2013 Reporting Experience

Including Trends (2007-2014)

Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program

April 8, 2015

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I. EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS) implemented two pay-for-reporting programs for eligible professionals.[1] The Physician Quality Reporting System, or PQRS, (formerly, Physician Quality Reporting Initiative or PQRI), authorized under Section 101(b) of division B of the Tax Relief and Health Care Act (TRHCA) of 2006 (Public Law 109-423; 120 Stat. 2975), entered its seventh year in 2013 and has grown substantially from its inception in 2007. The Electronic Prescribing (eRx) Incentive Program, authorized under Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), was introduced in 2009 as a separate incentive vehicle for eligible professionals; 2013 was the last year of the program. These programs encourage eligible professionals to report clinical quality data by providing a series of payment incentives for successful reporting, based on a percentage of the total estimated Part B Medicare Physician Fee Schedule (MPFS) allowed charges for covered professional services furnished by the eligible professional during the reporting period, and payment adjustments for unsuccessful reporters, based on a percent reduction in MPFS payment amounts. Beginning in calendar year 2012 and ending in 2014, a payment adjustment was applicable to eligible professionals who were not successful electronic prescribers under the eRx Incentive Program; a payment adjustment will also be applied under PQRS beginning in calendar year 2015, based on 2013 PQRS reporting.

This report summarizes the historical reporting experience of eligible professionals in the eRx Incentive and PQRS programs through program year 2013 as well as preliminary PQRS data for the 2014 program year. Unless otherwise noted, all tables and figures present 2013 data. Findings reported at the practice level include both eligible professionals participating individually, summarized at the practice level, as well as group practices that participated through the group practice reporting option (GPRO). Results for the group reporting option for PQRS also include eligible professionals participating as part of a Medicare Accountable Care Organization (ACO) under the Shared Savings Program (SSP). Eligible professionals participating in PQRS as part of a Pioneer ACO Model and the Comprehensive Primary Care (CPC) initiative are summarized as individual participants in this report.[2] While the GPRO is not an individual participation option, unless otherwise noted, participation and incentive eligibility information from eligible professionals who were part of group practices participating under the GPRO or as part of a Medicare ACO participating under the Shared Savings Program were combined with data for individual participants to describe the total number of eligible professionals that participated in the programs.

Incentive amounts presented in this report are prior to a two percent reduction required under sequestration.[3] Summaries of PQRS incentive payments also exclude incentive payments to

[1] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_List-of-EligibleProfessionals_022813.pdf

[2] Eligible professionals within ACOs that meet specific PQRS requirements, as incorporated by the SSP or Pioneer ACO Model, are eligible to receive PQRS bonuses and avoid the PQRS payment adjustment under the Medicare Shared Savings Program or the Pioneer ACO Model, respectively. Eligible professionals in the CPC initiative that elect a PQRS waiver and meet requirements under that program are eligible to receive PQRS bonuses and avoid the PQRS payment adjustment.

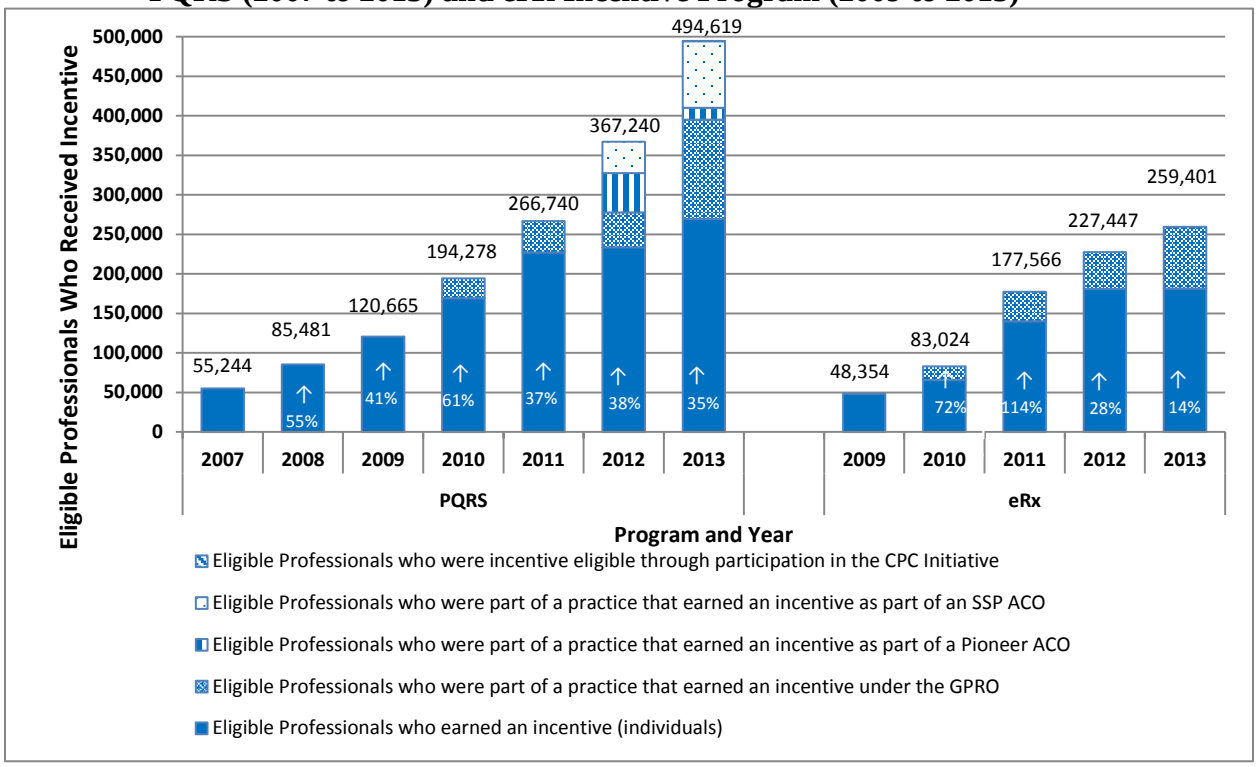
[3] As required by law, President Obama issued a sequestration order on March 1, 2013. Under these mandatory reductions, PQRS incentive payments made to eligible professionals and group practices have

eligible professionals that meet specified requirements related to participation in Maintenance of Certification Program Incentive (MOCP), although some tables present the additional incentive results separately.[4] For the eRx Incentive Program, counts of eligible professionals who were incentive eligible and incentive dollar amounts reflect everyone who earned an incentive through the eRx Incentive Program. However, some of these eligible professionals also earned an incentive through the Medicare EHR Incentive Program; eligible professionals could not be paid incentives for both of these programs and individuals who earned an incentive through both programs were only paid through the Medicare EHR Incentive Program; see the eRx Incentive Program section of this report for more details (Section IV).

Incentive Payments

- The number of eligible professionals who qualified for an incentive payment under PQRS and the eRx Incentive Program has increased each year (Figure 1).

Figure 1: Number of Eligible Professionals Who Qualified for an Incentive Payment: PQRS (2007 to 2013) and eRx Incentive Program (2009 to 2013)



Note for Figure 1: Results include all participation options (i.e. individual, GPRO, SSP and Pioneer ACOs, and the CPC initiative)

been reduced by two percent. This two percent reduction affected PQRS incentive payments for reporting periods that ended on or after April 1, 2013.

[4] Refer to section III.B of this report for more information on incentive payments related to participation in Maintenance of Certification Program Incentive.

