March 2014

2014 Physician Quality Reporting System (PQRS): 2016 PQRS Payment Adjustment

Background

The Physician Quality Reporting System (PQRS) is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs) and group practices. The program provides an incentive payment to practices with EPs (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN]) who successfully report clinical quality data for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer).

Section 1848(a)(8) of the Social Security Act, requires the Centers for Medicare & Medicaid Services (CMS) to subject EPs and group practices who do not report data on PQRS quality measures to a payment adjustment in 2016. EPs and group practices receiving a PQRS payment adjustment in 2016 will be paid 2.0% less than the PFS amount for services rendered January 1-December 31, 2016 (or receive 98% of his/her allowed Medicare Part B PFS amount for covered professional services that would otherwise apply to such services). The reporting period for the 2016 PQRS payment adjustment is the 2014 program year.

Purpose

This article provides information on the 2016 PQRS payment adjustment and guidance on how individual EPs and group practices can avoid the 2016 PQRS payment adjustment. Information provided in this article is based on the 2014 Medicare PFS Final Rule.

This article focuses only on the **PQRS payment adjustment** and does not provide guidance for Value-Based Payment Modifier upward adjustment or payment adjustments from other Medicare-sponsored programs.

If reporting for PQRS through another CMS program (such as the Medicare Shared Savings Program, Comprehensive Primary Care Initiative, Pioneer Accountable Care Organizations), please check the program's requirements for information on how to report quality data to earn a PQRS incentive and/or avoid the PQRS payment adjustment. Please note, although CMS has attempted to align or adopt similar reporting requirements across programs, eligible professionals should look to the respective quality program to ensure they satisfy the PQRS, EHR Incentive Program, Value-Based Payment Modifier (VBM), etc. requirements of each of these programs.

See the Additional Information section below for links to the CMS Value-Based Payment Modifier website, and the Medicare and Medicaid EHR Incentive Program website.

2016 PQRS Payment Adjustment Eligibility

Those providers considered eligible and able to participate in PQRS as outlined on the CMS PQRS website could be subject to the 2016 PQRS payment adjustment. EPs working for more than one organization need to meet the reporting criteria for each tax identification number (TIN) under which (s)he works during the 2014 PQRS program year to avoid the 2016 PQRS payment adjustment for each TIN.

Those groups who self-nominate or register to participate in PQRS as a group through the group practice reporting option (GPRO) will be analyzed at the TIN level; therefore, all providers under that TIN who bill Medicare Part B PFS will be included in analysis for purposes of the 2016 PQRS payment adjustment.

Exclusion Criteria for Individual EPs

Individual EPs (regardless of participation in other CMS incentive programs) will **avoid** the 2016 PQRS payment adjustment if ***at least one*** of the payment adjustment criteria (listed in Table 1) is met during the 2014 PQRS program year of **January 1-December 31, 2014**. A decision tree for avoiding the 2016 PQRS payment adjustment is available in Appendix 1.

Table 1: Individual EP Criteria for Avoiding the 2016 PQRS Payment Adjustment

Individual Eligible Professionals
Criteria 1: Meet the requirements to satisfactorily report or satisfactorily participate for incentive eligibility (same criteria as 2014 PQRS incentive eligibility as shown in Appendix 3).
Criteria 2a: Report at least **3 measures covering 1 NQS domain** for **at least 50 percent** of the EP's Medicare Part B FFS patients via claims or qualified registry. **Note:** An EP that reports fewer than 3 measures covering at least 1 NQS domain via claims or qualified registry reporting will be subject to the **Measure-Applicability Validation (MAV)** process, which will allow CMS to determine whether additional measures should have been reported. **Criteria 2b:** Participate via a qualified clinical data registry (QCDR) that selects measures for the EP, of which at least **3 measures covering a minimum of 1 NQS domain AND** submission of **at least 50 percent** of the EP's applicable patients.

Note: CMS will determine whether an individual EP (defined by individual rendering National Provider Identifier, or NPI) is subject to the 2016 PQRS payment adjustment for each TIN; therefore, if an EP changes TINs, the participation under the old TIN does not carry over to the new TIN, nor is it combined for final analysis.

Exclusion Criteria for Registered Groups (PQRS GPRO)

Group practices participating in PQRS GPRO will **avoid** the 2016 PQRS payment adjustment if ***at least one*** of the payment adjustment criteria (listed in Table 2) is met during the 2014 PQRS program year of **January 1-December 31, 2014**. A decision tree for avoiding the 2016 PQRS payment adjustment is available in Appendix 2.

