How to Report Once for 2015 Medicare Quality Reporting Programs

February 2015; Revised March 2015

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Please note: *If reporting for PQRS through another CMS program (such as the Medicare Shared Savings Program, Comprehensive Primary Care Initiative, Pioneer Accountable Care Organizations), 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.*

How to Report Once for 2015 Medicare Quality Reporting Programs: Individual Eligible Professionals

Overview

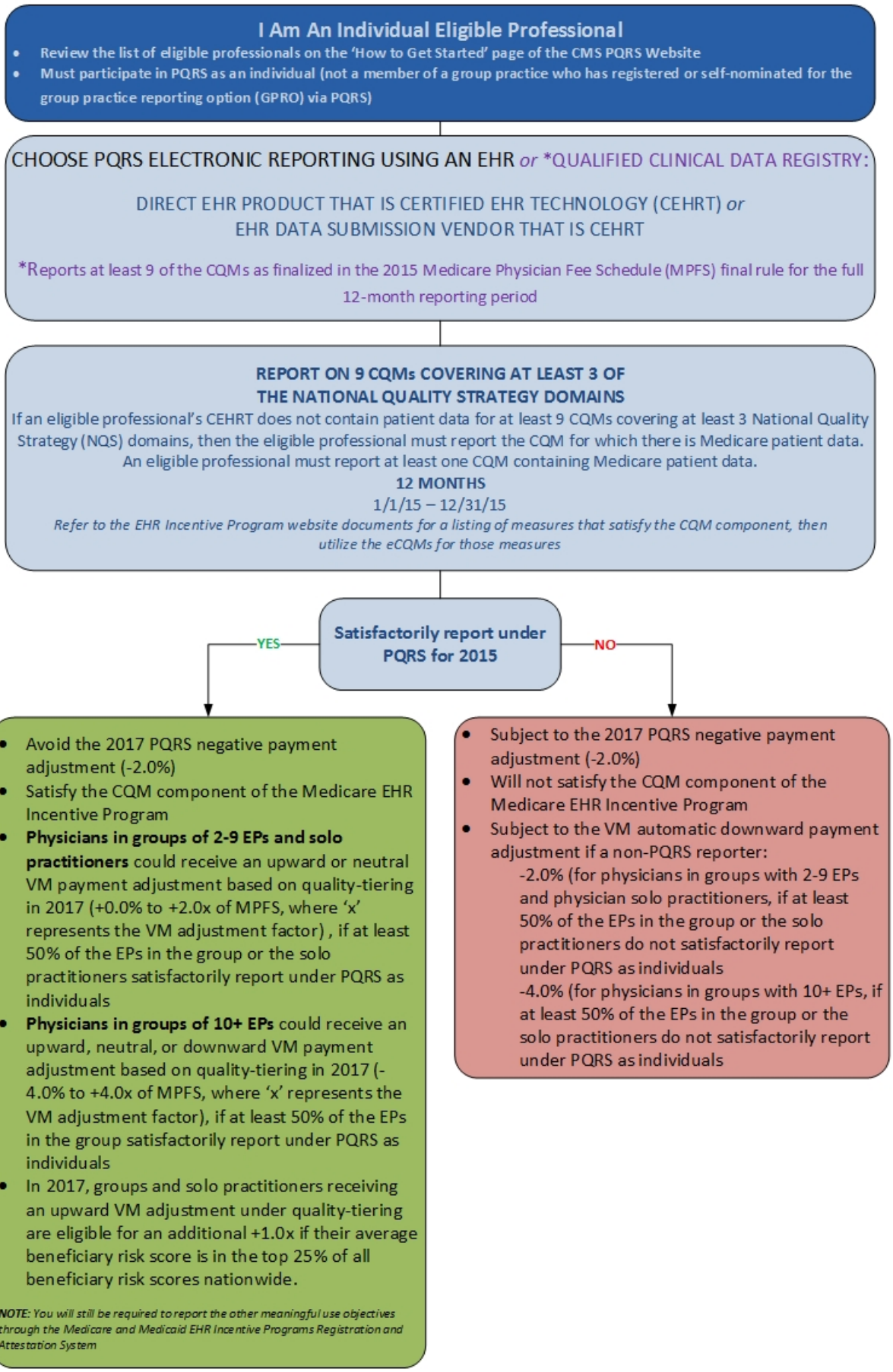
This section serves as a guide to individual eligible professionals wishing to report quality measures one time during the 2015 program year in order to avoid the 2017 Physician Quality Reporting System (PQRS) negative payment adjustment, satisfy the clinical quality measure (CQM) component of the Medicare Electronic Health Record (EHR) Incentive Program, and satisfy requirements for the 2017 Value-Based Payment Modifier (VM).

