2014 Physician Quality Reporting System (PQRS): Group Practice Reporting Option (GPRO)

GPRO 101 – Introduction

Training Presentation

Program Year 2014

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Purpose

- This presentation provides information about the Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) participation options for the 2014 program year.

Disclaimer: If reporting for PQRS through another CMS program (such as the Medicare Shared Savings Program, Comprehensive Primary Care Initiative [CPC], or Pioneer ACO Model), 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.

Agenda

- Physician Quality Reporting System (PQRS) Background
- Group Practice Reporting Option (GPRO) Background
- 2014 PQRS GPRO Reporting Mechanisms and Requirements
- 2016 PQRS Payment Adjustment
- Physician Value-Based Payment Modifier (VM)
- Next Steps
- Resources

PQRS GPRO Support Team

- **CMS**
  - Lisa Lentz, GPRO Lead
- **QualityNet Help Desk**
  - (866) 288-8912 or (TTY 1-877-715-6222)
  - qnetsupport@hcqis.org

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PQRS BACKGROUND

What is PQRS?

- The Physician Quality Reporting System (PQRS) is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs)
- The PQRS incentive payment is a lump sum payment given to EPs who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries
  - 2014 PQRS incentive of 0.5%
- The PQRS payment adjustment applies to all of the EP's Part B covered professional services under the Medicare PFS during the payment adjustment period
  - The PQRS payment adjustment begins in 2015 based on PQRS reporting in program year 2013
    - 2015 PQRS adjustment of -1.5%
  - Group practices will be subject to a payment adjustment in 2016 based on PQRS reporting in program year 2014
    - 2016 PQRS adjustment of -2.0%

PQRS Legislative History

- Originally created under the Tax Relief and Health Care Act of 2006 as a voluntary reporting program
- The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008
  - Made the program permanent
  - Authorized incentive payments through 2010
- Patient Protection and Affordable Care Act
  - Extended incentive payments through 2014
  - Established mandatory reporting beginning in 2015

How to Participate in PQRS

- EPs can participate:
  - as individuals analyzed by their rendering/individual National Provider Identifier (NPI);

    OR
  - register to report as a group under the group practice reporting option (GPRO), analyzed by their Tax Identification Number (TIN)
- EPs can also participate in the Maintenance of Certification Program to earn an additional 0.5% incentive
  - Additional information on the Maintenance of Certification Program can be found on the CMS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Maintenance_of_Certification_Program_Incentive.html
- This presentation will focus on participation in the 2014 PQRS GPRO

GPRO BACKGROUND

GPRO Background

- Originally modeled after CMS demonstration projects
  - Physician Group Practice (PGP)
  - Medicare Care Management Performance (MCMP)
- Group practices that satisfactorily report in program year 2014 can earn a 2014 incentive payment
  - 2014 incentive is 0.5% of the TIN's total estimated Medicare Part B PFS allowed charges for covered professional services furnished during the reporting period (January 1 – December 31, 2014)
- Group practices that satisfactorily report in program year 2014 can avoid a payment adjustment in 2016
  - Refer to slides 33-40 for additional information on the 2016 PQRS payment adjustment and VM

GPRO Background (cont.)

- Benefits of Participating as a Group Practice in the PQRS GPRO
  - Billing and reporting staff may report one set of quality measures data on behalf of all EPs within a group practice, reducing the need to keep track of EPs' reporting efforts separately
  - Incentive-eligible group practices will receive a larger incentive payment as it is calculated at the TIN-level (0.5% of all Medicare Part B PFS claims submitted under that TIN)
  - Those EPs who have difficulty meeting the reporting requirements for individual EPs may benefit from group reporting

Evolution of PQRS GPRO

2010

- GPRO Introduced
- 200+ EPs
- 26 Measures
- eRx Option
- Database tool securely exchanged between GPRO and CMS
- PGP, MCMP participation considered for PQRS Incentive

