



GROUP PRACTICE REPORTING OPTION (GPRO) REQUIREMENTS FOR SUBMISSION OF 2013 PHYSICIAN QUALITY REPORTING DATA

Background

Introduced in 2010 in accordance with section 1848(m)(3)(C)(i) of the Act, CMS is continuing the group practice reporting option (GPRO) for the 2013 Physician Quality Reporting System (Physician Quality Reporting). Group practices that satisfactorily report data on Physician Quality Reporting measures for assigned Medicare beneficiaries for 2013 are eligible to earn an incentive payment equal to 0.5% of the group practice's total estimated Medicare Part B Physician Fee Schedule (PFS) allowed charges for covered professional services furnished during the 2013 reporting period. As required by section 1848(m)(3)(C)(iii) of the Act, an individual eligible professional who is a member of a group practice selected to participate in Physician Quality Reporting GPRO is not eligible to separately earn a Physician Quality Reporting incentive payment as an individual eligible professional under that same Tax Identification Number (TIN) (that is, for the same TIN/National Provider Identifier, or NPI, combination). Once a group practice (TIN) is selected to participate in the GPRO, this is the only method of Physician Quality Reporting available to the group and all individual NPIs who bill Medicare under the group's TIN for 2013.

The 2010 model for the group practice reporting option (GPRO) closely followed the requirements that were created for the PGP demonstration. Initial requirements for participation in the Physician Quality Reporting System under the group practice reporting option included participation to large practices only. In 2011 this was expanded to include practices with 2-199 professionals which created a second reporting option (GPRO II) specifically for smaller group practices. For 2012, group practices with 25 or more professionals were able to report as a GPRO. Additional similarities with the PGP demonstration included physician group access to a pre-populated database, which assigned beneficiaries to each group practice using a patient assignment methodology modeled after the patient assignment methodology used in the PGP demonstration.

The Medicare Shared Savings Program (Shared Savings Program), and Pioneer Accountable Care Organization (ACO) Model have incorporated aspects of the Physician Quality Reporting System reporting requirements and incentives under those respective programs.

A "group practice" under 2013 Physician Quality Reporting consists of a physician group practice, as defined by a single TIN, with 2 or more individual eligible professionals (as identified by individual NPIs) who have reassigned their billing rights to the TIN. This definition of group practice is different from the definition of group practice that was applicable for the 2012 Physician Quality Reporting System, which defined a group practice as 25 or more eligible professionals.

Group practices consisting of 100+ eligible professionals, beginning in 2013 will be subject to the Value-based Payment Modifier (VM). A group practice with 100 or more eligible professionals may avoid a 2015 VM downward payment adjustment by satisfactorily reporting to avoid the 2015 PQRS payment adjustment.

Physician Quality Reporting Group Practice Reporting Option (GPRO) Requirements*

(*see separate ACO requirements for PQRS reporting)

As noted above, a group practice can have 2 or more eligible professionals. However, only group practices with 25 or more eligible professionals may use the web-based interface as a reporting method. Each group practice with 25 or more eligible professionals registered to participate in the 2013 Physician Quality Reporting GPRO may elect to report via the web-based interface or qualified registry.

PQRS Eligibility for ACOs in the Medicare Shared Savings Program (SSP)

The Medicare Shared Savings Program (SSP) requires that all EPs in ACO participating TINs be part of the ACO. Therefore, TINs participating in the Medicare Shared Savings Program may only follow the ACO guidelines for PQRS reporting and report via the GPRO Web Interface to meet the quality measure reporting requirements for the SSP. The SSP ACO may **not** separately participate in PQRS through the GPRO.

PQRS Eligibility for ACOs in the Pioneer ACO Model

The Pioneer ACO Model does not require that all EPs in an ACO participating TIN be a part of the ACO. "Split" TINs are allowed in the Pioneer ACO model, where the TIN can be made up of both ACO and non-ACO participant EPs. Therefore, a Pioneer ACO may be composed of full participant TINs, where all the EPs billing under a TIN are ACO participant EPs as well as split participant TINs. Pioneer ACO "Full" participant TINs will need to satisfy PQRS requirements by virtue of the ACO successfully reporting **ACO-GPRO Web Interface** measures. Split participants TINs, however, have two options to gain eligibility for PQRS:

1. Pioneer ACO "Split" TINs who are participant TINs in the ACO may register to participate in PQRS GPRO as an entire group (including both ACO participating and non-participating providers); **OR**
2. Pioneer ACO "Split" TIN non-ACO participating providers can participate as individuals through **traditional PQRS reporting methods** including EHR, claims or registry reporting.