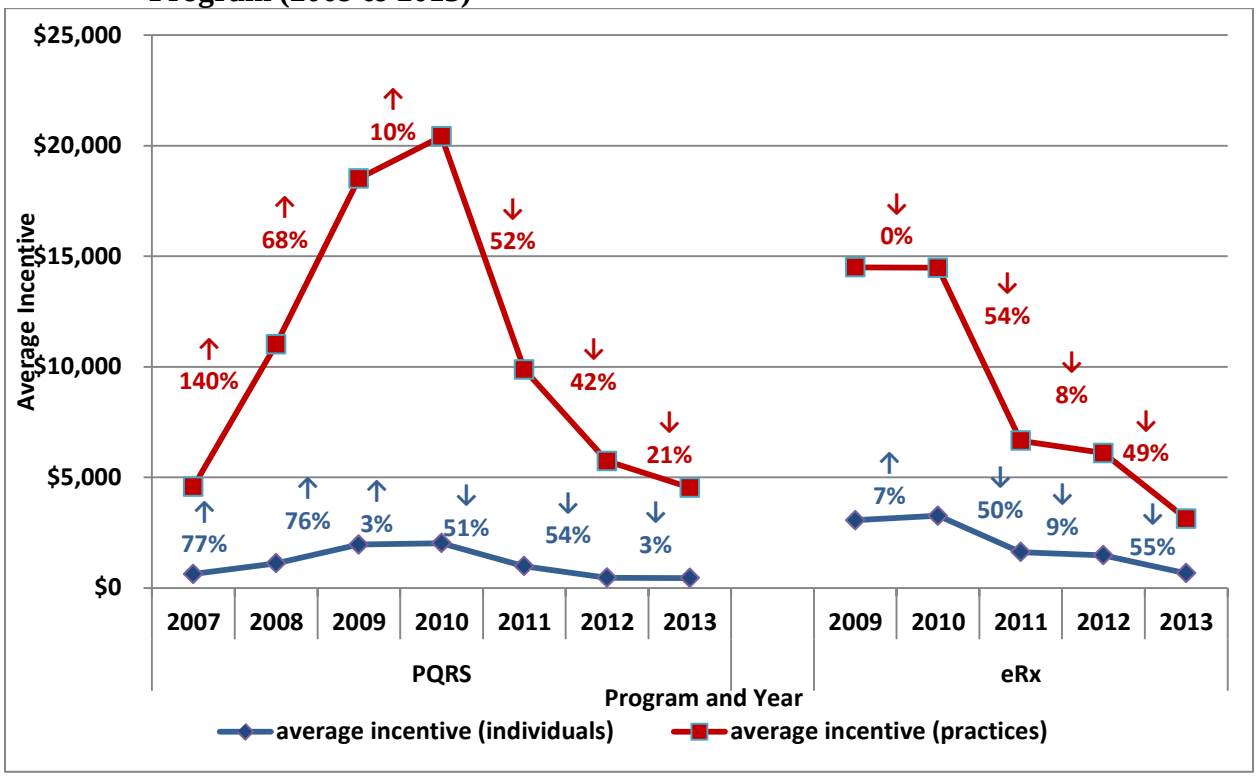
- Incentive eligible professionals earned a combined $390,663,021 through PQRS and the eRx Incentive Program in the 2013 program year (Table 5).[5]
- A total of $218,930,348 in PQRS incentive payments were earned in the 2013 program year, which reflects successful participation of 494,619 eligible professionals within 48,313 practices (Table 5).[6] For 2013, the earned incentive was equal to 0.5 percent of total estimated Medicare Part B Physician Fee Schedule allowed charges for the covered professional services furnished during 2013.
    - Total incentive payments for the 2013 PQRS program year increased by 31 percent compared to 2012 ($166,925,037).
    - The number of eligible professionals who qualified for an incentive for PQRS in 2013 increased by 35 percent from 2012 (N=367,240), including eligible professionals who were part of a group practice that were incentive eligible under the GPRO or through successfully meeting the requirements of the CPC Initiative or successful participation through a Medicare ACO under the Shared Savings Program or the Pioneer ACO Model.
    - The number of practices that received an incentive for the 2013 program year increased by 65 percent from 2012 (N=29,254).
    - The average incentive was $443 per eligible professional and $4,531 per practice; the average incentive decreased slightly from 2012 (Figure 2).
- The number of eligible professionals who qualified for an incentive payment under the eRx Incentive Program increased in every program year (Figure 1). For 2013, the earned incentive was equal to 0.5 percent of total estimated Medicare Part B Physician Fee Schedule allowed charges for the covered professional services furnished during 2013.
    - A total of $171,732,673 in eRx Incentive Program incentives were earned in the 2013 program year, which included 259,401 eligible professionals meeting incentive eligibility criteria within 54,854 practices (Table 5).
    - Total incentives earned for the 2013 eRx Incentive Program decreased 49 percent compared to 2012 ($335,331,216) following a decrease in the applicable quality percent from 1.0 to 0.5 percent.
    - The number of practices that qualified for an incentive in the 2013 eRx Incentive Program decreased slightly compared to 2012 (N=55,015).

[5] This total includes incentives earned by eligible professionals who were paid through the Medicare EHR Incentive Program rather than the eRx Incentive Program. See Section IV for more details. This total also includes PQRS incentives earned by eligible professionals through their participation in either the CPC Initiative, as part of a Medicare ACO under the Shared Savings Program or Pioneer ACO Model, or as part of a practice participating under the GPRO.

[6] These numbers include eligible professionals who participated individually, summarized at the practice level, as well as eligible professionals who were part of a group practice that participated under the GPRO, through the CPC Initiative, or as part of a Medicare ACO under the Shared Savings Program or Pioneer ACO Model.

- The average eRx incentive payment was $662 per eligible professional and $3,131 per practice (Figure 2).[7]

Figure 2: Average Incentive Payments for PQRS (2007 to 2013) and eRx Incentive Program (2009 to 2013)



Note for Figure 2: Results include incentives for participants under all participation options (individual, GPRO, SSP ACO and Pioneer ACO Model, and the CPC initiative).

Expansion of Programs and Eligibility

- In 2013, PQRS and the eRx Incentive Program generally retained the same reporting options and mechanisms from the 2012 program. Registry reporting was added as a reporting mechanism for practices participating in PQRS via the GPRO in 2013 (Table 1). In 2014, Qualified Clinical Data Registries will be added as a reporting mechanism in PQRS, as well as an EHR mechanism for the GPRO.

Table 1: Summary of Reporting Options, Mechanisms, and Alternative Programs for PQRS and the eRx Incentive Program (2011 to 2014)

Reporting Options, Mechanisms, and Alternative Programs	PQRS 2011	PQRS 2012	PQRS 2013	PQRS 2014	eRx 2011	eRx 2012	eRx 2013
Individual Participation	--	--	--	--	--	--	--

[7] Note that even though eligible professionals could earn an incentive equal to 0.5 percent of their Part B estimated MPFS charges for both PQRS and the eRx Incentive Program, the average incentive earned was different in the two programs; this is because the eligible professionals who earned an incentive in one program are not necessarily the same eligible professionals who earned an incentive in the other program.

Reporting Options, Mechanisms, and Alternative Programs	PQRS 2011	PQRS 2012	PQRS 2013	PQRS 2014	eRx 2011	eRx 2012	eRx 2013
Claims-based Individual Measures	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Claims-based Measures Groups	Yes	Yes	Yes	N/A	N/A	N/A	N/A
Registry Individual Measures	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Registry Measures Groups	Yes	Yes	Yes	Yes	N/A	N/A	N/A
EHR Individual Measures	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Qualified Clinical Data Registry (QCDR)	N/A	N/A	N/A	Yes	N/A	N/A	N/A
GPRO	--	--	--	--	--	--	--
GPRO I Web-interface	Yes	N/A	N/A	N/A	N/A	N/A	N/A
GPRO I Claims	N/A	N/A	N/A	N/A	Yes	N/A	N/A
GPRO I Registry	N/A	N/A	N/A	N/A	Yes	N/A	N/A
GPRO I EHR	N/A	N/A	N/A	N/A	Yes	N/A	N/A
GPRO II Claims	Yes	N/A	N/A	N/A	Yes	N/A	N/A
GPRO II Registry	Yes	N/A	N/A	N/A	Yes	N/A	N/A
GPRO II EHR	N/A	N/A	N/A	N/A	Yes	N/A	N/A
Small GPRO Web interface	N/A	Yes	N/A	N/A	N/A	N/A	N/A
Small GPRO Claims	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Small GPRO Registry	N/A	N/A	Yes	Yes	N/A	Yes	Yes
Small GPRO EHR	N/A	N/A	N/A	Yes	N/A	Yes	Yes
Medium GPRO Web interface	N/A	N/A	Yes	Yes	N/A	N/A	N/A
Medium GPRO Claims	N/A	N/A	N/A	N/A	N/A	N/A	Yes
Medium GPRO registry	N/A	N/A	Yes	Yes	N/A	N/A	Yes
Medium GPRO EHR	N/A	N/A	N/A	Yes	N/A	N/A	Yes
Large GPRO web interface	N/A	Yes	Yes	Yes	N/A	N/A	N/A
Large GPRO claims	N/A	N/A	N/A	N/A	N/A	Yes	Yes
Large GPRO registry	N/A	N/A	Yes	Yes	N/A	Yes	Yes
Large GPRO EHR	N/A	N/A	N/A	Yes	N/A	Yes	Yes
Accountable Care Organizations (ACO)	--	--	--	--	--	--	--
SSP ACO via GPRO Web Interface	N/A	Yes	Yes	Yes	N/A	N/A	N/A
Pioneer ACO via GPRO Web Interface	N/A	Yes	Yes	Yes	N/A	N/A	N/A
Comprehensive Primary Care Initiative (CPC)	**N/A**	**N/A**	**Yes**	**Yes**	**N/A**	**N/A**	**N/A**

