GIQuIC: A 2016 PQRS Qualified Clinical Data Registry

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Questions?

Your Participation

- Please submit your text questions and comments using the Questions Panel.

- You can access the presentation slides now via the GoToWebinar dialogue box.

- Today’s presentation is being recorded and will be available on the GIQuIC website within 48 hours.
This presentation provides information about the Physician Quality Reporting System (PQRS) participation option in Qualified Clinical Data Registries (QCDRs) for the 2016 program year, specifically the approved GIQuIc QCDR.
Objectives

• Review the history and success of GIQuIC
• Discuss PQRS reporting and the QCDR option
• Discuss PQRS requirements relative to reporting via the GIQuIC QCDR
• Discuss the initial steps required to utilize GIQuIC as a QCDR for your 2016 PQRS reporting
We created GIQuIC based on a belief that the scientific measurement of the quality of endoscopic procedures will provide valid and reliable comparative information to participating physicians and facilities to support their quality improvement initiatives.

~ Irving M. Pike, MD, FACG, FASGE
President, GI Quality Improvement Consortium
February 23, 2010
Background

• 2006 ASGE/ACG GI Procedure Quality Indicator Documents
• 2006-2009 Sentara Healthcare Pilot
• 2009 ACG and ASGE establish the GI Quality Improvement Consortium
• 2010 GIQuIC registry data collection begins
Goals

• Support units in developing the infrastructure for their quality improvement programs
  – Collect and report data electronically (manual option available)
  – Available wherever endoscopy is performed

• Create a safe, secure, and reliable platform
  – Partnership with Quintiles
Certified Vendors

- Amkai
- Cerner Powerchart™
- CORI
- eMerge Endo
- EndoSoft
- gMed
- MD-Reports
- Olympus EndoWorks
- Pentax
- ProVation
- Summit Imaging
Growth Rate June 2011-March 2016

Physicians

[Graph showing the growth rate of physicians from June 2011 to March 2016, with a steady increase over time.]
Growth Rate June 2011-March 2016

Colonoscopy Cases

- Y-axis: 0 to 3,500,000
- X-axis: June-11 to Feb

- Data points represent the growth rate of colonoscopy cases over the specified period.
Sample Measure Report

Adenoma Detection Rate
Percentage of patients age 50 and over undergoing screening colonoscopy with a finding of at least one adenomatous polyp.
Time Period: 01/2013 - 12/2015, Site: GIQuIC Sponsor Site (1026)

![Graph showing Adenoma Detection Rate](image)

<table>
<thead>
<tr>
<th>Benchmark Group</th>
<th>Time Period</th>
<th>Numerator</th>
<th>Denominator</th>
<th>% of Patients</th>
<th>95% C.I. Low</th>
<th>95% C.I. High</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Sites</td>
<td>2013</td>
<td>988</td>
<td>2947</td>
<td>33.5%</td>
<td>31.9%</td>
<td>35.3%</td>
</tr>
<tr>
<td>My Sites</td>
<td>2014</td>
<td>1,670</td>
<td>4,908</td>
<td>33.8%</td>
<td>37.4%</td>
<td>40.3%</td>
</tr>
<tr>
<td>My Sites</td>
<td>2015</td>
<td>1,042</td>
<td>2,304</td>
<td>45.2%</td>
<td>43.2%</td>
<td>47.3%</td>
</tr>
<tr>
<td>Entire Study</td>
<td>2013</td>
<td>97693</td>
<td>1,14423</td>
<td>32.9%</td>
<td>32.7%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Entire Study</td>
<td>2014</td>
<td>1,13614</td>
<td>3,15539</td>
<td>36.0%</td>
<td>35.9%</td>
<td>36.2%</td>
</tr>
<tr>
<td>Entire Study</td>
<td>2015</td>
<td>58962</td>
<td>1,60254</td>
<td>36.8%</td>
<td>36.6%</td>
<td>37.1%</td>
</tr>
</tbody>
</table>
GIQuIC Success Story

Goals

• Support units in demonstrating their quality to public and private payers
  – GIQuIC deemed a qualified clinical data registry (QCDR) for PQRS 2014, 2015, 2016 reporting years
  • A QCDR is an entity that collects medical or clinical data for the purposes of patient and disease tracking to foster improvement in the quality of care provided and that has self-nominated, successfully completed a qualification process, and been approved by CMS as a PQRS reporting mechanism
PQRS is a reporting program that uses negative payment adjustments to promote reporting of quality information by eligible providers and group practices.
Eligible providers that do not satisfactorily report or satisfactorily participate in PQRS will be subject to a payment adjustment.

