

## The CMS Physician Quality Reporting System (PQRS) Program: What Medicare Eligible Professionals Need to Know in 2014

Patrick Hamilton:

Hello, and welcome to the CMS Physician Quality Reporting System Program: What Medicare-Eligible Professionals Need to Know in 2014 presentation. My name is Patrick Hamilton from the Centers for Medicare and Medicaid Services. The purpose of today's presentation is to give an overview of the requirements of the Medicare PQRS Program, so that all eligible professionals can participate to earn the incentives that are available in 2014 for successfully participating in the program, as well as to avoid the payment adjustment in 2016 for not reporting this year. This MLN Connects video is part of the Medicare Learning Network.

2014 is a critical year for PQRS, as it is the last year that providers can earn an incentive for reporting PQRS quality measures. 2014 is also the participation year CMS will consider in determining whether an eligible professional will be assessed the PQRS payment adjustment of two percent in 2016. CMS has been working vigorously with the Medicare provider community to ensure that you have the most up to date knowledge and information available to assist you in meeting the requirements of PQRS.

I'm joined today by Dr. Shari Ling, Deputy Chief Medical Officer for the Centers for Medicare and Medicaid Services, and Medical Officer in the Center for Clinical Standards and Quality. She assists the CMS Chief Medical Officer in the agency's pursuit of higher-quality health care, healthier populations, and lower costs through quality improvement. Dr. Ling's longstanding focus is on the achievement of meaningful health outcomes through delivery of high quality, person-centered care across all care settings, with special interest in the care of persons with dementia, multiple chronic conditions, functional limitations, and reducing health disparities. Dr. Ling represents the Clinical Services Government Workgroup, and co-leads the Long-Term Services Work Group for the National Plan to Address Alzheimer's Disease. Thanks so much for joining us today, Dr. Ling.

Shari Ling:

I'm pleased to be here.

Patrick Hamilton:

You may recall the Physician Voluntary Reporting Program followed by the Physician Quality Reporting Initiative in 2007, which is the basis of the current PQRS Program. So the idea of collecting quality data is not new. Has there been an increase in Medicare providers' participation and quality reporting over the past seven years?

Shari Ling:

Yes, Patrick. Participation has steadily increased since the beginning of the program over time. And we're delighted to report that we have a record year. We have some one million plus physicians currently reporting to Physician Quality Reporting System, and really are participating. So, although, about 36 percent of all eligible physicians are currently participating, it's also good to know that those physicians who are caring for patient panels of 200 or greater of Medicare beneficiaries, actually, that segment of the physician population, over half are participating in PQRS.

Patrick Hamilton:

So the good news is more than one million Medicare providers have participated in PQRS in 2012. To what do you attribute this robust participation in the program?

Shari Ling:

Well, there are several factors that we believe have contributed to the increase participation rates that we've been observing. One factor, of course, is that when the program first began, it began with 74 measures with a single reporting vehicle, that being claims. And over time, this has expanded to over 13 reporting vehicles, including electronic health record-based reporting and registries, which, as you know, are the fastest growing mechanism by which physicians report and participate in PQRS.

There has also been a recognition that programs like this are important in providing technical assistance to physicians to professionals to office managers on how to participate and to submit their data accurately the first time. In addition, of course, the incentives really called attention to the fact that quality reporting, and the focus of quality, is an important priority to CMS as part of the three-part aim. Now, although we are enjoying a robust increase in participation, I would say that our job is not done yet. We certainly, over time, would like to evolve to include a set of measures that are really driving towards meaningful improvement of health outcomes on behalf of our beneficiaries, patients, and families, and that's where those who are listening to this broadcast today, can play an important role in contributing concepts, ideas and thoughts on what measures really matter, so, we can get all physicians into PQRS reporting.

Patrick Hamilton:

The past several years, CMS has been promoting its triple aim: better care for patients, better health for populations, and lower per capita costs. Aside from the incentives and payment adjustments, who does the reporting of quality measures in our programs help to realize those goals, and how do these programs help providers deliver better care?

Shari Ling:

Well, thank you for the question. The three-part aim of better care, delivering healthier populations, and providing care at lower cost through improvement has been a vehicle to fulfill the CMS mission. Physician-quality reporting system is, then, a vehicle to encourage measurement of quality with the purpose of improving on that quality of the services and care that are provided to patients and families. PQRS is evolving into a robust program that now has over one million professionals participating in it, and that number continues to increase.

The program is centered on the CMS quality strategy, and therefore, also, on the National Quality Strategy. And this strategy aligns measurement around six goals, that is, delivery of care that is safer, that engages people and families in their care, that there is no care that does not include me in the process of decision-making; care that's well-coordinated between providers, across care settings, and also that is effectively communicated, and that promotes effective and evidence-based preventive health practices as well as effective management and treatment of chronic diseases.

