eHealthUniversity
CENTERS FOR MEDICARE & MEDICAID SERVICES

QUALITY

02 INTERMEDIATE

PQRS Training Module:

2014 PQRS REPORTING REQUIREMENTS

Last Updated: September 2014

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

TRAINING MODULE OBJECTIVES

2014 PQRS Reporting Requirements is a training module for providers who understand the basics of the Physician Quality Reporting System, or PQRS, and are interested in learning how they can satisfactorily report and earn an incentive for the 2014 PQRS program. The module will also explain how they can avoid the PQRS 2016 payment adjustment and how group practices can avoid the 2016 Value Modifier.

DISCLAIMER

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.

NOTE:

Please note, although CMS has attempted to align or adopt similar reporting requirements across programs, eligible professionals should look to the respective quality programs to ensure they satisfy the requirements of each of these programs.

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Tip: *A definition of terms can be found at the back of the presentation*

REPORTING BASICS

Getting Started with 2014 PQRS Reporting

Before beginning to report, you should:

- [x] Determine eligibility to participate for purposes of the 2014 PQRS incentive payment and 2016 payment adjustment.
  - [ ] A list of **eligible professionals** for PQRS is available on CMS.gov/PQRS.
- [x] Determine which PQRS reporting method is best for you.
- [x] Select measures to report to CMS (unless reporting using the Web Interface, in which case all measures are required).

PQRS Reporting: Individuals

To participate in the 2014 PQRS program as an individual eligible professional, you may choose to report quality information to CMS through one of the following methods:

1. Claims
2. Qualified Registry
3. Qualified Clinical Data Registry (QCDR)
4. Direct electronic health record (EHR) using certified EHR technology (CEHRT)
5. CEHRT via data submission vendor

You should consider which PQRS reporting method best fits your practice when making this decision.

PQRS Reporting: Groups

To participate in the 2014 PQRS program as a group practice, you may choose to report quality information to CMS through one of the following methods:

Groups of 2 or more can report using:

1. Qualified registry
2. Directly from EHR using CEHRT
3. CEHRT using data submission vendor

Groups of 25 or more can also report using:

4. Web interface
5. CAHPS for PQRS

- Elective, in addition to selection of one of the previous reporting options, for groups of 25-99 eligible professionals and groups of 100+ reporting via registry or EHR
- Required for groups of 100+ reporting via GPRO web interface
- CMS will partner with a certified survey vendor and pay for the survey to be disseminated on groups' behalf for 2014

2014 Measure Count by Reporting Method

Measures that you can report vary by reporting method:

Reporting Method	2014 Total Measure Count
Claims Measures	**110**
Registry Measures	**201**
Measures Groups	**25**
EHR Measures	**64**
GPRO Web Interface Measures	**22** **(Includes subcomponents of composite measures)**
Certified Survey Vendor	**CAHPS for PQRS** **(12 Summary Survey Modules)**

All reporting methods require a 12-month reporting period (January 1- December 31, 2014).

Basics of Reporting

Most PQRS reporting options for 2014 require 9 measures covering at least 3 NQS domains for 2014 incentive purposes:

1. **1.** Patient Safety
2. **2.** Person and Caregiver-Centered Experience and Outcomes
3. **3.** Communication and Care Coordination
4. **4.** Effective Clinical Care
5. **5.** Community/Population Health
6. **6.** Efficiency and Cost Reduction

NOTE:

Group practices electing to report via the GPRO Web Interface have different reporting requirements. They must report all 22 Web Interface measures in order to be eligible for the 2014 PQRS incentive payment and to avoid the 2016 PQRS payment adjustment.

These same domains apply to clinical quality measures in the EHR Incentive Programs.

REPORTING OPTIONS FOR SATISFACTORILY REPORTING:

Individuals

Claims-Based Reporting

Steps for Claims-Based Reporting

1. Decide which individual measures to report.
2. Establish an office workflow.

   Allows each chosen measure's denominator-eligible patient to be accurately identified on the Medicare Part B claim.
3. Start reporting.

- This reporting option is available for individual eligible professionals **only.** It is not available to group practices.
- Not all individual measures are available via claims-based reporting.
- Guidance on how to implement measures reporting to satisfactorily meet reporting criteria is available on the **CMS website**.

  A sample CMS-1500 form is also available to assist eligible professionals in reporting individual measures via claims.

Claims-Based Reporting Requirements

- Report at least **9 measures** covering at least **3** of the NQS domains.

AND

- Report each measure for at least **50%** of your Medicare Part B Fee-For-Service (FFS) patients seen during the reporting period to which the measure applies.

NOTE:

Measures with a 0% performance rate will not be counted.