<table>
<thead>
<tr>
<th>PQRS Program Year</th>
<th>PQRS Payment Adjustment Period</th>
<th>Negative Adjustment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>2018</td>
<td>- 2.0%*</td>
</tr>
</tbody>
</table>

* Applies to all of the eligible provider’s or group practice’s Medicare Part B Physician Fee schedule (PFS) covered professional services under PFS during the payment adjustment period.
Who Can Participate in PQRS?

- A list of eligible medical care professionals is available on the [How to Get Started](#) page of the CMS PQRS website.

<table>
<thead>
<tr>
<th>Medicare physicians</th>
<th>Practitioners</th>
<th>Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor of Medicine</td>
<td>Physician Assistant</td>
<td>Physical Therapist</td>
</tr>
<tr>
<td>Doctor of Osteopathy</td>
<td>Nurse Practitioner*</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Doctor of Podiatric Medicine</td>
<td>Clinical Nurse Specialist*</td>
<td>Qualified Speech-Language Therapist</td>
</tr>
<tr>
<td>Doctor of Optometry</td>
<td>Certified Registered Nurse Anesthetist* (and Anesthesiologist Assistant)</td>
<td></td>
</tr>
<tr>
<td>Doctor of Oral Surgery</td>
<td>Certified Nurse Midwife*</td>
<td></td>
</tr>
<tr>
<td>Doctor of Dental Medicine</td>
<td>Clinical Social Worker</td>
<td></td>
</tr>
<tr>
<td>Doctor of Chiropractic</td>
<td>Clinical Psychologist</td>
<td></td>
</tr>
</tbody>
</table>

* Includes Advanced Practice Registered Nurse (APRN)
Who Can Participate in GIQuIC?

- Physicians from hospitals, universities, ambulatory surgery centers, and office-based endoscopy units nationwide for whom GIQuIC measures are applicable to their practice
PQRS Participation via “Registry”

• Qualified PQRS Registry
  – Individual eligible provider reporting
  – Group Practice Reporting Option (GPRO)
    *optional to vendor; check for availability*
  – Includes PQRS measures and measure groups

• Qualified Clinical Data Registry (QCDR)
  – Individual eligible provider reporting
  – Group Practice Reporting Option (GPRO)
    *optional to vendor; check for availability*
  – Can include PQRS or non-PQRS measures (or both)
PQRS Participation via “Registry”

The GIQuIC QCDR for 2016 PQRS reporting supports **only** individual eligible provider reporting

≠ Group Practice Reporting Option (GPRO)
≠ Accountable Care Organization (ACO)
• Criteria to avoid the 2018 PQRS payment adjustment
  – Report at least 9 individual measures, of which at least 2 must be outcome measures, covering at least 3 National Quality Strategy (NQS) domains for 50% or more of applicable patients of each eligible provider (12 months)
    • If the QCDR does not have 2 outcome measures, then the QCDR must have and report at least 1 outcome measure and 1 of the following other types of measure: 1 resource use, OR patient experience of care, OR efficiency/appropriate use, OR patient safety measure.
The Value-based Payment Modifier (VM) assesses both quality of care furnished and the cost of that care under the MPFS.

The VM is an adjustment made on a per claim basis to Medicare payments for items and services furnished under the MPFS.

- High-quality and/or low-cost groups can qualify for upward adjustments
- Low-quality and/or high-cost groups and groups that fail to satisfactorily report PQRS are subject to downward adjustments
Value-based Payment Modifier

• The VM is applied at the TIN level and applies to all physicians and also to physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs) and certified registered nurse anesthetists (CRNAs) in groups of 2+ EPs and those who are solo practitioners, billing under that TIN.
Value-based Payment Modifier

CY 2018 VM payment adjustment, for physicians, PAs, NPs, CNSs, and CRNAs in groups with 2+ EPs and those who are solo practitioners

PQRS Reporters - 3 types – Category 1
1a. Group reporters: Report as a group via a PQRS GRPRO and meet the criteria to avoid the 2018 PQRS payment adjustment OR
1b. Individual reporters in the group: at least 50% of EPs in the group report PQRS measures as individuals AND meet the criteria to avoid the 2018 PQRS payment adjustment
2. Solo practitioners: Report PQRS measures as individuals AND meet the criteria to avoid the 2018 PQRS payment adjustment