Note: *In 2017, the VM will apply to payments made under the Medicare Physician Fee Schedule (MPFS) to physicians in groups with 2 or more eligible professionals (EPs) and physician solo practitioners. In order to avoid an automatic -2.0% VM payment adjustment in 2017, solo practitioners, as defined as a single Taxpayer Identification Number (TIN) with one eligible professional (EP) who is identified by an individual National Provider Identifier (NPI) billing under the TIN, must participate in the PQRS as individuals in 2015 and meet the satisfactory reporting criteria to avoid the 2017 PQRS payment adjustment. Groups with 2 or more EPs can avoid the automatic VM payment adjustment (-2.0% or -4.0% depending on group size) in 2017 by (1) participating in the PQRS Group Practice Reporting Option (GPRO) in 2015 and meeting the satisfactory reporting criteria to avoid the 2017 PQRS payment adjustment, or (2) ensuring that the EPs in the group participate in the PQRS as individuals in 2015 and at least 50% of the EPs in the group meet the satisfactory reporting criteria to avoid the 2017 PQRS payment adjustment. We note that quality-tiering is mandatory for groups and solo practitioners subject to the VM in 2017. This section applies to the EPs in groups that want to meet the 2017 VM requirements by reporting under the PQRS as individuals and to solo practitioners.*

- For meaningful use beginning in calendar year 2015, EPs are not required to ensure that their CEHRT products are recertified to the most recent version of the electronic specifications for the CQMs. Though recertification is not required, EPs must still report using the most recent version of the electronic specifications for the CQMs.

- The reporting period for 2015 PQRS is 12 months; The Medicare EHR Incentive Program's 90-day reporting period only applies to first-time participants, so all other providers must report a full year of data.

How to Report Once for 2015 Medicare Quality Reporting Programs: Individual Eligible Professionals



How to Report Once for 2015 Medicare Quality Reporting Programs: Group Practices

Overview

This section serves as a guide to group practices wishing to report quality measures one time during the 2015 program year in order to avoid the Physician Quality Reporting System (PQRS) 2017 negative payment adjustment, satisfy the clinical quality measure (CQM) component of the Electronic Health Record (EHR) Incentive Program, and satisfy requirements for the 2017 Value-Based Payment Modifier (VM) .

Note: *In 2017, the VM will apply to payments made under the Medicare Physician Fee Schedule (MPFS) to physicians in groups with 2 or more eligible professionals (EPs) and physician solo practitioners. Groups with 2 or more EPs can avoid the automatic VM payment adjustment (-2.0% or -4.0% depending on group size) in 2017 by (1) participating in the PQRS Group Practice Reporting Option (GPRO) in 2015 and meeting the satisfactory reporting criteria to avoid the 2017 PQRS payment adjustment, or (2) ensuring that the EPs in the group participate in the PQRS as individuals in 2015 and at least 50% of the EPs in the group meet the satisfactory reporting criteria to avoid the 2017 PQRS payment adjustment. This section applies to groups that want to meet the 2017 VM requirements by reporting under the PQRS using one of the group practice report options.*

- EPs within the group practice (participating via GPRO) are required to collect CQM data for an EHR reporting period of any 90 consecutive days in 2015, and attest through the EHR Incentive Program Attestation System by February 29, 2016, in order to avoid the 2017 EHR Incentive Program payment adjustment.
- The reporting period for 2015 PQRS is 12 months; The EHR Incentive Program's 90-day reporting period only applies to first-time participants, so all other providers must report a full year of data.

How to Report Once for 2015 Medicare Quality Reporting Programs: Group Practices

I am a PQRS eligible professional who has assigned billing rights to a Group Practice TIN

A "group practice" is defined as a single Tax Identification Number (TIN) with 2 or more individual eligible professionals (as identified by Individual National Provider Identifier [NPI]) who have reassigned their billing rights to the TIN

REGISTER FOR PQRS UNDER ONE OF THE FOLLOWING REPORTING OPTIONS:

DIRECT EHR PRODUCT THAT IS CERTIFIED EHR TECHNOLOGY (CEHRT) *or* EHR DATA SUBMISSION VENDOR THAT IS CEHRT

These options are available to group practices of 2 or more individual EPs

REPORT ON 9 CQMs COVERING AT LEAST 3 OF THE NATIONAL QUALITY STRATEGY DOMAINS

If a group practice's CEHRT does not contain patient data for at least 9 CQMs covering at least 3 domains, then the group practice must report the CQM(s) for which there is Medicare patient data.

12 MONTHS
1/1/15 – 12/31/15

Refer to the EHR Incentive Program website documents for a listing of measures that satisfy the CQM component, then utilize the eCQMs for those measures

REPORT ON AT LEAST 6 CQMs COVERING AT LEAST 2 OF THE NATIONAL QUALITY STRATEGY DOMAINS AND Have all CAHPS for PQRS survey modules (12) reported on the group's behalf via a CMS-certified survey vendor

Of these 6 CQMs, if any EP in the group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice is required to report on at least 1 CQM in the cross-cutting measure set.

