2014 Physician Quality Reporting System (PQRS)
Qualified Clinical Data Registry (QCDR)

2014 Qualified Clinical Data Registry Reporting

Kick-Off

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Agenda

- Physician Quality Reporting System Overview
- EHR Incentive Program Overview
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Purpose

- This presentation provides information about the Physician Quality Reporting System (PQRS) participation option in Qualified Clinical Data Registries (QCDRs) for the 2014 program year

Disclaimer: If reporting for PQRS through another CMS program (such as the Medicare Shared Savings Program [MSSP], Comprehensive Primary Care Initiative [CPC], Pioneer Accountable Care Organizations [ACOs]), please check the program's requirements for information on how to report quality data to earn a PQRS incentive and/or avoid the PQRS payment adjustment. Please note, although CMS has attempted to align or adopt similar reporting requirements across programs, eligible professionals should look to the respective quality program to ensure they satisfy the PQRS, EHR Incentive Program, Value-Based Payment Modifier (VM), etc. requirements of each of these programs.

Physician Quality Reporting System Overview

Presenter: Dr. Green

Physician Quality Reporting System Overview

- PQRS has evolved since its inception in 2007 from an initiative with 74 individual measures and one reporting option for claims-based measures, to its current state in 2014 with over 285 individual measures, 25 measures groups, and multiple reporting options through claims-based reporting, registry-based reporting, EHR-based reporting (EHR data submission vendors and EHR direct vendors) and the new qualified clinical data registry-based reporting.

Physician Quality Reporting System Overview

- The new QCDR reporting option provides a new standard for individual eligible professionals (EPs) to satisfy the PQRS beginning in 2014.
- This standard is based on satisfactory participation in a QCDR in lieu of satisfactory reporting.
  - Satisfactory participation may earn the 2014 PQRS incentive and/or avoid the 2016 PQRS payment adjustment.
  - Satisfactory participation may also be used to determine application of an upward, downward or neutral adjustment for the Value-based Payment Modifier, if applicable.
  - Satisfactory participation may also be used for purposes of meeting the electronic clinical quality measure (eCQM) reporting component of meaningful use for the EHR Incentive Program

Physician Quality Reporting System Overview

- The applicable PQRS incentive amounts are:
  - 2014: 0.5 percent
  - No PQRS incentive payments are scheduled past 2014.
- The applicable PQRS payment adjustment amounts are:
  - 2016: -2.0 percent (based on 2014 submission)*

*Additional payment adjustment information can be found on the Payment Adjustment webpage of the CMS PQRS website http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html

Physician Quality Reporting System Overview

- Criteria to Earn the 2014 PQRS Incentive Payment: Participation
  - Individual EPs
    - Report at least 9 individual measures, with at least 1 outcome measure, covering at least 3 National Quality Strategy (NQS) domains for 50 percent or more of applicable patients of each EP (12 months)
      - Measures with a 0 percent performance rate will not be counted.

Please note that QCDRs are not able to submit on behalf of Group Practice Reporting Option (GPRO) group practices.

Physician Quality Reporting System Overview

- Criteria to Avoid the 2016 PQRS Payment Adjustment:
  - Individual EPs
    - Meet the criteria for satisfactory participating for the 2014 PQRS incentive payment;
    - Report at least 3 individual measures covering at least 1 NQS domains for 50 percent or more of applicable patients of each EP (12 months)
      - Measures with a 0 percent performance rate will not be counted.

EHR Incentive Program Overview

Presenter: Dr. Green

EHR Incentive Program Overview

- The Electronic Health Record (EHR) Incentive Program provides incentive payments to EPs, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.
- CMS will allow EPs, beyond their first year of demonstrating meaningful use, to submit eCQM information using QCDRs according to the definition and requirements set forth for the QCDRs.
- QCDRs who wish to report the eCQM reporting component of meaningful use for the EHR Incentive Program in 2014 must meet the QCDR requirements, as well as the remaining EHR Incentive Program requirements.

