Physician Quality Reporting System (PQRS)
Qualified Registry

Qualified Registry Reporting Overview

Program Year 2014

Disclaimers

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide. This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Agenda

- Physician Quality Reporting System (PQRS) Overview
- Value-based Payment Modifier (VM) Overview
- Qualified Registry Overview
- Help Resources

Purpose

- This presentation provides information about the PQRS reporting mechanism of Qualified Registries 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 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)
  - 2017: -2.0 percent (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 Eligible Professionals (EPs)
    - Report at least 9 individual PQRS registry measures across 3 National Quality Strategy (NQS) domains for 50% or more of applicable Medicare Part B FFS patients for each EP (12 months); **OR**
    - Report less than 9 measures and/or less than 3 NQS domains for 50% or more Medicare Part B FFS patients and successfully pass the Measure Applicability Validation (MAV) process (12 months); **OR**
    - Report at least one registry measures group for 20 patients, the majority of 11 must be Medicare Part B FFS patients (12 months); **OR**
    - Report at least one registry measures group for 20 patients, the majority of 11 must be Medicare Part B FFS patients (6 months).
      - Please note that the measures group reporting requirements are the same for the 12-month and 6-month reporting periods. Registries should select the 12-month reporting period so that the EPs can earn an incentive for the 12-months.

Note: Measures with a 0 percent performance rate will not be counted.

PQRS Overview

- Group Practice Reporting Option (GPRO) Group Practices
  - Report at least 9 individual PQRS registry measures across 3 NQS domains for 50% or more of applicable Medicare Part B FFS patients for each GPRO (12 months); **OR**
  - Report less than 9 measures and/or less than 3 NQS domains for 50% or more Medicare Part B FFS patients and successfully pass the Measure Applicability Validation (MAV) process (12 months); **OR**
  - Report all CG-CAHPS summary survey modules (12) AND

    Report at least 6 measures across 2 NQS domains for 50% or more of applicable Medicare Part B FFS patients for each GPRO (12 months)

Notes: Measures with a 0 percent performance rate will not be counted.

GPROs must use the individual measures from the 2014 Individual Claim/Registry Measure Specifications . The GPRO "Web Interface" measures are only for GPROs reporting via Web Interface

GPRO group practices wanting to submit their PQRS data via a qualified registry must elect to do so at the time of GPRO self-nomination/registration.

PQRS Overview

Reporting Option	Reporting Period	Reporting Mechanism	Reporting Criteria
Individual EP	12-month (01/01/14 – 12/31/14)	Qualified Registry	-Satisfactorily report at least 9 measures across NQS 3 domains for 50% or more Medicare Part B FFS patients. OR -Satisfactorily report less than 9 measures and/or less than 3 NQS domains for 50% or more Medicare Part B FFS patients and successfully pass the MAV process. OR -Satisfactorily report at least one registry measures group for 20 patients, the majority of 11 must be Medicare Part B FFS patients (12 months or 6 months) *Measures with a 0 percent performance rate will not be counted.
Group Practice (2+ EPs)	12-month (01/01/14 – 12/31/14)	Qualified Registry	-Satisfactorily report at least 9 measures across 3 NQS domains for 50% or more Medicare Part B FFS patients. OR -Satisfactorily report less than 9 measures and/or less than 3 NQS domains for 50% or more Medicare Part B FFS patients and successfully pass the MAV process. -Satisfactorily Report all CG-CAHPS summary survey modules (12) AND Report at least 6 measures across 2 NQS domains for 50% or more of applicable Medicare Part B FFS patients for each GPRO (12 months) *Measures with a 0 percent performance rate will not be counted.

PQRS Overview

- Criteria to Avoid the 2016 PQRS Payment Adjustment:
  - Individual EPs
    - Meet requirements for satisfactory reporting in the 2014 PQRS; **OR**
    - Report 3 or more individual measures across at least 1 NQS domain via qualified registry for 50% or more of applicable Medicare Part B FFS patients; **OR**
    - Report 1-2 individual measures across at least 1 NQS domain via qualified registry for 50% or more of applicable Medicare Part B FFS patients and successfully pass the MAV process

Note: Measures with a 0 percent performance rate will not be counted.

PQRS Overview

- GPRO Group Practices
  - Meet requirements for satisfactorily reporting in the 2014 PQRS; **OR**
  - Report at least 3 individual measure across 1 NQS domain as a group via qualified registry for 50% or more of the applicable Medicare Part B FFS patients; **OR**
  - Report 1-2 individual measures via qualified registry as a group for 50% or more of the group practice's applicable Medicare Part B FFS patients and successfully pass the MAV process

Notes: Measures with a 0 percent performance rate will not be counted.

GPROs must use the individual measures from the 2014 Individual Claim/Registry Measure Specifications . The GPRO "Web Interface" measures are only for GPROs reporting via Web Interface.

GPRO group practices wanting to submit their PQRS data via a qualified registry must elect to do so at the time of GPRO self-nomination/registration.