Notes for Table 1: In 2010, the Physician Quality Reporting System and eRx Incentive Program included a single option for group practices with 200 or more professionals (referred to as "GPRO I"). In 2011, the GPRO II option was added for practices with 2 to 199 professionals. In 2012, GPRO I and GPRO II were replaced with group practices reporting options for Large (100+ NPIs) and Small (25-99 NPIs) group practices. In 2013, reporting options for Small (2-24 NPIs), Medium (25-99 NPIs), and Large (100+ NPIs) group practices were available.

- The number of quality measures from which eligible professionals could choose to participate in the PQRS fell slightly in 2013 (Table 2).

Table 2: Number of PQRS Quality Measures (2010 to 2014)

Mechanism, Option, or Alternative Program	2011	2012	2013	2014
Total number of measures	198	266	258	284
Number of measures groups	14	22	22	25
Number of measures within measures groups	78	117	119	127
Number of measures reportable via claims	131	143	137	110
Number of measures reportable via registry	186	208	203	201
Number of measures reportable via EHR	20	51	51	64
Number of measures reportable via GPRO web interface	26	29	22	22
Number of measures reportable by ACOs via the GPRO web interface	N/A	22	22	22
Number of measures reportable under the CPC Initiative	N/A	N/A	14	11

Notes for Table 2: Total number of measures reflects all measures, including all possible reporting mechanisms and options. Refer to Section III.A for more information about how the GPRO has changed over time.

- Many of the measures reportable by the largest number of eligible professionals were preventive measures, which are not specific to a given diagnosis or condition and apply to a broad range of specialties (Tables 3 and 16).

Table 3: Top Five Individual PQRS Measures Reportable by the Largest Number of Eligible Professionals (2013)

Measure Number	Measure Name	Eligible Professionals
321	Participation by a Hospital, Physician or Other Clinician in a Systematic Clinical Database Registry that Includes Consensus Endorsed Quality	701,240
131	Pain Assessment and Follow-Up	664,919
130	Documentation of Current Medications in the Medical Record	663,342
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	639,568
317	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	634,348

Note for Table 3: Results include the claims, registry, and EHR mechanisms, excluding eligible professionals who were part of a practice that participated under the GPRO, participating in a Medicare ACO under the SSP or Pioneer ACO Model, or through the CPC initiative.

- More than 1.25 million professionals were eligible to participate in the 2013 PQRS, including those participating through the PQRS GPRO, those participating in Medicare ACOs under the SSP or Pioneer ACO Model and the CPC initiative (Figure 3).
- Specialties with large numbers of eligible professionals who were eligible to participate in PQRS included internal medicine, family practice, nurse practitioners, physician assistants, and emergency medicine.
    - CMS strives to include quality measures that are applicable to wide range of specialties and annually requests suggestions for measures to be included in PQRS. Appendix Table A6 presents trends in the number of eligible professionals who participated in PQRS by specialty.
- 808,697 eligible professionals could have participated in the 2013 eRx Incentive Program including those who were part of a group practice that self-nominated to participate via the GPRO for the eRx Incentive Program (Table 5).
- 677 practices (251 Small GPRO, 133 Medium GPRO, and 293 Large GPRO) self-nominated or registered to participate via the PQRS GPRO in 2013, compared to only 68 total practices that self-nominated for the GPRO in 2012 (data not shown).
    - Although not part of the traditional PQRS, another 220 practices were Medicare ACOs participating under the SSP, 23 practices participated under the Pioneer ACO Model, and 214 practices participated through the CPC program (data not shown).
- In the eRx Incentive Program, 99 practices self-nominated under the Small GPRO, 36 for Medium GPRO, and 116 practices self-nominated under the Large GPRO (data not shown).

Participation

- Participation increased every year in both PQRS and the eRx Incentive Program (Figures 3 and 4).
    - The number of participating eligible professionals increased by 47 percent and nine percent between 2012 and 2013 for PQRS and the eRx Incentive Program, respectively.
- In 2013, 641,654 (51 percent) eligible professionals (including those who belonged to group practices that reported under the GPRO, eligible professionals within a Medicare ACO participating under the SSP or Pioneer ACO Model, and eligible professionals participating through the CPC initiative) participated in PQRS, a six-fold increase from the roughly 100,000 who participated in 2007.[8]
    - In 2013, 131,690 eligible professionals participated in PQRS as part of practices electing to participate under the GPRO, while another 85,059 eligible

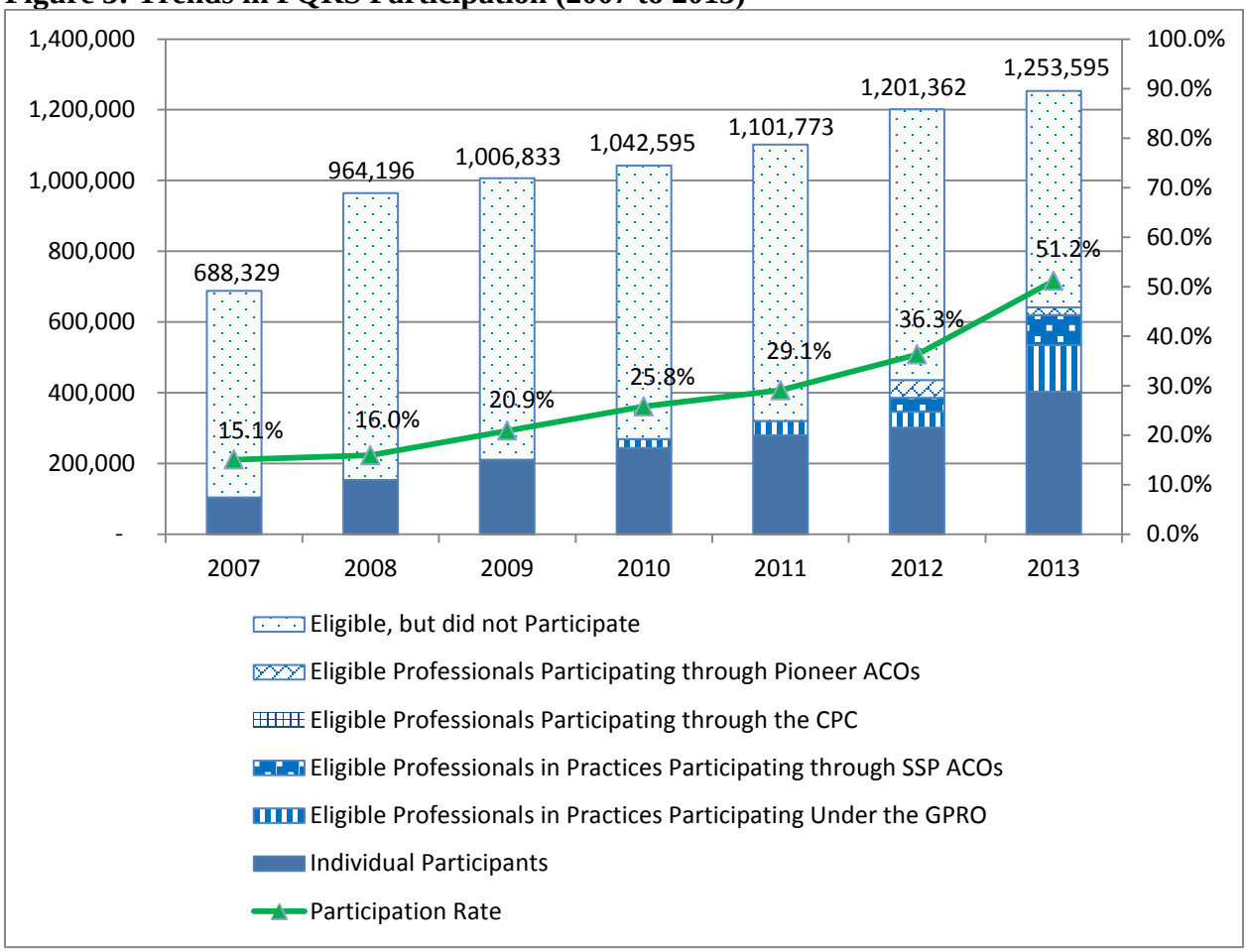
[8] Refer to Section III for a description of measure submission approaches.