Mandatory Quality-Tiering Calculation

Physicians, PAs, NPs, CNSs & CRNAs in groups of physicians with 2-9 EPs and physician solo practitioners

Upward, no, or downward VM adjustment based on quality-tiering (-2.0% to +2.0x)

Physicians, PAs, NPs, CNSs & CRNAs in groups of physicians with 10+ EPs

Upward, no, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x)

PAs, NPs, CNSs & CRNAs in groups consisting of non-physician EPs only and those who are solo practitioners

Upward or no VM adjustment based on quality-tiering (0.0% to +2.0x)

Non-PQRS Reporters – Category 2
1. Groups: Do not avoid the 2018 PQRS payment adjustment as a group OR do not meet the 50% threshold option as individuals
2. Solo Practitioners: Do not avoid the 2018 PQRS payment adjustment as individuals

-2.0% (for physicians, PAs, NPs, CNSs & CRNAs in groups of physicians with 2-9 EPS; physician solo practitioners; PAs, NPs, CNSs and CRNAs in groups consisting of non-physician EPs only and those who are solo practitioners)
-4.0% (for physicians, PAs, NPs, CNSs & CRNAs in groups of physicians with 10+ EPs) (Automatic VM downward adjustments)

Note: The VM payment adjustment is separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs.
Physician Compare

Encourage consumers to make informed choices
Incentivize physicians to maximize performance
• 2016 QCDR measures are available for public reporting on Physician Compare
  – PQRS and non-PQRS measures
  – No first year measures
GIQuIC and the EHR Incentive Program

- GIQuIC is a specialized registry to improve population health outcomes. Participants using certified electronic health record technology (CEHRT) to transmit data to the GIQuIC registry can attest to using a “specialized registry” for the purposes of Meaningful Use Objective 10: Public Health Reporting, Measure Option 3 – Specialized Registry Reporting.

- GIQuIC participation does not satisfy the electronic clinical quality measure (eCQM) reporting component of the EHR Incentive Program.
• The measures that make up the eCQM reporting component of meaningful use (MU) for the EHR Incentive Program are not specific to gastroenterology
• The ASC Quality Reporting Program submission process is via CMS’ QualityNet website
  – An option to report to this program via a registry does not currently exist
Criteria to avoid the 2018 PQRS payment adjustment

<table>
<thead>
<tr>
<th>Requirement</th>
<th>GIQuIC QCDR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report at least 9 individual measures</td>
<td>The GIQuIC QCDR has 13 individual measures from which to choose</td>
</tr>
<tr>
<td>At least 2 must be outcome measures</td>
<td>The GIQuIC QCDR has 4 outcome measures with those 13</td>
</tr>
<tr>
<td>Covering at least 3 National Quality Strategy (NQS) domains</td>
<td>The 13 GIQuIC QCDR measures cover 4 NQS domains</td>
</tr>
<tr>
<td>For 50% or more of applicable patients of each eligible provider (12 months)</td>
<td>To participate in GIQuIC a provider must upload 100% of colonoscopy cases done at the participating site(s)</td>
</tr>
</tbody>
</table>
Physician Quality Reporting System (PQRS)
Meaningful Use

Physician Quality Reporting System (PQRS)

CMS Approves GIQuIC as a PQRS Qualified Clinical Data Registry

Learn how you can successfully participate in PQRS submitting GI-specific measures

We are pleased to announce that the GIQuIC Registry has again been approved as a Qualified Clinical Data Registry (QCDR) for reporting to the Physician Quality Reporting System (PQRS) for the 2016 reporting year. The QCDR reporting mechanism is a dynamic reporting option that allows providers to report on measures that are meaningful to their specialty practice and foster improvement in the quality of care provided to patients.

Since 2010, GIQuIC has grown in value as a clinical benchmarking tool for gastroenterology practices, surpassing 3 million colonoscopy cases in April 2016. CMS approved GIQuIC as a QCDR for the 2014, 2015 and 2016 PQRS reporting year, facilitating endoscopists’ documentation of compliance with quality measures. Over 600 GIQuIC participants elected to utilize the GIQuIC QCDR for their 2014 PQRS reporting, and over 1,100 participants did so for their 2015 PQRS reporting.

For the 2016 reporting year, eligible providers who satisfactorily participate in PQRS will avoid the 2018 payment adjustment of negative 2.0%, an adjustment that will be compounded further by the value-based payment modifier up to an additional negative 4.0% depending upon group size.