12 MONTHS
1/1/15 – 12/31/15

Refer to the EHR Incentive Program website documents for a listing of measures that satisfy the CQM component, then utilize the eCQMs for those measures

GPRO WEB INTERFACE

This option is only available to group practices of 25 or more individual EPs

Groups 25-99 REPORT ON ALL MEASURES INCLUDED IN THE WEB INTERFACE FOR THE PRE-POPULATED BENEFICIARY SAMPLE PLUS (OPTIONAL) Have all CAHPS for PQRS survey modules (12) reported on the group's behalf via a CMS-certified survey vendor

12 MONTHS
1/1/15 – 12/31/15

Groups 100 or more REPORT ON ALL MEASURES INCLUDED IN THE WEB INTERFACE FOR THE PRE-POPULATED BENEFICIARY SAMPLE AND Have all CAHPS for PQRS survey modules (12) reported on the group's behalf via a CMS-certified survey vendor

12 MONTHS
1/1/15 – 12/31/15

Satisfactorily report under PQRS for 2015

YES

- Avoid the 2017 PQRS negative payment adjustment (-2.0%)
- Satisfy the CQM component of the Medicare EHR Incentive Program

  NOTE: *Eligible professionals will still be required to report the other meaningful use objectives through the Medicare and Medicaid EHR Incentive Programs Registration and Attestation System*
- **Physicians in groups of 2-9 EPs** could receive an upward or neutral VM payment adjustment based on quality-tiering in 2017 (+0.0% to +2.0x of MPFS, where 'x' represents the VM adjustment factor)
- **Physicians in groups of 10+ EPs** could receive an upward, neutral, or downward VM payment adjustment based on quality-tiering in 2017 (-4.0% to +4.0x of MPFS, where 'x' represents the VM adjustment factor)
- In 2017, groups receiving an upward VM adjustment under quality-tiering are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25% of all beneficiary risk scores nationwide

NO

- Subject to the 2017 PQRS negative payment adjustment (-2.0%)
- Will not satisfy the CQM component of the Medicare EHR Incentive Program
- Subject to the VM automatic downward payment adjustment if a non-PQRS reporter:
  - -2.0% (for physicians in groups with 2-9 EPs and physician solo practitioners, if at least 50% of the EPs in the group or the solo practitioners do not satisfactorily report under PQRS as individuals
  - -4.0% (for physicians in groups with 10+ EPs, if at least 50% of the EPs in the group or the solo practitioners do not satisfactorily report under PQRS as individuals

How to Report Once for 2015 Medicare Quality Reporting Programs: Medicare Shared Savings Program Accountable Care Organizations

