

REGISTRY REQUIREMENTS FOR SUBMISSION OF 2011 PHYSICIAN QUALITY REPORTING SYSTEM DATA ON BEHALF OF ELIGIBLE PROFESSIONALS

The Tax Relief and Health Care Act of 2006 (TRHCA), enacted December 20, 2006, initially authorized the Physician Quality Reporting System (Physician Quality Reporting, formerly Physician Quality Reporting Initiative or PQRI). The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) made the Physician Quality Reporting program permanent. As required by the Medicare, Medicaid, SCHIP Extension Act (MMSEA), signed into law on December 29, 2007 (Pub. Law 110-173), the Centers for Medicare & Medicaid Services (CMS) established alternative criteria for satisfactorily reporting and alternative reporting periods for reporting measures groups and registry-based reporting. As part of this process, CMS will, in February and March 2012, accept quality measure results and numerator and denominator data for 2011 Physician Quality Reporting measures submitted by qualified registries on behalf of their participants. This will be an alternative that eligible professionals can choose in lieu of submitting Physician Quality Reporting data via claims or EHR submission methods. These submissions must relate to Medicare Physician Fee Schedule (MPFS) covered professional services furnished in one of two reporting periods in 2011: a 12-month reporting period beginning January 1, 2011, and a six-month reporting period beginning July 1, 2011. Both of the reporting periods will conclude December 31, 2011. All quality measure results and numerator and denominator data must be received in proper format by CMS by March 31, 2012 for consideration. Registries are no longer permitted to include non-Medicare patients for reporting.

Eligible professionals whose 2011 Physician Quality Reporting quality measure information is successfully submitted by a CMS qualified registry and who satisfy the applicable criteria for satisfactorily reporting for the January-December (full-year) reporting period OR the July-December (half-year) reporting period may earn an incentive payment equal to 1.0 percent of their total allowed charges for all MPFS covered professional services furnished during the applicable 2011 reporting period. Successful submission requires that the quality measure results and numerator and denominator data be sent by the registry to CMS in the specified format and include all of the required information based on the reporting option selected by the eligible professional or CMS selected group practice.

To be considered a qualified registry for purposes of submitting individual quality measures and measures groups on behalf of eligible professionals or CMS selected group practices who choose this reporting mechanism, both new and previously qualified registries must:

- Have been in existence as of January 1, 2011
- Have at least 25 participants by January 1, 2011
- Provide at least one feedback report per year to participating eligible professionals
- Not be owned or managed by an individual locally-owned single-specialty group, in other words, single-specialty practices with only one practice location or solo practitioner practices would be prohibited from self-nominating to become a qualified Physician Quality Reporting registry
- Participate in on-going 2011 Physician Quality Reporting mandatory support conference calls hosted by CMS (approximately one call per month, including an in-person registry kick-off meeting to be held at CMS headquarters in Baltimore, MD. Registries who miss more than one meeting will be precluded from submitting Physician Quality Reporting data for the 2011 reporting year)
- Be able to collect all needed data elements and transmit to CMS the data at the Tax Identification Number(TIN)/National Provider Identifier (NPI) level for eligible professionals at least three measures in the 2011 Physician Quality Reporting System (according to the posted 2011 Physician Quality Reporting Quality Measure Specifications)
- Be able to calculate and submit measure-level reporting rates or the data elements needed to calculate the reporting rates at the TIN/NPI level
- Be able to calculate and submit, by TIN/NPI for eligible professionals, a performance rate (that is, the percentage of a defined population who receive a particular process of care or achieve a particular

outcome) for each measure or measures group on which the eligible professional reports or the data elements needed to calculate the reporting rates

- Be able to separate out and report on Medicare Fee-For-Service (FFS) Part B patients
- Provide the name of the registry
- Provide the reporting period start date the registry will cover
- Provide the reporting period end date the registry will cover
- Provide the measure numbers for the Physician Quality Reporting System quality measures for which the registry is reporting
- Provide the measure title for the Physician Quality Reporting System quality measures for which the registry is reporting
- Report the number of eligible instances (reporting denominator)
- Report the number of instances of quality service performed (numerator)
- Report the number of performance exclusions
- Report the number of reported instances, performance not met (eligible professional receives credit for reporting, not for performance)
- Be able to transmit this data in a CMS-approved XML format
- Comply with a CMS-specified secure method for data submission, such as submitting registry's data in an XML file through an identity management system specified by CMS or another approved method such as over the NHIN (National Health Information Network) if technically feasible
- Submit an acceptable "validation strategy" to CMS by March 31, 2011. A validation strategy ascertains whether eligible professionals have submitted accurately and on at least the minimum number (80 percent) of their eligible patients, visits, procedures, or episodes for a given measure. Acceptable validation strategies often include such provisions as the registry being able to conduct random sampling of their participants' data, but may also be based on other credible means of verifying the accuracy of data content and completeness of reporting or adherence to a required sampling method
- Perform the validation outlined in the strategy and send the results to CMS by June 30, 2012 for the 2011 reporting year's data
- Enter into and maintain with its participating professionals an appropriate Business Associate arrangement that provides for the registry's receipt of patient-specific data from eligible professionals, as well as the registry's disclosure of quality measure results and numerator and denominator data on behalf of eligible professionals who wish to participate in the Physician Quality Reporting System
- Obtain and keep on file signed documentation that each holder of an NPI whose data are submitted to the registry has authorized the registry to submit quality measures results and numerator and denominator data to CMS for the purpose of Physician Quality Reporting System participation. This documentation must be obtained at the time the eligible professional signs up with the registry to submit Physician Quality Reporting System quality measures data to the registry and must meet any applicable laws, regulations, and contractual business associate agreements
- Provide CMS access (if requested for validation purposes) to review the Medicare beneficiary data on which 2011 Physician Quality Reporting System registry-based submissions are founded or provide to CMS a copy of the actual data (if requested)
- Indicate the reporting options the registry seeks to submit on behalf of its users in addition to individual measures (measures groups, GPRO II, eRx for individuals, eRx for GPROs, 6 month, 12 month reporting periods)
- Provide the reporting option(s) (reporting period and reporting criteria) that the eligible professional has satisfied or chosen
- Provide CMS a signed, written attestation statement via mail or email which states that the quality measure results and any and all data including numerator and denominator data provided to CMS are accurate and complete