professionals participated under the GPRO as part of a Medicare ACO participating under the SSP (Table 5).

  - Another 21,678 eligible professionals participated as part of a Pioneer ACO under the Pioneer ACO model, and 508 participated under the CPC initiative.

- The participation rate among all eligible professionals using any method to participate in PQRS increased from 15 percent to 51 percent between 2007 and 2013, including those who belong to group practices that participated under the GPRO, those that participated as part of a Medicare ACO participating under the SSP or Pioneer ACO Model, those participating through the CPC initiative.
- Of the 677 practices that self-nominated to participate under the PQRS GPRO, 550 participated: 161 practices encompassing 1,933 eligible professionals participated via Small GPRO, 114 practices encompassing 7,029 eligible professionals participated via the Medium GPRO, and 275 practices encompassing 122,728 eligible professionals participated via the Large GPRO (Table 5).
  - There were 220 practices encompassing 85,059 eligible professionals that, for the purpose of earning a PQRS incentive, reported under the SSP.
  - There were 23 practices with eligible professionals participating via the Pioneer ACO Model and out of 214 practices eligible to participate via the CPC initiative, 67 actually did participate (that is, the practices were able to take advantage of the PQRS waiver).

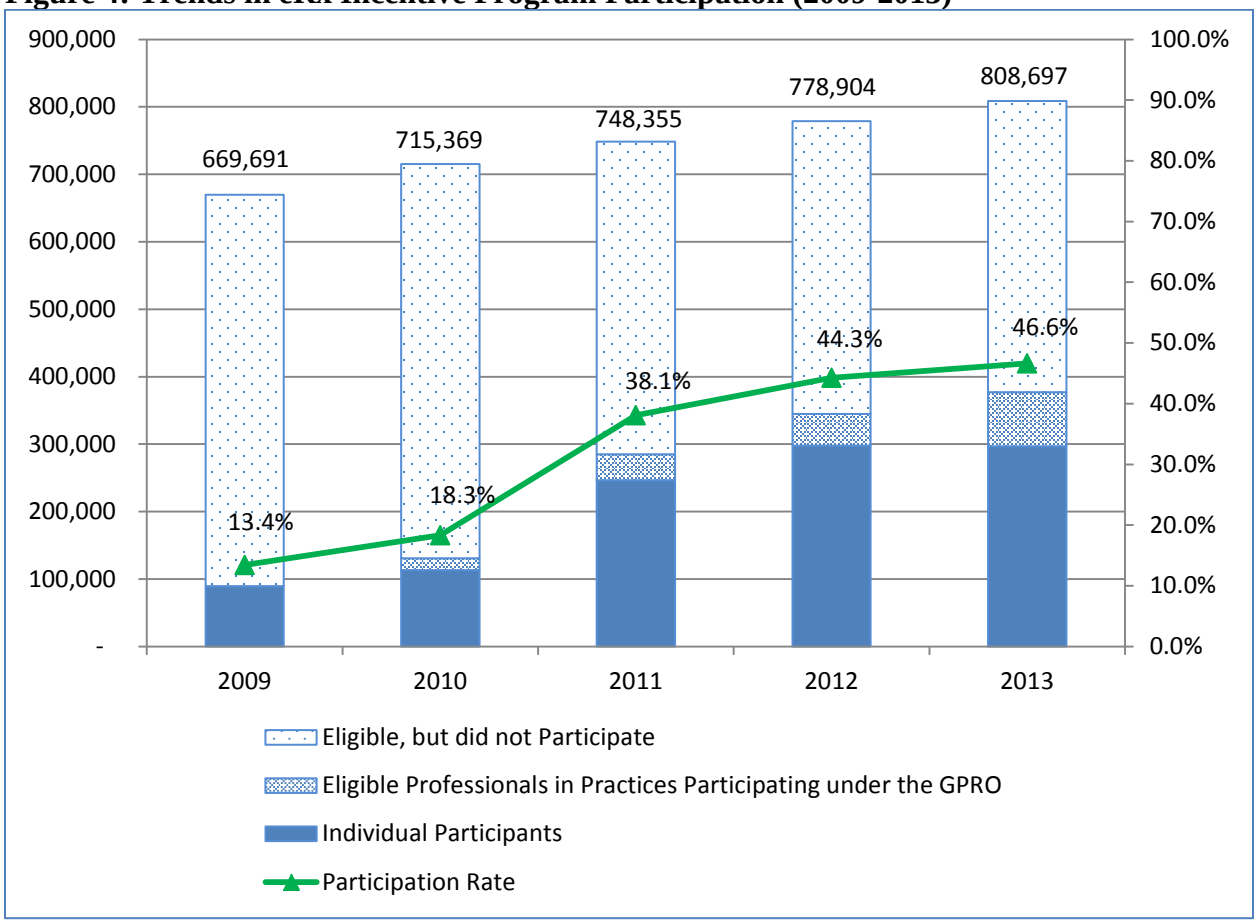
Figure 3: Trends in PQRS Participation (2007 to 2013)



Note for Figure 3: Results include all reporting mechanisms and options.

- Participation in the eRx Incentive Program has grown substantially from program inception, although the participation rate increased modestly between 2012 and 2013, from 44 to 47 percent (Figure 4).
    - Much of the growth in 2013 was driven by a 71 percent increase in the number of eligible professionals participating in the eRx Incentive Program under the GPRO between 2012 and 2013 (Figure 4).
    - 70 group practices encompassing 837 eligible professionals participated in the eRx Incentive Program under the Small GPRO, 27 practices encompassing 1,839 eligible professionals participated under the Medium GPRO, and 111 practices encompassing 77,333 eligible professionals participated in eRx under the Large GPRO (Table 5).