Start Reporting

Start reporting the quality-data codes (QDCs) listed in the **individual measures** selected on applicable Medicare Part B claims.

Helpful tips to aid in the reporting process:

- Report the QDC on each eligible claim that falls into the denominator. Failure to submit a QDC on claims for these Medicare patients will result in a "missed" reporting opportunity that can impact incentive eligibility.
- Avoid including multiple dates of service and/or multiple rendering providers on the same claim.
- For measures that require more than one QDC, please ensure that all codes are captured on the claim.

All claims adjustments, re-openings, or appeals processed by the Carrier or A/B MAC must reach the national Medicare claims system data warehouse (National Claims History [NCH] file) **by February 27, 2015** to be included in the 2014 PQRS analysis.

MAV Process Overview for Claims Reporting

If you satisfactorily submit quality data for fewer than 9 PQRS measures and/or fewer than 3 domains by the claims reporting method, CMS will apply the measure-applicability validation (MAV) process to determine whether you are eligible for an incentive.

» Through the MAV process, CMS determines whether you could have submitted additional measures or additional measures with additional domains.

NOTE:

When fewer than 9 measures and/or fewer than 3 domains are available for reporting, report on all applicable measures and all applicable domains for at least 50% of eligible patient visits.

Registry Reporting

Steps for Registry Reporting: Individuals

1. Decide whether to report **individual measures** or **measures groups**.
2. Choose a PQRS qualified **registry**.
3. Report for the 2014 calendar year.
4. Work directly with a registry to **submit 2014 PQRS data**.

- This reporting option is available for both individual eligible professionals and group practices of 2 or more eligible professionals.
- Individual eligible professionals also have the option of reporting individual measures or measures groups.

Registry Reporting Requirements

Reporting requirements depend on whether you have chosen to report individual measures or measures groups:

» Report on at least **9** measures covering **3** NQS domains for at least **50%** of your Medicare Part B FFS patients.

OR

» Report at least **1** measures group on a **20**-patient sample, a majority of which (at least 11 out of 20) must be Medicare Part B FFS patients.

Working with the Registry

- The registry will provide specific instructions on how and when to submit data for the selected measures or measures group chosen to report.
- Work directly with the registry to ensure data is submitted appropriately for incentive purposes.
- The 2014 PQRS data submission window will be in the first quarter of 2015, with data due by **March 31, 2015**.

MAV Process Overview for Registry Reporting

If you satisfactorily submit quality data for fewer than 9 PQRS measures and/or fewer than 3 domains by the registry reporting method, CMS will apply the measure-applicability validation (MAV) process to determine whether you are eligible for an incentive.

» Through the MAV process, CMS determines whether you could have submitted additional measures or additional measures with additional domains.

NOTE:

When fewer than 9 measures and/or fewer than 3 domains are available for reporting, report on all applicable measures and all applicable domains for at least 50% of eligible patient visits.

Qualified Clinical Data Registries (QCDRs) Reporting

Steps for QCDR Reporting

1. Choose a QCDR from the **list** of CMS-designated QCDRs.
2. Report for the 2014 calendar year.
3. Work directly with the QCDR to submit your PQRS data (via a CMS-approved XML format) by **March 31, 2015.***

This is a new reporting option that is available for individual eligible professionals only.

A QCDR is a **CMS-approved entity** that:

- Collects medical and/or clinical data for the purposes of patient and disease tracking
- Has self-nominated and successfully completed a qualification process
- Fosters quality improvement

A QCDR is different from a qualified registry in that it is not limited to measures within PQRS.

**February 28, 2015* is the deadline to submit PQRS data via QRDA category III. Eligible professionals who would like to report once for Medicare EHR Incentive Program CQM credit must meet that submission deadline.*

QCDR Reporting Requirements

- Report on a minimum of **9** measures covering **3** NQS domains for at least **50%** of your applicable patients seen during the 2014 participation period.

- At least **1** of the **9** measures submitted must be an outcome measure (containing denominator data fulfilling both exceptions and exclusions, as well as numerator data).

Working with the QCDR

- The QCDR will provide specific instructions on how to collect and provide patient data for use by the QCDR.
- Work directly with the QCDR to ensure data is submitted appropriately for PQRS incentive and avoidance of payment adjustment purposes.
- The QCDR will submit 2014 data by **March 31, 2015.***

* ***February 28, 2015*** *is the deadline to submit PQRS data via QRDA category III. Eligible professionals who would like to report once for Medicare EHR Incentive Program CQM credit must meet that submission deadline.*

EHR-Based Reporting

This reporting option is available for both individual eligible professionals and group practices.

There are two EHR-based reporting options:

- Submit PQRS quality measure data directly from your CEHRT.
- Submit PQRS quality measure data extracted from your CEHRT to a qualified Data Submission Vendor.