2011

- GPRO I (200+ EPs)
- GPRO II (2-199 EPs)
- 26 Measures for GPRO I
- Measures Group (s) and Individual Measures for GPRO II
- eRx Option
- Web Interface Introduced but only used by GPRO I
- GPRO II reported via claims/registry
- PGP, EHR Demo participation considered for PQRS incentive

2012

- Large GPRO (100+ EPs)
- Small GPRO (25-99 EPs)
- 29 Measures
- New Disease Modules Introduced (COPD, IVD)
- Patient Safety Measures Introduced
- eRx GPRO Option
- Web Interface
- PGP, ACO participation considered for PQRS Incentive
- Steps Made to Align PQRS and ACO program measures
- Many ACO Measures also collected via the GPRO Web Interface

2013

- Group sizes: 100+ EPs, 25-99 EPs, and 2-24 EPs
- Can select eRx GPRO only option
- 22 GPRO Web Interface Measures
- Web Interface, qualified registry and administrative claims reporting options available
- Reporting for 2015 PQRS payment adjustment and VM introduced
- Further alignment with CMS ACO initiatives

2014

- Group sizes: 100+ EPs, 25-99 EPs, and 2-24 EPs
- eRx GPRO is no longer an option
- 22 GPRO Web Interface Measures
- Web Interface, Data Submission Vendor, EHR Direct, qualified registry and Certified Survey Vendor
- Reporting for 2016 PQRS payment adjustment, VM and Medicare EHR Incentive Program
- VM tiering required for groups with 10+ EPs
- Further alignment with the ACO program

Who can Participate in GPRO?

- What is a PQRS group practice?
  - A “group practice” under 2014 PQRS consists of a physician group practice, as defined by a single TIN, with 2 or more individual EPs (as identified by individual NPIs) who have reassigned their billing rights to the TIN
  - If a TIN decides to report as a group, any individual EP who has assigned billing rights to that TIN must report via the GPRO and CANNOT participate as an individual using that TIN/NPI combination
  - If the EP also reports through a different TIN that is not participating as a group, then the EP may report individually through that alternate TIN
  - If an organization or EP changes TINs, the participation under the old TIN does not carry over to the new TIN, nor is it combined for final analysis
- Other CMS programs, such as the Shared Savings Program, will utilize the GPRO to meet physician quality reporting objectives
  - EPs should look to the respective quality program to ensure they satisfy the reporting requirements
  - If your group practice is participating in an ACO, then you do not need to register for PQRS GPRO via the PV-PQRS System

2014 PQRS GPRO Participation

- PQRS GPRO participation will count for:
  - PQRS
  - VM
  - Electronic Clinical Quality Measure (eCQM) component of Meaningful Use
    - Only if the group registers to report via Web Interface or EHR reporting
    - EPs will need to individually meet the other Meaningful Use objectives through the Medicare EHR Incentive Program Registration and Attestation System (attestation)
    - Only EPs beyond their first year of Meaningful Use may earn 2014 eCQM credit through 2014 PQRS GPRO reporting
    - EPs in their first year of Stage 1 will need to report both Meaningful Use objectives and CQMs via attestation by **10/1/2014,** and also report 12 months of data through a PQRS reporting mechanism, or through the PQRS GPRO

Consequences of Changing TIN

- Changing TINs during the program year may have consequences
- If a group changes their TIN during the program year:
  - The group may not have enough claims data to populate the patient sample required for Web Interface reporting
    - These groups should consider reporting via registry or EHR reporting mechanisms
  - The group's incentive payment will ***only*** reflect PFS charges made under the TIN used during PQRS GPRO Registration

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2014 REQUIREMENTS AND PARTICIPATION OPTIONS

2014 PQRS GPRO Requirements (cont.)

- In order to participate in the 2014 PQRS GPRO, groups are required to register
  - Registration must be through the Physician Value-Physician Quality Reporting System (PV-PQRS) Registration System from **April 1 – September 30, 2014**
  - Groups will need an Individuals Authorized Access to the CMS Computer Services (IACS) account to access the PV-PQRS Registration System
  - Registration lets CMS know which groups want to be analyzed at the group level (or TIN-level analysis)
  - Complete information about IACS and 2014 PQRS GPRO registration is available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html