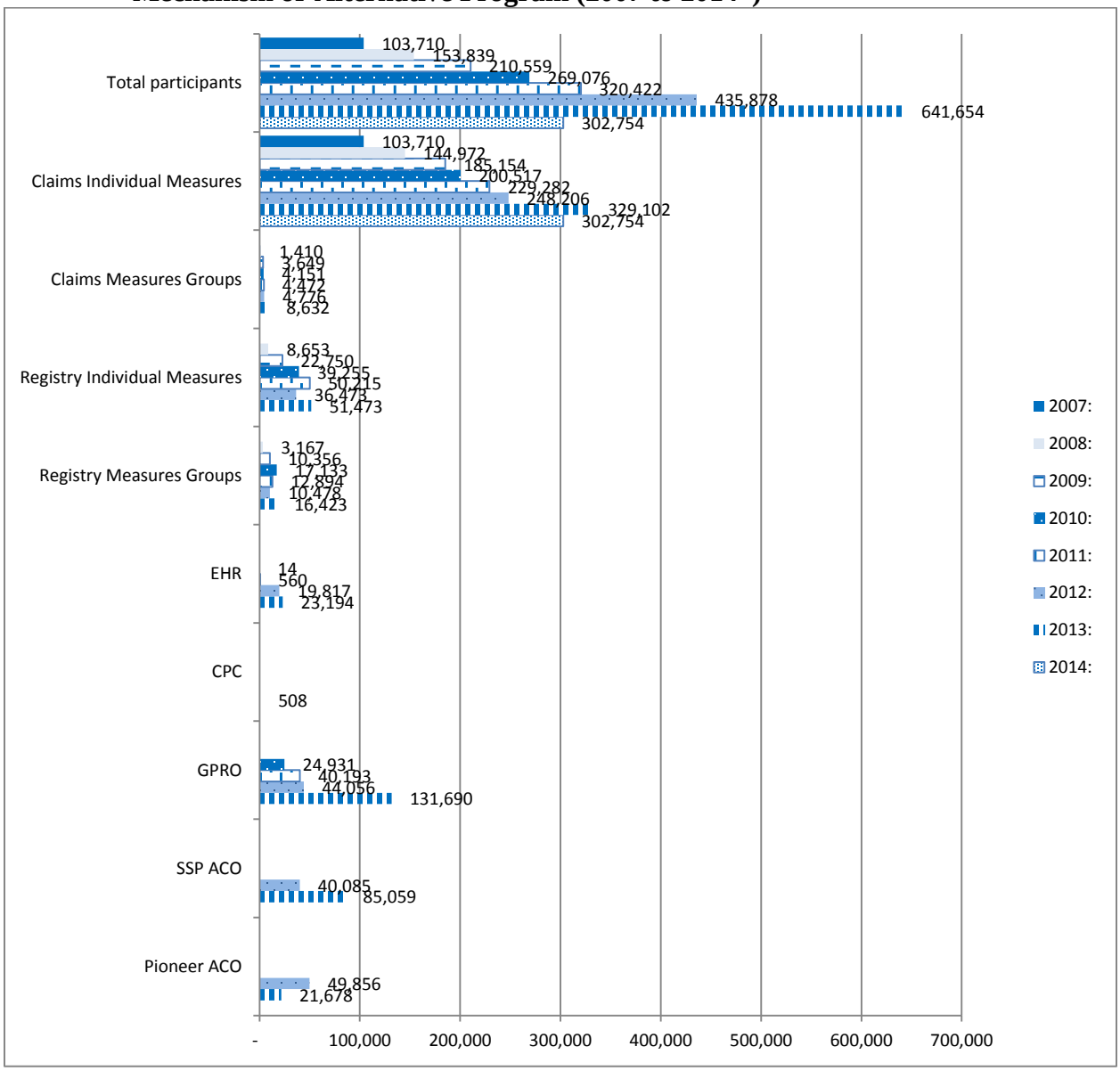
Figure 4: Trends in eRx Incentive Program Participation (2009-2013)



Note for Figure 4: Results include all reporting mechanisms and options.

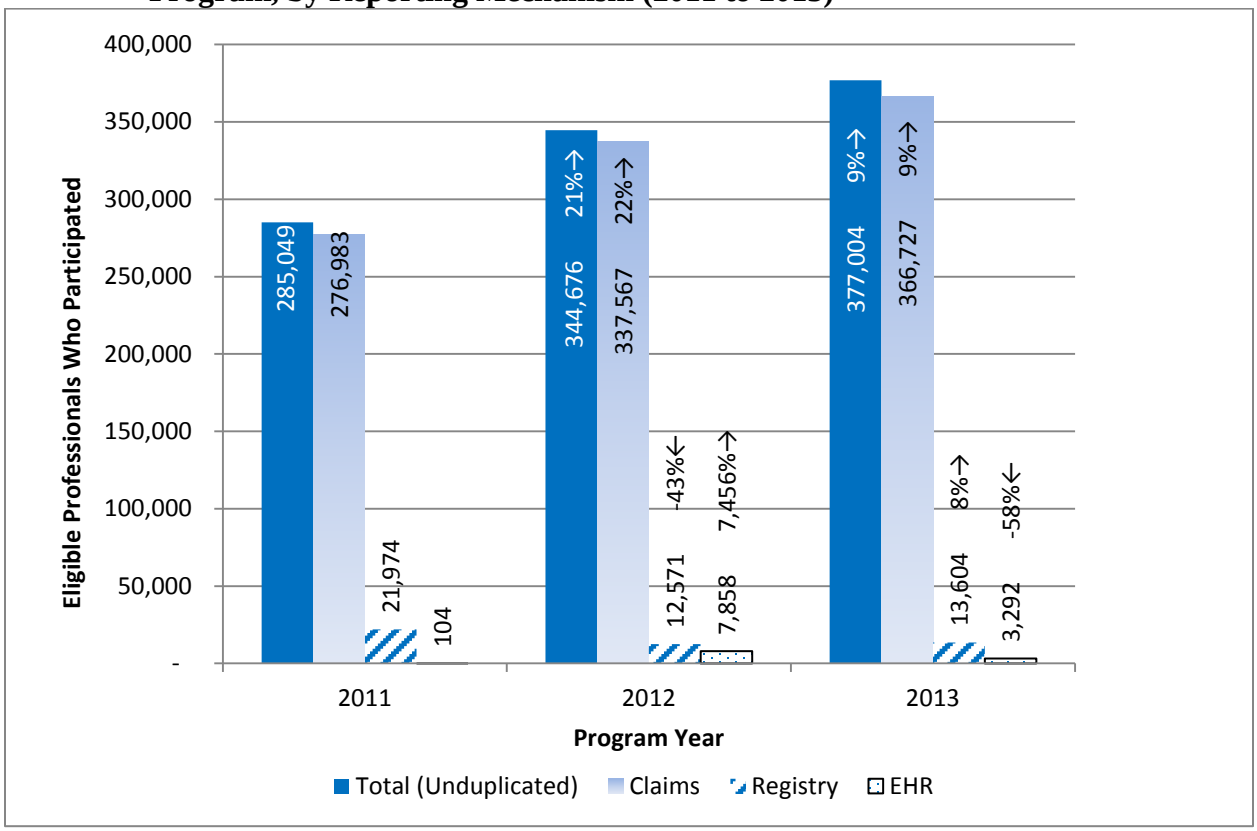
- The most common participation method in both programs in 2013 continued to be reporting individual measures through claims (Figures 5 and 6).
    - Registry reporting in PQRS increased in 2013 after a dip in 2012; registry reporting in eRx also increased modestly in 2013.
    - EHR reporting had marked increases each year from 2010 to 2012 in both programs, but had a more moderate increase from 2012 to 2013 in PQRS, and a significant drop in eRx in 2013. The majority of eligible professionals no longer using EHR reporting for eRx did earn an incentive through the Medicare EHR Incentive Program.