If using EHRs for PQRS participation, you must ensure you are using 2014 CEHRT, in accordance with the Medicare and Medicaid EHR Incentive Programs **Certified Health IT Product List**.

Steps for Reporting using Direct Submission from your CEHRT

1. Determine which June 2013 eCQMs apply to your practice. (Exception: CMS140 uses the December 2012 version)
2. Choose an ONC-Certified EHR Product.
    - Direct EHR product must be certified to the specified June 2013 eCQM versions.
3. Document all patient care and visit-related information in your EHR system for the 2014 calendar year.
4. Register for an Individuals Authorized Access to CMS Computer Services (IACS) account to upload your files.
5. Work with your EHR vendor to create the required reporting files from your EHR system so they can be uploaded through the Portal using IACS.
    - If you are using CEHRT, it should already be programmed to generate these files.
6. Participate in testing.
7. Ensure data submission by **February 28, 2015**.

Steps for Reporting using EHR Data Submission Vendor

1. Determine which June 2013 eCQMs apply to your practice. (Exception: CMS140 uses the December 2012 version)

2. Choose an ONC-Certified EHR Product.

    - EHR Data Submission Vendor must be certified to the specified eCQM versions.

3. Document all patient care and visit-related information in your EHR system for the 2014 calendar year.

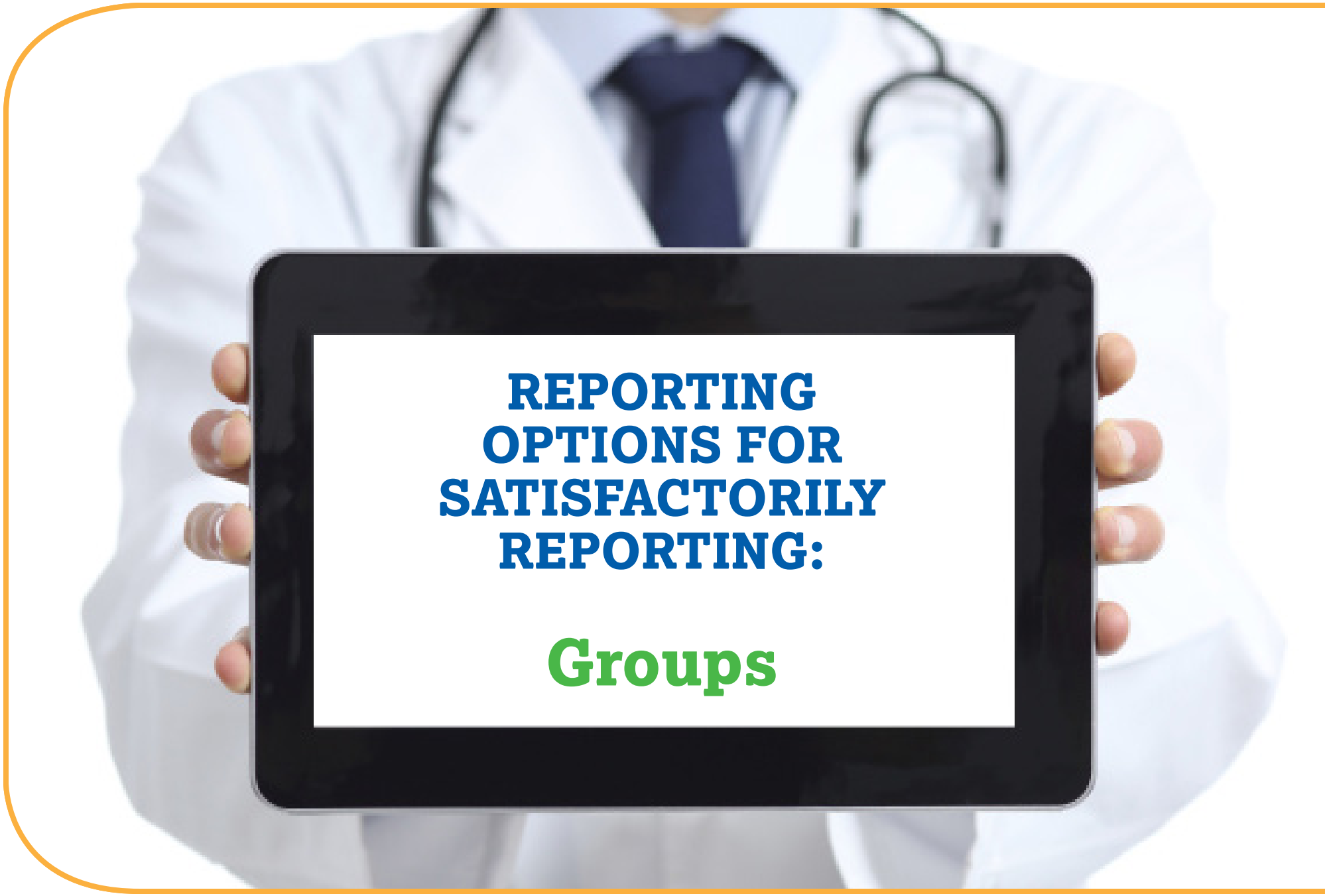
4. Participate in testing.