The web-based interface is partially pre-populated with an assigned sample of beneficiaries and those beneficiaries' demographic and utilization information. The group practice will then be required to populate the remaining data fields necessary for capturing quality measure information for each consecutively assigned Medicare beneficiary with respect to services furnished during the 2013 calendar year reporting period). The selected group practices will be provided access to the pre-populated web interface for data submission, during the first quarter of 2014.

Group practices with 2 or more eligible professionals selected to participate in the 2013 Physician Quality Reporting GPRO, may report via a qualified registry. Groups with 2-24 eligible professionals may not report via the GPRO web-based interface, and therefore must use the registry option.

For purposes of determining whether a group practice satisfactorily reports Physician Quality Reporting quality measures data for 2013, the following criteria will be used.

NOTE: A group practice's size will be the size of the group at the time the group's participation is approved by CMS. For example, if a group practice is comprised of 100 eligible professionals at the time it self-nominates for participation as a GPRO in 2013, and the group practice's size then drops to 99 eligible professionals at the time the group practice's participation is approved by CMS, the group practice would need to meet the reporting criteria for a group size of 99. Likewise, if a group practice is comprised of 99 eligible professionals at the time it self-nominates for participation as a GPRO in 2013, and the group practice's size increases to 100 eligible professional at the time the group practice's participation is approved by CMS, the group practice would need to meet the reporting criteria for a group size of 100.

For group practices comprised of 2-24 eligible professionals:

- Qualified Registry
 - Group practices report three (3) measures; AND
 - Report each measure for at least 80% of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies.
 - Measures with a 0 percent performance rate will not be counted.

For group practices comprised of 25-99 eligible professionals:

- Qualified Registry
 - Group practices report three (3) measures; AND
 - Report each measure for at least 80% of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies.
 - Measures with a 0 percent performance rate will not be counted.
- Web-based interface
 - Group practices report on all GPRO measures included in the web interface
 - The group practice will need to populate the remaining data fields in the web interface necessary for capturing quality measure information on each of the assigned beneficiaries - up to 218 beneficiaries for each module or preventive care measure
 - If the pool of eligible assigned beneficiaries for any module or preventive care measure is less than 218, then the group practice will need to populate the remaining data files for 100 percent of eligible beneficiaries for that module or preventive care measure
 - For each module and preventive care measure, the group practice must report information on the assigned patients in the order in which they appear in the group's sample

For group practices comprised of 100 or more eligible professionals:

- Qualified Registry
 - Group practices report three (3) measures; AND
 - Report each measure for at least 80% of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies.
 - Measures with a 0 percent performance rate will not be counted.
- Web-based interface
 - Group practices report on all Physician Quality Reporting System GPRO quality measures included in the web interface
 - The group practice will need to populate the remaining data fields in the web interface necessary for capturing quality measure information on each of the assigned beneficiaries - up to 411 beneficiaries for each module and preventive care measure
 - If the pool of eligible assigned beneficiaries for any module or preventive care measure is less than 411, then the group practice will need to populate the remaining data files for 100 percent of eligible beneficiaries for that module and preventive care measure. For each module and preventive care measure, the group practice must report information on the assigned patients in the order in which they appear in the group's sample

All group practices participating in the 2013 Physician Quality Reporting System GPRO via the web-based interface, regardless of size, are required to report on all quality measures grouped into 18 measures (including two composite measures for a total of 22 measures) and seven disease modules: Care Coordination/Patient Safety (Care), Preventive Care (PREV), Coronary Artery Disease (CAD), Diabetes Mellitus (DM), Heart Failure (HF), Hypertension (HTN), and Ischemic Vascular Disease (IVD).

