2016 PQRS Group Practice and ACO Web Interface Reporting Mechanism

Web Interface Q&A Session Support Call

Program Year 2016

February 2, 2017

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Announcements

1. During this support call, Pioneer Model Accountable Care Organizations (ACOs), Next Generation ACOs, Shared Savings Program ACOs, and PQRS group practices will be collectively referred to as organizations.
2. Review the Web Interface measure specifications and supporting documents on the GPRO Web Interface page of the CMS website.

Reminders

1. Important Dates for 2016 Web Interface Data Submission

Date	Topic
1/16/2017 through 3/17/2017	Web Interface submission period
3/20/2017 through 4/21/2017	Access submission reports

Note: The Web Interface will close at **8:00PM ET on 3/17/2017**. CMS encourages organizations to submit data well *before* 8:00PM ET to ensure it is fully submitted before the Web Interface closes.

Reminders (cont.)

2. Upcoming 2016 Web Interface Data Submission Support Calls

Date	Time (ET)	Topic
2/9/2017	1:00-2:00 PM	Web Interface Q&A Session
2/16/2017	1:00-2:00 PM	Web Interface Q&A Session
2/23/2017	1:00-2:00 PM	Web Interface Q&A Session
3/2/2017	1:00-2:00 PM	Web Interface Q&A Session
3/9/2017	1:00-2:00 PM	Web Interface Q&A Session
3/14/2017	12:00-1:00 PM	Web Interface Q&A Session
4/6/2017	1:00-2:00 PM	Web Interface Lessons Learned

Note: Support calls will offer a question and answer session if the title indicates “Q&A Session”

Reminders (cont.)

3. **2017 Upcoming Outages/Maintenance Weekend Schedule:** The Physician and Other Health Care Professionals Quality Reporting Portal (Portal) will be unavailable for scheduled maintenance; therefore, the Web Interface will not be accessible during the following periods:
   - Every Tuesday starting at 8:00PM ET–Wednesday at 6:00AM ET
   - Every Thursday starting at 8:00PM ET–Friday at 6:00AM ET
   - Third weekend of each month starting Friday at 8:00PM ET–Monday at 6:00AM ET
     - February (2/24/2017 – 2/27/2017)*

*The third weekend of February (2/17-2/20) is skipped due to a federal holiday

Reminders (cont.)

4. **Reporting Requirements**: Organizations must completely report the required number of beneficiaries in order to satisfactorily report:
   - Minimum of 248 consecutively confirmed and completed beneficiaries in each module; OR
   - 100 percent of beneficiaries if they have fewer than 248 beneficiaries available in the sample

Reminders (cont.)

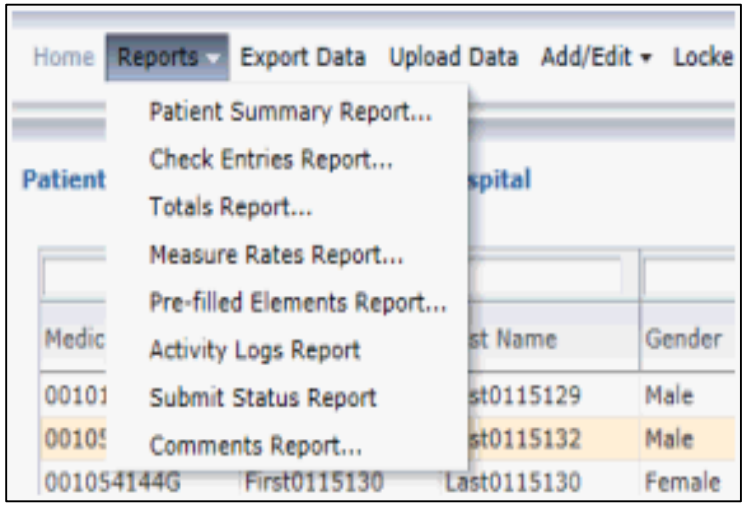
5. **Avoiding future payment adjustments:** Satisfactorily reporting all 18 Web Interface quality measures will allow PQRS group practices and EPs participating in an ACO to avoid the 2018 PQRS payment adjustment
6. **Alignment with the Medicare EHR Incentive Program:** EPs participating in an ACO or PQRS group practice who meet 2016 Web Interface submission requirements will satisfy their CQM reporting for the Medicare EHR Incentive Program
   - PQRS group practices are required to use EHR technology certified to the 2014 Edition to populate the Web Interface
   - EPs participating in an ACO must use certified EHR technology to abstract data to report to the ACO, in the form and manner specified by the ACO. ACOs must then satisfactorily report the Web Interface measures.
   - All EPs must individually attest separately to the EHR Incentive Program for other program requirements
7. **Shared Savings Program:** ACOs who fail to satisfactorily report Web Interface measures will not meet the quality performance standard and will be ineligible to share in savings, if earned

Presenter: Sue Hanlon, CMS Contractor

WEB INTERFACE DATA SUBMISSION

Web Interface Reports

- The Web Interface has 8 reports to assist you in successfully completing your GPRO data submission.