Figure 5: Total Number of Eligible Professionals Participating in PQRS, by Reporting Mechanism or Alternative Program (2007 to 2014*)



*Notes for Figure 5: Results include individually participating eligible professionals as well as eligible professionals in group practices that participated under the GPRO, eligible professionals in Medicare ACOs participating under the SSP and Pioneer ACO Models, and eligible professionals participating through the CPC initiative. Some eligible professionals participated in more than one reporting mechanism. *Results for 2014 are preliminary only (six months) and include claims-based reporting only.*

Figure 6: Total Number of Eligible Professionals Participating in the eRx Incentive Program, by Reporting Mechanism (2011 to 2013)



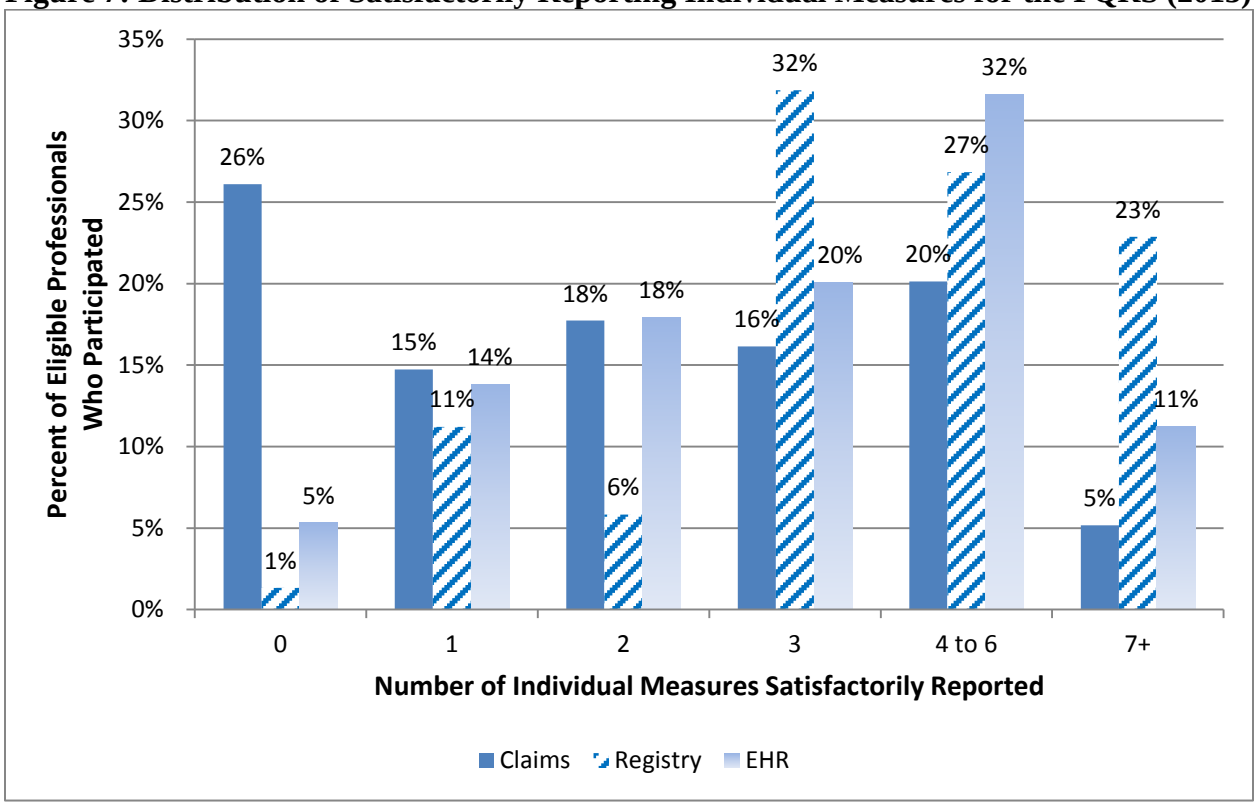
Note for Figure 6: Results include individually participating eligible professionals as well as eligible professionals in group practices that participated under the GPRO.

- Some specialties participated in greater numbers and/or at higher rates in the 2013 programs than others.
    - Internal medicine, family practice, and emergency medicine were the specialties with the largest numbers of participants in PQRS across all reporting options; pathology and emergency medicine had the highest participation rates of any specialty (79 percent and 74 percent, respectively; Appendix Table A8).
    - Family practice, internal medicine, and nurse practitioner were the specialties with the largest number of participants in the eRx Incentive Program; nurse anesthetist, physical/occupational therapy, pathology, and rheumatology had the highest participation rates (95 percent, 82 percent, 80 percent, and 74 percent, respectively; Appendix Table A44).
- About half of eligible professionals (56 percent) and practices (46 percent) of those eligible to do so participated in both PQRS and the eRx Incentive Program in 2013 (Table 4).

Satisfactory Reporting and Challenges to Reporting

- Rates of satisfactory reporting of at least one measure in PQRS varied by participation method. Nearly three-quarters (74 percent) of eligible professionals who participated through claims satisfactorily reported at least one measure, compared to 95 percent for EHR participants, and 99 percent for registry participants (Figure 7).
    - That is, 26 percent of those who attempted to participate via claims were unable to submit any measures satisfactorily, compared to one percent for those using a registry or five percent using an EHR.
- The most common claims-based submission error was reporting a measure-specific Quality Data Code (QDC) on a claim that did not also have the required procedure code.
- The most common reporting errors via registry were incorrect performance rates and submitting data for an eligible professional that had no Part B MPFS allowed charges.
- The most common errors for EHR reporting were use of invalid HIC numbers and eligible professionals without MPFS charges.

Figure 7: Distribution of Satisfactorily Reporting Individual Measures for the PQRS (2013)

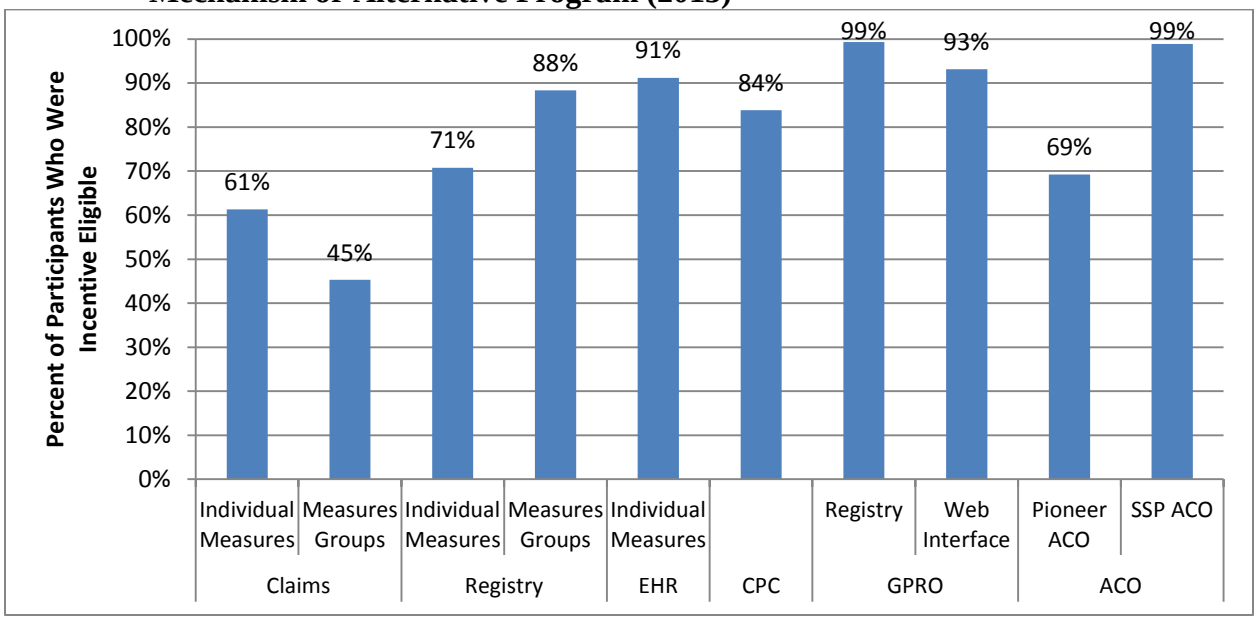


Notes for Figure 7: Satisfactory reporting required reporting at least 50 percent of eligible instances for claims-based reporting and 80 percent of eligible instances for registry- and EHR-based reporting. The results for '0' above indicate that no measures were reported satisfactorily.

Incentive Eligibility

- Across all reporting options, just over three-quarters (77 percent) of participants in the 2013 PQRS met the criteria for incentive eligibility.[9]
    - Among all eligible professionals who were eligible to participate in PQRS, 39 percent earned an incentive for the program in 2013, compared to 31 percent in 2012.
- Incentive eligibility rates varied by reporting mechanism: 62 percent among eligible professionals participating via claims (individual or measures groups), 75 percent among those using registry (individual or measures groups), and 91 percent for EHR (Figure 8 and Appendix Table A4).
    - Within the GPRO, 97 percent of eligible professionals participating in a practice in the Small GPRO were incentive eligible, compared to 93 percent for Medium GPRO, and 95 percent for Large GPRO.
    - 99 percent of eligible professionals in Medicare ACOs participating under the SSP were incentive eligible, compared to 69 percent of eligible professionals in Pioneer ACOs and 84 percent among those in CPC practices.

