FACT SHEET

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2016 Physician Quality Reporting System (PQRS)
Payment Adjustment Fact Sheet

Overview of the Program

PQRS is a quality reporting program that uses negative payment adjustments to promote reporting of quality information by individual eligible professionals (EPs), EPs providing services at a Critical Access Hospital (CAH) billing under method II, and PQRS group practices participating in the group practice reporting option (GPRO). Those who do not satisfactorily report data on quality measures for covered Medicare Physician Fee Schedule (MPFS) services furnished to Medicare Part B beneficiaries (including Railroad Retirement Board, Medicare Secondary Payer, and Critical Access Hospitals [CAH] method II) or satisfactorily participate in a qualified clinical data registry (QCDR) will be subject to a negative payment adjustment under PQRS.

What are quality measures?
Quality measures are indicators of the quality of care provided by physicians and other healthcare providers. They are tools that help us measure or quantify health care processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include: effective, safe, efficient, patient-centered, equitable, and timely care.

The PQRS measures address various aspects of care, such as prevention, chronic- and acute-care management, care processes and procedures, resource utilization, and care coordination. Individual EPs, EPs providing services at a CAH billing under method II, and PQRS group practices are not required to report on all of the measures (with the exception of GPRO Web Interface mechanism), and can select which measures they would like to report.

What data are eligible professionals required to report?
Measures are classified according to the 6 National Quality Strategy (NQS) domains based on the NQS priorities. For 2015, PQRS reporting mechanisms typically require an individual EP or PQRS group practice to report 9 or more measures covering at least 3 NQS domains, and cross-cutting measures for EPs with billable face-to-face encounters for satisfactory reporting or participation to avoid the 2017 negative payment adjustment. This differs from the steps providers needed to take to avoid the 2016 negative payment adjustment, where an individual EP or PQRS group practice had to either meet reporting requirements for earning the 2014 PQRS incentive or report 3 or more measures covering at least 1 NQS domain for at least 50 percent of Medicare patients.

There is still time to report PQRS for 2015 to avoid the 2017 PQRS negative payment adjustment. PQRS offers several reporting mechanisms for reporting measures to avoid the 2017 negative payment adjustment. Please see the 2015 PQRS Implementation Guide for Decision Trees designed to help participants select among the multiple reporting mechanisms available in PQRS. Individual EPs, EPs providing services at a CAH billing under method II, and PQRS group practices should consider which reporting mechanism best fits their practice and should choose measures within the same option of reporting.
How is a measure calculated?
Generally speaking, calculating the PQRS reporting rate (e.g., dividing the number of reported numerator outcomes by denominator-eligible encounters) identifies the percentage of a defined patient population that was reported for the measure. For performance rate calculations (e.g., dividing the number of “meets performance” instances by the reporting rate numerator minus exclusions), some patients may be subtracted from the denominator based on medical, patient, or system performance exclusions allowed by the measure.

The final performance rate calculation represents the eligible population that received a particular process of care or achieved a particular outcome (e.g., measure-defined “performance met” outcome). It is important to review and understand each measure's specification for the applicable reporting mechanism, as it contains definitions and specific instructions for reporting the measure. More information may be found on the PQRS Measures Codes page.

How does it help beneficiaries and the health care system?
Driving quality improvement is a core function of CMS. The vision for the CMS Quality Strategy, which is based on the National Strategy for Quality Improvement in Health Care (NQS), is to optimize health outcomes by leading clinical quality improvement and health system transformation. PQRS plays a crucial role to facilitate physician participation in this process committed to quality improvement.

2016 PQRS Negative Payment Adjustment
What is the 2016 PQRS negative payment adjustment?
Individual EPs, EPs providing services at a CAH billing under method II, and PQRS group practices who do not satisfactorily report data on quality measures for covered professional services will be subject to a negative payment adjustment for their Part B covered professional services under the MPFS beginning in 2015. In 2016, individual EPs, EPs providing services at a CAH billing under method II, and PQRS group practices receiving a payment adjustment will be two percent (2%) less than the MPFS amount for that service. The 2016 negative payment adjustment is based on 2014 PQRS reporting. Please note that this adjustment is separate from any additional adjustment that may be applied to EPs who are physicians under the Physician Value-Based Payment Modifier (Value Modifier) program and the Medicare Electronic Health Record (EHR) Incentive Program in 2016.