To see the detailed specifications of the clinical quality measures on which the GIQuIC QCDR will report for the 2016 reporting year, please click here.

To provide the details surrounding the QCDR reporting option and the GIQuIC registry, GIQuIC hosted an informational webinar on April 12, 2016. The slides can be accessed by selecting here.

For more information email info@giqic.org.
## PQRS Participation via the GIQuIC QCDR

### GiQuIC QCDR for 2016 PQRS Reporting

Following is an overview of the clinical quality measures available for 2016 PQRS reporting via the GiQuIC Qualified Clinical Data Registry (QCDR). Additional detail for each measure follows on the subsequent pages.

<table>
<thead>
<tr>
<th>GIQuIC #</th>
<th>Title</th>
<th>Type</th>
<th>Standard/Inverse</th>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Adequacy of bowel preparation</td>
<td>Process</td>
<td>Standard</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td>3</td>
<td>Photodocumentation of the cecum (also known as cecal intubation rate) – All Colonoscopies</td>
<td>Process</td>
<td>Standard</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td>4</td>
<td>Photodocumentation of the cecum (also known as cecal intubation rate) – Screening Colonoscopies</td>
<td>Process</td>
<td>Standard</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td>5</td>
<td>Incidence of perforation</td>
<td>Outcome</td>
<td>Inverse</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>6</td>
<td>Appropriate follow-up interval for normal colonoscopy in average risk patients</td>
<td>Process</td>
<td>Standard</td>
<td>Communication and Care Coordination</td>
</tr>
<tr>
<td>8</td>
<td>Age appropriate screening</td>
<td>Outcome</td>
<td>Inverse</td>
<td>Efficiency and Cost Reduction</td>
</tr>
<tr>
<td>9</td>
<td>Documentation of history and physical rate – Colonoscopy</td>
<td>Process</td>
<td>Standard</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>10</td>
<td>Appropriate management of anticoagulation in the peri-procedural period rate – EGD</td>
<td>Process</td>
<td>Standard</td>
<td>Communication and Care Coordination</td>
</tr>
<tr>
<td>11</td>
<td><em>Helicobacter pylori</em> (H. pylori) status rate</td>
<td>Process</td>
<td>Standard</td>
<td>Communication and Care Coordination</td>
</tr>
<tr>
<td>12</td>
<td>Appropriate indication for colonoscopy</td>
<td>Process</td>
<td>Standard</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td>14</td>
<td>Repeat screening colonoscopy recommended within one year due to inadequate bowel preparation</td>
<td>Outcome</td>
<td>Standard</td>
<td>Efficiency and Cost Reduction</td>
</tr>
<tr>
<td>15</td>
<td>Appropriate follow-up interval of 3 years recommended based on pathology findings from screening colonoscopy in average-risk patients</td>
<td>Process</td>
<td>Standard</td>
<td>Communication and Care Coordination</td>
</tr>
<tr>
<td>16</td>
<td>Adenoma Detection Rate</td>
<td>Outcome</td>
<td>Standard</td>
<td>Effective Clinical Care</td>
</tr>
</tbody>
</table>

**Standard measure**: A higher performance rate (closer to 100, not zero) is the goal.

**Inverse measure**: A lower performance rate (closer to zero, not 100) is the goal.
• Adenoma Detection Rate [Outcome]
  – Percentage of patients age 50 and over undergoing screening colonoscopy at least one conventional adenoma or colorectal cancer detected during screening colonoscopy.

• Adequacy of Bowel Preparation [Process]
  – Percentage of colonoscopies with a bowel preparation documented as adequate or better
Photodocumentation of the cecum, which is also known as cecal intubation rate – All Colonoscopies [Process]

- Percentage of colonoscopies into the cecum including photodocumentation of one or more of the cecal landmarks (ileocecal valve, appendiceal orifice, or terminal ileum)
• Photodocumentation of the cecum, which is also known as cecal intubation rate – Screening Colonoscopies [Process]
  – Percentage of screening colonoscopies into the cecum including photodocumentation of one or more of the cecal landmarks (ileoceleal valve, appendiceal orifice, or terminal ileum)
• Documentation of history and physical rate – Colonoscopy [Process]
  – Percentage of colonoscopies with history and physical documented