Table 2: 2014 Registered Groups - Criteria for Avoiding the 2016 PQRS Payment Adjustment

Registered Groups (PQRS GPRO)
Criteria 1: Meet the requirements for satisfactorily reporting for incentive eligibility (same criteria as 2014 PQRS incentive eligibility as shown in Appendix 3).
Criteria 2: Report at least 3 measures covering 1 NQS domain for at least 50 percent of the group practice's Medicare Part B FFS patients via qualified registry. **Note:** A group that reports fewer than 3 measures covering at least 1 NQS domain via qualified registry reporting will be subject to the **Measure-Applicability Validation (MAV)** process, which will allow CMS to determine whether additional measures should have been reported.

Note: CMS will determine whether the group practice (defined by TIN) is subject to the 2016 PQRS payment adjustment. Group practices participating in the PQRS GPRO are analyzed at the TIN level under the TIN submitted at the time of registration; therefore, if an organization or EP changes TINs, the participation under the old TIN does not carry over to the new TIN, nor is it combined for final analysis.

New for 2014, group practices of 10 or more EPs may be subject to the 2016 Value-based Payment Modifier (VM). More information on the VM can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.

Additional Information

- For information on CMS PQRS, including information on reporting requirements, go to http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS.
- For information on reporting 2014 PQRS through a registry, go to the direct link at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Registry-Reporting.html.
- For information on registering to report in 2014 PQRS as a group, go to the direct link at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html.
- For information on the PQRS payment adjustment, go to the direct link at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html.
- For information on the Value-Based Payment Modifier, go to the CMS Value-Based Payment Modifier website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.
- For information on the Medicare and Medicaid EHR Incentive Program, go to http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/.

CMS provides the following resource to answer inquiries regarding PQRS, incentive payments, payment adjustment, feedback reports, and IACS registration:

QualityNet Help Desk – 7:00 a.m. – 7:00 p.m. CST

- General CMS PQRS and eRx Incentive Program information
- Portal password issues
- Feedback report availability and access
- PQRS-IACS registration questions
- PQRS-IACS login issues

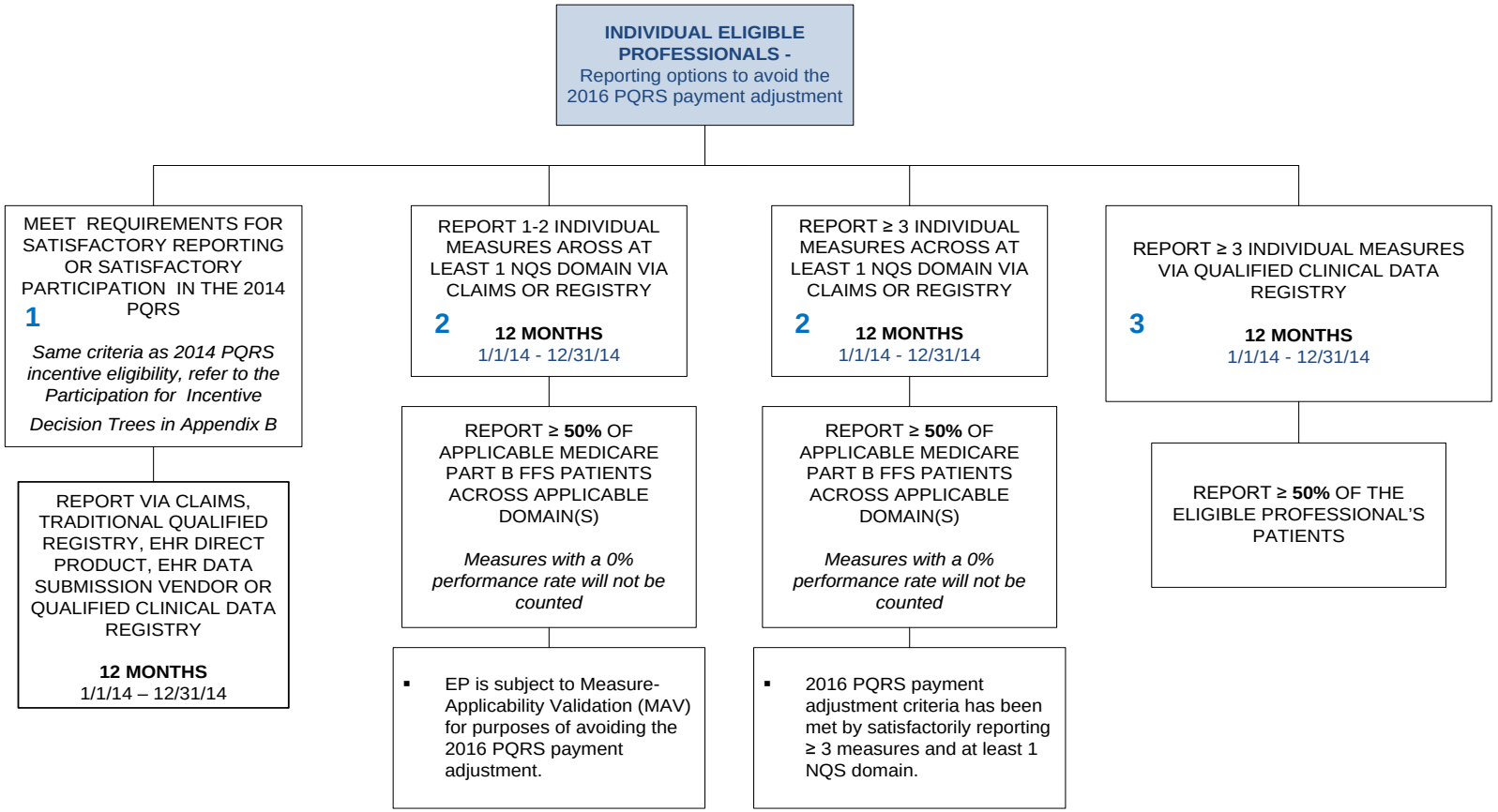
Phone: 1-866-288-8912
TTY: 1-877-715-6222
Email: Qnetsupport@hcqis.org