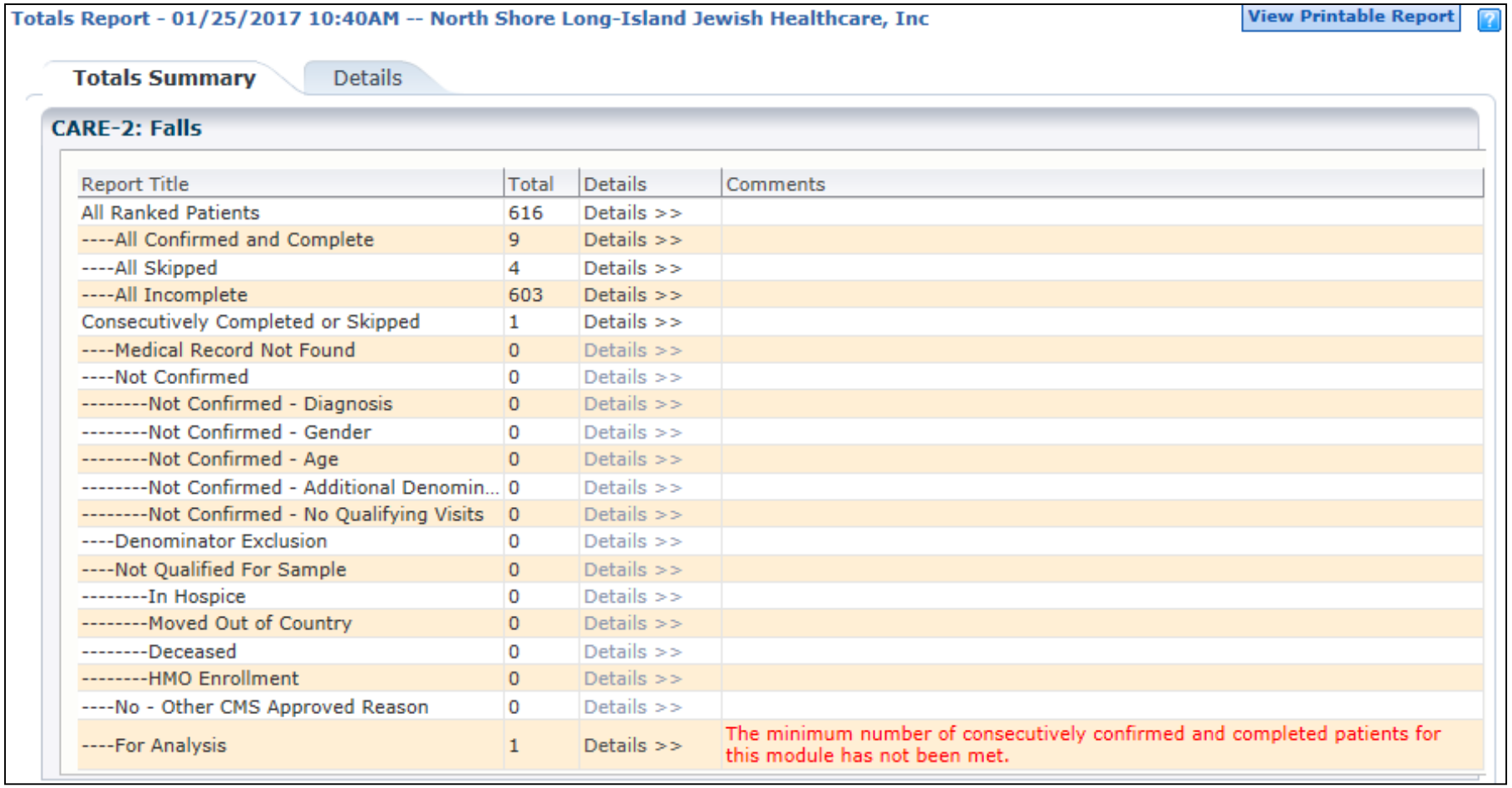


- Extremely useful are the Totals Report and the Measure Rates Report.

Totals Report

- Totals Report contains completeness information by measure:
  - Summary section contains completeness information in a number of categories.
  - Detail section is a drill-down to patient specifics for selected completeness category.

Totals Report (cont.)