EHR Incentive Program Overview

- EHR Incentive Program Requirements
  - Use a Certified Electronic Health Record Technology (CEHRT) that is certified to all of the certification criteria required for CQMs, including certification of the QCDR itself for the functions it will fulfill.
    - The 2014 Edition certification criteria established by the Office of the National Coordinator for Health IT (ONC) set the requirements for certification that cover the functionality needed to "capture and export", "import and calculate", and for "electronic submission" of each CQM that will be reported.
  - Report eCQMs included in the Stage 2 final rule and use the same electronic specifications established for the EHR Incentive Program.
    - For 2014, PQRS will accept the June 2013 versions of the eCQMs under the EHR Incentive Program, except for the following measure – CMS140v2, Breast Cancer Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer (NQF 0387).
  - Submit the eCQM data in a quality data reporting architecture (QRDA) category III format.

Information for the EHR Incentive Program can be found: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/

Value-based Payment Modifier Overview

Presenter: Letonya Smith

Value-based Payment Modifier Overview

- The Value-based Payment Modifier (VM) provides for differential payment to an EP or group practice under the Physician Fee Schedule (PFS) based upon the quality of care furnished compared to cost during a performance period.
- The calendar year (CY) 2016 VM uses the criteria for satisfactory reporting (or the criteria for satisfactory participation) during the CY 2014 performance period for the 2016 PQRS payment adjustment.
- The CY 2016 VM will apply to groups of physicians with 10 or more EPs.
  - Groups of 10-99 are subject to upward or neutral adjustments.
  - Groups of 100+ are subject to upward, neutral or downward adjustments.
- VM will accommodate the various ways in which physicians can participate in the PQRS in CY 2014
  - Group practice participating in the PQRS GPRO
  - Individual EP

Value-based Payment Modifier Overview

- VM categorizes EPs into two categories
  - Category 1*:
    - Includes groups of physicians that meet the criteria for satisfactory reporting of data on PQRS quality measures through the GPRO for the CY 2016 PQRS payment adjustment.
    - Includes groups of physicians that do not register to participate in the PQRS as a group practice in CY 2014 and that have at least 50 percent of the group's EPs meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the CY 2016 PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a QCDR for the CY 2016 PQRS payment adjustment.
  - Category 2:
    - Include groups of physicians that are subject to the CY 2016 value-based payment modifier and do not fall within Category 1.

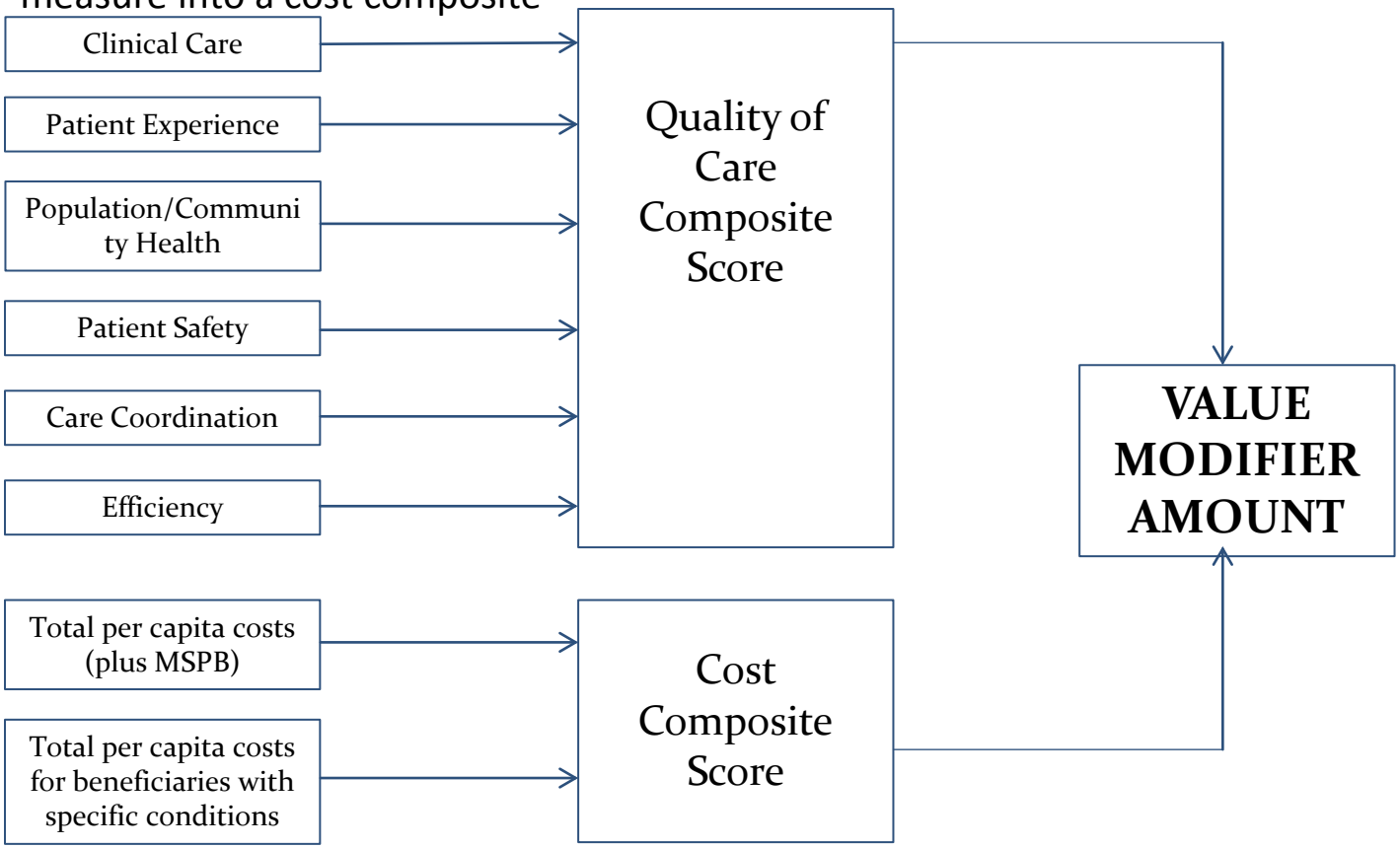
*Groups of physicians in Category 1 will not have the option to elect quality tiering for the CY 2016 value-based payment modifier and instead will be subject to mandatory quality tiering.