Appendix 1: Individual EP - 2014 Participation to Avoid 2016 PQRS Payment Adjustment Decision Tree

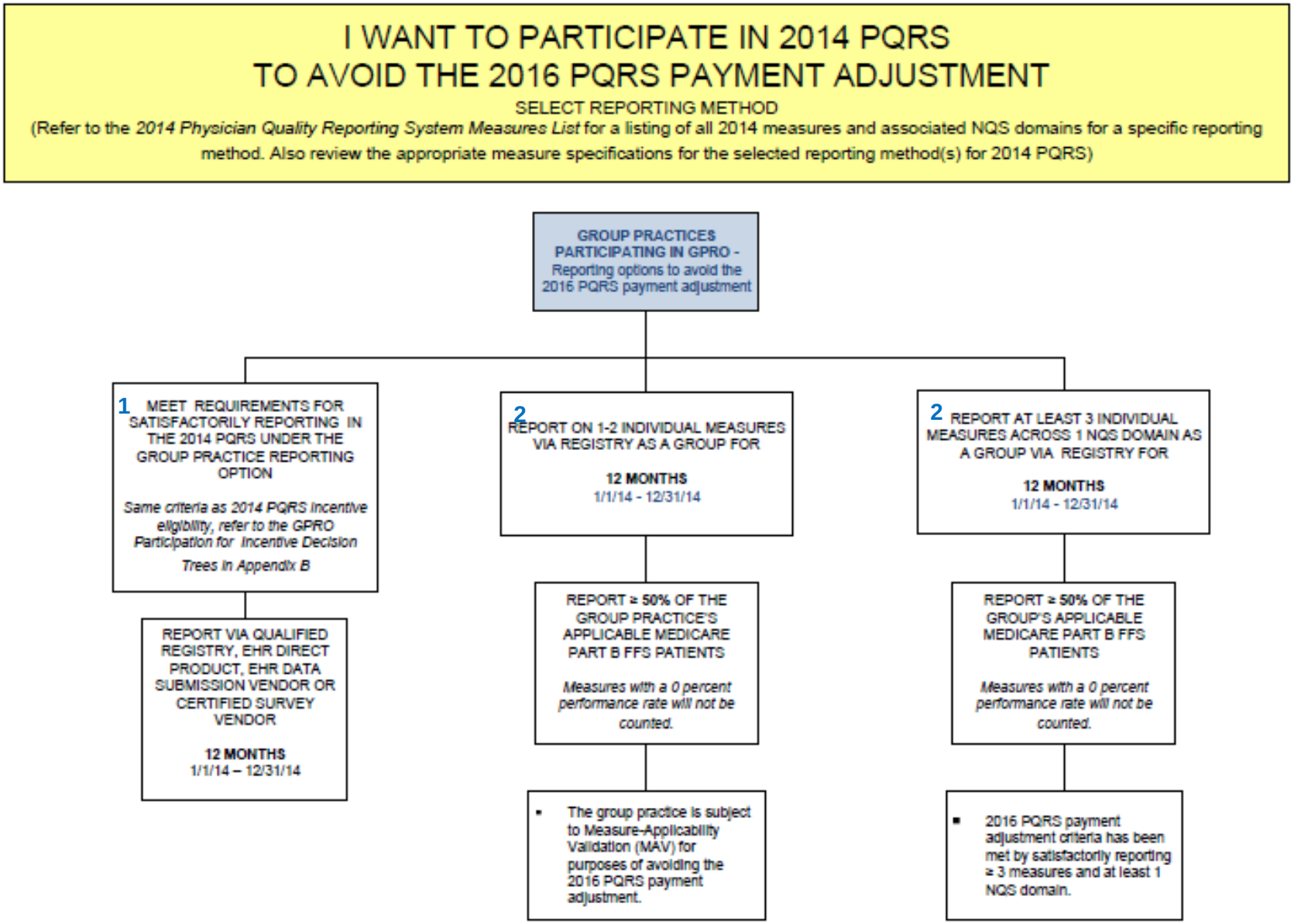
I WANT TO PARTICIPATE IN 2014 PQRS TO AVOID THE 2016 PQRS PAYMENT ADJUSTMENT

SELECT REPORTING METHOD

(Refer to the *2014 Physician Quality Reporting System Measures List* for a listing of all 2014 measures and associated NQS domains for a specific reporting method. Also review the appropriate measure specifications for the selected reporting method(s) for 2014 PQRS)



Appendix 2: Group Practices - 2014 Participation to Avoid 2016 PQRS Payment Adjustment Decision Tree



2014 PQRS Participation to Avoid the 2016 PQRS Payment Adjustment Decision Tree Options

Number assigned coordinates with appropriate boxes in Appendix 1 and 2.

Appendix 1: Individual EPs

1. Meet the requirements to satisfactorily report or satisfactorily participate for incentive eligibility as defined in the 2014 PQRS measure specifications (same criteria as 2014 PQRS incentive eligibility)

   Note: *If reporting for PQRS through another CMS program (such as the Medicare Shared Savings Program, Comprehensive Primary Care Initiative, Pioneer Accountable Care Organizations), please check the program's requirements for information on how to report quality data to earn a PQRS incentive and/or avoid the PQRS payment adjustment. Please note, although CMS has attempted to align or adopt similar reporting requirements across programs, eligible professionals should look to the respective quality program to ensure they satisfy the PQRS, EHR Incentive Program, Value-Based Payment Modifier (VBM), etc. requirements of each of these programs.*

2. A) Report at least 3 measures covering 1 NQS domain for at least 50 percent of the EP's Medicare Part B FFS patients via claims or qualified registry.

   Note: An **EP** who reports fewer than 3 measures covering at least 1 NQS domain via claims or qualified registry reporting will be subject to the Measure-Applicability Validation (MAV) process, which allows CMS to determine whether additional measures domains should have been reported.