Figure 8: Incentive Eligibility Rate by the Physician Quality Reporting System Reporting Mechanism or Alternative Program (2013)



Note for Figure 8: Individual eligible professionals could be counted under more than one method if they participated and were incentive eligible under more than one method.

- More than two-thirds of eligible professionals (69 percent) who participated in the 2013 eRx Incentive Program qualified for an incentive, including eligible professionals who

[9] The Data and Methods section in the Appendix describes the criteria to qualify for an incentive payment under both programs. For PQRS, incentive eligibility results include eligible professionals who earned an incentive as part of an ACO under the SSP or Pioneer ACO Model or the CPC initiative.

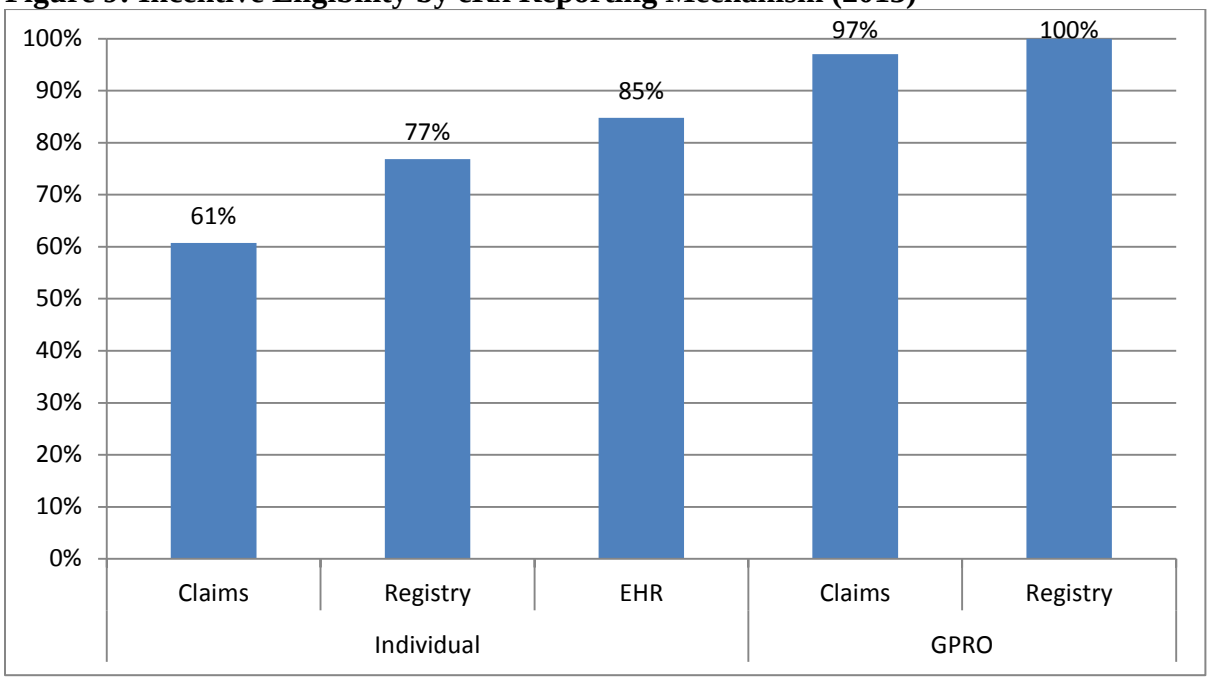
were part of a group practice that reported under the GPRO. The incentive eligibility rate increased modestly from 66 percent in 2012.

  - Among all eligible professionals who could have participated in the eRx Incentive Program, 32 percent earned an incentive in 2013, compared to 29 percent in 2012.

- The incentive eligibility rate for the eRx Incentive Program ranged by reporting mechanism, from 61 percent among those participating via individual claims, to 77 percent for individual registry participants, to 85 percent for EHR participants.

  - Incentive eligibility rates by mechanism were higher for eligible professionals who reported under the GPRO: claims (97 percent) and registry (100 percent) (Figure 9).

Figure 9: Incentive Eligibility by eRx Reporting Mechanism (2013)



Note for Figure 9: Individual eligible professionals could be counted under more than one method if they participated and were incentive eligible under more than one method.

- Just under two-thirds of eligible professionals (63 percent) who participated in both PQRS (including eligible professionals participating in Medicare ACOs participating under the SSP or Pioneer ACO Model, and eligible professionals participating through the CPC Initiative) and the eRx Incentive Program qualified for an incentive through both programs (Table 4).

  - There were 280,114 eligible professionals who participated in both PQRS and the eRx Incentive Program in 2013, and among these, 175,445 were incentive eligible for both programs.

Table 4: Eligible Professionals and Practices Participating in Both the Physician Quality Reporting System and eRx Incentive Program (2012 to 2013)

Interaction of Participation and Incentives for eRx and PQRS	Eligible Professionals in 2012	Eligible Professionals in 2013	Practices in 2012	Practices in 2013
Participated in Either Program	580,763	738,544	94,520	120,393
Participated in PQRS or eRx and Eligible for Both Programs	416,865	499,831	81,601	92,429
Participated in Both Programs	199,791	280,114	26,653	42,147
Percent Participated who were Eligible for Both Programs	47.9%	56.0%	32.7%	45.6%
Incentive Eligible for Both Programs	132,078	175,445	15,539	20,980
Percent Incentive Eligible who Participated in Both Programs	66.1%	62.6%	58.3%	49.8%
Total Payments	$265,913,678	$221,371,392	$274,796,419	$231,288,608
Average Payments	$2,013	$1,262	$17,684	$11,024

Note for Table 4: Data include eligible professionals who were part of a practice that participated under the GPRO or as part of a Medicare ACO participating under the SSP or Pioneer ACO Model or through the CPC initiative.

- Table 5 presents a side-by-side summary of eligibility, participation, and incentive eligibility in the PQRS and the eRx Incentive Program in 2013.

Table 5: Eligible Professionals' and Practices' Reporting Results for PQRS and the eRx Incentive Program (2013)

Outcome and Mechanism or Alternative Program	Eligible Professionals in PQRS	Eligible Practices in PQRS	Eligible Professionals in eRx	Eligible Practices in eRx
Eligible	1,253,595	284,570	808,697	218,607
Participated via Any Method	641,654	84,832	377,004	77,708
Participated via Pioneer ACO	21,678	23	N/A	N/A
Participated via CPC	508	67	N/A	N/A
Participated via Claims	331,668	69,320	292,388	77,238
Participated via Registry	67,631	15,353	7,934	946
Participated via EHR	23,194	4,200	3,292	373
Participated via Small GPRO	1,933	161	837	70
Participated via Medium GPRO	7,029	114	1,839	27
Participated via Large GPRO	122,728	275	77,333	111
Participated via SSP ACO	85,059	220	N/A	N/A
Incentive Eligible	494,619	48,313	259,401	54,854
Total Incentives Earned	$218,930,348	$218,930,348	$171,732,673	$171,732,673
Average Incentives Earned	$443	$4,531	$662	$3,131