Value-based Payment Modifier Overview

- **How Does CMS Use the Quality and Cost Measures to Create a Value Modifier Payment Adjustment**
  - Each group receives two composite scores (quality and cost)
  - CMS uses the following steps to create each composite:
    - Create a standardized score for each measure (performance rate for performance period – prior year benchmark / standard deviation)
    - Equally weight each measure's standardized score within each domain.
    - Equally weight each domain's score into the composite score.

Value-based Payment Modifier Overview

- **Quality-Tiering Methodology**
  - Use domains to combine each quality measure into a quality composite and each cost measure into a cost composite



Value-based Payment Modifier Overview

- 2016 VM Quality Tiering based on 2014 data
  - Each group receives two composite scores (quality of care; cost of care), based on the group's **standardized performance** (e.g., how far away from the national mean).
  - Group cost measures are adjusted for specialty composition of the group
  - This approach identifies statistically significant outliers and assigns them to their respective cost and quality tiers.

CY 2016 Value-Based Payment Modifier Amounts			
Cost/Quality	Low quality	Average quality	High quality
Low cost	+0.0%	+1.0x*	+2.0x*
Average cost	-1.0%	+0.0%	+1.0x*
High cost	-2.0%	-1.0%	+0.0%

* Eligible for an additional +1.0x if reporting clinical data for quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores.

Information for the Value-based Payment Modifier can be found:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html

Qualified Clinical Data Registry Overview

Presenter: Dr. Green

Qualified Clinical Data Registry Overview

- Qualified Clinical Data Registry (QCDR) is a CMS approved entity that has self-nominated and successfully completed a qualification process that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients

Qualified Clinical Data Registry Overview

- A QCDR must perform the following functions:
  - Submit quality measures data or results to CMS for purposes of demonstrating that, for a reporting period, its EPs have satisfactorily participated in PQRS. A QCDR must have in place mechanisms for the transparency of data elements and specifications, risk models, and measures.
  - Submit to CMS, for the purposes of demonstrating satisfactory participation, quality measures data on multiple payers, not just Medicare Patients
  - Provide timely performance reports to participants at the individual participant level. A QCDR must provide timely feedback at least four times per year on the measures for which the QCDR would report on the individual EPs behalf for purposes of the EP meeting the criteria for satisfactory participation under PQRS.