   B) **QCDR:** Participate via a qualified clinical data registry (QCDR) that selects measures for the EP, of which at least 3 measures covering a minimum of 1 NQS domain AND submission of at least 50 percent of the EP's applicable patients seen during the participation period to which the measure applies.

Appendix 2: 2014 Group Practices PQRS GPRO

1. Meet the requirements for satisfactorily reporting for incentive eligibility as defined in the applicable 2014 PQRS measure specification (same criteria as 2014 PQRS incentive eligibility as shown in Table 6 of Appendix 3). Group practices participating in PQRS GPRO should reference the *2014 PQRS GPRO Web Interface Specifications,* or the *2014 PQRS Measure Specification for Claims/Registry Reporting of Individual Measures* based on reporting method indicated during self-nomination/registration.

   Note: *If reporting for PQRS through another CMS program (such as the Medicare Shared Savings Program, Comprehensive Primary Care Initiative, Pioneer Accountable Care Organizations), please check the program's requirements for information on how to report quality data to earn a PQRS incentive and/or avoid the PQRS payment adjustment. Please note, although CMS has attempted to align or adopt similar reporting requirements across programs, eligible professionals should look to the respective quality program to ensure they satisfy the PQRS, EHR Incentive Program, Value-Based Payment Modifier (VBM), etc. requirements of each of these programs.*

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

   Note: A group practice who reports fewer than 3 measures covering 1 NQS domain via the registry-based reporting mechanism will be subject to the MAV process, which would allow CMS to determine whether a group practice should have reported on additional measures.