• Appropriate indication for colonoscopy [Process]
  – Percentage of colonoscopy procedures performed for an indication that is included in a published standard list of appropriate indications and the indication is documented
• Incidence of Perforation [Outcome]
  – Percentage of total patients experiencing a perforation during colonoscopy, recognized immediately (before the patient leaves the facility)
• Appropriate follow-up interval for normal colonoscopy in average-risk patients [Process]
  – Percentage of average-risk patients aged 50 to 75 years receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report
• Appropriate follow-up interval of 3 years recommended based on pathology findings from screening colonoscopy in average-risk patients [Process]
  – Percentage of average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of 3-10 adenomas, Advanced Neoplasm (≥ 10 mm, high grade dysplasia, villous component), Sessile serrated polyp ≥ 10 mm OR sessile serrate polyp with dysplasia OR traditional serrated adenoma who had a recommended follow-up interval of 3 years for repeat colonoscopy
• Appropriate management of anticoagulation in the peri-procedural period rate – EGD [Process]
  – Percentage of patients undergoing an EGD on an anti-platelet agent or an anticoagulation who leave the endoscopy unit with instructions for management of this medication
• *Heliobacter pylori* (*H. pylori*) status rate

[Process]

– Percentage of patients undergoing an EGD with a duodenal or gastric ulcer whose *H. pylori* status is unknown who have a plan documented for assessing *H. pylori* status
Efficiency and Cost Reduction

• Repeat screening colonoscopy recommended within one year due to inadequate bowel preparation [Outcome]
  – Percentage of patients with an inadequate bowel preparation who received a recommendation for a repeat screening colonoscopy of one year or less

• Age appropriate screening colonoscopy [Outcome]
  – Percentage of patients aged 85 years or older undergoing screening colonoscopy
Complete the provider online consent process by September 30, 2016

- The eligible provider must include the NPI/TIN combination under which s/he bills for professional services

  - NPI
    - The individual NPI can be found in form field 24-J of the CMS-1500 claim form

  - TIN
    - The TIN can be found in form field 25 of the CMS-1500 claim form
• Continue to submit all case data to GIQuIC as normal

• Run your measure reports – at least 4X prior to end of December 2016
  – Reminder: The GIQuIC registry Home Page includes User Guides and training recordings. Additionally, live training sessions are held monthly.

• Respond to data validation requests promptly
GIQuIC 2016 QCDR Timeline

- **September 30, 2016**: The online consent form process must be completed by each provider.
- **Mid January 2017**: All data from 2016 must be entered into the GIQuIC registry and QCDR measures must be selected.
- **Mid February 2017**: Providers attest to accuracy of data GIQuIC will be submitting on their behalf by completing the Data Readiness Confirmation process.
- **Mid March 2017**: GIQuIC submits quality measure data on behalf of providers to CMS for PQRS reporting.
Lessons Learned from 2015 Reporting

• Know your NPI/TIN combination under which you bill for professional services
  – **NPI**: The individual NPI can be found in form field 24-J of the CMS-1500 claim form. **Individual NPIs** should be used for reporting PQRS, **not the group NPI**
  – **TIN**: The TIN can be found in form field 25 of the CMS-1500 claim form

• Do **not** register for the Group Practice Reporting Option if you plan to report via the GIQuIC QCDR
  – The GIQuIC QCDR supports **only** individual eligible provider reporting for PQRS 2016

• Ensure you are not affiliated with an Accountable Care Organization (ACO)
  – QCDRs are not able to support participants that have registered as an ACO
• Run your measure reports – at least 4X prior to end of December 2016
  – **Reminder:** The GIQuIC registry Home Page includes User Guides and training recordings. Additionally, live training sessions are held monthly
  – Investigate if unexpected performance results stem from inaccurate documentation or low-level performance and respond accordingly

• Respond to data validation requests promptly
Lessons Learned from 2015 Reporting

- For those who are not currently participating in GIQuIC and wish to use the 2016 GIQuIC QCDR for reporting, arrange for your unit to register in the near future and begin submitting data to ensure you can meet the 50% case threshold for measures
  - To discuss registration further, contact Hannah Miller at hmiller@gi.org
Questions?

Your Participation

- Please continue to submit your text questions and comments using the Questions Panel.

- You can access the presentation slides now via the GoToWebinar dialogue box.

- Today’s presentation is being recorded and will be available on the GIQuIC website within 48 hours.
Additional Questions

- **QualityNet Help Desk**
  866-288-8912
  7:00 a.m.–7:00 p.m. CST M-F or
  qnetsupport@hcqis.org

- **GIQuIC/ACG**
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