Qualified Clinical Data Registry Overview

- Possess benchmarking capacity that allows the quality of care one EP provides to be compared with other EPs performing the same or similar functions (reporting the same measure).
  - Benchmarking would require that a QCDR provide metrics to compare the quality of care its participating EP provides. Example: The National Committee for Quality Assurance (NCQA) provides national and regional benchmarks for certain measures. Adopting benchmarks such as those provided by NCQA could satisfy this requirement.
- Demonstrate a plan to risk adjust the quality measures data for which it collects and intends to transmit to CMS
  - Risk adjustment is a corrective tool used to level the playing field regarding the reporting of patient outcomes, adjusting for the differences in risk among specific patients (see http://www.sts.org/patient-information/what-risk-adjustment). Risk adjustment also makes it possible to compare performance fairly. Example: If an 86-year old female with diabetes undergoes bypass surgery, there is less chance for a good outcome when compared with a healthy 40 year-old male undergoing the same procedure. To take factors into account which influence outcomes, for example, advanced age, emergency operation, or previous heart surgery, a risk adjusted model is used to report surgery results.

QCDR Requirements

- In order to self-nominate, QCDRs had to attest to meeting all of the following requirements listed in the 2014 PFS Final Rule:
  - Be in existence as of **January 1, 2013,** to be eligible to participate for purposes of data collected in 2014.
  - Have at least 50 QCDR participants by **January 1, 2013,** to be eligible to participate under the program with regard to data collected in 2014. Please note that not all participants would be required to participate in PQRS.
  - Not be owned or managed by an individual, locally-owned, single-specialty group (for example, single-specialty practices with only 1 practice location or solo practitioner practices would be precluded from becoming a QCDR).
  - Enter into and maintain with its participating professionals an appropriate Business Associate Agreement that provides for the QCDR's receipt of patient-specific data from the EPs, as well as the QCDR's public disclosure of quality measure results.
  - Obtain and keep on file for at least 7 years signed documentation that each holder of an NPI whose data are submitted to the QCDR has authorized the QCDR to submit quality measure results and numerator and denominator data and/or patient-specific data on beneficiaries to CMS for the purpose of PQRS participation.

QCDR Requirements

- Provide CMS a signed, written attestation statement via e-mail which states that the quality measure results and any and all data, including numerator and denominator data, provided to CMS are accurate and complete.
- Provide information on how the entity collects quality measurement data, if requested.
- Submit quality measures data or results to CMS for purposes of demonstrating that, for a reporting period, its EPs have satisfactorily participated in PQRS. A QCDR must have in place mechanisms for the transparency of data elements and specifications, risk models, and measures.
- Be compliant with applicable privacy and security laws and regulations, by describing its plan to maintain Data Privacy and Security for data transmission, storage and reporting.
- Report on behalf of its individual EP participants a set of measures from one or more of the following categories: CG-CAHPS; NQF endorsed measures (information of which is available at http://www.qualityforum.org/Home.aspx); current PQRS measures; measures used by boards or specialty societies; measures used in regional quality collaboratives, and/or the QCDRs own measures approved for use by CMS.

QCDR Requirements

- Be able to collect all needed data elements for at least 9 individual measures covering at least 3 of the NQS domains.
- Report on behalf of its individual EP participants the results of at least 1 outcomes-based measure.
- Upon request and for oversight purposes, provide CMS access to the QCDR's database to review the beneficiary data on which the QCDR-based submissions are based or provide to CMS a copy of the actual data.
- Make available to CMS samples of patient level data to audit the entity for purposes of validating the data submitted to CMS by the QCDR, if determined to be necessary.
- Execute and provide a data validation execution report to CMS by June 30, 2015, based on the QCDRs (March 2014) data validation strategy.

QCDR Requirements

- QCDRs who wish to report the eCQM reporting component of meaningful use for the Medicare EHR Incentive Program in 2014 must also satisfy the following criteria:
  - Use 2014 Edition of Certified Electronic Health Record Technology (CEHRT) that meets all of the certification criteria required for eCQMs as required under the Medicare EHR Incentive Program.
  - Report eCQMs included in the Stage 2 final rule and use the same electronic specifications established for the EHR Incentive Program.
    - For 2014, PQRS will accept the June 2013 versions of the eCQMs under the EHR Incentive Program, except for the following measure – CMS140v2, Breast Cancer Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer (NQF 0387).
  - Submit the eCQM data in a quality data reporting architecture (QRDA) category III format.