Totals Report - 01/25/2017 10:40AM -- North Shore Long-Island Jewish Healthcare, Inc

View Printable Report

Totals Summary | Details

CARE-2: Falls

Report Title	Total	Details	Comments
All Ranked Patients	616	Details >>	
----All Confirmed and Complete	9	Details >>	
----All Skipped	4	Details >>	
----All Incomplete	603	Details >>	
Consecutively Completed or Skipped	1	Details >>	
----Medical Record Not Found	0	Details >>	
----Not Confirmed	0	Details >>	
--------Not Confirmed - Diagnosis	0	Details >>	
--------Not Confirmed - Gender	0	Details >>	
--------Not Confirmed - Age	0	Details >>	
--------Not Confirmed - Additional Denomin...	0	Details >>	
--------Not Confirmed - No Qualifying Visits	0	Details >>	
----Denominator Exclusion	0	Details >>	
----Not Qualified For Sample	0	Details >>	
--------In Hospice	0	Details >>	
--------Moved Out of Country	0	Details >>	
--------Deceased	0	Details >>	
--------HMO Enrollment	0	Details >>	
----No - Other CMS Approved Reason	0	Details >>	
----For Analysis	1	Details >>	The minimum number of consecutively confirmed and completed patients for this module has not been met.

Measure Rates Report

- Measure Rates Report contains performance information for each measure:
  - Summary level lists the number of patients in components of the performance equation.
  - Summary level contains the measure rate.
  - Detail level contains specific patient identifying data for the selected component.

Measure Rates Report (cont.)

Measure Rates Report - 08/21/2016 10:18AM -- (A1229) Mercy ACO, LLC

View Printable Report

Summary | Details

Measure	Total Eligible(1)	Denominator Exceptions(2)	Denominator(3)	Measure Not Met(4)	Measure Met(5)	Measure Rate(6)	Total Complete(7)	Total Incomplete(8)
CARE-2	0 >>	0 >>	0 >>	0 >>	0 >>	---	2 >>	614 >>
* CARE-3	0 >>	0 >>	0 >>	0 >>	0 >>	---	2 >>	614 >>
CAD-7	0 >>	0 >>	0 >>	0 >>	0 >>	---	1 >>	615 >>
(9)DM-2	0 >>	0 >>	0 >>	0 >>	0 >>	---	1 >>	615 >>
DM-7	0 >>	0 >>	0 >>	0 >>	0 >>	---	1 >>	615 >>
DM-COMP	0 >>	0 >>	0 >>	0 >>	0 >>	---	1 >>	615 >>
HF-6	0 >>	0 >>	0 >>	0 >>	0 >>	---	1 >>	615 >>
HTN-2	0 >>	0 >>	0 >>	0 >>	0 >>	---	2 >>	614 >>
IVD-2	0 >>	0 >>	0 >>	0 >>	0 >>	---	3 >>	613 >>
MH-1	0 >>	0 >>	0 >>	0 >>	0 >>	---	1 >>	615 >>
PREV-5	0 >>	0 >>	0 >>	0 >>	0 >>	---	0 >>	616 >>
PREV-6	0 >>	0 >>	0 >>	0 >>	0 >>	---	1 >>	615 >>
PREV-7	0 >>	0 >>	0 >>	0 >>	0 >>	---	1 >>	615 >>
PREV-8	0 >>	0 >>	0 >>	0 >>	0 >>	---	1 >>	615 >>
PREV-9	0 >>	0 >>	0 >>	0 >>	0 >>	---	1 >>	615 >>
PREV-10	0 >>	0 >>	0 >>	0 >>	0 >>	---	1 >>	615 >>
PREV-11	0 >>	0 >>	0 >>	0 >>	0 >>	---	0 >>	616 >>
PREV-12	0 >>	0 >>	0 >>	0 >>	0 >>	---	1 >>	615 >>
PREV-13	0 >>	0 >>	0 >>	0 >>	0 >>	---	1 >>	615 >>

Footnotes

1. Total Eligible = the number of consecutively completed and confirmed Patients/Visits eligible for the measure (meets inclusion criteria).
2. Denominator Exceptions = the number of eligible patients that were taken out of the Denominator for medical, patient or system exception reasons (where applicable).
3. Denominator = total Patients/Visits minus Denominator Exceptions.
4. Measures Not Met = the number of eligible Patients/Visits that did not meet the measure criteria.
5. Measure Met = the number of eligible Patients/Visits that met the measure criteria.
6. Measure Rate = Measure Met divided by Denominator multiplied by 100%.
7. Total Complete = the number of Patients that have been completed in any order for the measure.
8. Total Incomplete = the number of Patients that are incomplete for the measure.
9. For DM-2, a lower rate indicates better performance/control.

* = Visit measure. Summary report (columns 1 thru 6) provides counts by each visit. Detail report provides counts by unique patient.

N/A = No Patients have been sampled for the measure.

--- = The Denominator is zero. No measure rate exists for the measure.

