



The Physician Quality Reporting System & the Value-based Payment Modifier

What Medicare Eligible Professionals
Need to Know in 2015



Topics

- 2015 PQRS Updates
- 2015 Incentive Payments and 2017 Payment Adjustments
- 2015 PQRS Reporting
- 2015 PQRS: Group Practice Reporting Option (GPRO)
- 2015 Updates to the Value-based Payment Modifier (VM)
- Quality-Tiering Approach for 2017
- 2017 VM Policies for Shared Savings Program Participants, Pioneer ACOs, CPC Initiative, etc.
- Informal Inquiry Process for the Value-Based Payment Modifier
- Physician Compare

2015 PQRS Updates

2015 PQRS Updates

- Added 23 measures for Individual and Measures Groups reporting; removed 50 individual measures and 38 measures from within measures groups
- Added 2 new measures groups: Sinusitis and Otitis (AOE); removed 4 measures groups: Perioperative Care, Back Pain, Cardiovascular Prevention; and Ischemic Vascular Disease
- 6-month reporting option for measures groups removed
- EPs in Critical Access Hospitals billing method II can participate in PQRS using ALL reporting mechanisms, including claims

2015 Incentive Payments and 2017 Payment Adjustments

2015 Incentive Payments and 2017 Payment Adjustments

	PQRS	Value Modifier					EHR Incentive Program			Total Medicare Payment Adjustments at Risk for Non-Participation in PQRS and Meaningful Use in 2017		
		2-9 EPs & solo		10+ EPs			Medicare Inc. (2015)	Medicaid Inc. (2015)	Medicare Pay Adj (2017)			
		PQRS-Reporting (2017)	Non-PQRS Reporting (2017)	PQRS-Reporting (Up or Neutral Adj) (2017)	PQRS-Reporting (Down Adj) (2017)	Non-PQRS Reporting (2017)						
MD & DO	-2.0% of MPFS	+2.0 (x), +1.0(x), or neutral	-2.0% of MPFS	+4.0 (x), +2.0(x), or neutral	-2.0% or -4.0% of MPFS	-4.0% of MPFS	\$4,000-\$12,000 (based on when EP 1 st demo MU)	\$8,500 or \$21,250 (based on when EP did A/I/U)	-3.0% of MPFS	Physicians in groups of 2-9 EPs & Solo physicians: <u>-7.0%</u>		
DDM												
Oral Sur												
Pod.											N/A	Physicians in groups of 10+ EPs: <u>-9.0%</u>
Opt.												
Chiro.												