Ultimately, this also will enable better health and communities and provision of care that is affordable. In addition to expansion of measurements to permit participation of specialty as well as primary care practices, PQRS has also expanded to include many reporting options. The notion here is to enable participation from a broad array of professionals to improve quality. EHR and registry reporting options for PQRS have been growing quickly over time and aligns to encourage participation in other provider programs, as well as in PQRS. That is, optimally, to report once and gain credit for multiple programs.

Patrick Hamilton:

And quality improvement and quality measurement are the main focus of the programs that you oversee. In this year, for the first time, CMS has made great strides in aligning the reporting requirements the various quality programs including the Physician Quality Reporting System, or PQRS, meaningful use and the Medicare Share and Savings Program.

Shari Ling:  
[affirmative]

Patrick Hamilton:

Can you explain how aligning these programs will help Medicare providers?

Shari Ling:

Certainly. So, measure alignment also means measure simplification. That is, taking a vast array of measures and actually consolidating around goals of the National Quality Strategy, which has recently also been incorporated into the CMS Quality Strategy. So alignment of measures around those goals can really get all providers and physicians onto the same page on, as to what matters. And those goals are very important to patients as well. This means that what is sought is the attainment of care that is safe, care that is well-coordinated and effectively communicated that involves patients and families in their care, that can then translate into effective management based on the best-known evidence of chronic conditions and ideally also preventive strategies, then, can help mitigate the development of those chronic conditions, which then, also, results in healthier populations and, of course, care that is safer, as well as less expensive through quality improvement. So I think there are benefits for physicians and providers, and, by the way, the ideal scenario is to be able to report once and gain credit for multiple programs concurrently, but also that that measurement and use of the program and vehicles then translates into better care for our beneficiaries.

Patrick Hamilton:

Dr. Ling, thank you for joining us today. Today's presentation will include information on a variety of topics that are essential to the PQRS Program, including eligibility for the PQRS Program, the 2014 PQRS updates, including new reporting requirements and new methods of data submission, the incentives available for 2014 and payment adjustments that could be assessed in 2016; the reporting requirements for both individual E.P.s and for group practices, the measure's applicability process to determine if an E.P. submitted the requisite number of measures, the physician compare website and the information that will be posted to it by the end of this year, and finally accessing your QRUR Report, so you can review the report, determine your success in your reporting, and inform CMS of any comment you have regarding your QRUR Report. We will also be walking through a number of decision trees that have been created to help providers ask the necessary questions on determining how best to participate in 2014.

We'll begin by talking about the eligibility for the Physician Quality Reporting System, and, as you can see in the next slide, the chart that we've developed here shows the eligibility criteria for both the PQRS Program and the EHR Incentive Program as well as how individual physicians and other practitioners factor in the value modifier. We'll talk about the value modifier in a separate presentation, but since we're talking about the Physician Quality Reporting System, we'll focus on that column. As you can see, all Medicare physicians, whether they are MDs, Dos, podiatrists, optometrists, dentists, or chiropractors, as well as all of the practitioners and the therapists listed here are both eligible for the incentive in 2014, and conversely, will be subject to the payment adjustment in 2016 for not participating in PQRS this year. The eligibility criteria was defined in the legislation that passed the PQRS Program back in 2007, and has remained intact, with the exception of the addition of audiologists, since the inception of the program.

Starting in 2014, for the first time, professionals who reassign their benefits to a Critical Access Hospital, that bill professional services as the facility level, which is also sometimes known as CAH Method II Billing, can now participate in PQRS. They can do so using any reporting method except for claims, because these providers do not submit claims, bill according to the Part B Physician Fee Schedule. However, it is very important that the Critical Access Hospital includes the individual NPI of the rendering physician on those institutional claims, as we track your activity by the individual NPI.

There may be some instances where some professionals could be eligible to participate because of their specialty, but due to their particular billing method, they're not able to participate. Also, services that are billed to other fee schedules, such as an ambulance fee schedule or the lab fee schedule, even though they are considered Part B, would not be eligible because they are not billing to the physician fee schedule. So the general rule of thumb would be any services that are billed to the Medicare Part B Physician Fee Schedule.

We'll now go over some of the major changes to the PQRS Program for 2014. For the 2014 PQRS Program, we are emphasizing really two things: what providers need to do in order to earn the 2014 incentive, and also what they can do in order to avoid the 2016 payment adjustment. This is the final year, 2014, that CMS will offer an incentive payment for participating in PQRS successfully. This is the last year, therefore, that we'll have a dull focus on what you need to do to both earn the incentive and avoid the payment adjustment. For 2014, the new requirement

generally is that providers are to report nine measures across three National Quality Strategy domains, and we'll go over those domains shortly.

We've also lowered the percentage of patients that are to be reported for PQRS on some of the reporting options from 80 percent to 50 percent. This makes it possible for providers to possibly start a little bit later in 2014. You may remember, last year, the CMS gave the opportunity for providers to avoid the payment adjustment by doing one of two additional things: either by electing the administrative claims option, or by, you would ask CMS to administer it, administratively analyze your claims, or we allow you to report just one measure for one beneficiary or one measures group for one beneficiary simply to avoid the payment adjustment that will be assessed in 2015.

