on behalf of the provider.

Those not subject to PQRS include:

- ✓ Federally Qualified Health Centers
- ✓ Independent Diagnostic Testing Facilities
- ✓ Independent Laboratories

Reporting Basics

If you're reporting as an individual, the gold standard for a successful PQRS submission is to submit at least nine measures in three domains for at least 50% of the Medicare patients in your practice who are eligible for each measure. Measures with 0% performance won't be counted.

You also must have at least one cross-cutting measure if you have at least one face-to-face visit within a year. A cross-cutting measure is one that is broadly applicable to most patients and across specialties.

Alternatively, you may submit a Measure Group as an individual provider. A Measure Group is a series of four to nine measures that have a common theme, for example diabetes or oncology. If you use a Measure Group, you report on just 20 patients that are eligible for that Measure Group.

At least 50% of providers in your group must make a successful PQRS submission to avoid the Value Modifier penalty.

Group Practice Reporting Option (GPRO)

GPRO allows providers to submit PQRS as a group. With one GPRO submission, you qualify ALL your providers to avoid the PQRS and VM penalty. Without GPRO, you have to be sure that at least 50% of your providers participate in PQRS or you'll be subject to up a 4% penalty under the VM.

Other than Measure Groups for small practices, we believe that GPRO Registry is the most reliable, cost-effective method that eases the burden of reporting for PQRS, since all providers succeed on just one submission. Using a Registry has the added benefit of giving you the widest choice of measures.

By June 30, 2016, you had to declare in the CMS Enterprise portal that you would submit as a GPRO. But, as of November 2015, you're no longer trapped in your choice. Though it is not encouraged, you are able to change your submission method from GPRO to individual submissions.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a required survey for all practices with more than 100 practitioners submitting GPRO and is optional for any group of two or more providers. Medicare no longer pays for this survey and practices must contract with a CAHPS-for-PQRS survey vendor.

CAHPS counts for three measures and one non-specific domain. Some practices may not have enough attributed patients to be eligible for this survey. If you are eligible, then you will only need six more measures and two more domains for a complete submission.

Available 2016 Measures by Method

	2014	2015	2016
Claims Measures	110	72	79
EHR (CQM) Measures	64	62	63
Registry Measures	201	175	198
Web Interface Measures	22	17	18
Measure Groups	24	22	25

What if I Can't Report on Nine Measures?

If you don't feel like you're able to report on nine measures across three domains, you can submit fewer measures depending on your submission method:

Submission Method	Measures
Claims & Registry Reporting	Submit one MAV cluster
EHR Reporting	Submit what you have
Web Interface	Submit what you have
Qualified Clinical Data Registry	Must always submit nine measures in three domains plus two outcome measures

To MAV or Not to MAV?

Only resort to the Measure Applicability Validation test, or MAV, if reporting nine measures and three domains is simply not appropriate or possible for your practice. While Medicare discourages taking advantage of this option, it may be the only option for your type of practice or specialty. Our team can talk with you about the best approach for your submission.

Feedback Reports

Once you've made your submission, Medicare will publish the results in reports available in the CMS Enterprise Portal. A limited subset of information will also be publicly available on the Physician Compare website. Here are the types of feedback and performance reports that will be available:

Report	Related to	Available
Feedback Report	PQRS	Third Quarter
Quality Resource and Utilization Report (QRUR)	Value Modifier and Quality Tiering	Third Quarter
QRUR Supplemental	Episode of Care Cost Performance	Fourth Quarter
QRUR Mid-Year	Split Year Last July-Jun Cost and Administrative Claims Performance	Second Quarter
Interim Feedback Report	YTD Claims Performance	Sporadically



There is helpful data in each report, but you'll need to be on the lookout for each one.

Medicare doesn't always announce when they become available, so you'll need to check frequently and you will need an EIDM account to access them in the CMS Enterprise portal.

If you're going to get penalized, you have 60 days to file an informal review. This gives you the chance to make a case as to why you should not receive a penalty.

Progam	Timeframe
PQRS	Must be requested within 60 days following publication of the PQRS feedback report.
VM	Requests due 60 days after publication of QRUR

Within CMS, PQRS and VM are completely different programs, which means they can each have a different decision when it comes whether or not you receive a penalty.

PQRS Timeline

If there are no delays for MIPS and the new Quality Payment Program, the following timeline is a visual guide for what you can expect this year and next.

2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2
2016 Providers: Provide Care Document Care Accumulate Data					
JAN-MAR 2015 Submissions Submission Portal Opens EHR & QCDR QRDA Due GPRO Web Interface Due Registry & QCDR XML Due	APR-JUN 2015 Submissions Submission Portal Opens EHR & QCDR QRDA Due GPRO Web Interface Due Registry & QCDR XML Due	JUL GPRO 2016 Self Nomination Due AUG-SEPT 2015 Feedback Reports and QRUR Available	OCT-DEC Apply for Informal Review 2017 Pentalty Notices	JAN-MAR Full Year Data Set 2016 Submissions Submission Portal Opens EHR & QCDR QRDA Due GPRO Web Interface Due Registry & QCDR XML Due	
				MIPS Begins	PQRS Ends

Medicare's Final Rule on the future of quality reporting will be released in November 2016. But even if there are changes, it's important to know that quality reporting will not go away. PQRS and Meaningful Use will simply be renamed and remixed as they roll into MIPS and the Quality Payment Program.

For a more in-depth overview on this topic, watch the full, on-demand webinar [here](#).

And for more information regarding your practice's specific reporting options, please don't hesitate to contact our team so we can ease the burden of Medicare reporting for you.

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