2015 Incentive Payments and 2017 Payment Adjustments

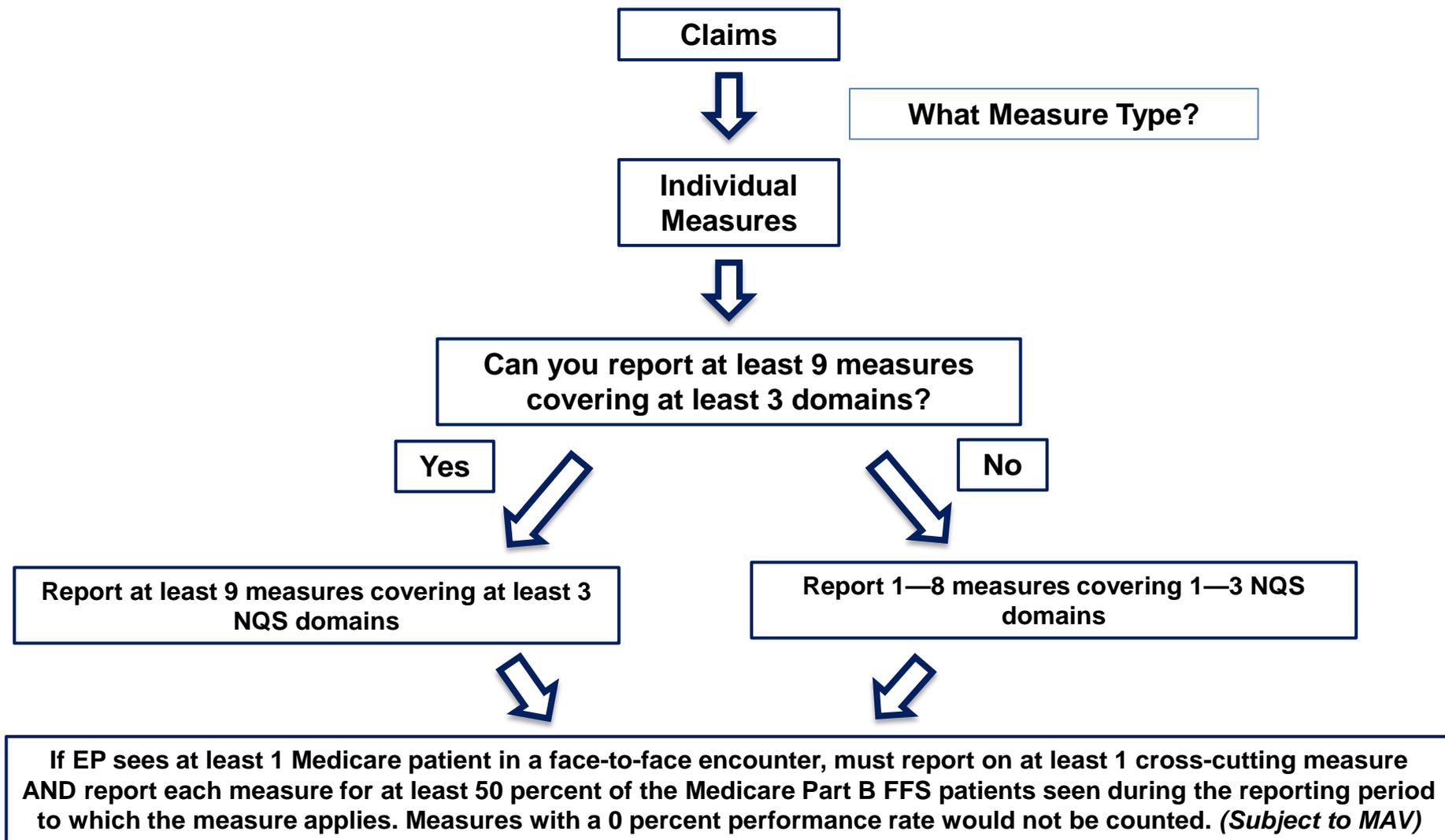
	PQRS	Value Modifier	EHR Incentive Program			Total Medicare Payment Adjustments at Risk for Non-Participation in PQRS and Meaningful Use in 2017
	Pay Adj. (2017)	Groups of 2+ EPs	Medicare Inc.	Medicaid Inc. (2015)	Medicare Pay Adj.	
Practitioners						
Physician Assistant	-2.0% of MPFS	EPs included in the definition of "group" to determine group size for application of the value modifier in 2017 (2 or more EPs). In 2017, VM only applies to payments made to physicians under the MPFS; beginning in 2018, VM will also apply to non-physician EPs	N/A	\$8,500 or \$21,250 (based on when EP did A/I/U)	N/A	-2.0% of MPFS
Nurse Practitioner				N/A		
Clinical Nurse Specialist				\$8,500 or \$21,250 (based on when EP did A/I/U)		
Certified Registered Nurse Anesthetist				N/A		
Certified Nurse Midwife				N/A		
Clinical Social Worker				N/A		
Clinical Psychologist				N/A		
Registered Dietician				N/A		
Nutrition Professional				N/A		
Audiologists				N/A		
Therapists						
Physical Therapist	-2.0% of MPFS	See above	N/A	N/A	N/A	-2.0% of MPFS
Occupational Therapist						
Qualified Speech-Language Therapist						

2015 PQRS Reporting

2015 PQRS: Reporting Via Claims

- Requirement is to report 9 measures across 3 National Quality Strategy (NQS) domains
 1. Patient Safety
 2. Person and Caregiver-Centered Experience and Outcomes
 3. Communication and Care Coordination
 4. Effective Clinical Care
 5. Community/Population Health
 6. Efficiency and Cost Reduction
- Same domains as the Clinical Quality Measures (CQM) domains for meaningful use
- Required to report one “cross-cutting” measure if at least one Medicare face-to-face encounter
- Measure-applicability validation (MAV) process will be used to determine if EP should have chosen a cross-cutting measure when he/she did not

Individual Reporting Criteria for the 2017 PQRS Payment Adjustment



2015 PQRS Cross-Cutting Measures

NQS Domain	Measure Title	Claims	CSV	Registry	EHR	GRPO Web Interface	Measures Group	Other Quality Programs
Community/Population Health	Tobacco Use and Help with Quitting Among Adolescents			X			X	
Effective Clinical Care	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk			X				
Communication and Care Coordination	Medication Reconciliation	X		X				
Communication and Care Coordination	Care Plan	X		X			X	
Community/Population Health	Preventive Care and Screening: Influenza Immunization	X		X	X	X	X	ACO MU2
Community/Population Health	Pneumonia Vaccination Status for Older Adults	X		X	X	X	X	ACO MU2
Effective Clinical Care	Diabetes: Hemoglobin A1c Poor Control	X		X	X	X	X	ACO MU2

2015 PQRS Cross-Cutting Measures

NQS Domain	Measure Title	Claims	CSV	Registry	EHR	GRPO Web Interface	Measures Group	Other Quality Programs
Community/Population Health	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	X		X	X	X	X	ACO MU2
Patient Safety	Documentation of Current Medications in the Medical Record	X		X	X	X	X	ACO MU2
Communication and Care Coordination	Pain Assessment and Follow-Up	X		X			X	
Community/Population Health	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	X		X	X	X	X	ACO MU2
Communication and Care Coordination	Functional Outcome Assessment	X		X				
Community/Population Health	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	X		X	X	X	X	ACO MU2 Million Hearts