In 2014, those options are no longer available, so we've eliminated the administrative claims option, and the opportunity to report just one measure for the purposes of avoiding the payment adjustment. However, we have given providers one additional opportunity to avoid the 2016 payment adjustment, if they're not ready to, or cannot fully participate in the program this year to earn the incentive. And that opportunity is for E.P.s to report on only three measures on 50 percent of their Medicare Part B Fee-for-Service patients. And, again, this would not be to earn the incentive payment, but simply to avoid the payment adjustment in 2016. This option would only apply to eligible professionals or groups who are using the qualified registry or individual claims if you're an individual provider.

Additional changes to the PQRS Program in 2014, we are now only allowing measures groups to be reported via registry option. In years past, we allowed measures groups to be reported through claims, but that is no longer an option. So, if you are going to be utilizing measures group, and we'll talk about measures group on the next slide, you must do so through the registry process. Also, in our attempt to further align the PQRS Program with the EHR Incentive Program, we have added EHR reporting for group practices as an option to submit PQRS measures. This will give groups the opportunity to submit measures for both programs one time and get credit for both.

New in 2014 are new qualified clinical data registries, and we'll talk about those in detail in future slides, but this is an additional way for providers to report their quality measures in 2014. And also, we have added the CG-CAHPs Survey, which has been part of the Accountable Care Organizations and the Shared Savings Program since 2012. We are allowing the opportunity for groups of 25 or more who register to participate in PQRS through the GPRO, to use the results of their CAHPs Survey in order to get credit for PQRS. Slide nine shows the measures groups that are available for those groups who are going to use the registry process. In 2014, we have 25 measures groups, many of them are general practice-related, some of them are more specialty-focused. But they all include clinical-related measures that are identified by CMS to be reported as a group through the registry-based submission process.

As I mentioned previously, 2014 is the last year that PQRS will be offering incentives for eligible professionals in groups who are participating in the programs, E.P.s who satisfactorily report their quality measures data regardless of the method that they choose, will be eligible to an incentive of 0.5 percent of the E.P.'s estimated total allowed charges for covered Medicare Part B

Physician Fee Schedule Services provided in 2014. Additionally, physicians who are participating in the program are eligible for an additional 0.5 percent incentive if they are participating in a Maintenance of Certification Program, usually through their specialty board.

Keeping in the practice of a two-year look back period, this year is also the performance year for assessment of the 2016 PQRS payment adjustment. So what that means is that to determine whether or not CMS will assess the payment adjustment of 2 percent to an eligible professional, we will look at their 2014 PQRS activity to determine whether or not they satisfactorily reported the measures that they were required to do so.

The charts on the next two slides are charts that we have developed to give providers and groups and bird's-eye view of the incentives and the payment adjustments that they could be entitled to or assessed, based on their activity in 2014. This first chart focuses on Medicare physicians. So, if we look at the PQRS Program, or the PQRS column, we'll see that all physicians obviously are eligible to earn the incentive, and again, it's 0.5 percent of their Part B allowed charges, and then, an additional half a percent for a total of one percent if they're doing a Maintenance of Certification. For physicians who opt not to report for the PQRS Program in 2014, then it's a payment adjustment in 2016 of 2 percent.

Moving over to the value modifier column, the value modifier is applied to physician reimbursement. The value modifier will start to be assessed to physicians starting in 2015 for those physicians who practice in groups of 100 or more E.P.s. In 2016, it will be applied to physicians working in groups of 10 to 99 E.P.s, and by 2017, all Medicare physicians will be assessed the value modifier.

Starting in 2016, for any physician, regardless of your group size, whether you're between 10 and 99 E.P.s or 100 or more E.P.s, not participating in PQRS means an automatic reduction of two percent for your value modifier. So what that means is that if you are a physician in a group of 10 or more, and you choose not to do PQRS in 2014, you're looking at a four percent automatic reduction in 2016. In terms of the incentives that you earn through the value modifier, groups of 10 through 99 could get an upward or a neutral adjustment, and groups of 100 or more could get an upward, a neutral, or a downward adjustment, and that's based on quality tiering, and we'll go into more details on the value modifier presentation.

In terms of the EHR Incentive Program, all physicians who are listed on this chart are eligible for the Medicare program. If an E.P. has already started the Medicare program based on the payment year in which they are in, they could receive an incentive payment of anywhere between \$4,000 and \$12,000. For those physicians who are eligible for the Medicaid Program, your incentive payment would be either \$8,500 or \$21,250, again, based on either when you started meaningful use or when you did your adopt, implement or upgrade attestation. Looking at the payment adjustment for the incentive program in 2016, it is also a 2 percent payment adjustment. So what this means is that if an eligible professional chooses not to participate in PQRS or in meaningful use in 2014, they can be looking at a maximum of a 6 percent payment adjustment in 2016.