2014 PQRS GPRO Requirements (cont.)

- Group practices with 2 or more EPs that wish to cancel their registration for participation in the 2014 PQRS GPRO must contact the QualityNet Help Desk **before** the registration period closes on **September 30, 2014 (at 11:59 pm EDT)**
  - Group practices will not be allowed to cancel their 2014 GPRO registration after this date.
- If a group practice with 10 or more EPs wishes to cancel its PQRS GPRO registration, then the group can still avoid the -2.0% Value Modifier payment adjustment in 2016, if the EPs in the group participate in the PQRS as individuals in 2014 and **at least 50% of the EPs** in the group meet the satisfactory reporting criteria as individuals via:
  - claims, a qualified PQRS registry, or EHR (or in lieu of satisfactory reporting, satisfactorily participate in a Qualified clinical data registry) to avoid the 2016 PQRS payment adjustment.
- No registration is necessary if the EPs in a group practice participate in the PQRS as individuals

2014 PQRS GPRO Requirements

- During registration, the group practice will need to indicate the size of their group at the time they register for GPRO
  - Group size is based on the number of EPs billing under the TIN
  - Be sure Medicare Provider Enrollment, Chain, and Ownership System (PECOS) information is updated for your group before registration
- There are three PQRS GPRO group sizes
  - 100+ EPs
  - 25-99 EPs
  - 2-24 EPs
- PQRS GPRO reporting mechanisms and requirements vary depending on the group size at the time of GPRO registration

2014 PQRS GPRO Requirements (cont.)

- Registration requirements
  - New and returning groups ***must*** register to participate in the GPRO every year
  - Provide complete information during registration (the group practice's TIN, name of group practice, and contact information to complete registration)
  - Groups who register for 2014 PQRS GPRO can change their PQRS reporting method or group information
  - Once a group registers to participate in PQRS GPRO, they are ***not*** allowed to withdraw their registration
- Groups must have the following technical capabilities, at a minimum:
  - Standard PC image with Microsoft® Office and Microsoft® Access software installed
  - Minimum software configurations (only applies to group practices reporting via the Web Interface)
  - Be able to comply with a secure method for data submission

2014 PQRS GPRO Requirements (cont.)

- Registering for GPRO indicates:
  - CMS is allowed to review the Medicare beneficiary data on which PQRS GPRO submissions are founded or provide to CMS a copy of the actual data
  - The group agrees to have the results of the performance of their PQRS measures publicly posted on the Physician Compare website
  - The group has billed Medicare Part B on or after January 1, 2014 and prior to the last Friday in October 2014

2014 PQRS GPRO Reporting Methods

Reporting methods available to groups participating in PQRS GPRO based on group size at the time of registration

Group Size	Reporting Period	Reporting Method
2-24 EPs	January 1, 2014 – December 31, 2014	Registry Data Submission Vendor or EHR Direct*
25-99 EPs	January 1, 2014 – December 31, 2014	Registry Data Submission Vendor or EHR Direct* GPRO Web Interface* Certified Survey Vendor
100+ EPs	January 1, 2014 – December 31, 2014	Registry Data Submission Vendor or EHR Direct* GPRO Web Interface* CMS-Certified Survey Vendor

**If a group practice satisfactorily reports for 2014 PQRS, the participating NPIs will also satisfy the eCQM component of Meaningful Use; however, the individual EPs will still be required to meet the other Meaningful Use objectives through attestation.*

Reporting Requirements for Incentive Payment by Reporting Mechanism

Reporting requirements for 2014 PQRS incentive payment based on group size and reporting method elected at time of registration

Reporting Method	Criteria for Satisfactorily Reporting for 2014 PQRS Incentive Payment
Qualified Registry (for all group sizes)	Submit more than or equal to 9 individual PQRS measures across 3 National Quality Strategy (NQS) domains on at least 50% of the group's applicable Medicare Part B FFS patients for those measures.
Data Submission Vendor (for all group sizes)	Using an EHR data submission vendor that is Certified EHR Technology (CEHRT), report on at least 9 measures covering 3 National Quality Strategy (NQS) domains. If the group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.
EHR Direct (for all group sizes)	Using a direct EHR product that is CEHRT, report on at least 9 measures covering 3 National Quality Strategy (NQS) domains. If the group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.