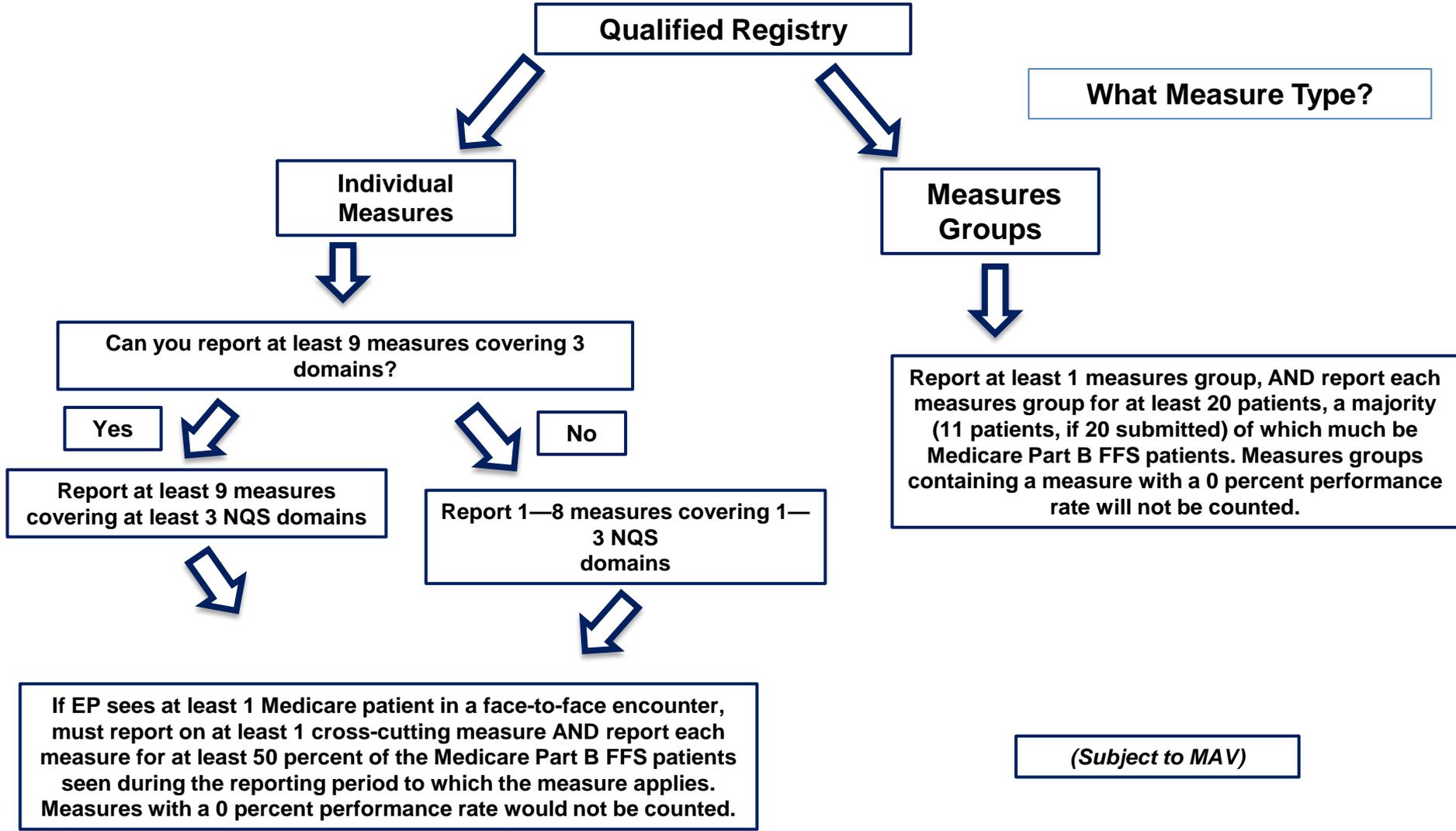
2015 PQRS Cross-Cutting Measures

NQS Domain	Measure Title	Claims	CSV	Registry	EHR	GRPO Web Interface	Measures Group	Other Quality Programs
Effective Clinical Care	Controlling High Blood Pressure	X		X	X	X		ACO MU2 Million Hearts
Community/Population Health	Childhood Immunization Status				X			MU2
Community/Population Health	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	X		X	X	X	X	ACO MU2 Million Hearts
Patient Safety	Falls: Screening for Fall Risk				X	X		ACO MU2
Person and Caregiver Experience and Outcomes	CAHPS for PQRS Clinician/Group Survey		X					ACO
Communication and Care Coordination	Closing the Loop: Receipt of Specialist Report				X			MU2

2015 PQRS: Reporting Via Qualified Registry

- Can report either individual claims (9 measures across 3 quality domains) or measures groups
- Requirement to report on at least one cross-cutting measure if the EP has at least one Medicare face-to-face encounter
- 6-month reporting period option has been removed
- Deadline extended to March 31, 2016 to submit quality measures data for the 2015 reporting period

Individual Reporting Criteria for the 2017 PQRS Payment Adjustment



If EP sees at least 1 Medicare patient in a face-to-face encounter, must report on at least 1 cross-cutting measure AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.