This slide focuses on the non-physician practitioners and therapists, and as you can see, these practitioners and therapists basically will be focused on PQRS, because they are eligible for the program, they are eligible to earn the 0.5 percent incentive, and also, conversely, if they do not report in 2014, they could be assessed the negative 3 percent payment adjustment on their reimbursement. In terms of the EHR Program, for the most part, practitioners are not eligible professionals with the exception of Physician Assistant's Nurse Practitioners and Certified Nurse Midwives, who, in limited circumstances, could be eligible to participate in the Medicaid Program. But, regardless, they would not be subject to any payment adjustments for the EHR Program.

So moving on to slide 13, we get a lot of questions at CMS from providers and group practices who ask us, how do we decide which measures we're going to report? Some of the factors that you want to consider when selecting the measures are: what are the things that your patients are coming in the office for? What are the conditions that you are usually treating? What's the type of care that you're providing to your patients? Do you focus more on preventive care? We have had an increase on the emphasis of preventive care over the past decade at CMS. So we have been adding more of the preventive care measures to the program. Or, do you focus on patients that have more acute or chronic conditions? Where you administer your care may be consideration. Are you administering your care in an office setting? Are you administering it in an emergency setting of a hospital, or an ambulatory care setting? What are your internal goals? What are you trying to achieve in your practice? And also, are you participating in other programs? For example, if you're participating in the meaningful use program, and you want to align your quality measure reporting with the Clinical Quality Measure Requirement of the meaningful use program, then you're going to be looking at a smaller subset of CQMs, the 64 that are included with the electronic health record program, in determining the measures that you're going to choose for PQRS.

Slide 14 shows the six National Quality Strategy Domains that have been developed and are being utilized for both the PQRS and the Meaningful Use Program in 2014. When you're looking at these domains, if you're using the claims-based reporting option, registry, or EHR, you will see that these six domains will contain the measures from which you must choose at least nine. And again, it was no accident that these six domains are the same that you will find in the Clinical Quality Measure Program, as we are attempting to align both programs this year.

Slide 15 is an overview of the PQRS measures list; they can be found on the PQRS page of the CMS website. The measures list is a chart that gives you: the ID, the National Quality Form ID, with whom we've partnered to develop the measured; the PQRS ID; the domain that those measures come from; a summary description of all of those measures; who developed it; and also the reporting options that those measures are available for. It's important to note that not all the measures that are part of the PQRS Program in 2014 can be reported using all of the reporting options. So when you are choosing which method you want to report, you want to make sure that the measures can be reported using that reporting option.

So the first question that you're going to ask is, how are you going to participate? Are you going to participate as an individual, or are you going to participate as a group, if you are part of a group practice? And if you are going to participate in a group, how many people are in your

group, because that will determine how or what option you can use to actually participate. We'll talk about the group reporting option in a few moments.

So we're going to focus on individual reporting. In 2014, individuals, individual E.P.s who are participating as individuals, can use one of five reporting methods: they can use claims to report individual measures, they can use a qualified registry to report individual measures or the measures groups that we talked about earlier, they can use their certified EHR product or if they have a data submission vendor for EHR that is certified, that is another way to use your HER data; and also new to 2014, we have the Qualified Clinical Data Registries, or QCDRs.

New for 2014, the QCDR method provides a new standard to satisfy PQRS requirements based on satisfactory participation. The QCDR is a CMS-approved entity, such as a registry, certification board, collaborative, et cetera, that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care furnished to patients. The data submitted to CMS via a QCDR covers quality measures across multiple pairs and is not limited to just Medicare beneficiaries.

The QCDR is different from a qualified registry, in that it is not limited to measures within just PQRS. At a minimum, the QCDR must be able to perform the following functions: it must be able to submit quality measure data or results to CMS; it must also be able to submit to CMS quality measure data for multiple pairs, so not just Medicare but also for other pairs that the provider is affiliated with; it must be able to provide timely feedback to the participants of the registry; and they must also have the capacity to benchmark their quality measures.

At a minimum, the QCDR must have at least nine measures, covering at least three of the six quality domains available for reporting, again, because this is the minimum requirement for reporting, PQRS in 2014. In addition, they must include at least one outcome measure, but they can also have a number of processed measures included as well. QCDR has handed self-nominee to CMS by January 31st that they intended to participate in the program, and then by March 31st, they had to tell CMS exactly how they were going to set up the registry, that is, how the numerators, the denominators, exceptions, exclusions, et cetera, were going to be calculated and defined. This is also an additional and a new way for E.P.s to meet the Clinical Quality Measurement Reporting requirement for meaningful use. So if an eligible professional decides that they want to enroll with the QCDR for purposes of PQRS, and if they're reporting for a full year of data for the Clinical Quality Measures for meaningful use, they can use this QCDR to satisfy the requirements for both programs.

We're now going to focus on the individual reporting criteria for the 2014 incentive. We've created a series of decision trees that will help you walk through the questions that you need to ask to determine how you're going to participate. We're going to focus on what you need to do to earn the incentive and then also how to avoid the payment adjustment. So we're going to start with the individuals, then we'll move to groups. And we're going to do this based on the reporting method that you will chose.

