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

QCDR
Reporting Overview

Program Year 2014

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Agenda

- Physician Quality Reporting System (PQRS) Overview
- Electronic Health Record (EHR) Incentive Program Overview
- Value-based Payment Modifier (VM) Overview
- Qualified Clinical Data Registry (QCDR) Requirement Overview
- Help Resources

Purpose

- This presentation provides information about the PQRS reporting mechanism of 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.

PQRS Overview

PQRS 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 200 individual measures, 25 measures groups, and multiple reporting options through claims-based reporting, qualified registry reporting, qualified clinical data registry reporting, and EHR-based reporting through ONC Certified EHR systems or modules.

PQRS 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

PQRS Overview

- The applicable PQRS incentive amounts are:
  - 2014: 0.5 %
  - No PQRS incentive payments are scheduled past 2014
- The applicable PQRS payment adjustment amounts are:
  - 2016: -2.0 % (based on 2014 submission)
  - 2017: -2.0 % (based on 2015 submission)

Additional PQRS 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

PQRS Overview

- Criteria to Earn the 2014 PQRS Incentive Payment:
  - 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% or more of the applicable patients (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.

PQRS Overview

- Criteria to Earn the 2014 PQRS Incentive Payment:

Reporting Option	Reporting Period	Reporting Mechanism	Reporting Criteria
Individual EP	12-month (01/01/14 – 12/31/14)	Qualified Clinical Data Registry	Satisfactorily report at least 9 measures, with at least 1 outcome measure, covering at least 3 NQS domains for at least 50 percent of the applicable patients. *Measures with a 0 percent performance rate would not be counted.

PQRS Overview

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

PQRS Overview

- Criteria to Avoid the 2016 PQRS Payment Adjustment

Reporting Option	Reporting Period	Reporting Mechanism	Reporting Criteria
Individual EP	12-month (01/01/14 – 12/31/14)	Qualified Clinical Data Registry	Meet requirements for satisfactory participation in the 2014 PQRS. -OR- Report 3 or more individual measures across at least 1 NQS domain for 50% or more applicable Medicare Part B FFS patients.

EHR Incentive Program Overview

EHR Incentive Program Overview

- The 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 electronic clinical quality measure (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 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

Value-based Payment Modifier Overview

- The Value-based Payment Modifier (VM) provides for differential payment to an EP or group practice under the 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 PQRS-qualified clinical data registry 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.