Based on Medicare Part B claims with dates of service beginning January 1, 2013 and processed by December 31, 2013, CMS will randomly assign Medicare beneficiaries to each physician group practice TIN. Assigned beneficiaries would be limited to those Medicare FFS beneficiaries with Medicare Parts A and B for whom Medicare is the primary payer. Medicare Advantage enrollees will not be included in patient assignment. CMS is adopting the beneficiary assignment and sampling methodology used under the Medicare Shared Savings Program, which, unlike the current methodology to populate the GPRO web interface, requires that the beneficiary being assigned had at least one primary care service furnished by a group practice physician. We understand that as a result of this requirement, there could

be some group practices (such as groups consisting only of non-physician practitioners) that would not be able to report PQRS quality measures using the GPRO web interface because no beneficiaries would be assigned to them. However, we do not expect this would affect many group practices.

The Administrative Claims Reporting Method

The Administrative Claims Reporting Method is a method where group practices report Medicare Part B claims data for CMS to determine whether the group practice has performed services applicable to certain individual Physician Quality Reporting System quality measures. Group practices may use the administrative claims reporting method for 2015 payment adjustment purposes, but not for 2013 incentive payments. Group practices electing to report via the administrative claims method must submit their administrative claims election statement via the web by October 18, 2013. Please note that the ability to elect the administrative claims-based reporting mechanism will not be available until the summer of the applicable reporting period.

HOW/WHERE CAN I SIGN-UP FOR THE CMS-CALCULATED ADMINISTRATIVE CLAIMS-BASED REPORTING OPTION?

The election of the 2013 CMS-calculated administration claims-based reporting is available **only** via the web from **July 15, 2013 through October 18, 2013**. Please use the information and instructions that follow to sign up for the CMS-calculated administrative claims reporting option:

1. Go to <https://portal.cms.gov>. On the right hand side, select **Login to CMS Secure Portal**.
2. After accepting the **Terms and Conditions**, enter your IACS User ID and Password in the **Welcome to CMS Enterprise Portal** screen. Select **Login** to continue.
3. Select the **PV-PQRS** tab at the top of the screen, and then select **Registration** from the dropdown menu.
4. You will see a screen where the group practice(s) and EP(s) (if applicable) that are associated with your IACS account are listed. To register a group practice for the first time, select the **Register** link to the right of the group practice you want to register.

Note: *If your group practice is participating in the **Medicare Shared Savings Program**, then you will see an alert message letting you know that it is not necessary for you to register the group practice or EP (if applicable) in the PV-PQRS Registration System.*

Complete information and instructions are available in the *Group Practice Registration in the PV-PQRS Registration System Quick Reference Guide* or the *Individual Eligible Professional Registration in the PV-PQRS Registration System Quick Reference Guide* located on the Medicare FFS Physician Feedback Program/Value-Based Payment Modifier website in the downloads section of the Self Nomination/Registration page at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html>.

PQRS GPRO Self-Nomination

To be considered as a PQRS GPRO, participants must comply with the following requirements:

1. Have billed Medicare Part B on or after January 1, 2013 and prior to December 31, 2013
2. Agree to have the results on the performance of their Physician Quality Reporting System measures publicly posted on the Physician Compare Web site
3. Have technical capabilities, at a minimum: standard PC image with Microsoft® Office and Microsoft® Access software installed; and minimum software configurations
4. Be able to comply with a secure method for data submission
5. Provide CMS access to review the Medicare beneficiary data on which Physician Quality Reporting System GPRO submissions are founded or provide to CMS a copy of the actual data
6. Indication of group practice's participation in the 2013 eRx Incentive Program with intended reporting method identified and/or request for a hardship exemption from the 2014 eRx payment adjustment
7. Indicate desire to participate in the Physician Quality Reporting System and eRx as individuals or as a GPRO
8. Provide all requested data on the CMS Communication Support Page (CSP)

To be considered for 2013 Physician Quality Reporting GPRO, all group practices must address the above requirements in a self-nomination statement received via the web by October 15, 2013. Group practices must also select their reporting method at the time of self-nomination, and may change this method at any time prior to the October 15, 2013 deadline.

We anticipate that a list of qualified registries will be posted on the CMS website in the summer of 2013.

Note that there are two different self-nomination deadlines for 2013 GPRO. The deadline to self-nominate for PQRS GPRO is October 15, 2013. However, the deadline to self-nominate for eRx GPRO is January 31, 2013. Please see the eRx GPRO requirements for additional discussion on the eRx GPRO program.