So we'll start with individuals who are going to report via claims, and again, the measure type that is available for the claims reporting option is individual measures. So the first question that

you would ask would be whether or not you can report at least nine measures covering at least three of the domains. And if the answer is yes, then that is what you'll do, report at least nine measures from at least three of the quality domains. If you cannot find nine measures that pertain to your scope of practice, then we do allow you to report at least one through eight measures that cover one, two, or three of the quality domains. Regardless, you're going to report the measures that you can report for at least 50 percent of your Medicare Part B Fee-for-Service patients seen during the reporting period, to which the measures that you choose actually apply. Keep in mind that measures that have a zero percent performance rate would not be counted. So make sure that you choose measures that you're actually going to have actual data for. In the instance where you are reporting less than nine measures from three quality domain, you will be subject to what is known as the Measures Applicability Validation, process and we'll go into detail as to what the MAV process entails in later slides.

Moving over to the qualified registry reporting option, there are two different measure types that can be reported via the qualified registry. We'll start by talking about individual measures and you'll see that this decision tree is going to mirror the one that we just discussed. If through the qualified registry you're reporting individual measures, you would ask whether or not you can report at least nine measures covering three of the quality domains. And if you can, then you're going to report your nine measures through the three quality domains. If not, again, we'll give you the opportunity to report one through eight measures covering one, two, or three of the domains and, again, you have to make sure that you do so for at least 50 percent of your Medicare Part B fee-for-service patients seen during the reporting period to which the measure applies.

Moving over to measures group. With the measures group, there are actually two reporting periods that you can choose. One is a full 12-month period which would run from January 1st through December 31st, 2014, and then a second six-month period which runs from July 1st through December 31st. We offer this six-month reporting period to E.P.s who are not yet ready to report in January. Regardless of the reporting period that you choose with measures group in the qualified registry, you must report at least one of the measures group and again you can choose one from the 25 that we showed on the previous slide and you must report each measures group for at least 20 patients. So, you must make a sample of at least 20 patients, a majority of which must be Medicare Part B fee-for-service patients. So, for example, if you are going to do a sample of 20 patients, at least 11 or a majority must be Medicare Part B fee-for-service patients.

The MAV process will be applied to providers who are choosing qualified registry reporting individual measures if they cannot meet the minimum requirement of nine measures covering at least three domains. If you are going to be using your certified EHR product, or if you have an EHR data submission vendor that is certified, then that is an additional method, new method, to report quality measures this year in PQRS. The measure type that you will be reporting our individual measures and again the requirement would be for reporting of nine measures covering at least three of the quality domains.

Now, if your certified system does not contain patient data for at least nine measures covering the three domains, then the eligible professional would be required to report the measures for

which there is Medicare patient data. An E.P. must report on at least one measure for which there is Medicare patient data. Again, keep in mind that your certified system is going to have information that covers all different types of pairs, but you must make sure that you have one measure, at least one measure, that has Medicare patient data included.

Finally, for individuals who want to earn the incentive for 2014, the qualified clinical data registry is another option. The measures that are reported using this option would be the measures that are selected by the qualified clinical data registry. And again they've gone through a nomination process with CMS where they told CMS the measures that will be included. And in order to be approved as a QCDR, they must include at least nine measures covering at least three of the quality domains and the requirement, again, is to report for at least 50 percent of the E.P.'s applicable patients seen during the reporting period to which the individual measures apply. Again, keep in mind that measures that have a 0 percent performance rate are not included. Also, keep in mind that for the QCDR, at least one outcome measure must be included.

Moving on to how individuals can report to avoid the 2016 payment adjustment, it's important to note that the easiest, simplest way to avoid the payment adjustment is to earn the incentive. So basically, if you meet the criteria for which you are qualified to earn the incentive, then you will be automatically avoiding the payment adjustment for 2016. However, as I mentioned in the beginning of the presentation, there are additional ways that providers and groups can avoid the payment adjustment in 2016. So we've created a series of decision trees specifically to discuss how to avoid the payment adjustment for individuals. And if an individual E.P. is using claims, again they're going to be reporting individual measures.

The question we would ask is do you plan to meet the 2014 incentive criteria. And if the answer is yes, we do plan to meet the criteria in order to earn the incentive, and again you will automatically avoid the 2016 PQRS payment adjustment. If the answer is no, we cannot report on nine measures that cover three domains. Then we would ask, well can you find at least three measures that apply to your scope of practice that you can report. And if the answer is yes, we can, then you would report those three measures. If the answer is no, you cannot report at least three measures, then we do give you the opportunity to report at least one or two measures to avoid the payment adjustment. Regardless, keep in mind you must report each measure for at least 50 percent of your Medicare Part B fee-for-service patients seen during the reporting period for which the measures apply. 0 percent performance rates are not counted and the MAV process will go into effect if you're reporting one or two measures to avoid the payment adjustment.