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Reporting Requirements for Incentive Payment by Reporting Mechanism (cont.)

Reporting Method	Criteria for Satisfactorily Reporting for 2014 PQRS Incentive Payment
CMS-Certified Survey Vendor Plus qualified registry, direct EHR product, EHR data submission vendor, or Web Interface (for groups of 25-99 EPs)	**Groups of 25 -99 EPs:** patients report all 12 CAHPS for PQRS summary survey modules via a CMS-certified survey vendor (CMS will bear the cost of administering this optional survey) **AND** 1. Report at least 6 measures covering at least 2 of the NQS domains using a qualified registry, a CEHRT direct product, or a CEHRT data submission vendor; **OR** 2. Report all 22 GPRO Web Interface measures • *Note: The Certified Survey Vendor is optional for groups of 25-99 EPs.* • *Note: Group practices with an insufficient number of beneficiaries to produce reliable data may not be allowed to choose this option.*

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Reporting Requirements for Incentive Payment by Reporting Mechanism (cont.)

Reporting Method	Criteria for Satisfactorily Reporting PQRS
CMS-Certified Survey Vendor Plus qualified registry, direct EHR product, EHR data submission vendor, or Web Interface (for groups of 100+ EPs)	**Groups of 100 or more EPs:** patients report all 12 CAHPS for PQRS summary survey modules via a CMS-certified survey vendor (CMS will bear the cost of administering this optional survey) **AND** 1. Report at least 6 measures covering at least 2 of the NQS domains using a qualified registry, a CEHRT direct product, or a CEHRT data submission vendor; **OR** 2. Report all 22 GPRO Web Interface measures • *Note: The Certified Survey Vendor is optional for groups of 100+ EPs who report quality measures via registry, CEHRT direct product or a CEHRT data submission vendor. The Certified Survey Vendor is **required** for groups of 100+ EPs that report via the Web Interface.* • *Note: Group practices with an insufficient number of beneficiaries to produce reliable data may **not** be allowed to choose this option.*

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Reporting Requirements for Incentive Payment by Reporting Mechanism (cont.)

Reporting Method	Criteria for Satisfactorily Reporting PQRS
GPRO Web Interface (for groups of 25-99 EPs)	Report on all PQRS GPRO measures included in the Web Interface; **AND** Populate data fields for the first **218** consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample (with an over-sample of 327) for each module or patient care measures. If the pool of eligible assigned beneficiaries is less than 218, then report on 100% of assigned beneficiaries. CMS will bear the cost of the CAHPS for PQRS survey for group practices of 25-99 EPs reporting via Web Interface.
GPRO Web Interface (for groups of 100+ EPs)	Report on all PQRS GPRO measures included in the Web Interface; **AND** Populate data fields for the first **411** consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample (with an over-sample of 616) for each module or patient care measures. If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries. Groups with 100+ EPs reporting via Web Interface will be ***required*** to have patients report the CAHPS for PQRS survey. CMS will continue to bear the cost of the CAHPS for PQRS survey for group practices of 100 or more EPs reporting via Web Interface.

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2016 PQRS PAYMENT ADJUSTMENT

2016 PQRS Payment Adjustment

- Section 1848(a)(8) of the Social Security Act, requires the CMS to subject EPs and group practices participating in the GPRO who do not satisfactorily report data on PQRS quality measures for covered professional services during the 2014 program year to a payment adjustment in 2016
- PQRS payment adjustment is 2.0% for 2016 and beyond
  - Group practices participating in PQRS GPRO will receive 98% of their allowed Medicare Part B PFS amount for covered professional services that would otherwise apply to such services