Program Requirements

- QCDRs are responsible for calculating and submitting quality measures data to CMS in a CMS-specified format(s) on behalf of the EP for the respective program year.
  - Reporting methods cannot be combined (i.e., QCDR & Registry).
- Provider Consent Statements
  - Document between Registry and EP/group practice authorizing the Registry to submit all data on their behalf.
    - CMS does not need a copy of the Provider Statements.
  - Provider Consents must be obtained for each TIN/NPI prior to submission
    - QCDRs should begin obtaining from providers as soon as possible and not at the time of final submission.
  - Suggest having TIN and NPI on the Provider statement for security of Registry and EP.
  - Electronic Statement is acceptable.
  - Update annually

Program Requirements

- Attestation Statements
  - Document between CMS and registry indicating the data they are sending in is true and accurate, appropriate documentation on file from Provider, etc.
  - Must be provided annually
- Identity Management Accounts Required
  - Currently, the PQRS portal uses IACS accounts for identity management.
    - An IACS account will be needed to access the PQRS portal for testing and/or production submission.
  - CMS may be updating to a new identity management system this year
    - If this update occurs, QCDRs will be required to obtain the new accounts.

Program Requirements

- 2014 QCDR Qualified Posting
  - 2014 QCDR will be listed on a qualified posting document that is posted on the CMS website.
  - QCDRs are required to 'sign-off' on the information included in the document attesting that they will provide the service(s) as stated on the posting.
  - QCDRs are required to provide cost information on this document.
  - QCDRs will not be able to add or remove any measures from this listing.

Program Requirements

- National Provider Calls
  - National Provider Calls are generally scheduled every 1 to 3 months.
  - QCDR attendance is encouraged
  - Call topics and registration information can be found on the CMS Sponsored Calls page of the CMS PQRS website http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/CMSSponsoredCalls.html
- CMS Listserv
  - QCDRs are encouraged to register for Medicare FFS Provider ListServ communications.
  - QCDRs may subscribe to the Medicare FFS Provider ListServ here: https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819

Question and Answer Session

Measure Overview

Presenter: PQMM

Measures Requirements

- On March 31, 2014, all QCDRs measures were locked down.
  - The addition of measures (PQRS or non-PQRS) is **NOT** allowed for program year 2014 after the deadline.
  - The removal of measures is **NOT** allowed for program year 2014 after the deadline.
- QCDRs may submit the PQRS measures.
  - This includes individual registry measure, measures group only measures, GPRO/ACO Web Interface measures, and eCQMs.
  - Please note that CMS is allowing QCDRs to support these measures but QCDRs are not able to report on behalf of GPROs, or entities considered GPROs (i.e., ACOs). The GPROs and ACOs must submit through a CMS approved submission mechanism.
- QCDRs may **NOT** submit PQRS measures groups.
  - Should a QCDR require its EPs to report on a cluster of measures similar to PQRS measures groups, the measures within the measures group would count as separate, individual measures.

Measures Requirements

- QCDRs may submit up to 20 non-PQRS measures.
  - Non-PQRS measures include
    - Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS)
      - CAHPS Measures for PQRS are considered 3 measures covering 1 NQS Domain
    - National Quality Forum (NQF)-endorsed measures
    - Measures used by boards or specialty societies
    - Measures used in regional quality collaborations

Measures Requirements

- A QCDR must have at least 1 outcome measure available for reporting.
- A QCDR may report on process measures.
- The outcome and process measures reported must contain denominator data, numerator data, denominator exceptions, and denominator exclusions.
- The entity must demonstrate that it has a plan to risk adjust the quality measures data for which it collects and intends to transmit to CMS. This must be integrated with the complete measure specifications.

Measures Requirements

- Measure Types
  - **Outcome Measure:** A measure that assesses the results of health care that are experienced by patients (i.e., patients' clinical events; patients' recovery and health status (end result of care of procedure); patients' experiences in the health system; and efficiency/cost).
  - **Process Measure:** A measure that focuses on a process which leads to a certain outcome, meaning that a scientific basis exists for believing that the process, when executed well, will increase the probability of achieving a desired outcome.