For those individuals who are opting to use the qualified registry and reporting on individual measures, if you meet the -- if you plan to meet the 2014 incentive criteria, then again you will automatically avoid the 2016 PQRS payment adjustment. If not through the registry, you can also report at least three measures and if you can do so, then you will report your three measures. If not, if less than three measures apply to the EP's scope of practice, then you report just one to two measures. Again, in each case, report for at least 50 percent of your Medicare Part B fee-for-service patients. 0 percent performance rates aren't counted and the MAV process will go into effect for E.P.s reporting just one or two measures.

For individuals who will be reporting on measures groups, again your reporting period will be either 12 months or six months. However, for purposes of avoiding the payment adjustment through the qualified registry reporting option, the only way to avoid the payment adjustment is to successfully report for the 2014 incentive.

Individual E.P.s who are going to use their certified EHR system or use an EHR data submission vendor reporting individual measures to avoid the payment adjustment, the only way to do so is to successfully report for the 2014 incentive payment. For those providers who are going to opt to use the QCDR or the qualified clinical data registry in 2014, you'll be reporting on the measures selected by the QCDR. If you plan to meet the incentive criteria, then again you will avoid the 2016 payment adjustment. If not, then we give you the opportunity to report at least three measures covering at least one NQS domain and report it for at least 50 percent of the eligible professionals applicable patients that are seen during the reporting period to which the measure applies.

We're now going to move over from individual reporting to the group practice reporting option. For purposes of PQRS, we have a specific definition of group practice. Group practice is defined as a single tax identification number with two or more individual E.P.s who are identified by their individual NPI number, or National Provider Identifier, who reassign their billing rights to that tax identification number of the group. A group must register to participate in the PQRS group practice reporting option or GPRO. And the method that is chosen by that group is the only way that the individual E.P.s who have signed up or reassigned themselves to that group can participate. Now if an organization or if an eligible professional changes their tax identification number, then the participation under the old TIN does not carry over to the new TIN, nor is it combined for final analysis. So it's always about a TIN NPI combination.

Now for those providers who are participating or those groups who are participating in the accountable care organization in the Medicare shared savings program or in the pioneer ACO model do not need to register. How you report for the group practice reporting option is going to depend on the size of the group. Again, we mentioned earlier that claims-based reporting for groups are no longer an option starting in 2014 and all reporting periods are for 12 months, so that option for that six-month reporting period that we talked about earlier for individuals is not available for groups. It's also important to note that there is no requirement that a group who exists as a group in PECOS must participate as a group. There are a number of reasons why individual E.P.s who are part of a group may wish to participate in the program as individuals and that is completely allowable.

So, based on your group practice size, you have a number of methods that you can report. If your group practice is between two and 24 E.P.s, then you have three options. You can use a qualified registry. You can report your quality data through your EHR-certified system directly. Or you could use an EHR data submission vendor that is certified. For groups that have 25 to 99 E.P.s, you have an additional option. You can use your qualified registry. You can use the EHR product or the data submission vendor. Or if you're a group that has 25 or more you may use the GPRO website interface. For groups of 100 or more, the options are basically the same with the

exception that for groups of 100 or more that are going to use the GPRO web interface, they are required to report the results of the CG CAP survey.

The CG CAP survey is a new reporting mechanism that's available to group practices participating in PQRS under the GPRO starting this year in 2014. It is available for group practices of 25 or more E.P.s who choose to report the results of their surveys as part of their quality measures. However it is a requirement for groups of 100 or more using the GPRO web interface reporting method. For groups of 25 to 99 that are using the GPRO web interface, it's optional. But if you're in a group of 100 or more, you must include the results of your CAP survey with your web interface data.

For all groups who are selecting the CAP survey, CMS will select and pay for a certified survey vendor to administer the survey on the group's behalf, and this is regardless of size. The data that's collected on the measures will be submitted on behalf of the group practice by the certified survey vendor who's chosen by CMS and the results will be placed on the physician compare website sometime in 2014.

Slide 33 gives an overview of the 12 points or the 12 survey questions that are included in the CG CAP survey. As you can see, these are patient experience-based questions and these are the same questions that have been included with the CAP survey since the beginning of the shared savings program.

We'll now move into the decision trees that have been created for the group practices to determine how they can earn the 2014 incentive and then we'll talk about how they can avoid the 2016 payment adjustment. And again, we're going to focus and we'll do these decision trees based on the reporting method that you would choose. So, for groups, we would start with the qualified registry option and this would be available to groups of any size, so if you have two or more E.P.s in your group and, again, if the group registered to participate in PQRS as a GPRO by September 30th, they can choose the qualified registry option. And if they do so, the question you would need to ask is can you report at least nine measures covering at least three of the quality domains. And if the answer is yes, that's what the group will do. Report nine measures covering three domains. If not, then the group would report one through eight measures covering one through three domains as it pertains to the scope of their practice. And again, as with the individual reporting requirements, you must -- the group must report each measure for at least 50 percent of the group's Medicare Part B fee-for-service patients seen during the reporting period to which each of the measures applies. The 0 percent performance rates will not be counted and you would be subject to the validation process if you're reporting just one through eight measures covering one through three domains.