2015 PQRS Measures Groups

- In 2015, a measure group is defined as a subset of 6 or more PQRS measures that have a particular clinical condition or focus in common
- All measures within the group must be reported at least once for all patients in the sample seen by the EP during the reporting period

Diabetes	Chronic Kidney Disease	Preventive Care	Coronary Artery Bypass Graft	Rheumatoid Arthritis
Acute Otitis Externa (AOE)	Cataracts	Hepatitis C	Heart Failure	Coronary Artery Disease
Optimizing Patient Exposure to Ionizing Radiation	HIV/AIDS	Asthma	Chronic Obstructive Pulmonary Disease	Inflammatory Bowel Disease
Sleep Apnea	Dementia	Parkinson's Disease	Sinusitis	
	Oncology	Total Knee Replacement	General Surgery	

Specialty Measure Sets

- CMS is collaborating with specialty societies to ensure that the measures represented within Specialty Measure Sets accurately illustrate measures associated within a particular clinical area (suggested, NOT required)

1. Cardiology
2. Emergency Medicine
3. Gastroenterology
4. General Practice/Family
5. Internal Medicine
6. Multiple Chronic Conditions
7. Obstetrics/Gynecology
8. Oncology/Hematology
9. Ophthalmology
10. Pathology
11. Radiology
12. Surgery

2015 PQRS: Reporting Using a Direct EHR or Data Submission Vendor (DSV)

- CMS continues to encourage electronic reporting using an EHR or DSV to fulfill requirements of both PQRS and Meaningful Use
- EHRs and DSVs must comply with QRDA-I and QRDA-III file formats
- EPs and group practices reporting electronically are required to use the July 2014 version of the eCQMs for 2015 reporting
- EP's certified system does NOT need to be tested and certified to the most recent version of measures

Individual Reporting Criteria for the 2017 PQRS Payment Adjustment

Direct EHR product that is CEHRT
-OR-
EHR data
Submission vendor that is CEHRT



Individual
Measures

What Measure Type?



Report 9 measures covering at least 3 of the NQS domains. If an EP's CEHRT or EHR data submission vendor does not contain patient data for at least 9 measures covering at least 3 domains, then the EP must report the measures for which there is Medicare patient data.

An EP must report on at least 1 measure for which there is Medicare patient data.

2015 PQRS: Reporting Via Qualified Clinical Data Registry (QCDR)

- EPs must report on 2 outcome measures, or if less than 2 are available report 1 outcome measure and 1 additional of the following:
 - Patient Safety
 - Resource Use
 - Patient experience of care
 - Efficiency/appropriate use
- May submit quality measures for up to 30 non-PQRS measures
- Beginning with the 2015 reporting period, QCDRs must publicly report the quality measure data collected and provide a link to those data to CMS to include on Physician Compare OR the QCDR must provide data to Physician Compare to consider for public reporting

Individual Reporting Criteria for the 2017 PQRS Payment Adjustment

Qualified Clinical Data Registry



Individual PQRS measures and/or non-PQRS measures reportable via a QCDR

What Measure Type?



Report at least 9 measures covering at least 3 NQS domains AND report each measure for at least 50 percent of the EP's applicable patients seen during the reporting period to which the measure applies.

