2016 AOA CAP for PQRS Registry FAQ

What is the Physician Quality Reporting System (PQRS)?
PQRS (formerly PQRI) was developed by CMS in 2007 as a voluntary pay-for-reporting program that provides a financial incentive to physicians and other eligible professionals who report data on quality measures for covered services furnished to Medicare beneficiaries. Eligible providers for the current period (calendar year 2015) should complete PQRS reporting to avoid a downward payment adjustment of 2% of their total allowed Medicare charges for Physician Fee Schedule (PFS) covered services in calendar year 2017. For more information about PQRS, you can access the CMS website at [http://www.cms.gov/PQRS](http://www.cms.gov/PQRS).

What is the AOA CAP for PQRS Registry?
AOA CAP Registry is an easy to use online tool to help physicians and other eligible professionals quickly and easily participate in PQRS. Similar to online tax preparation software, the AOA CAP Registry helps guide professionals through a few easy steps to rapidly collect, validate and submit their results to CMS. The AOA CAP Registry is a CMS Qualified Registry for PQRS reporting, powered by CECity.

What do I have to do to participate?
You will need to select your measures, complete the registration, and enter data from your Medicare Part B patients (for measure group reporting only, non-Medicare patients are also permitted). You will be presented with a series of questions for each patient. It only takes a few minutes to enter each patient. The AOA CAP Registry will submit your completed report to CMS on your behalf.

What is the cost to use the AOA CAP PQRS Registry?

<table>
<thead>
<tr>
<th>Eligible Professional</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>AOA Members</td>
<td>$199</td>
</tr>
<tr>
<td>Non-Members (DOs/MDs/Nurse Practitioners/Physician Assistants/Certified Nurse Specialists/Registered Dieticians/Others)</td>
<td>$299</td>
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What is the PQRS Penalty?
There is no longer an incentive payment for PQRS participation, the PQRS program carries an automatic 2% penalty for non-participation in reporting PQRS measures by eligible solo providers and GPRO group practices.

Eligible professionals who do not satisfactorily report data on quality measures for covered professional services will incur a downward payment adjustment. The PQRS payment adjustment applies to all of the eligible professional’s Part B covered professional services under the Medicare Physician Fee Schedule (PFS). Reporting during the 2016 PQRS program year will be used to determine whether a 2.0% penalty applies in 2018.
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I have not coded PQRS codes into my claims for 2016, can I still participate?
YES! You can still be eligible for your 2016 reporting even if you have not changed the way you code your claims. You can report through the AOA CAP Registry, because it utilizes the registry-based approach to PQRS reporting. Because of this, you can report your patients to the registry, without coding your claims. You can report patients from encounters earlier in 2016, as well as prospective 2016 encounters.

I have been submitting PQRS data through my claims or to another registry. Can I switch to the AOA CAP Registry?
YES! If you would like to switch to AOA CAP Registry, you can do so. CMS will review and analyze each of your submissions independently and will use the submission that is most advantageous to you.

What measures are available through AOA CAP Registry?
AOA CAP Registry supports all measure groups and individual measures for registry reporting.

Which measures should I report?
It is recommended that you choose measures that apply to a significant portion of your patient population. AOA CAP Registry includes a measures selection guide to help you select the appropriate measures. It's important to note that a 0% performance rate for any one measure reported may result in payment adjustment. AOA CAP Registry will prompt you to enter additional patients should this scenario occur.

What if I do not see measures that are applicable to my practice?
If you don’t see any measures that can be applied to your patient population (see question above), then you may wish to contact CMS to determine how best to proceed.

How much time will it take me to complete my PQRS reporting using AOA CAP Registry?
The answer to this question largely depends on your accessibility to patients and information about their treatments. AOA CAP Registry’s approach is designed to reduce the amount of time and subsequent reporting errors that may occur when reporting PQRS measures. Many users of the AOA CAP Registry have completed their report in just a few hours.