5. Ensure data submission by **February 28, 2015**.

EHR-Based Reporting Requirements

Report on at least **9** measures covering **3** NQS domains.

If your CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then report the measures for which there is Medicare patient data. You must report on at least **1** measure for which there is Medicare patient data.



REPORTING OPTIONS FOR SATISFACTORILY REPORTING:

Groups

Register to Participate in PQRS as a Group Practice

- If you wish to participate in the 2014 PQRS program as a group practice (for groups of two or more eligible professionals), you must first **register** for the **group practice reporting option (GPRO)**.

Registration is not required for individual reporting.

- Register by accessing the PV-PQRS Registration System at **https://portal.cms.gov**.

Valid IACS User ID and password are required to choose your group's reporting mechanism.

- The registration system is open **until September 30** for the 2014 PQRS program.

- For more information on registration, please see the **2014 Group Practice Registration in the PV-PQRS Registration System** guide or the **Self Nomination/Registration** page on the **CMS website**.

NOTE:

Group practices participating in GPRO are analyzed at the Tax Identification Number (TIN) level; therefore, all providers (NPIs) billing under the group's TIN will be taken into account for the 2014 PQRS analysis.

Registry Reporting

Steps for Registry Reporting: Group

1. Choose PQRS qualified **registry.**
2. Report for the 2014 calendar year.
3. Work directly with a registry to **submit 2014 PQRS data**.

- This reporting option is available for both individual eligible professionals and group practices of 2 or more eligible professionals.
- Groups of 25 or more eligible professionals have the option to supplement their registry-based reporting with CAHPS for PQRS survey.

Registry Reporting Requirements for Group Practices

Report on at least **9** measures covering **3** NQS domains for at least **50%** of your group's Medicare Part B FFS patients.

MAV Process Overview for Registry Reporting

If your group satisfactorily submits quality data for fewer than 9 PQRS measures and/or fewer than 3 domains by registry reporting method, CMS will apply the measure-applicability validation (MAV) process to determine whether you are eligible for an incentive.

Through the MAV process, CMS determines whether you could have submitted additional measures or additional measures with additional domains.

NOTE:

When fewer than 9 measures and/or fewer than 3 domains are available for reporting, report on all applicable measures and all applicable domains for at least 50% of your group's eligible patient visits.

Registry with CAHPS for PQRS Reporting Requirements for Group Practices of 25 or More

To supplement your PQRS registry reporting with the CAHPS for PQRS survey, report the following:

- Patients report all **12** CAHPS for PQRS summary survey modules via a CMS-certified survey vendor (CMS will bear the cost of administering this optional survey).

AND

- Report at least **6** measures covering at least **2** of the NQS domains using a qualified registry.

Groups of 25 or More: CMS-Certified Survey Vendors and CAHPS for PQRS

CMS-certified survey vendor is a new supplemental reporting mechanism available to group practices in 2014 reporting through the EHR-based, registry, and Web Interface reporting methods.

This method is available to group practices of 25 or more eligible professionals wishing to report the CAHPS for PQRS survey.

- It is required for groups of 100 or more eligible professionals that choose to report using the Web Interface

The CMS-certified survey vendor will administer and collect all 12 summary survey modules on behalf of the group practice's patients. The results of which may subsequently be posted on the CMS Physician Compare website.

CMS has selected the CMS-Certified Survey Vendor for CAHPS for PQRS for the 2014 performance year on behalf of group practices. Group practices will not need to contact the CMS-certified survey vendor directly to participate in CAHPS for PQRS.

Once CAHPS for PQRS has been identified as a valid option for a group practice to report, CMS will work with the certified survey vendor on survey implementation.

CAHPS for PQRS: Summary Survey Modules

CAHPS for PQRS includes the following survey modules:

- Getting Timely Care, Appointments, and Information
- How Well Providers Communicate
- Patient's Rating of Provider
- Access to Specialists
- Health Promotion & Education
- Shared Decision Making
- Health Status/Functional Status
- Courteous and Helpful Office Staff
- Care Coordination
- Between Visit Communication
- Helping You to Take Medication as Directed
- Stewardship of Patient Resources

Reference **http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/CMS-Certified-Survey-Vendor.html** for more information on the CAHPS for PQRS.