Where is the final determination on whether or not the individual EP or PQRS group practice met at least one of the 2014 PQRS criteria for avoiding the 2016 PQRS payment adjustment?
The 2014 PQRS feedback reports will be available September 8, 2015 for EPs who submitted quality data on MPFS Part B services between January 1, 2014 and December 31, 2014. Feedback reports will be available for every Taxpayer Identification Number (TIN) under which at least one individual EP (identified by his or her National Provider Identifier, or NPI) or PQRS group practice submitting MPFS claims reported at least one valid PQRS measure at least once during the 2014 reporting period. The feedback reports do not contain claim-level details.

For information on 2014 feedback reports and how to request them, individual EPs should visit the PQRS Payment and Analysis web page and access the 2014 Individual Performance Report User Guide. Feedback reports for program year 2015 will be available in late 2016. To request an Enterprise Identity Management (EIDM) account in order to access the CMS Enterprise portal, check out the Quick Reference and User Guides.

Group practices that participated in the 2014 PQRS Group Practice Reporting Option (GPRO) can access PQRS feedback through the 2014 Annual Quality and Resource Use Reports (QRURs). The 2014 QRURs can be accessed on the CMS Enterprise Portal at https://portal.cms.gov using an Enterprise Identify Management (EIDM) account with the correct role. See the How to Obtain a QRUR Page for instructions on how to set up an
EIDM account and access your TIN’s QRUR. Information about the QRURs is available on the 2014 QRUR website.

**How could I have avoided the 2016 PQRS negative payment adjustment?**
Individual EPs and PQRS group practices had 3 options for avoiding the 2016 PQRS negative payment adjustment:

1. Meet the reporting requirements for earning the 2014 PQRS incentive (9 measures across 3 domains for 50% of Medicare patients, or complete GPRO Web Interface, or report at least one registry measures group for 20 patients, at least 11 of whom must be Medicare Part B FFS patients)
2. Report 3 measures across 1 domain for 50% of Medicare patients
3. Satisfactorily participate in a QCDR

**The Future of PQRS**

**What is CMS’ vision for physician quality reporting?**

There are five statements which define the CMS Physician Quality Reporting Programs Strategic Vision (the “Strategic Vision”) for the future of such programs:

- CMS quality reporting programs are guided by input from patients, caregivers, and healthcare professionals.
- Feedback and data drives rapid cycle quality improvement.
- Public reporting provides meaningful, transparent, and actionable information.
- Quality reporting programs rely on an aligned measure portfolio.
- Quality reporting and value-based purchasing program policies are aligned.

CMS relies heavily on quality measurement and public reporting to facilitate the delivery of high quality care. Our Strategic Vision articulates how we will build upon successful physician quality reporting programs to reach a future-state where quality measurement and public reporting are optimized to help achieve the CMS Quality Strategy’s goals and objectives, and, therefore, contribute to improved healthcare quality across the nation, including better care, smarter spending, and healthier people.

The Strategic Vision evolved out of CMS’s desire to plan for the future in how PQRS, Value Modifier, and other physician quality reporting programs are administered. With passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), key components of the PQRS, the Medicare EHR Incentive Program, and the Value Modifier will serve as the foundation for the Merit-based Incentive Payment System (MIPS) and Eligible Alternative Payment Models.

**What are the MIPS and Eligible Alternative Payment Models?**

MACRA established new mandates that will have a direct effect on the physician quality reporting programs, the MIPS, and the incentive payments for participation in eligible alternative payment models for EPs. These are scheduled to be implemented beginning in January 2019 with a CY2017 performance period.

While PQRS, the Medicare EHR Incentive Program, and the Value Modifier program will end in 2018, quality and performance-based reporting will remain a priority for CMS. EPs are encouraged to visit the CMS website for more information on MIPS as it becomes available.
Where can I go for more information?

- 2015 MPFS Final Rule
- CMS PQRS Website
  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS
- PFS Federal Regulation Notices
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html
- Federal Register
  https://www.federalregister.gov/public-inspection
- Medicare and Medicaid EHR Incentive Programs
- Medicare Shared Savings Program
  http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Quality_Measures_Standards.html
- CMS Value-Based Payment Modifier Website
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html
- Physician Compare
  http://www.medicare.gov/physiciancompare/search.html
- Frequently Asked Questions (FAQs)
  https://questions.cms.gov/
- MLN Connects™ Provider eNews
  http://cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Index.html

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