PQRS Overview

Reporting Option	Reporting Period	Reporting Mechanism	Reporting Criteria
Individual EP	12-month (01/01/14 – 12/31/14)	Qualified Registry	Meet requirements for satisfactory reporting 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. -OR- Report 1-2 individual measures across at least 1 NQS domain for 50% or more of applicable Medicare Part B FFS patients and successfully pass the MAV process. *Measures with a 0 percent performance rate will not be counted.
Group Practice	12-month (01/01/14 – 12/31/14)	Qualified Registry	Meet requirements for satisfactory reporting in the 2014 PQRS. -OR- Report at least 3 individual measures across 1 NQS domain as a group for 50% or more of the Medicare Part B FFS patients. -OR- Report on 1-2 individual measures as a group for 50% or more of the group practice's applicable Medicare Part B patients. The group practice is subject to the Measure-Applicability Validation (MAV) for the purposes of avoiding the 2016 PQRS payment adjustment. *Measures with a 0 percent performance rate will not be counted.

PQRS Overview

- 2014 Registry Measure Applicability Validation (MAV) Process
  - The MAV process will determine whether an EP or GPRO should have submitted for additional measures. Eligible professionals or group practices who fail MAV will not earn the PQRS incentive payment for 2014 and may be subject to the 2016 Payment Adjustment.
    - EPs and GPROs who satisfactorily submit quality data for less than 9 measures and/or less than 3 NQS will be subject to the MAV process to determine whether they should be considered incentive eligible or avoid the payment adjustment.
  - For more information, refer to the 2014 PQRS Registry Measure Applicability Validation zip file on the CMS PQRS web site, Analysis and Payments web page at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html

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.

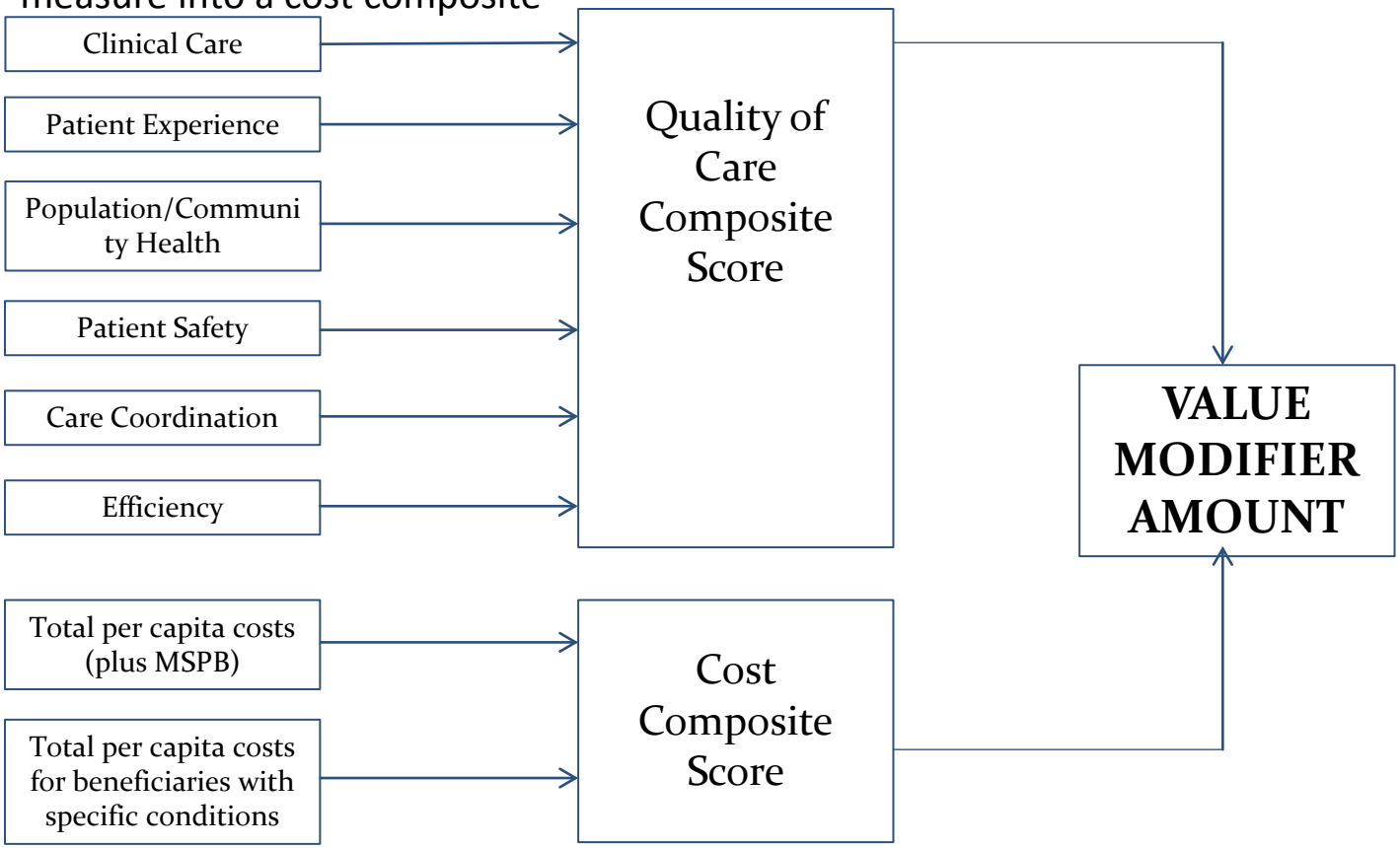
*Groups of physicians in Category 1 will not have the option to elect quality tiering for the CY 2016 value-based payment modifier and instead will be subject to mandatory quality tiering.