In addition to the above, registries (both new and previously qualified) who intend to report on 2011 Physician Quality Reporting System measures must:

- Indicate the reporting period selected for each eligible professional who chooses to submit data on measures groups
- Base reported information on measures groups only on patients to whom services were furnished during the 12-month reporting period of January through December 2011 or the 6-month reporting period of July 1, 2011 through December 31, 2011
- Agree that the registry's data may be inspected or a copy requested by CMS and provided to CMS under CMS oversight authority
- Be able to report data on all applicable measures in a given measures group on either 30 patients or more Medicare Part B FFS patients from January 1 through December 31, 2011 or on 80 percent of applicable Medicare Part B FFS patients for each eligible professional (with a minimum of 15 patients during the January 1 through December 31, 2011 reporting period or a minimum of 8 patients during the July 1 through December 31, 2011 reporting period)

Registries are no longer permitted to include non-Medicare patients for measures group(s) reporting. Additionally, in an effort to reduce the variation in measures results across registries and better allow eligible professional comparisons, all current and future registries must meet the following **new** requirements:

- Use Physician Quality Reporting System measure specifications and a standard set of measure calculation logic provided by CMS to calculate reporting rates or performance rates unless otherwise stated.
- Provide a calculated result using the CMS-supplied logic and XML file for each measure that the registry intends to calculate. The registries will be required to show that they can calculate the proper measure results (that is, reporting and performance rates) using the CMS-supplied logic and send the calculated data back to CMS in the specified format.
- Provide the individual data elements used to calculate the measures if so requested by CMS for validation purposes. Registries that are subject to validation will be asked to send discrete data elements for a measure (determined by CMS) in the required data format for us to recalculate the registries' reported results. Validation will be conducted for several measures at a randomly selected sample of registries in order to validate their data submissions.

Registries (**regardless of prior year participation**) who can meet the above requirements, and who wish to participate in the 2011 registry payment program should submit a self-nomination letter requesting inclusion in 2011. The letter should also include which 2011 Physician Quality Reporting measures the registry intends to submit on behalf of its participants and the reporting period(s) and method(s) the registry offers its participants. The letter should be sent to:

**2011 Physician Quality Reporting Registry Nomination
Centers for Medicare & Medicaid Services
Office of Clinical Standards and Quality
Quality Measurement and Health Assessment Group
7500 Security Boulevard
Mail Stop S3-02-01
Baltimore, MD 21244-1850**

The letter must be received no later than **5 p.m. on January 31, 2011**.

Registries that were "qualified" for 2010 and wish to participate in 2011 will not need to be "re-qualified" for 2011 but instead demonstrate that they can meet the new 2011 data submission requirements. Letters of intent to participate in 2011 from 2010 "qualified" registries should be submitted to CMS by October 31, 2010.

Registries that were “qualified” for 2010, but did not successfully submit 2010 data will need to go through a full self-nomination and vetting process for 2011. Self-nomination letters should be received by CMS no later than March 31, 2011, at which time all above requirements must also be met.

Due to technical reasons CMS does not expect to be able to complete the vetting process for the new 2011 data submission requirements until mid-2011. Therefore, names of registries that are qualified for the 2011 Physician Quality Reporting System will not be posted until that time. CMS plans to post a list of conditionally qualified registries (this list will include both registries that were previously qualified and those that self-nominate to be newly qualified for 2011) by Summer 2011. After the vetting concludes CMS will finalize the list of 2011 Physician Quality Reporting System registries. This list is anticipated to be available by the Fall of 2011.

All of the information contained within this document will also apply to registries that would like to become qualified to report on the electronic prescribing measure for the 2011 Electronic Prescribing (eRx) Incentive Program. Registries that want to report the 2011 eRx measure for the eRx Group Practice Reporting Option (GPRO I or II) will also have to follow the requirements contained in this document. Any registry that wants to report on the eRx measure and/or the eRx measure for GPRO I or II should indicate this in their self-nomination letter.