2016 PQRS Payment Adjustment (cont.)

- Groups participating in the PQRS GPRO are analyzed at the TIN-level under the TIN submitted at the time of final GPRO registration
  - All EPs under the TIN who bill Medicare Part B PFS during the 2014 reporting year will be included in analysis for purposes of the 2016 PQRS payment adjustment
  - If an organization or EP changes TIN, the participation under the old TIN does not carry over to the new TIN, nor is it combined for final analysis

How to Avoid the 2016 PQRS Payment Adjustment

- To avoid the 2016 PQRS payment adjustment, you must take action in 2014
- Group practices participating in the 2014 PQRS GPRO can avoid the 2016 PQRS payment adjustments by meeting one of the following criteria during the 2014 PQRS program year:
  - Meet the requirements for satisfactorily reporting for incentive eligibility as defined in the applicable 2014 PQRS measure specifications; **OR**
  - Report at least 3 measures covering one NQS domain for at least 50% of the group practice's Medicare Part B FFS patients via qualified registry
    - Report 1-8 measures covering 1-3 NQS domains for which there is Medicare patient data (subjecting the group practice to the MAV process*), **AND** report each measure for at least 50% of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies.
    - A group practice who reports fewer than 3 measures covering 1 NQS domain via the registry-based reporting mechanism will be subject to the MAV process, which would allow CMS to determine whether a group practice should have reported on additional measures.

Reporting Requirements to Avoid the 2016 PQRS Payment Adjustment

- This table outlines the reporting requirements by group size and reporting method for avoiding the 2016 PQRS payment adjustment

Reporting Mechanism	Group Size	Satisfactory Reporting Criteria
Web Interface	25-99 EPs	Report on all measures included in the Web Interface; **AND** Populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100% of assigned beneficiaries.
Web Interface	100+ EPs	Report on all measures included in the Web Interface; **AND** Populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries. In addition, the group practice ***must*** report all CAHPS for PQRS survey measures.
Qualified Registry	2 + EPs	Report at least 9 measures covering at least 3 of the NQS domains, **OR**, if less than 9 measures covering at least 3 NQS domains apply to the group practice, report 1-8 measures covering 1-3 NQS domains for which there is Medicare patient data, **AND** Report each measure for at least 50% of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted. For a group practice who reports fewer than 9 measures, the group practice would be subject to the MAV process to determine whether a group practice should have reported on additional measures and/or measures covering additional NQS domains.

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Reporting Requirements to Avoid the 2016 PQRS Payment Adjustment (cont.)

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Reporting Mechanism	Group Size	Satisfactory Reporting Criteria
Qualified Registry	2 + EPs	Report at least 3 measures covering at least 1 of the NQS domains, **OR**, if less than 3 measures covering 1 NQS domain apply to the group practice, report 1-2 measures covering 1 NQS domain for which there is Medicare patient data, **AND** Report each measure for at least 50% of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted. For a group practice who reports fewer than 3 measures covering 1 NQS domain, the group practice would be subject to the MAV process to determine whether additional measures should have been reported.
Direct EHR product that is CEHRT **or** EHR data submission vendor that is CEHRT	2+ EPs	Report 9 measures covering at least 3 of the NQS domains. If a group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data. A group practice must report on ***at least*** 1 measure for which there is Medicare patient data.
CMS-Certified Survey Vendor Plus qualified registry, direct EHR product, EHR data submission vendor, **or** Web Interface	25+ EPs	Report all enhanced CAHPS for PQRS survey measures via a CMS-Certified Survey Vendor, **AND** Report at least 6 measures covering at least 2 of the NQS domains using a qualified registry, direct EHR product, EHR data submission vendor, **OR** all 22 Web Interface measures. *Note: Groups with 100+ EPs who select the Web Interface reporting method **must** report all 22 Web Interface measures in addition to reporting all CAHPS for PQRS survey measures.*

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Value-Based Payment Modifier (VM)

What is the Value-Based Payment Modifier (VM)?