Working with the Registry

- The registry will provide specific instructions on how and when to submit data for the selected measures or measures group chosen to report.
- Work directly with the registry to ensure data is submitted appropriately for incentive purposes.
- The 2014 PQRS data submission window will be in the first quarter of 2015, with data due by **March 31, 2015.**

EHR-Based Reporting

This reporting option is available for both individual eligible professionals and group practices of 2 or more eligible professionals.

There are two EHR-based reporting options:

- Submit PQRS quality measure data directly from your CEHRT.
- Submit PQRS quality measure data extracted from your CEHRT to a qualified Data Submission Vendor.

If using EHRs for PQRS participation, you must ensure you are using 2014 CEHRT, in accordance with the Medicare and Medicaid EHR Incentive Programs **Certified Health IT Product List**.

NOTE:

Groups of 25 or more eligible professionals have the option to supplement their EHR-based reporting with CAHPS for PQRS survey.

Steps for Reporting using Direct Submission from your CEHRT

1. Determine which June 2013 eCQMs apply to your practice. (Exception: CMS140 uses the December 2012 version)
2. Choose an ONC-Certified EHR Product.
    - Direct EHR product must be certified to the specified eCOM versions.
3. Document all patient care and visit-related information in your EHR system for the 2014 calendar year.
4. Register for an Individuals Authorized Access to CMS Computer Services (IACS) account to upload your files.
5. Work with your EHR vendor to create the required reporting files from your EHR system so they can be uploaded through the Portal using IACS.
    - If you are using CEHRT, it should already be programmed to generate these files.
6. Participate in testing.
7. Ensure data submission by **February 28, 2015**.

Steps for Reporting using EHR Data Submission Vendor

1. Determine which June 2013 eCQMs apply to your practice. (Exception: CMS140 uses the December 2012 version)

2. Choose an ONC-Certified EHR Product.

    - EHR Data Submission Vendor must be certified to the specified eCQM versions.

3. Document all patient care and visit-related information in your EHR system for the 2014 calendar year.

4. Participate in testing.

5. Ensure data submission by **February 28, 2015**.

EHR-Based Reporting Requirements

» Report on at least **9** measures covering **3** NQS domains.

» If your group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then report the measures for which there is Medicare patient data. Your group practice must report on at least **1** measure for which there is Medicare patient data.

EHR-Based Reporting with CAHPS for PQRS Requirements for Group Practices of 25 or More

To supplement your PQRS EHR-based reporting with the CAHPS for PQRS survey, report the following:

- Patients report all **12** CAHPS for PQRS summary survey modules via a CMS-certified survey vendor (CMS will bear the cost of administering this optional survey).

AND

- Report at least **6** measures covering at least **2** of the NQS domains using a CEHRT direct product or a CEHRT data submission vendor.

Groups of 25 or More: CMS-Certified Survey Vendors and CAHPS for PQRS

CMS-certified survey vendor is a new supplemental reporting mechanism available to group practices in 2014 reporting through the EHR-based, registry, and Web Interface reporting methods.

- This method is available to group practices of 25 or more eligible professionals wishing to report the CAHPS for PQRS survey.
  - It is required for groups of 100 or more eligible professionals that choose to report using the Web Interface
- The CMS-certified survey vendor will administer and collect all 12 summary survey modules on behalf of the group practice's patients. The results of which may subsequently be posted on the CMS Physician Compare website.
- CMS has selected the CMS-Certified Survey Vendor for CAHPS for PQRS for the 2014 performance year on behalf of group practices. Group practices will not need to contact the CMS-certified survey vendor directly to participate in CAHPS for PQRS.
- Once CAHPS for PQRS has been identified as a valid option for a group practice to report, CMS will work with the certified survey vendor on survey implementation.

CAHPS for PQRS: Summary Survey Modules

CAHPS for PQRS includes the following survey modules:

- Getting Timely Care, Appointments, and Information
- How Well Providers Communicate
- Patient's Rating of Provider
- Access to Specialists
- Health Promotion & Education
- Shared Decision Making
- Health Status/Functional Status
- Courteous and Helpful Office Staff
- Care Coordination
- Between Visit Communication
- Helping You to Take Medication as Directed
- Stewardship of Patient Resources

Reference **http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/CMS-Certified-Survey-Vendor.html** for more information on the CAHPS for PQRS.

Web Interface Reporting

Steps for Web Interface Reporting

1. Report for the 2014 calendar year.
2. Submit data to CMS in first quarter of 2015.

- This reporting option is only available to group practices of 25 or more eligible professionals.
- Groups of 25-99 eligible professionals have the option to supplement their Web Interface reporting with CAHPS for PQRS survey.
- Groups of 100 or more eligible professionals that choose to report using the Web Interface reporting method are required to also submit CAHPS for PQRS survey.