Other Reports

- **Check Entries** – shows existing errors in the data uploaded via XML or through data entry
- **Submission Status** – displays the status of the practices data submission with measure specific status
- **Patient Summary** – contains the data currently in the database listed for the patient selected
- **Pre-filled Elements** – displays the original data value and the current data value for pre-filled elements
- **Comments** – provides user comments for all patients in selected measures
- **Activity Log** – shows a comprehensive audit trail of all user activities performed for the organization during the submission period

Presenter: Deb Kaldenberg, CMS Contractor

FREQUENT MEASURES QUESTIONS

Web Interface Measure Questions

Number	Question	Answer
1	Question: For one of our patients we have visit dates selected by CMS but these visits were only for Lab work (pt. did not see a doctor) Should we be using option: "Patient seen on this date": Yes or No-visit outside the practice	Look for a visit within the 1-2 days of the lab visit as a visit was found in claims to prepopulate the Web Interface. No-Visit Outside of Practice should only be selected if the patient was not seen at the office/clinic visit on that date (+/- 2 days) The Evaluation Codes tab of the CARE Supporting Document includes the visits used to attribute patients to the CARE-3 measure. The Supporting Documents can be found on the CMS website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html From the posted Q&A: The CARE-3 measure is not intended to be limited to providers listed in the three PCP locations in the Web Interface (NPI1, NPI2, and NPI3), so you should abstract those patients seen by other providers. Keep in mind, all populated visits were taken from claims billed by one of your group's participant TINs (i.e., these visits are considered 'within the ACO') or at your group practice.
2	For the measure PREV-9: BMI Screening and Follow-up Plan, if a patient has a chronic condition such as diabetes or hypertension, along with an abnormal BMI, and the provider counsels them to watch their diet or exercise, would this satisfy the measure?	If an abnormal BMI was calculated during an encounter when a patients diagnosis was being addressed (for example diabetes) and the documented recommended follow up plan addressed both conditions, this would be acceptable. PREV Data Guidance at the following link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html

Presenter: Michael Kerachsky, CMS Contractor

RESOURCES & WHERE TO GO FOR HELP

Educational Resources

- **Web Interface Webpage of the CMS PQRS Website:** http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html
  - Web Interface support call presentations
  - Assignment Methodology and Sampling Document
  - GPRO Web Interface XML Specification
  - Supporting Documents
    - *Data Guidance is included as a separate tab in each of the supporting documents' workbooks*
  - Web Interface Quality Reporting Questions and Answers
  - Educational Demonstrations
  - Portal: https://qnpapp.qualitynet.org/pqrs/home.html
- **Shared Savings Program ACO:**
  - Website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html
  - Quality Measures, Reporting and Performance Standards: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality-Measures-Standards.html
  - Portal: https://portal.cms.gov/
    - EIDM and Measure Quick Reference Guides, Quality Reporting News and Updates
  - Weekly ACO Spotlight Newsletter
- **Pioneer ACO Model:**
  - Website: http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/
  - Portal: https://portal.cms.gov/
- **Next Generation ACO Model:**
  - Website: https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/
  - Portal: https://app.innovation.cms.gov/NGACOConnect/

Help Desks

- **QualityNet Help Desk (PQRS and EIDM Web Interface)**
  - E-mail: qnetsupport@hcqis.org
  - Phone: (866) 288-8912 (TTY 1-877-715-6222)
  - Fax: (888) 329-7377
- **CAHPS for PQRS Survey Project Team**
  - E-mail: pqrscahps@hcqis.org
- **EHR Incentive Program Information Center**
  - Phone: (888) 734-6433 (TTY 888-734-6563)
- **Value-based Payment Modifier Help Desk**
  - Phone: (888) 734-6433 Option 3 or pvhelpdesk@cms.hhs.gov
- **Physician Compare**
  - E-mail: PhysicianCompare@westat.com
- **Medicare Shared Savings Program ACO**
  - Email: sharedsavingsprogram@cms.hhs.gov
- **Pioneer ACO**
  - E-mail: PIONEERQUESTIONS@cms.hhs.gov
- **Next Generation ACO**
  - E-mail: NextGenerationACOModel@cms.hhs.gov

Acronyms

- **ACO** – Accountable Care Organization
- **CAHPS** –Consumer Assessment of Healthcare Providers and Systems summary surveys
- **CMS** – Centers for Medicare & Medicaid Services
- **CQMs** – Clinical Quality Measures [for attestation]
- **eCQMs** – Electronic Clinical Quality Measures [for electronic reporting]
- **EHR** – Electronic Health Record
- **EIDM** – Enterprise Identify Management System
- **EP** – Eligible Professional
- **FFS** – Fee-for-Service
- **GPRO** – Group Practice Reporting Option
- **MPFS** – Medicare Physician Fee Schedule
- **NPI** – National Provider Identifier
- **ONC** – Office of the National Coordinator for Health Information Technology
- **PQRS** – Physician Quality Reporting System
- **Value Modifier** – Value-based Payment Modifier

QUESTIONS & ANSWERS