There are multiple practitioners in my practice, which are eligible for reporting?
PQRS is intended for physicians, therapists, and other practitioners that would ordinarily submit claims for Medicare Part B services. To see the full list of eligible professionals, visit this link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016_PQRS_List_of_EP.pdf

Do I have to apply for reporting for each practitioner?
Yes. PQRS performance scores are calculated using your individual NPI and TIN combination. The NPI and TIN combination that you provide during registration will be used by CMS to determine your eligibility for PQRS reporting. If you need to register multiple NPI and TIN combinations, then each additional combination will require a new AOA CAP Registry account registration and report submission.
How many patients do I need to report? Does it matter which ones I choose?
There are different requirements for reporting on Measure Groups versus Individual Measures.
• For Measures Groups reporting, CMS requires that you report on twenty (20) patients that are eligible for the Measures Group. You must have a minimum of 11 Medicare Part B Fee-For-Service (FFS) within your 20-patient sample, and the remaining patients may be non-Medicare.

• For Individual Measures reporting, you must report on 50% of your Medicare Part B FFS patients that are eligible for a minimum of nine individual measures across 3 National Quality Strategy (NQS) Domains. Providers who see patients in a face-to-face encounter must report on at least 1 Cross-Cutting measure within their measure selection. All patients reported must have been seen during the 2016 calendar year.

What is considered a “Face-to-Face” Encounter?
CMS defines a face to face encounter as an instance in which the EP billed for services that are associated with face-to-face encounters under the Medicare Physician Fee Schedule (MPFS). This includes general office visits, outpatient visits, and surgical procedure codes; however, CMS does not consider telehealth visits as a face-to-face encounter.

How do I know that I’ve completed the process?
The AOA CAP Registry "Progress Monitor" will visually display the requirements and track the number of eligible patients entered based on the measures selected. Once you have met the requirements, the AOA CAP Registry will indicate that your report is complete and allow you to submit your report. Until you meet the requirements, you will not be able to submit your report.

I have entered all of my data and submitted my PQRS report through AOA CAP Registry. When will I be able to access my feedback report?
CMS has not provided specific information as to when the 2016 feedback will be available. However, based on previous years, it’s likely that the 2016 feedback will be available by the fall of 2017. For more information about your reporting or feedback report for any year, contact the CMS PQRS Help Desk.

How can I contact the CMS PQRS Help Desk?
Your PQRS-related questions can be addressed to the QualityNet Help Desk, 7:00 AM – 7:00 PM CST. You can reach the QualityNet Help Desk by phone: 1-866-288-8912, or Email: qnetsupport@hcqis.org.

Where can I find the CMS Measure Specifications Manual?
Click here to access information on the CMS website about PQRS quality measures, including detailed specifications and related release notes for the individual PQRS quality measures and measures groups.
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How do I select between Measures Groups and Individual Measures?
Review the available Measures Groups and Sets of Individual Measures by clicking the applicable Member on Non Member Start Now button within the AOA CAP for PQRS website, and scroll to the Product Selection Guide. It is recommended that you choose measures that apply to a significant portion of your patient population. It’s important to note that a 0% performance rate for any one measure reported will result in incentive ineligibility.

To select the method that fits your practice best, review the required sample of patients, eligible denominator information such as diagnosis code and encounter/procedure code, and select the method that is most applicable to your practice.

How do I report Individual Measures?
Report at least 9 measures covering at least 3 of the NQS domains (and a Cross Cutting measure, if you see patients in a face to face setting), OR, if less than 9 measures covering at least 3 NQS domains apply to the eligible professional, report 1—8 measures covering 1-3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50% of the eligible professional’s Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.

For an eligible professional who reports fewer than 9 measures covering 3 NQS domains via the registry-based reporting mechanism, the eligible professional will be subject to the MAV process, which would allow CMS to determine whether an eligible professional should have reported on additional measures and/or measures covering additional NQS domains.