Web Interface Reporting Requirements for Groups of 25-99

- Report on all measures included in the Web Interface.

AND

- Populate data fields for the first **218** consecutively ranked and assigned beneficiaries in the order in which they appear in your group's sample for each module or preventive care measure.

  - *If the pool of eligible assigned beneficiaries is less than 218, then report on 100% of assigned beneficiaries.*

Web Interface with CAHPS for PQRS Reporting Requirements for Groups of 25-99 (Optional)

Report on all measures included in the Web Interface.

AND

Populate data fields for the first **218** consecutively ranked and assigned beneficiaries in the order in which they appear in your group's sample for each module or preventive care measure.

- *If the pool of eligible assigned beneficiaries is less than 218, then report on **100%** of assigned beneficiaries*

AND

Report all CAHPS summary survey modules via a CMS-certified survey vendor (CAHPS for PQRS).

- *CMS will bear the cost of administering.*

Web Interface with CAHPS for PQRS Reporting Requirements for Groups of 100+ (Required)

Report on all measures included in the Web Interface.

AND

Populate data fields for the first **411** consecutively ranked and assigned beneficiaries in the order in which they appear in your group's sample for each module or preventive care measure.

- *If the pool of eligible assigned beneficiaries is less than 411, then report on **100%** of assigned beneficiaries*

AND

Report all CAHPS summary survey modules via a CMS-certified survey vendor (CAHPS for PQRS).

- *CMS will bear the cost of administering.*

Groups of 25 or More: CMS-Certified Survey Vendors and CAHPS for PQRS

CMS-certified survey vendor is a new supplemental reporting mechanism available to group practices in 2014 reporting through the EHR-based, registry, and Web Interface reporting methods.

This method is available to group practices of 25 or more eligible professionals wishing to report the CAHPS for PQRS survey.

- It is required for groups of 100 or more eligible professionals that choose to report using the Web Interface

The CMS-certified survey vendor will administer and collect all 12 summary survey modules on behalf of the group practice's patients. The results of which may subsequently be posted on the CMS Physician Compare website.

CMS has selected the CMS-Certified Survey Vendor for CAHPS for PQRS for the 2014 performance year on behalf of group practices. Group practices will not need to contact the CMS-certified survey vendor directly to participate in CAHPS for PQRS.

Once CAHPS for PQRS has been identified as a valid option for a group practice to report, CMS will work with the certified survey vendor on survey implementation.

CAHPS for PQRS: Summary Survey Modules

CAHPS for PQRS includes the following survey modules:

- Getting Timely Care, Appointments, and Information
- How Well Providers Communicate
- Patient's Rating of Provider
- Access to Specialists
- Health Promotion & Education
- Shared Decision Making
- Health Status/Functional Status
- Courteous and Helpful Office Staff
- Care Coordination
- Between Visit Communication
- Helping You to Take Medication as Directed
- Stewardship of Patient Resources

Reference **http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/CMS-Certified-Survey-Vendor.html** for more information on the CAHPS for PQRS.

OPTIONS FOR AVOIDING 2016 PAYMENT ADJUSTMENTS

Avoiding PQRS Payment Adjustments in 2016: Individuals

- Individuals avoid adjustment by satisfactorily reporting for the incentive.

OR

- Report at least **3** measures covering **1** NQS domain for at least **50%** of Medicare Part B FFS patients via claims or qualified registry.

OR

- Participate via a QCDR that selects measures for you; at least **3** measures covering **1** NQS domain for at least **50%** of applicable patients.

Avoiding PQRS Payment Adjustments in 2016: Groups

Groups avoid adjustment by satisfactorily reporting for the incentive.

OR

Report at least **3** measures covering **1** NQS domain for at least **50%** of your group practice's Medicare Part B FFS patients via qualified registry.

- *If your group reports through the Web Interface, you must report on all 22 Web Interface measures in order to avoid the payment adjustment.*