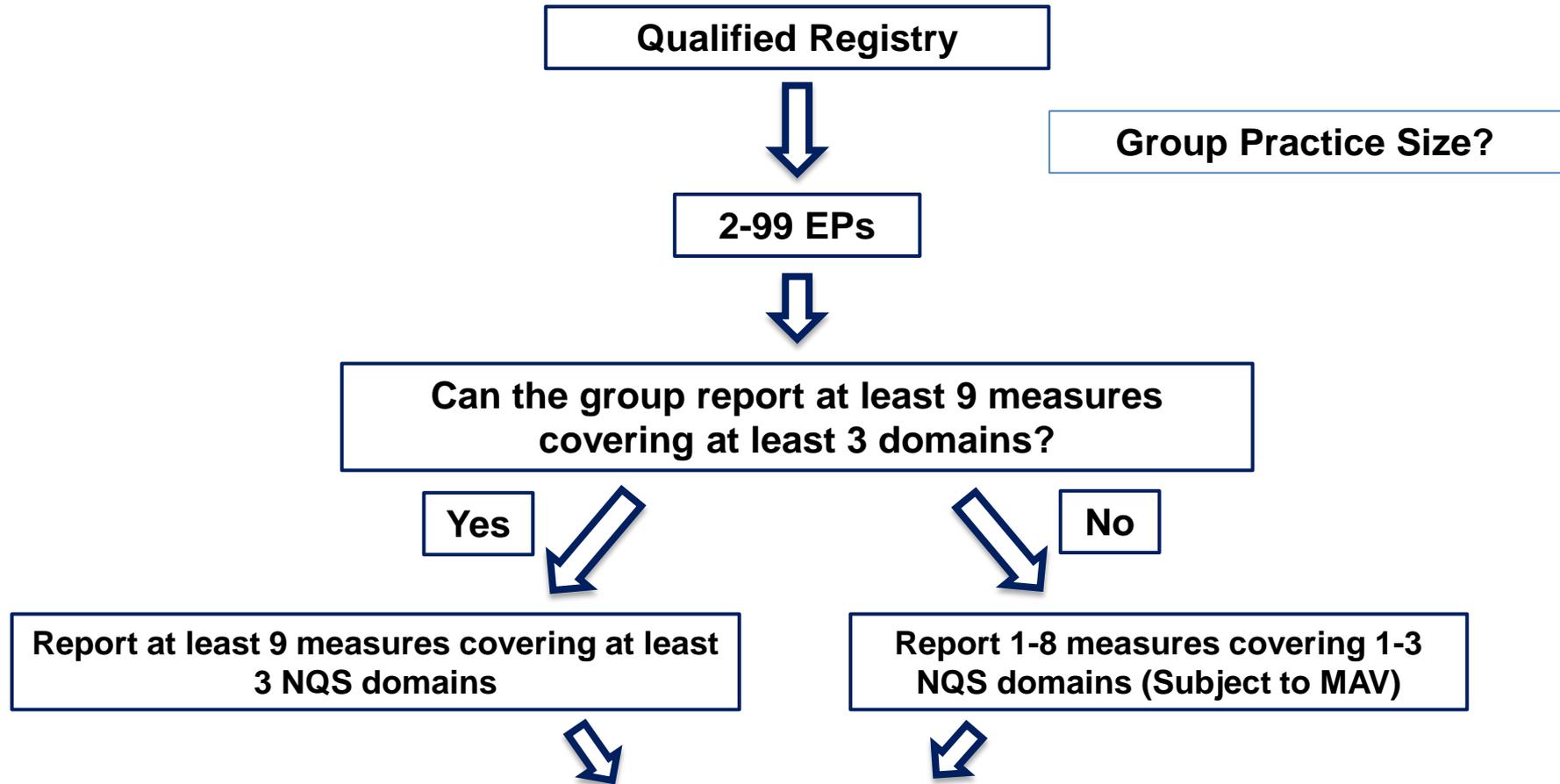
Of the measures reported via a qualified clinical data registry, the EP must report on at least 2 outcome measures, OR if 2 outcome measures are not available, report on at least 1 outcome measure and at least 1 of the following: resource use, patient experience of care, efficiency/appropriate use, or patient safety

2015 PQRS: Group Practice Reporting Option (GPRO)

2015 PQRS: Group Practice Reporting Option (GPRO)

- Group practices will be able to register for the PQRS GPRO between April 1, 2015 and June 30, 2015
- Size of the group will determine the GPRO options
 - GPRO Web Interface available for groups of 25+ Eps
- Starting in 2015, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS is mandatory for groups of 100+ EPs

GPRO Reporting Criteria for the 2017 Payment Adjustment



If group practice sees at least 1 Medicare patient in a face-to-face encounter, must report on at least 1 cross-cutting measure AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.

GPRO Reporting Criteria for the 2017 Payment Adjustment

**Direct EHR product that is CEHRT
-OR-
EHR data submission vendor that is CEHRT**



2-99 EPs

**Group Practice
Size?**



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.

2015 PQRS: Reporting Via GPRO Web Interface

- Beneficiary sample size has been adjusted to 248 beneficiaries for groups of all sizes
- If there are less than 248 patients in the group practice, group would report on 100 percent of assigned beneficiaries
- If group does not have any Medicare patients for any of the GPRO measure in the Web Interface, another reporting option must be chosen

GPRO Reporting Criteria for the 2017 Payment Adjustment

GPRO Web Interface



25+ EPs

Group Practice Size?

Report on all measures included in the web interface; AND Populate data fields for the first 248 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 248, then report on 100 percent of assigned beneficiaries.

**A PQRS group practice is required to report on at least one measure for which there is Medicare patient data.*

Groups of 100+ EPs: In addition, the group practice must report all CG CAHPS survey measures via certified survey vendor.

2015 PQRS: CAHPS for PQRS Survey

- Starting in 2015, CAHPS is mandatory for groups of 100+ EPs (in addition to other reporting methods)
- Optional for groups of 2-99 Eps
- Group practices required to contract with a CMS certified vendor and bear administrative costs for the CAHPS survey
- The CMS-certified survey vendor will administer and collect 12 summary survey modules on behalf of the group practice's patients
- 12 survey modules are the same as the 2014 survey

GPRO Reporting Criteria for the 2017 Payment Adjustment

Groups of 2-99 EPs: Optional Methods Below

Groups of 100+ EPs: MANDATORY....MUST CHOOSE ONE OF THESE OPTIONS

Report all CAHPS for PQRS survey measures via a CMS-certified survey vendor PLUS:

Qualified Registry

Report at least 6 additional measures outside of CAHPS for PQRS, covering at least 2 NGS domains; if less than 6 apply to group, report up to 5 measures. If EP in group sees at least 1 Medicare patient in face-to-face encounter, must report at least 1 cross-cutting measure.

GPRO Web Interface (25+ EPs only)

Report on all measures included on web interface; AND populate data fields for first 248 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 248, then report on 100 percent of assigned beneficiaries

Direct EHR product that is CEHRT -OR- EHR data submission vendor that is CEHRT

Report at least 6 additional measures outside of CAHPS for PQRS, covering at least 2 NGS domains; if less than 6 apply to group, report up to 5 measures. Group practice required to report on at least 1 measure for which there is Medicare patient data.