Measures Requirements

- Measure Definitions
  - **Numerator Data:** The upper portion of a fraction used to calculate a rate, proportion, or ratio. The numerator must detail the quality clinical action expected that satisfies the condition(s) and is the focus of the measurement for each patient, procedure, or other unit of measurement established by the denominator (that is, patients who received a particular service or providers that completed a specific outcome/process)
  - **Denominator Data**: The lower portion of a fraction used to calculate a rate, proportion, or ratio. The denominator must describe the population eligible (or episodes of care) to be evaluated by the measure. This should indicate age, condition, setting, and timeframe (when applicable). For example, "Patients aged 18 through 75 years with a diagnosis of diabetes."

Measures Requirements

- Measure Definitions
  - **Denominator Exceptions:** Conditions that should remove a patient, procedure or unit of measurement from the denominator of the performance rate only if the numerator criteria are not met. Denominator exceptions allow for adjustment of the calculated score for those providers with higher risk populations. Denominator exceptions allow for the exercise of clinical judgment and should be specifically defined where capturing the information in a structured manner fits the clinical workflow. Generic denominator exception reasons used in measures fall into three general categories: medical, patient, or system reasons
  - **Denominator Exclusions:** Patients with conditions who should be removed from the measure population and denominator before determining if numerator criteria are met. (For example, patients with bilateral lower extremity amputations would be listed as a denominator exclusion for a measure requiring foot exams.)

Validation & Feedback

Presenter: Vetting Contractor

Validation

- Validation Strategy
  - QCDR must implement the validation strategy submitted to CMS.
    - A validation strategy details how the QCDR will determine whether EPs succeed in reporting measures or that the data submitted to the QCDR is true, accurate and complete.
    - Acceptable validation strategies often include such provisions as the entity being able to conduct random sampling of their participant's 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.
    - QCDRs supporting the EHR Incentive Program should also review the template for data validation and integrity that includes the requirements for certification of an EHR product by the Office of the National Coordinator for Health Information Technology (ONC) that are explained at http://www.healthit.gov/sites/default/files/cypress_test_procedure_12042013.pdf.

Validation

- Validation Execution Report
  - By June 30, 2015, QCDRs must perform the validation outlined in the validation strategy and send evidence of successful results to CMS for data collected in the reporting periods occurring in 2014.
  - The validation execution report must be sent via e-mail to the QualityNet Help Desk at Qnetsupport@hcqis.org by 5:00 PM EST on June 30, 2015. The e-mail subject should be *PY2014 QCDR Data Validation Execution Report.*

Feedback Reports

- By December 31, 2014, QCDRs must have provided feedback, at least four times on the measures at the individual participant level for which the QCDR reports on the EP's behalf for purposes of the individual EP's satisfactory participation in the QCDR.
  - QCDRs may have feedback reports that are readily available via the web or other communication mechanism that allows EPs to generate reports on demand in order to fulfill this requirement.

Submission Overview

Presenter: Vetting Contractor

Data Submission

- Data Submission for QCDRs
  - QCDRs will aggregate and calculate the data on behalf of their EPs.
  - QCDRs must be able to collect all needed data elements and transmit the data on quality measures to CMS in one of two formats.
    - The CMS-approved QCDR XML format must be used when submitting PQRS-specified measures or QCDR-specified measures for purposes of PQRS participation.
    - The QRDA category III format must **only** be used when submitting the eCQMs for purposes of PQRS and EHR Incentive Program participation. Please note that the correct version of eCQM specifications must be used.

Program	PQRS Only	PQRS and EHR Incentive Program
Data Submission File Type	QCDR XML	QRDA Category III

Data Submission

- QCDR XML
  - The QCDR XML Specifications will be available in June 2014 on the Qualified Clinical Data Registry Reporting webpage of the PQRS website http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Qualified-Clinical-Data-Registry-Reporting.html.
  - The Submission Engine Validation Tool (SEVT) will be updated and available for testing with the QCDR XML Specification in December 2014.
- QRDA Category III
  - The QRDA Category III specifications will be available in April 2014 on the Clinical Quality Measure webpage of the EHR Incentive Program website http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/ClinicalQualityMeasures.html
  - The SEVT will be updated and available for testing with the QRDA Category III Implementation Guide in October 2014.