How do I report Measures Groups?
Report at least one Measures Group, AND report each measures group for at least 20 patients, a majority of which must be Medicare Part B FFS patients. To select a Measures Group, click the applicable Member on Non Member Start Now button, scroll to the Product Selection Guide and select "Measures Groups".

What is the Measure Applicability Validation Process (MAV)?
The PQRS Measure Applicability Validation Process, or MAV, is the validation process for 2014PQRS incentive eligibility and payment adjustment for eligible professionals or GPRO group practices who satisfactorily submit quality data for fewer than 9 PQRS measures across 3 domains or 9 or more PQRS measures across less than 3 domains. The MAV process will determine whether those professionals should have submitted additional measures or additional measures with additional domains to be considered incentive eligible.

Eligible Professionals or group practices with a specialty that has less than 9 measures or less than 3 domains would be subject to MAV but could still be eligible for incentive payment or avoid the payment adjustment. For payment adjustment considerations for those eligible professionals or group practices who satisfactorily submit quality data for fewer than three PQRS measures, the MAV process will determine whether an eligible professional or group practice should have submitted for additional measures.

Eligible professionals or group practices who fail MAV may be subject to the 2018 Payment Adjustment.

Additional information regarding the PQRS Payment Adjustment can be located here (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS).
What is the Value-Based Payment Modifier (VBM)?
Beginning in the 2016 PQRS reporting period, the value-based payment modifier (VBM) applies to ALL Physicians, PAs, NPs, CNSs & CRNAs and Non-Physician EPs. The VBM takes into account both PQRS quality data and Medicare cost data to calculate a provider’s overall VBM score. The budget-neutral VBM program provides upward payment adjustments to high-performing providers, applies a downward payment adjustment to low-performing providers, and applies a neutral payment adjustment to those in the middle.

VBM payment adjustments are additive to PQRS, and are automatically applied to all providers and group practices who do not successfully report PQRS. For those who do report PQRS, the VBM payment adjustment is applied through quality-tiering. For the 2016 reporting period, groups and solo practitioners consisting of non-physician EPs are exempt from downward quality-tiering adjustments, but eligible for the neutral or upward quality-tiering payment adjustments. Providers who are eligible for quality-tiering payment adjustments may receive a neutral, downward or upward adjustment. See chart below for details.

Value Modifier Penalty for 2016 PQRS Non-Reporters
- Groups with 2-9 EPs and solo practitioners: automatic -2.0% of MPFS downward adjustment
- Groups with 10+ EPs: Automatic -4.0% of MPFS downward adjustment

Quality-Tiering for Successful 2016 PQRS Reporters
- Groups with 2-9 EPs and solo practitioners: Upward or neutral or downward VM adjustment only based on quality-tiering (-2.0% to +2.0x of MPFS)
- Groups with 10+ EPs: Upward, neutral, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x of MPFS)
- Groups & solo practitioners consisting of non-physician EPs: Upward or no VM adjustment based on quality-tiering (0.0% to +2.0x of MPFS)

What is the Group Practice Reporting Option (GPRO)?
This reporting option requires the submission of one PQRS report per TIN for the designated reporting period January 1 - December 31, 2016. Group practices with 2 or more eligible professionals may elect this option.

- Report at least 9 measures covering at least 3 of the NQS domains with the inclusion of a Cross Cutting measure if your practice sees patients in a face-to-face setting, OR, if less than 9 measures covering at least 3 NQS domains apply to the group practice, report 1—8 measures covering 1-3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50% of the group practice’s Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.
- For a group practice that reports fewer than 9 measures covering at least 3 NQS domains via the registry-based reporting mechanism, the group practice will be subject to the MAV process, which would allow CMS to determine whether a group practice should have reported on additional measures and/or measures covering additional NQS domains.
- Note: Measures group reporting is not permitted when reporting as a GPRO.
- PLEASE NOTE: The AOA CAP does not offer the GPRO option.