2015 Updates to the Value-based Payment Modifier (VM)

2015 Updates to the Value-based Payment Modifier

- The 2015 MPFS Final rule further expands the application of the VM in CY 2017
- Physicians in groups with 2-9 EPs and physician solo practitioners receive only the upward or neutral VM adjustment under quality-tiering
- Physicians in groups with 10+ EPs can receive upward, neutral, or downward VM adjustment under quality-tiering
- VM will apply to physicians in TINs that participate in the Shared Savings Program, Pioneer ACO Model, CPC Initiative, or other similar Innovation Center models or CMS initiatives during the CY 2015 performance period
- **Beginning in CY 2018, the VM will apply to non-physician EPs in groups with 2+ EPs and to non-physician EPs who are solo practitioners**

VM Policies for 2015 - 2017

Value Modifier Components	2015 Finalized Policies	2016 Finalized Policies	2017 Finalized Policies
Performance Year	2013	2014	2015
Group Size	100+	10+	2+ EPs and solo practitioners
Available Quality Reporting Mechanisms	GPRO-Web Interface, CMS Qualified Registries, Administrative Claims	GPRO-Web Interface, CMS Qualified Registries, EHRs, and 50% of EPs reporting individually	Same as 2016
Payment at Risk	-1.0%	-2.0%	-2.0% (Groups with 2-9 EPs and solo practitioners) -4.0% (Groups with 10+ EPs)
Outcome Measures NOTE: The performance on the outcome measures and measures reported through the PQRS reporting mechanisms will be used to calculate a quality composite score for the group for the VM.	All Cause Readmission Composite of Acute Prevention Quality Indicators: (bacterial pneumonia, urinary tract infection, dehydration) Composite of Chronic Prevention Quality Indicators: (chronic obstructive pulmonary disease (COPD), heart failure, diabetes)	Same as 2015	Same as 2015
Patient Experience Care Measures	N/A	PQRS CAHPS: option for groups of 25+ EPs	CAHPS for PQRS: Optional for groups with 2-99 EPs; required for all groups with 100+ EPs Groups may elect to include their CAHPS results in the calculation of the 2017 VM

VM Policies for 2015 - 2017

Value Modifier Components	2015 Finalized Policies	2016 Finalized Policies	2017 Finalized Policies
Cost Measures	<p>Total per capita costs measure (annual payment standardized and risk-adjusted Part A and Part B costs)</p> <p>Total per capita costs for beneficiaries with four chronic conditions: COPD, Heart Failure, Coronary Artery Disease, Diabetes</p>	<p>Same as 2015 and:</p> <p>Medicare Spending Per Beneficiary measure (includes Part A and B costs during the 3 days before and 30 days after an inpatient hospitalization)</p>	Same as 2016
Benchmarks	<p>Cost: - 100+EPs TINs are compared against groups of 100+ EPs - 1-99EPs TINs are compared against 1+ EP TINs</p> <p>Quality: No differentiation by group size</p>	No differentiation by group size (“compared to everyone”) for both cost and quality measures	No differentiation by group size (“compared to everyone”) for both cost and quality measures
Quality Tiering	Optional	<p>Mandatory</p> <p>Groups of 10-99 EPs receive only the upward (or neutral) adjustment, no downward adjustment. Groups of 100+ both the upward and downward adjustment apply (or neutral adjustment).</p>	<p>Mandatory: Groups with 2-9 EPs and solo practitioners receive only the upward or neutral VM adjustment (no downward adjustment)</p> <p>Groups with 10+ EPs can receive upward, neutral, or downward VM adjustment</p>
Application of the VM to Participants of the Shared Savings Program, Pioneer ACO Model, and the CPC Initiative	Not applicable	Not applicable	Applicable (See slides 40 & 41)

VM Policies for 2015 - 2017

Value Modifier Components	2015 Current Policy	2015 Finalized Policy	2016 & 2017 Finalized Policies
VM Informal Review Process: Timeline	Not specified. After the dissemination of the annual Physician Feedback reports, a group of physicians may contact CMS to inquire about its report and the calculation of the value-based payment modifier.	Deadline of February 28, 2015 for a group to request correction of a perceived error made by CMS in the 2015 VM payment adjustment.	Establish a 60 day period that would start after the release of the QRURs for the applicable reporting period for a group or solo practitioner (as applicable) to request correction of a perceived error made by CMS in the determination of the group or solo practitioner's VM for that payment adjustment period.
VM Informal Review Process: <u>If CMS made an error</u>	Not specified	<ul style="list-style-type: none"> • Classify a TIN as “average quality” in the event we determine that we have made an error in the calculation of quality composite. • Recompute a TIN’s cost composite if CMS made an error in its calculation. • Adjust a TIN’s quality tier. 	<ul style="list-style-type: none"> • Recompute a TIN’s quality composite in the event we determine that we have made an error in the calculation of quality composite. • Otherwise, the same as 2015.