For groups who are going to either directly report using their certified EHR system or using their EHR data submission vendor, again that option is available to groups of all sizes, so two or more E.P.s, and the requirements who earn the 2014 incentive would be to report the nine measures covering three domains. If your group's certified system does not have the patient data for at least nine of the measures covering the three domains, then the group will report the measures for which there is Medicare patient data. But again, keep in mind because your certified system

will have information for all payers that you must choose at least one measure that you have Medicare patient data.

The next decision tree focuses on the GPRO web interface and groups who choose that method of reporting. The requirements for the GPRO web interface will differ based on how big the group is. So, we'll focus first on groups of 25 to 99 E.P.s. The requirement for this group who is going to choose the GPRO web interface would be to report on all the measures that are included in the interface and also they must populate the data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group sample. Now, if you have less than 218 beneficiaries, then you would have to report on 100 percent of all assigned beneficiaries.

Moving over to groups of 100 or more E.P.s, they also are going to report on all the measures that are included in the web interface. However, they're going to populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group sample for each module or preventive care measure. And again, if these large groups of 100 or more do not have 411 beneficiaries, then they would report on 100 percent of assigned beneficiaries. Again, in addition for large groups of 100 or more E.P.s who are opting to use the GPRO web interface, they are required to report the C.G. CAP survey measures via a survey vendor. The GPRO web interface is another method that individual E.P.s within these groups can satisfactorily report the clinical quality measures needed for meaningful use.

Now we'll discuss the requirements for groups who are participating in PQRS via the GPRO to avoid the 2016 payment adjustment. Again, for groups, the simplest way to avoid the payment adjustment is to meet the criteria for the incentive payment in 2014. However, if that's not possible, then we do give an additional opportunity for groups to avoid the payment adjustment based on the method of reporting.

For groups who are going to be using a qualified registry, and again this would be for any group size of two or more E.P.s, if you do plan to meet the 2014 incentive criteria, then you'll automatically avoid the 2016 payment adjustment for PQRS. If you're using the qualified registry and you cannot report nine measures covering three domains, we would ask whether or not you can report at least three measures. And if the answer is yes, then that is what the group will do. You'll report at least three measures. If not, if three measures genuinely do not pertain to the scope of practice of the group, then you can report just one to two measures. And again, you're reporting for at least 50 percent of your Medicare Part B fee-for-service patients seen during the reporting period and you'll be subject to the validation process if you're reporting just one to two measures.

For groups who are going to use their EHR system or using an EHR data submission vendor, the only way to avoid the 2016 payment adjustment is to successfully report for the 2014 incentive payment. Likewise, for groups who opt to use the GPRO web interface, regardless of the size of group, whether you are a group of 25 to 99 E.P.s or a group of 100 or more E.P.s, the only way to avoid the payment adjustment in 2016 is to successfully report for the 2014 incentive payment.

Now we're going to discuss the measures applicability validation process or MAV process and when it is actually and how it is actually initiated in PQRS reporting. Individual E.P.s and groups, regardless of size, could be subject to the validation process if they are choosing the individual claims option or the qualified registry reporting option. And it's initiated when the minimum requirements for either earning the incentive payment or avoiding the payment adjustment aren't quite met. The process is initiated when an E.P. or group satisfactorily reports QDCs or quality measures for only one to eight measures across one or more domains or if the group actually does report nine measures but does not hit that three domain requirement. So, if they're reporting their nine measures for less than three domains, the validation process would kick in.

Individual professionals who are using either the claims reporting option or the qualified registry and groups who are using the qualified registry reporting option must report for at least 50 percent of their eligible patients or encounters for each of the measures. In order to receive the 2014 incentive payment, we will initiate the validation process to validate if more measures or if more domains may have been applicable for reporting if the minimum has not been met. Conversely, to avoid the 2016 payment adjustment, if only one or two measures were reported, we will analyze claims through the validation process to determine if more measures could have been applicable for reporting in order to avoid the payment adjustment. Now, note that E.P.s who satisfactorily report three or more measures across one or more domains won't be subject to the validation process for purposes of avoiding the payment adjustment but would be subject to the validation process to determine if more measures or if more domains could have been chosen in order to earn the incentive for 2014.

The MAV process that's been developed by CMS has actually a two-step process. A clinical relation domain test and a minimum threshold test. The clinical relation domain test is the first step in the two-step MAV process that will be applied to those who are subject to the validation process of reported measures or domains. The test is based on an extension of the statutory presumption that if an E.P. submits data for a measure, then that measure applies to his or her practice. And the concept that if one measure in a cluster of measures related to a particular clinical topic or eligible professional service is applicable to an eligible professional's practice and it's possible that other closely related measures or measures in that same cluster might also be applicable.