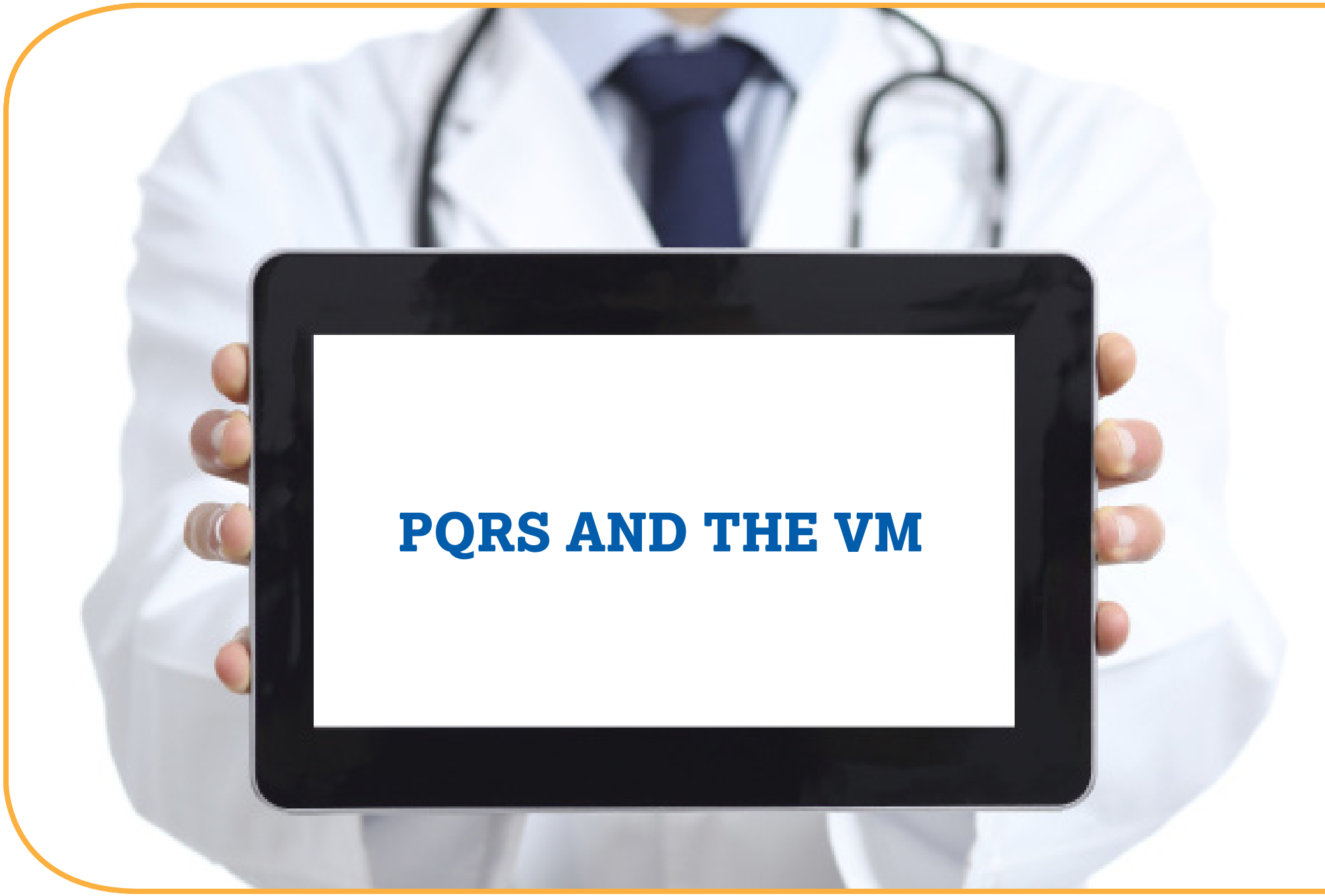
MAV Process Overview for Claims and Registry Reporting

If you or your group satisfactorily submits quality data for fewer than 9 PQRS measures and/or fewer than 3 domains by the claims (for individuals only) and registry reporting (for individuals and group practices) methods, CMS will apply the measure-applicability validation (MAV) process to determine whether you are eligible for an incentive.

Through the MAV process, CMS determines whether you or your group should have submitted additional measures or additional measures with additional domains.

NOTE:

When fewer than 9 measures and/or fewer than 3 domains are available for reporting, report on all applicable measures and all applicable domains for at least 50% of eligible patient visits.



PQRS AND THE VM

What is the Value Modifier?

- Value-Based Payment Modifier (VM) assesses both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule (PFS).

- The VM is a per-claim adjustment under the Medicare PFS that is applied at the group (Taxpayer Identification Number or TIN) level and varies by calendar year.

NOTE:

The 2016 VM does ***not*** apply to groups of physicians in which any of the group's physicians participate in the Shared Saving Program, Pioneer ACO, or the Comprehensive Primary Care initiative.

VM and PQRS

- VM is based on participation in PQRS.
- Groups of physicians with 10 or more eligible professionals must use the PQRS reporting mechanisms available to them in 2014 for purposes of the 2016 VM.
  - For the 2016 VM, if you are in a group of 10–99, you are subject to an upward or neutral payment adjustment.
  - For the 2016 VM, if you are in a group of 100 or more, you are subject to receive an upward, neutral, or downward payment adjustment.
- The VM downward adjustment is separate from the PQRS payment adjustment, and payment adjustments from other Medicare sponsored programs.
- Group practices that have elected or are required to report the CAHPS for PQRS survey may choose, and the group can elect to include their performance on the 2014 CAHPS for PQRS survey in the calculation of the group's 2016 VM.