Quality-Tiering Approach for 2017

Quality-Tiering Approach for 2017 (Based on 2015 PQRS Performance): Solo Practitioners and Groups of 2-9 EPs

- An automatic -2.0% VM downward adjustment will be applied for not meeting the satisfactorily reporting criteria to avoid the 2017 PQRS payment adjustment.
- Under quality-tiering, the maximum upward adjustment is up to +2.0x ('x' represents the upward VM payment adjustment factor).
- Groups with 2-9 EPs and physician solo practitioners are held harmless from any downward adjustments under quality-tiering in 2017.

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0x*	+2.0x*
Average Cost	+0.0%	+0.0%	+1.0x*
High Cost	+0.0%	+0.0%	+0.0%

** Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores*

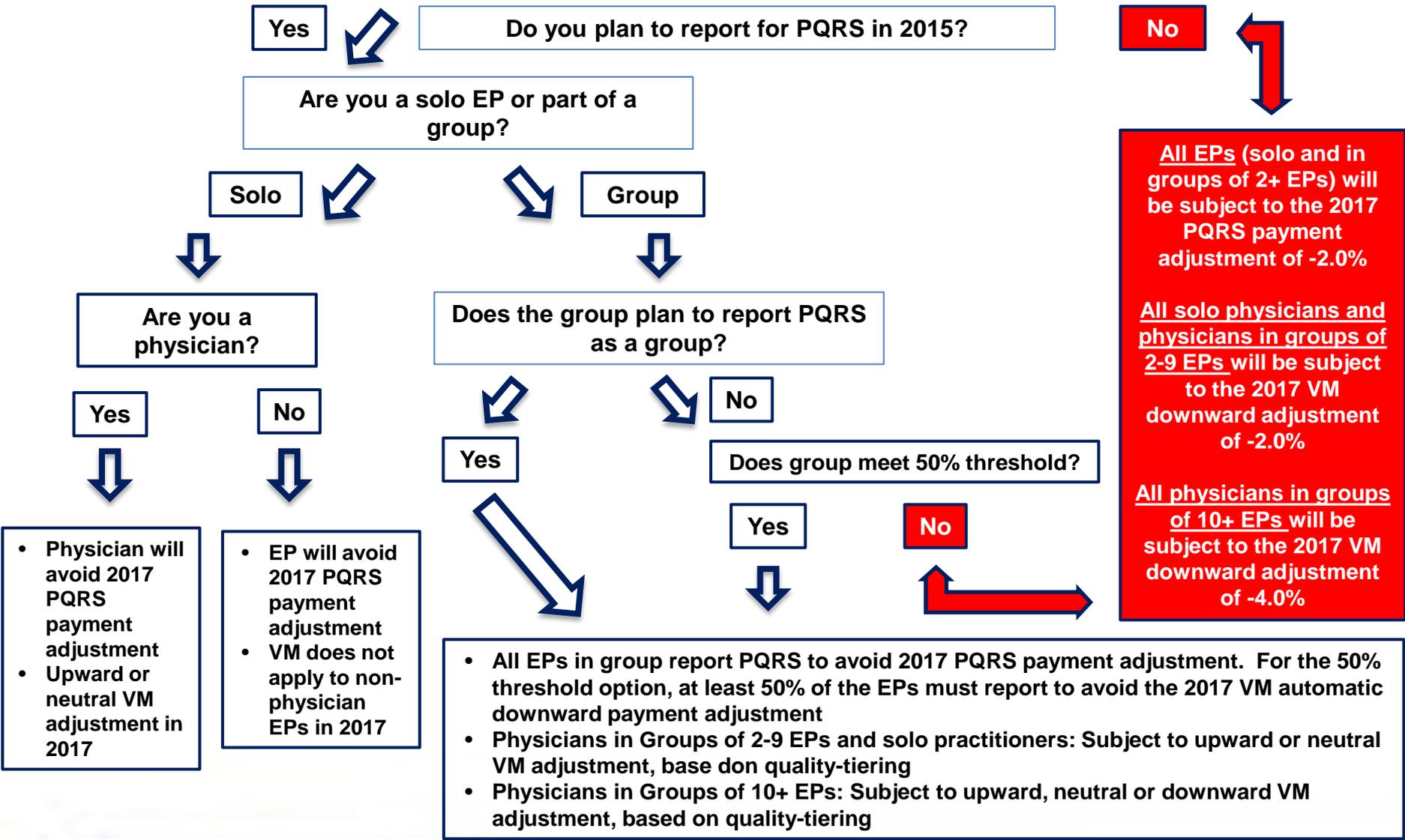
Quality-Tiering Approach for 2017 (Based on 2015 PQRS Performance): Groups of 10+ EPs

- An automatic -4.0% VM downward adjustment will be applied for not meeting the satisfactory reporting criteria to avoid the 2017 PQRS payment adjustment.
- Under quality-tiering, the maximum upward adjustment is up to +4.0x ('x' represents the upward VM payment adjustment factor), and the maximum downward adjustment is -4.0%.