For those E.P.s who satisfactorily submit quality measures for nine PQRS measures for only one or two domains, we will make a determination if additional measures with additional domains may also be applicable to the E.P. based on the clinical cluster to earn the 2014 PQRS incentive. The minimum threshold test is based on the concept that during the 2014 reporting period, if an E.P. treated more than a certain number of Medicare patients with a condition to which a certain measure applied -- so that is, if an eligible professional treated more than a threshold number of patients or encounters, then that E.P. should be accountable for submitting quality data for that measure. The common minimum threshold, based on statistical and clinical frequency considerations will not be less than 15 patients or encounters for the 12-month reporting period for each of the 2014 PQRS measures.

I also want to briefly mention some of the data that will be going onto the physician compare website in 2014. In 2014 for groups regardless of size, if they are participating in the GPRO web interface, all the measures that are collected through the interface will be posted on the physician compare website. Additionally, we are going to publically report the CG CAPs measures for large groups of 100 or more E.P.s who are participating in the PQRS GPRO regardless of the method that they are submitting their data. Also, we are going to be reporting a subset of the 2012 PQRS GPRO and accountable care organizations, diabetes and coronary artery disease-related measures in early 2014, and then later on in the year we're going to publically report a subset of the 2013 PQRS GPRO and ACO measures that related to diabetes and coronary artery disease.

Before we wrap up, we want to make sure that providers and groups know how they can access their quality and resource use reports, or QRURs. If you're not familiar with the QRUR reports, think of it as your quality report card. These are annual reports that are generated by CMS that give groups of physicians a lot of information, including comparative information about the quality of care and the cost of that care that they are furnishing to their Medicare fee-for-service beneficiaries. It also gives beneficiary-specific information that helps providers to coordinate and improve the quality and the efficiency of the care they are providing. And it also gives the group information specifically about how they would fare under the value-based payment modifier and we'll go into detail with the value-based payment modifier in another presentation. The 2012 QRURs have been produced and they've been made available to all groups of physicians who have 25 or more E.P.s within the group. CMS expects by late summer or early fall of 2014 to produce these reports for groups of all sizes and also for all solo practitioners.

The next few slides give you a quick rundown of how you can actually access and download the reports and then we'll also give you an example of what a page of the report looks like. The reports are found in the CMS portal which you can find at the website listed here: <https://portal.cms.gov>. You are then going to log into the portal using your IACS user I.D. and password. And if you do not have a user I.D. or if you forgot your password, you can go to the IACS website in order to reregister. Once in, you are going to click the PVPQRS tab. A dropdown menu will appear and you will select QRUR dash Reports. After you select "QRUR-Reports," you are then going to be asked to complete your role attestations. So basically how you plan to use the data. And then in step five, you're going to navigate to the folders report. You will see "Access Your QRUR" which is the general report and then you'll also see the opportunity to access drilldown reports. These drilldown reports are the individual eligible professional performance reports that are on the right-hand side.

Now, you may have to select your medical group practice if your IACS account is associated with multiple TIN numbers. If you do have multiple TIN numbers for step number six, you will get a list of all the groups that the physicians are tied to. You want to click on the group of physicians that you want. You will move over to the right-hand side of the screen and in the bottom, left-hand corner you hit "Run Report" and then you'll actually get your report generated for you. Step seven and eight show how you can export both the QRUR report and the drilldown reports. The QRUR report generally is downloaded as a PDF file. The drilldown reports can be downloaded as Excel files in case you need to do any type of internal data manipulation or reconfiguration on the reports.

So, once you have accessed and downloaded and exported your report, how will you use the QRUR? You can do it for a number of things. You can verify that Medicare did it right in terms of identifying which eligible professional is actually billed under the group's TIN. You can see how the group would have fared under the value modifier. You can look to see the number of beneficiaries and who they are and you can also get the identity of the beneficiaries that have been attributed to your group. You will be able to understand your performance on the cost and quality measures and how they compare to other groups, and that will make more sense when we talk more in-depth of the value modifier. You can understand which attributed beneficiaries are driving your cost measures and who may be in greater need of care coordination. And you can also see which beneficiaries are driving your group's performance on the three hospital-related care coordination outcome measures that we prepare for every group and again, they are specifically related to the value-based payment modifier. We would strongly encourage all physicians and group practices when they become available to access your QRUR report.

This slide shows the performance highlights page from a 2012 report and here you can see the group's quality and cost composite scores, the group's beneficiary's average risk score, the graph that shows where the group's performance stands in relation to all other groups of 25 or more E.P.s and then you can also determine on this graph where an adjustment would have been made or if an adjustment would have been made to the group's payment based on quality tiering for the value modifier.

And then with that look at how to access your QRUR reports, that will conclude our presentation. Thank you for viewing this MLN Connects video on the PQRS program. This MLN Connects video is part of the Medicare Learning Network. The information in this presentation was correct as of the date it was recorded. This presentation is not a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

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