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

Qualified Registry Overview

Qualified Registry Overview

- Qualified registries collect clinical quality data directly from claims, web-based tool, practice management system, and/or electronic health records (EHR).
- Qualified registries are responsible for calculating and submitting quality measures data to CMS in a CMS-specified format(s) on behalf of the eligible professional or group practice for the respective program year.

Qualified Registry Requirements

- In order to self-nominate, qualified registries 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 25 participants by **January 1, 2013**, to be eligible to participate under the program with regard to data collected in 2014.
  - 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 qualified registry vendor).

Qualified Registry Requirements

- Enter into and maintain with participating professionals an appropriate Business Associate Agreement that provides for the qualified registry's receipt of patient-specific data from the EPs and GPROs, as well as the qualified registry's disclose of patient-specific data on Medicare beneficiaries on behalf of EPs and GPROs who wish to participate in PQRS.
- Obtain and keep on file signed documentation that each holder of an NPI has authorized the qualified registry to submit PQRS data on Medicare beneficiaries to CMS for the purpose of PQRS participation. This documentation must be obtained at the time the EP or GPRO signs up with the qualified registry for purposes of PQRS participation and must meet any applicable laws, regulations, and contractual business associate agreements.
  - These documents are between the registry and EP/GPRO.
    - Must be obtained at a TIN/NPI level for each EP being submitted as an individual.
    - Must be obtained at a TIN level for each group practice being submitted as a GPRO.
  - Electronic statements are acceptable.
  - Update annually

Qualified Registry Requirements

- Provide CMS a signed, written attestation statement stating that the quality measure results and any and all data, including numerator and denominator data provided to CMS, are accurate and complete.
- Use 2014 PQRS measure specifications (individual and/or measures groups) to calculate reporting rates and performance rates, unless otherwise agreed to by CMS.
- Be able to separate out and report on Medicare Part B FFS patients (primary or secondary).
  - Medicare Advantage may be included if the information cannot be filtered out
  - Other Payers will only be allowed for the Measures Group 20 patient sample reporting option (a majority [11] must be Medicare Part B FFS Patients).
- Be able to collect all needed data elements for at least 9 individual measures covering at least 3 of the NQS domains or a measures group.
- Be able to transmit data in a CMS-approved XML format.
- Provide CMS access (upon request) to review the Medicare beneficiary data on which 2014 PQRS registry-based submissions are founded or provide to CMS a copy of the actual data.

Qualified Posting

- 2014 Qualified Registry Posting
  - By **May 30, 2014**, CMS will post a finalized list of qualified registries on the Registry Reporting page of the CMS PQRS website. The qualified registry 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 registry must:
    - Verify the information and qualifications for the qualified registry prior to posting (includes names, contact, measures, cost, etc.) and furnish/support for all of the services listed for the qualified registry on the CMS Website.
      - Qualified registries 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.
      - Qualified registries will not be able to remove any measures from this listing. However, vendors will be able to add measures in late Spring. We will notify vendors via email and update the timeline when additional measures will be accepted.
    - Inform CMS of the cost the qualified registry charges to submit PQRS data to CMS.

Validation Strategy

- Validation Strategy
  - By **March 31, 2014**, qualified registries must implement the validation strategy submitted to CMS.
    - A validation strategy details how the qualified registry will determine whether EPs succeed in reporting measures or that the data submitted to the qualified registry 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.
- Validation Execution Report
  - By **June 30, 2015**, qualified registries 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 Qualified Registry Data Validation Execution Report.*

Feedback Reports

- By **December 31, 2014**, qualified registries must have provided feedback, at least two times, on the measures at the participant level for which the qualified registry reports on the EP's or GPRO's behalf for purposes of the satisfactory reporting in the qualified registry.
  - Qualified registries 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 qualified registries.
- If inaccurate data is found, CMS has the ability to audit and disqualify qualified registries. A disqualified registry will not be allowed to submit quality measures data on behalf of its EPs or GPROs for purposes of meeting the criteria for satisfactory reporting for the following year.
  - Disqualified entities must become re-qualified as a registry before it may submit quality measures data on behalf of its EPs or GPROs for purposes of the participants meeting the criteria for satisfactory reporting under PQRS.
  - In addition, inaccurate data collected will be discounted for purposes of an EP or GPRO meeting the criteria for satisfactory reporting through a qualified registry.

Help Resources

Help Resources

- QualityNet Help Desk:
  - 866-288-8912 or qnetsupport@hcqis.org
  - Monday – Friday, 7:00 AM – 7:00 PM CT
- VM Help Desk:
  - 888-734-6433 or pvhelpdesk@cms.hhs.gov