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+2.0x*	+4.0x*
Average Cost	-2.0%	+0.0%	+2.0x*
High Cost	-4.0%	-2.0%	+0.0%

** Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores*

How Does 2015 PQRS Participation Affect the VM in 2017?



2017 VM Policies for Shared Savings Program Participants, Pioneer ACOs, CPC Initiative, etc.

2017 VM Policies for Shared Savings Program Participants

- Groups and solo practitioners participating in an ACO under the Shared Savings Program in the CY 2015 performance period will have their Value Modifier calculated as follows for the CY 2017 payment adjustment period:
 - Cost Composite: Average
 - Quality Composite: Based on ACO's quality data*
 - *Determination of whether a group or solo practitioner is an ACO participant will be based on whether the TIN was an SSP ACO participant in the performance year.
 - *We will apply the VM benchmarks to the ACO's quality data submitted through the GPRO web interface and will use the ACO all cause hospital readmission measure as calculated under the Shared Savings Program
- If the ACO fails to successfully report on quality measures, all groups and solo practitioners under the ACO will be subject to the automatic downward adjustment

2017 VM Policies for Pioneer ACO Model, Comprehensive Primary Care (CPC) Initiative, and other similar initiative Participants

Pioneer ACO Model and CPC Initiative

- Physician solo practitioners and physician groups in which at least one eligible professional participates in the Pioneer ACO Model or CPC Initiative in 2015 will have their Value Modifier calculated as follows for 2017:
 - Cost Composite: Average
 - Quality Composite: Average
- Solo practitioners and groups in which at least one eligible professional participates in the Pioneer ACO Model or CPC Initiative in 2015 will be classified as Category 1 and will not be subject to the VM downward adjustment for CY 2017.

Similar Innovation Center models and CMS initiatives

- If a model or initiative is determined to be “similar” based on the criteria in the CY 2015 PFS final rule, physician solo practitioners and physician groups in which at least one eligible professional participates in the model or initiative in the performance period will be assessed under the same policies as Pioneer ACO and CPC Initiative participants.

Informal Inquiry Process for the Value-Based Payment Modifier

Expansion of the Informal Inquiry Process for the Value-Based Payment Modifier

- For the CY 2015 payment adjustment period we finalized:
 - A February 28, 2015 deadline for a group to request correction of a perceived data error made by CMS in the determination of its VM
 - A policy to classify a TIN as “average quality” in the event CMS determines we made an error in the calculation of the quality composite
 - For 2015 and beyond, if CMS determines an error in the calculation of the cost composite we will re-compute the cost composite to correct the error
- Beginning with the CY 2016 payment adjustment period:
 - The deadline to submit informal review requests will be 60 calendar days after the release of the QRURs for the applicable performance year
 - Starting in CY 2016 we plan to re-compute the quality composite to correct certain errors made by CMS or a third-party vendor.

*In the event that it is not possible to re-compute the quality composite we will continue the approach for the CY 2015 payment adjustment period (as noted above).

Physician Compare

Physician Compare Updates for 2015

The 2015 MPFS final rule outlines further expansion of public reporting on Physician Compare:

Groups

- All PQRS GPRO measures via the Web Interface, Registry, & EHR
- All ACO measures
- CAHPS for PQRS and CAHPS for ACOs

Individuals

- 2015 individual PQRS measures in support of Million Hearts®
- All 2015 individual PQRS measures via Registry, EHR, & Claims
- 2015 QCDR Measures
 - Individual EP-level
 - PQRS and non-PQRS measures
 - No first year measures

How Can I Report PQRS in 2015 and What Does It Mean for 2017?

	Claims	Qualified Registry	EHR/DSV	QCDR	GPRO Web Interface	CAHPS Survey	PQRS Reporting	VM: PQRS-Reporter	VM: PQRS Non-Reporter
Solo physician	✓	✓	✓	✓			Avoid 2017 PQRS adj (-2.0%)	Upward/Neutral adj (+1.0x, +2.0x, 0.0%)	-2.0% Downward adj
Solo Non-physician Practitioner	✓	✓	✓	✓			Avoid 2017 PQRS adj (-2.0%)	Does not apply in 2017	Does not apply in 2017
Group 2-9 EPs		✓	✓			Optional	Avoid 2017 PQRS adj (-2.0%)	Upward/Neutral adj (+1.0x, +2.0x, 0.0%)	-2.0% Downward adj
Group 10-24 EPs		✓	✓			Optional	Avoid 2017 PQRS adj (-2.0%)	Upward/Neutral/Downward adj (+4.0x, +2.0x, 0.0%, -2.0%, 4.0%)	-4.0% Downward adj
Group 25-99 EPs		✓	✓		✓	Optional	Avoid 2017 PQRS adj (-2.0%)	Upward/Neutral/Downward adj (+4.0x, +2.0x, 0.0%, -2.0%, 4.0%)	-4.0% Downward adj
Group 100+ EPs		✓	✓		✓	Mandatory	Avoid 2017 PQRS adj (-2.0%)	Upward/Neutral/Downward adj (+4.0x, +2.0x, 0.0%, -2.0%, 4.0%)	-4.0% Downward adj

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