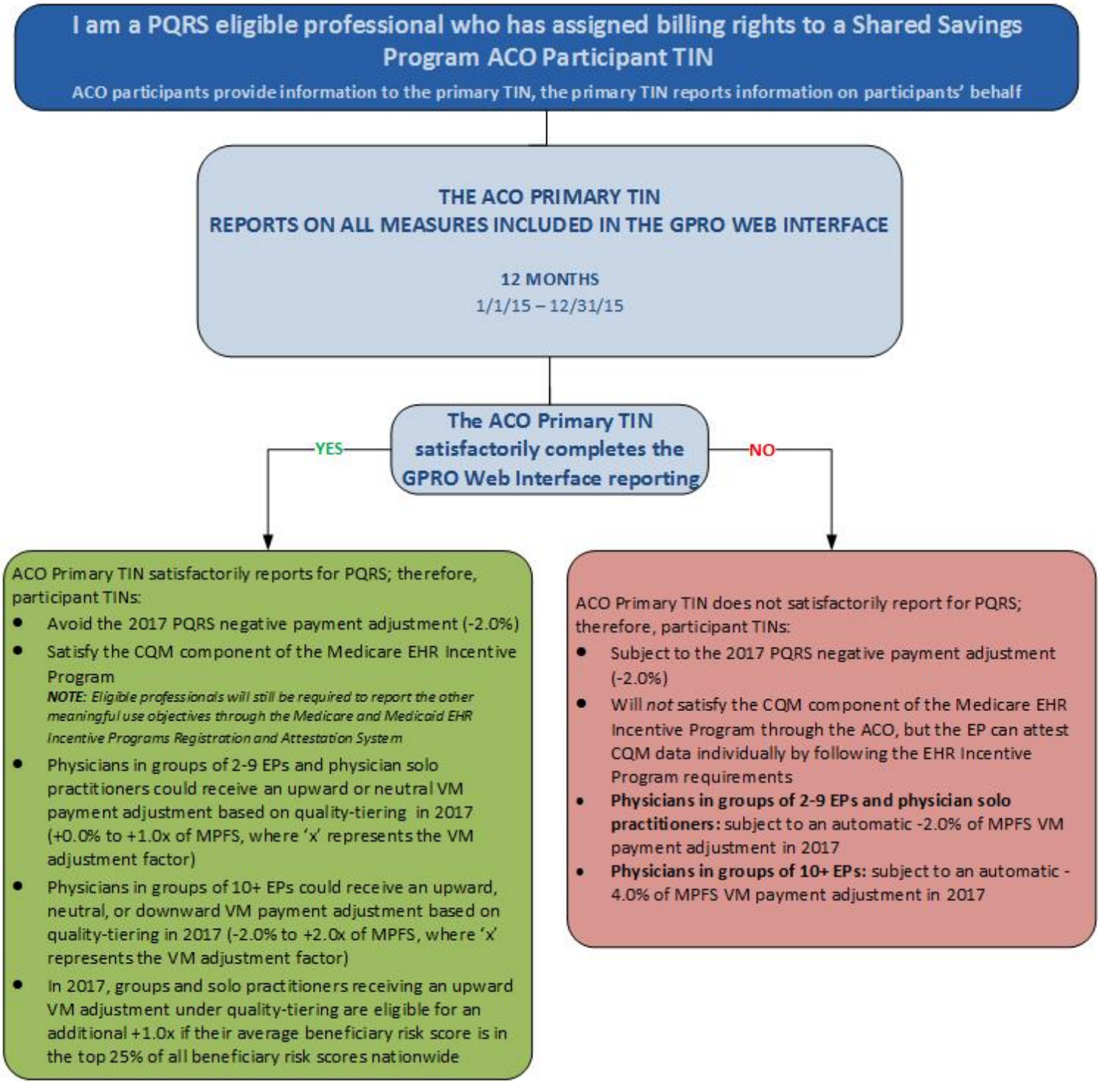
Overview

This section serves as a guide to Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs) participants wishing to avoid the 2017 Physician Quality Reporting System (PQRS) payment adjustment, satisfy the clinical quality measure (CQM) component of the Medicare Electronic Health Record (EHR) Incentive Program, and satisfy requirements for the 2017 Value-Based Payment Modifier (VM) .

Note: *The 2017 VM will apply to physicians in TINs that participate in the Shared Savings Program during the calendar year 2015 performance period.*

- Medicare EPs within the ACO group practice (participating via GPRO) are required to attest to the objectives and measures of meaningful use by February 29, 2016 to demonstrate meaningful use in the EHR Incentive Programs.
- The reporting period for 2015 PQRS is 12 months; The EHR Incentive Program's 90-day reporting period only applies to first-time participants, so all other providers must report a full year of data.

How to Report Once for 2015 Medicare Quality Reporting Programs: Medicare Shared Savings Program Accountable Care Organizations



How to Report Once for 2015 Medicare Quality Reporting Programs: Pioneer Accountable Care Organizations

Overview

This section serves as a guide to Pioneer ACOs wishing to avoid the 2017 Physician Quality Reporting System (PQRS) payment adjustment, satisfy the clinical quality measure (CQM) component of the Medicare Electronic Health Record (EHR) Incentive Program, and satisfy requirements for the 2017 Value-Based Payment Modifier (VM). Non-participating providers in Pioneer ACO TINs should refer to GPRO Requirements for Submission, available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html.

Note: *The 2017 VM will apply to physicians in TINs that participate in the Pioneer ACO Model, Comprehensive Primary Care (CPC) Initiative, or other similar innovation center models or CMS initiatives during the CY 2015 performance period.*

- For Pioneer ACOs, providers in "split" participation TINs (participating TINs under which only some providers (identified by NPIs) opt to participate in the ACO) can participate in PQRS outside of the ACO via the options below:
    1. Split TINs can participate as an entire group (both ACO and non-ACO participating providers) by reporting via one of the PQRS GPRO reporting options or
    2. Non-ACO participating providers in split TINs can participate as PQRS individuals via EHR, registry, QCDR, or claims-based reporting.
- If at least one EP billing under a TIN that participates in the Pioneer ACO Model in 2015, the TIN will receive average cost and average quality and a neutral (0%) VM in 2017, regardless of whether other EPs under the TIN participate in the Pioneer ACO Model.
- EPs within the Pioneer ACO group practice (participating via GPRO) are required to collect CQM data for an EHR reporting period of any 90 consecutive days in 2015, and attest through the EHR Incentive Program Attestation System by February 29, 2016, in order to avoid the 2017 EHR Incentive Program payment adjustment.
- The reporting period for 2015 PQRS is 12 months; The EHR Incentive Program's 90-day reporting period only applies to first-time participants, so all other providers must report a full year of data.

How to Report Once for 2015 Medicare Quality Reporting Programs: Pioneer Accountable Care Organizations