- The value modifier provides for differential payment to physicians and groups of physicians under the Medicare PFS based upon the quality of care furnished compared to cost during a specified performance period
  - Differential payments can result in an upward, neutral or downward adjustment
- The VM calculation is based on:
  - Performance on the quality measures reported through a PQRS reporting mechanism, either as an individual or as a group (e.g, GPRO Web Interface, qualified registry, or EHR) and three outcome measures, and
  - Performance on six cost measures
- The VM will begin to be applied in 2015 and it will be fully implemented by 2017

What is the Value-Based Payment Modifier (VM)? (cont.)

- Groups of 10 or more EPs who submit claims to Medicare under a single TIN will be subject to the VM in 2016, based on their performance in Program Year 2014
  - Groups of 10-99 EPs only receive either an upward or neutral adjustment; these groups will not be subject to a downward payment adjustment
  - Groups of 100 or more EPs may receive an upward, neutral or downward payment adjustment
  - Adjustments are only applied to TINs in which at least one eligible professional is a physician

What is the Value-Based Payment Modifier (VM)? (cont.)

- Groups may elect to report via three PQRS GPRO quality reporting mechanisms: GPRO Web Interface, qualified registry or EHR
- If a group does not seek to report quality measures through the GPRO, CMS will calculate the group's quality performance if at least 50% of the EPs within the group participate in PQRS as individuals in 2014
  - At least 50% of the group's EPs must satisfactorily report to avoid the 2016 PQRS payment adjustment for physicians in the group to avoid the additional VM downward adjustment
  - The VM will not apply to groups who participate in the Shared Savings Program , the Pioneer ACO Model, or the CPCI in 2014

VM Analysis

Two-Category Approach for Determining the VM

- Category 1 includes:
  a. Groups that registered for PQRS and met the criteria to avoid the 2016 PQRS payment adjustment

  OR

  b. Groups in which at least 50% of the individual EPs participated in PQRS as individuals and met the criteria to avoid the 2016 PQRS payment adjustment

  – Groups in Category 1 will have their VM calculated using the quality-tiering method:
    - CMS will calculate a quality composite based on the group's performance on reported quality measures and their performance on three outcome measures
    - CMS will also calculate a cost composite based on the group's performance in two cost domains: total per capita costs (2 measures) and total per capita costs for beneficiaries with four chronic conditions (4 measures)
    - Quality tiering may result in an upward, downward or neutral payment adjustment

VM Analysis (cont.)

- Category 2 includes groups that are subject to the VM in 2016 and that do not fall into either subcategory of Category 1
  - This includes those groups of 10 or more EPs that do not register to participate as a PQRS GPRO and do not meet the criteria for satisfactory reporting
  - These groups will be subject to a -2.0% payment adjustment in 2016
- Additional information on the VM and the quality-tiering methodology can be found on the CMS website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

VM Next Steps

- CMS encourages solo practitioners and physicians in smaller groups to participate in PQRS now
  - The Social Security Act requires that CMS apply the VM to all physicians and groups of physicians by January 1, 2017
  - CMS anticipates that the input to the quality composite will continue to be based on PQRS data
- Groups with 10+ EPs
  - Participate in the 2014 PQRS as an individual or through the GPRO
  - If participating through the PQRS GPRO, select a PQRS GPRO reporting mechanism and complete the registration
    - Web Interface
    - Qualified registry
    - Direct EHR product that is CEHRT/EHR data submission vendor that is CEHRT
    - CMS-Certified Survey Vendor (to supplement Web Interface, qualified registry or EHR reporting)

    Note: Review the measure specifications for each reporting method to make sure the measures are applicable to the services your group furnishes

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RESOURCES

Resources/Where to Begin

- **PQRS GPRO website:** http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html
- **PQRS GPRO Registration website:** http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html
- **VM website:** http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html
- **CMS Frequently Asked Questions (FAQs):** https://questions.cms.gov/
- **QualityNet Help Desk**
  - Monday – Friday: 7:00 am - 7:00 pm CT
  - E-mail: qnetsupport@hcqis.org
  - Phone: (866) 288-8912 or (TTY 1-877-715-6222)
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