Appendix 3: Requirements for Satisfactorily Reporting 2014 PQRS for Incentive Payment

Individual EPs – 2014 PQRS Reporting Options for Incentive Payment

(Dates of Service 1/1/2014-12/31/2014)

Table 1: Criteria for Claims-based Reporting of Individual Measures

Reporting Criteria	Reporting Period
9 measures covering at least 3 NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the EP, report 1-8 measures covering 1-3 NQS domains as applicable, 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% performance rate would not be counted. For an EP that reports fewer than 9 measures covering less than 3 NQS domains, the EP would be subject to the MAV process, which would allow CMS to determine whether an EP should have reported quality data codes for additional measures and/or covering additional NQS domains.	January 1, 2014 – December 31, 2014

Table 2: Criteria for Qualified Registry-based Reporting of Individual Measures

Reporting Criteria	Reporting Period
At least 9 measures covering at least 3 of the NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the EP, report 1-8 measures covering 1-3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50 percent of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted. For an EP that reports fewer than 9 measures covering less than 3 NQS domains, the EP would be subject to the MAV process, which would allow CMS to determine whether an EP should have reported on additional measures and/or measures covering additional NQS domains.	January 1, 2014 – December 31, 2014

Table 3: Criteria for Qualified Registry-based Reporting of Measures Groups

Reporting Criteria	Reporting Period
1 measures group for 20 applicable patients of each EP. A majority of patients (11 out of 20) must be Medicare Part B FFS patients. Measures Groups containing a measure with a 0% performance rate will not be counted.	January 1, 2014 – December 31, 2014
1 measures group for 20 applicable patients of each EP. A majority of patients (11 out of 20) must be Medicare Part B FFS patients. Measures Groups containing a measure with a 0% performance rate will not be counted.	July 1, 2014 – December 31, 2014

Table 4: Criteria for Direct EHR Product that is CEHRT or EHR Data Submission Vendor that is CEHRT

Reporting Criteria	Reporting Period
Individual EHR Measures: Report 9 measures covering at least 3 of the NQS domains. If an EP's CEHRT 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.	January 1, 2014 – December 31, 2014

Table 5: Criteria for Qualified Clinical Data Registry Participation (QCDR)

Participation Criteria	Participation Period
Individual QCDR Measures: At least 9 measures, of which 1 must be an outcome measure, available for submission under the qualified clinical data registry covering at least 3 of the NQS domains; **AND** Submit each measure for at least 50 percent of the EP's applicable patients seen during the participation period to which the measure applies. Measures with a 0% performance rate would not be counted.	January 1, 2014 – December 31, 2014

Group Practices – 2014 PQRS GPRO Reporting Options for Incentive Payment

(Dates of Service 1/1/2014-12/31/2014)

Table 6: Criteria for the Group Practice Reporting Option

Reporting Period	Group Practice Size	Reporting Mechanism	Reporting Criteria
January 1, 2014 – December 31, 2014	2+ EPs	Qualified Registry	Report at least 9 measures, covering at least 3 NQS domains OR, if less than 9 measures covering at least 3 NQS domains apply to the group practice, report 1-8 measures covering 1-3 NQS domains for which there is Medicare patient data (subjecting the group practice to the MAV process), **AND** Report each measure for at least 50% of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted.

Reporting Period	Group Practice Size	Reporting Mechanism	Reporting Criteria
January 1, 2014 – December 31, 2014	2+ EPs	Direct EHR product that is CEHRT/ EHR data submission vendor that is CEHRT	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.
January 1, 2014 – December 31, 2014	25-99 EPs	GPRO Web Interface	Report on all measures included in the Web Interface; **AND** Populate data field for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100% of assigned beneficiaries.
January 1, 2014 – December 31, 2014	25-99 EPs	CMS-certified survey vendor + qualified registry, direct EHR product, EHR data submission vendor, or GPRO Web Interface	Report all CG CAHPS survey measures via a CMS-certified survey vendor, **AND** report at least 6 measures covering at least 2 of the NQS domains using a qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface. CG CAHPS summary survey modules are optional.
January 1, 2014 – December 31, 2014	100+ EPs	GPRO Web Interface	Report on all measures included in the Web Interface; **AND** Populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each disease module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries. In addition, the group practice is required to report all CG CAHPS summary survey modules via CMS-certified survey vendor at CMS' expense.