Test Submission

- CMS strongly encourages that QCDRs perform the file testing for the aggregate XML file and/or QRDA category III file as it will help QCDRs to understand what components are required and alleviate issues with the file format and submission that may occur when submitting the quality measure data.
  - Additional information regarding test submission will be made available later this year on the Qualified Clinical Data Registry Reporting webpage of the CMS PQRS website (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Qualified-Clinical-Data-Registry-Reporting.html)

Production Submission

- PQRS Only
  - QCDRs must submit the quality measure data in the proper format to CMS by **March 15, 2015.**
- PQRS and EHR Incentive Program
  - QCDRs must submit the quality measure data in the proper format to CMS by **February 28, 2015.**
  - Please note that the difference in dates is due to a deadline for the EHR Incentive Program. Any submissions that occur after February 28, 2015 will not be processed for the EHR Incentive Program.

* Submit early and often to ensure data is submitted and questions/issues can be resolved prior to the end of the submission period.

Production Submission

- Data Submission Size Restrictions
  - QCDR XML files must be greater than 0 bytes but not exceed 80 MB.
  - QRDA Category III must be greater than 0 bytes but not exceed 10 MB.
  - Production files of the same file type may be zipped.
- Submission User Guides
  - Submission User Guides are available on the PQRS portal (https://www.qualitynet.org/pqrs) in the User Guide section on the lower left pane.
    - PQRS Portal User Guide
    - PQRS/eRx SEVT User Guide
    - PQRS/eRx Submission User Guide
    - PQRS/eRx Submission Report User Guide

Program Lessons Learned

Presenter: Dr. Green

Production Submission

- Data Quality Lessons Learned
  - TIN/NPIs submitted during the production submission process need to be accurate, revisions are not possible after submission to CMS.
    - Ensure TIN/NPI combinations are accurate.
      - Include TIN/NPI combinations on Provider Consents for verification of accuracy
      - Verify TIN/NPI combinations submitted on Medicare Claims
      - Request tax documentation to confirm TINs
      - Use national database like NPPES to confirm NPIs
    - Individual NPIs should be used for reporting PQRS, not the group NPI.
    - Resubmissions will not be accepted once portal is closed.
  - TIN/NPIs must match what is used for Medicare billing.
  - TIN/NPI counts must match what is actually submitted.

Production Submission

- Submission Lessons Learned
  - Send in all data, not just for successful providers.
  - Begin preparing for submissions as early in the process as possible; do not wait until the deadline is near to begin. (It is not necessary to wait until you have all data from every provider/group before submitting.)
  - Ensure all questions are answered on calculation of various measure types (e.g. Patient process, patient intermediate, etc).
  - Verify that the data received from providers is accurate prior to submission.
  - Submit data for providers that are eligible to participate.
    - List of EPs for PQRS is located http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html.
    - List of EPs for the EHR Incentive Program is located http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/.
  - Coding must ONLY be completed on CMS approved specifications.

QCDR Audit and Disqualification Process

Presenter: Dr. Green

QCDR Audit and Disqualification Process

- After data submission concludes, CMS will analyze the data submitted by QCDRs. If inaccurate data is found, CMS has the ability to audit and disqualify QCDRs. A disqualified QCDR will ***not*** be allowed to submit quality measures data on behalf of its EPs for purposes of meeting the criteria for satisfactory participation for the following year. Disqualified entities must become re-qualified as a QCDR before it may submit quality measures data on behalf of its EPs for purposes of the individual EP participants meeting the criteria for satisfactory participation under PQRS. In addition, inaccurate data collected will be discounted for purposes of an individual EP meeting the criteria for satisfactory participation in a QCDR.

Timeline

Presenter: Vetting Contractor

Help Resources

Presenter: Vetting Contractor

Help Resources

- QualityNet Helpdesk –
  - Monday–Friday 7:00 AM–7:00 PM CT
    - 866-288-8912
    - qnetsupport@hcqis.org
- EHR Incentive Program EHR Information Center
  - 888-734-6433 (TTY 888-734-6563)

Question and Answer Session

Recap and Closure

Presenter: Dr. Green