NOTE:

CMS urges solo practitioners and physicians in smaller groups to participate in PQRS now because the VM will apply to all physicians in 2017.

Reporting Quality Data at the Individual Level - 50% Threshold Option

Groups who do not seek to report as a group must ensure at least 50% of the eligible professionals in their group successfully report in order to avoid the automatic VM downward adjustment and to be eligible for VM upward adjustments.

Eligible professionals may report on measures available to individual eligible professionals via the following reporting mechanisms:

1. Claims
2. Qualified Registries
3. EHR
4. QCDRs

NOTE:

The TIN (group) does ***not*** have to register for this option.

VM Schedule

VM adjustments are applied two years after the PQRS reporting period:

Calendar Year 2015:

CMS will apply the VM to groups of physicians with 100 or more eligible professionals based on 2013 PQRS performance.

Calendar Year 2016:

CMS will apply the VM to groups of physicians with 10 or more eligible professionals based on 2014 PQRS performance.

Calendar Year 2017:

CMS is required to apply the VM to all physicians and groups of physicians.

Will My Group Be Subject to 2016 VM?

For 2014 program year, groups of physicians with 10+ EPs

Participate in PQRS (2 Options)

Option 1: Report via 2014 GPRO – Register for GPRO Web Interface, qualified registry, or EHR reporting **and** meet the criteria to avoid the 2016 PQRS payment adjustment

Option 2: Report as an Individual EP for 2014 PQRS – At least 50% of EPs under TIN meet the criteria to avoid the PQRS 2016 payment adjustment

Mandatory Quality Tiering

Groups of physicians with 10-99 EPs

Upward or neutral 2016 VM adjustment based on quality tiering

Groups of physicians with 100+ EPs

Upward, neutral, or downward 2016 VM adjustment based on quality tiering

Do NOT Participate in PQRS

Do **not** register to participate in the 2014 GPRO and at least 50% of EPs under TIN **do not** meet the criteria to avoid the PQRS 2016 payment adjustment

Groups of physicians with 10+ EPs

-2.0%
(Automatic 2016 VM downward adjustment)

NOTE:
The VM download adjustment is separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs.

What Should a Physician Group Do in 2014 for the 2016 VM?

- [x] Decide whether and how to participate in PQRS for 2014.
  - [ ] Group reporting- If group reporting, register between April 1, 2014 - September 30, 2014: **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html**
  - [ ] Individual Reporting – No registration necessary
- [x] Decide which PQRS measures to report and understand the measure specifications.
  - [ ] Review quality measure benchmarks: **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html**
- [x] Obtain your Quality and Resource Use Report – Available Fall 2014.


QUALITY RESOURCES

Help Desks

QualityNet Help Desk:

866-288-8912 (TTY 877-715-6222)
7:00 a.m.–7:00 p.m. CT M-F or
qnetsupport@hcqis.org

- Portal password issues
- PQRS/eRx feedback report availability and access
- IACS registration questions
- IACS login issues
- PQRS and eRx Incentive Program questions

NOTE:

You will be asked to provide basic information such as name, practice, address, phone, and e-mail.

CMS-Certified Survey Contact Information:

pqrscahps@hcqis.org

EHR Incentive Program Information Center:

888-734-6433 (TTY 888-734-6563)

VM Help Desk:

1-888-734-6433 or
pvhelpdesk@cms.hhs.gov

ACO Help Desk:

1-888-734-6433 or
cmsaco@cms.hhs.gov

Resources

- **PFS Federal Regulation Notices**
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html
- **CMS PQRS Website**
  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS
- **Medicare Shared Savings Program**
  http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html
- **CMS Value-based Payment Modifier (VM) Website**
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html
- **Medicare and Medicaid EHR Incentive Programs**
  http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms
- **Frequently Asked Questions (FAQs)**
  https://questions.cms.gov/
- **Physician Compare**
  http://www.medicare.gov/physiciancompare/search.html

Definition of Terms

PQRS – Physician Quality Reporting System

CQM – Clinical Quality Measure

EHR – Electronic Health Record

ACO – Accountable Care Organization

VM – Value-Based Payment Modifier

GPRO – Group Practice Reporting Option

NQS – National Quality Strategy

CEHRT – Certified Electronic Health Record Technology

QCDR – Qualified Clinical Data Registry

QMAT – Quality Measure Assessment Tool

TIN – Tax Identification Number

QRDA – Quality Reporting Document Architecture

CAHPS – Consumer Assessment of Healthcare Providers and Systems