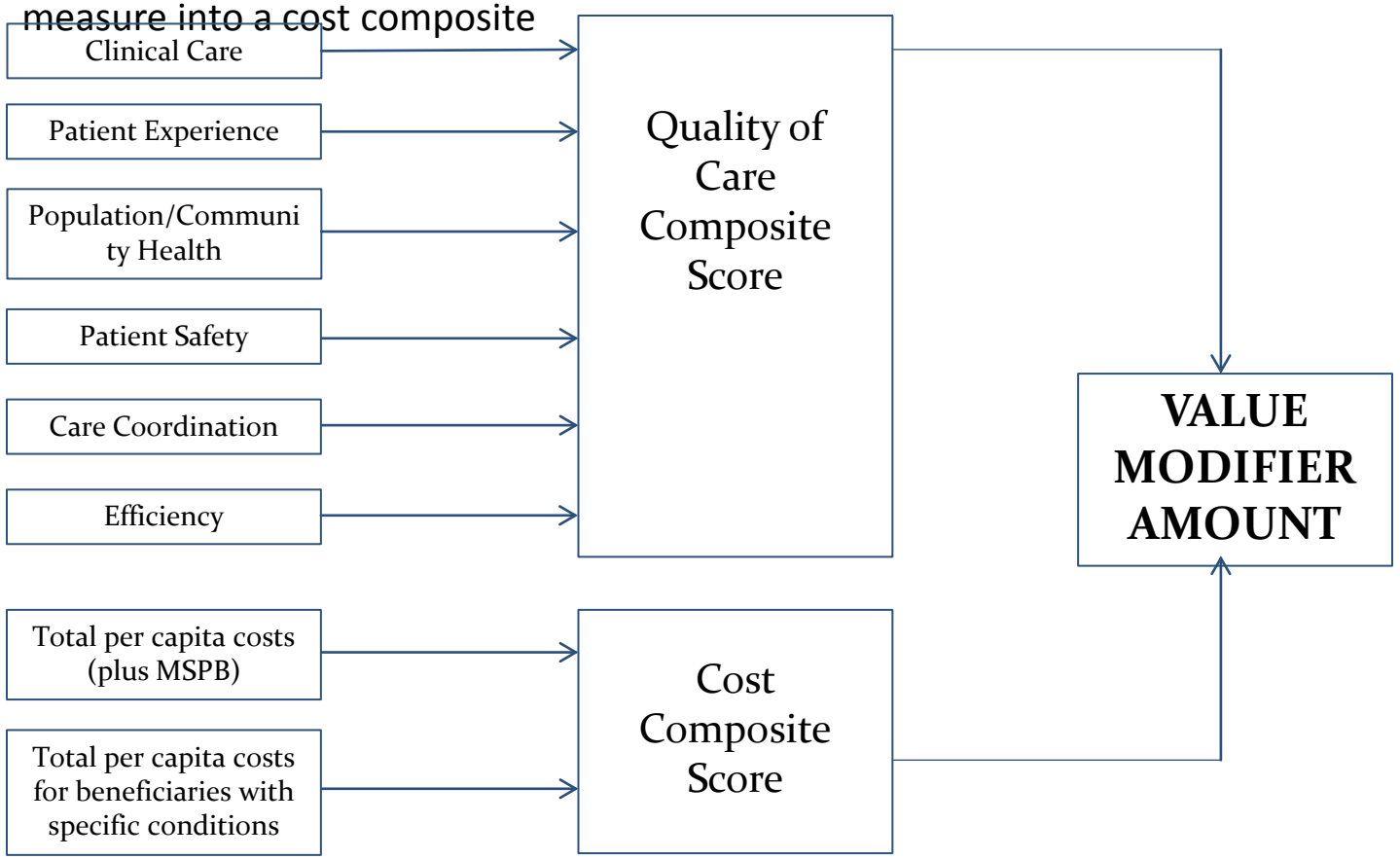
*Groups of physicians in Category 1 will not have the option to elect quality tiering for the CY 2016 value-based payment modifier and instead will be subject to mandatory quality tiering.

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

QCDR Overview

QCDR Overview

- 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

QCDR 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.

QCDR 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).

QCDR Requirements

- 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.
  - These documents are between the QCDR and EP.
    - Must be obtained at a TIN/NPI level for each EP being submitted as an individual.
  - Electronic statements are acceptable.
  - Update annually

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.

Qualified Posting

- 2014 QCDR Posting
  - By **May 30, 2014**, CMS will post a finalized list of QCDRs on the Qualified Clinical Data Registry Reporting page of the CMS PQRS website. The QCDR posting includes the vendor name, contact information, the programs being supported, measures being supported, and cost information for the services they provide to clients. Prior to posting, the QCDR must:
    - Verify the information and qualifications for the QCDR prior to posting (includes names, contact, measures, cost, etc.) and furnish/support for all of the services listed for the QCDR 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 will not be able to add or remove any measures from this listing.
    - Inform CMS of the cost the QCDR charges to submit PQRS data to CMS.

Validation Strategy

- Validation Strategy
  - By **March 31, 2014**, QCDRs 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 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 that 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.

CMS Communications

- National Provider Calls
  - National Provider Calls are generally scheduled every 1 to 3 months.
    - Vendor attendance is encouraged but not required.
  - Call topics and registration information can be found on the CMS Sponsored Calls page of the CMS PQRS website.
    - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/CMSSponsoredCalls.html
- CMS Listserv
  - Vendors are encouraged to register for Medicare FFS Provider ListServ communications.
    - Medicare FFS Provider ListServ information can be found here: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MailingLists_FactSheet.pdf
    - Vendors may subscribe to the Medicare FFS Provider ListServ here: https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819

2014 Audit and Disqualification Process

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 may be discounted for purposes of an individual EP meeting the criteria for satisfactory participation in a QCDR

Help Resources

Help Resources

- QualityNet Help Desk:
  - 866-288-8912 or qnetsupport@hcqis.org
  - Monday – Friday, 7:00 AM – 7:00 PM CT
- EHR Incentive Program EHR Information Center:
  - 888-734-6433
  - Monday – Friday, 7:30 AM to 6:30 PM CT
- VM Help Desk:
  - 888-734-6433 or pvhelpdesk@cms.hhs.gov