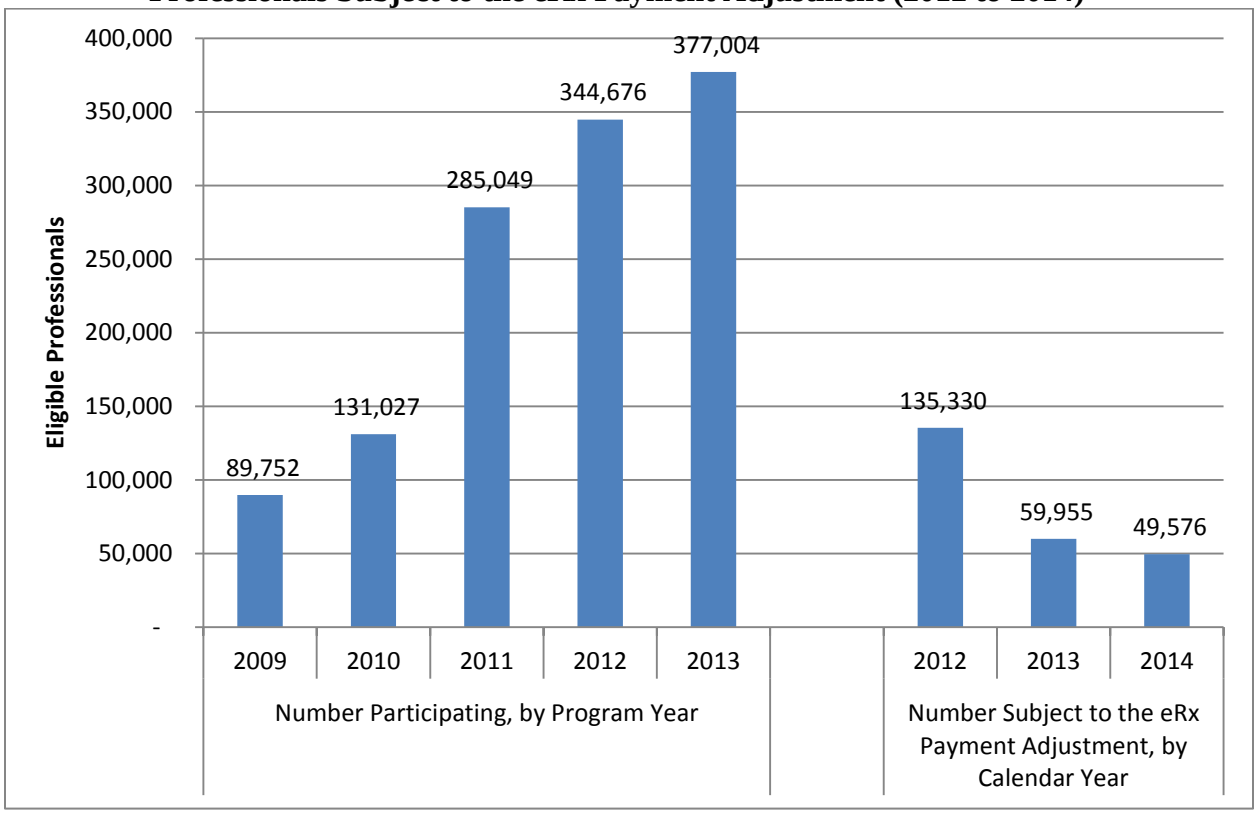
Note for Table 5: Some eligible professionals participated in more than one reporting method. Results include eligible professionals who were part of a practice that participated under the GPRO, as part of a Medicare ACO participating under the SSP or Pioneer ACO Model, or through the CPC initiative.

2014 eRx Payment Adjustment

- 49,576 eligible professionals (including those participating under the GPRO) were subject to the 2014 eRx payment adjustment because they did not have a qualifying reason to avoid the payment adjustment, did not meet exclusion criteria for the adjustment, were not successful e-prescribers in 2012, and did not meet eRx reporting requirements in the first half of 2013 (Appendix Table A49).[10]
    - Roughly 80 percent of those subject to the payment adjustment did not participate in the eRx Incentive Program at all in 2013 (data not shown).
- Following a hierarchy of reasons as shown in Figure 19, the number of eligible professionals who avoided the 2014 eRx payment adjustment were as follows:
    - 231,857 did not have enough eligible encounters; 124,409 were not in a qualifying specialty (MD/DO, podiatrist, nurse practitioner, or physician assistant); and 5,555 did not meet the 10 percent limitation threshold.
    - 233,045 eligible professionals reported the required number of eRx encounters and 22,609 were successful electronic prescribers in 2012.
    - Excluding the eligible professionals who avoided the payment adjustment for one of the reasons above, there were 51,797 who avoided the payment adjustment under a hardship exemption related to participation in the EHR Incentive Program (Meaningful Use) and another 11,679 eligible professionals who avoided the payment adjustment either by being approved for a significant hardship exemption (other than those related to participation in the EHR Incentive Program) or through CMS informal review.
- As seen in Figure 10, the number of electronic prescribers has been increasing steadily and accordingly, the number of eligible professionals subject to a payment adjustment has been declining.

[10] See section IV.E for more detail on the eRx payment adjustment.

Figure 10: Electronic Prescribing Trends – Participation (2009 to 2013) and Eligible Professionals Subject to the eRx Payment Adjustment (2012 to 2014)



2015 PQRS Payment Adjustment

- Prior to the informal review process, more than six out of ten eligible professionals avoided the reduction of 1.5 percent of their 2015 Part B MPFS charges, based on 2013 PQRS reporting; this left 469,755 eligible professionals who were subject to the adjustment (Table 22).[11]
    - 98 percent of those subject to the adjustment did not attempt to participate in PQRS, while 1.7 percent attempted participation but were not successful because they submitted only invalid QDCs and did not avoid the 2015 PQRS payment adjustment for any other reason. For more information on various types of QDC errors, please refer to the section on Challenges to Successful Reporting in Section III.C of this report.
- Eligible professionals who avoided the 2015 PQRS payment adjustment did so most often by reporting the required data or electing the administrative claims option (Figure 17, see section III.E of this report):
    - About 13 percent of eligible professionals (individual or group participants) avoided the adjustment because they did not meet the definition of an eligible

[11] See section III.E of this report for more information on the PQRS payment adjustment.

professional for the PQRS payment adjustment, had no 2013 MPFS charges, or did not have at least one denominator-eligible claim.

- Among eligible professionals not avoiding the payment adjustment based on reasons above, about one-fifth (N=165,680) avoided the adjustment by electing the administrative claims option.
- Finally, two thirds of those avoiding the payment adjustment (N=515,632), who did not avoid the payment adjustment for any of the reasons above, avoided it by actively reporting in PQRS and meeting the reporting criteria.

II. INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) implemented two pay-for-reporting programs for eligible professionals. The Physician Quality Reporting System (PQRS), authorized under Section 101(b) of division B of the TRHCA of 2006 (Public Law 109-423; 120 Stat. 2975), entered its seventh year in 2013 and has grown substantially from its inception in 2007. The Electronic Prescribing (eRx) Incentive Program, authorized under section 132 of the MIPPA, began in 2009; the program ended in 2013. These programs reward eligible professionals with payment incentives —determined based on a percentage of the estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional during the applicable reporting period – and provide for payment adjustments based on whether eligible professionals meet applicable requirements for reporting information on standardized clinical quality measures. For PQRS, 2014 is the last year in which eligible professionals can earn an incentive payment.

This report summarizes the 2013 and historical reporting experience of eligible professionals in the PQRS and eRx Incentive programs and preliminary PQRS data for the 2014 program year. Section III of this report presents detailed findings for PQRS, and Section IV presents similar information for the eRx Incentive Program. Sections V and VI describe information about feedback reports available under PQRS and the eRx Incentive Program and the services available from the Help Desk. Section VII provides overall conclusions. The Appendix is a separate document for interested readers, which contains additional descriptions of data and methods, as well as detailed tables of results. Since 2013 is the last year for the eRx Incentive Program, this will be the last year CMS will include results for the eRx incentive program in this report.

This report uses the term "eligible professional" to describe physicians and other health care professionals who could participate in PQRS and the eRx Incentive Program. The health care professionals who are eligible to participate in these programs are precisely identified on the CMS website.[12] In general, this includes professionals who furnish MPFS covered services to Medicare Part B (including Railroad Retirement Board [RRB] and Medicare Secondary Payer [MSP]) beneficiaries for whom selected PQRS measure(s) or the eRx Incentive Program measure are applicable.

The unit of analysis for describing eligible professionals was a combination of a professional's National Provider Identifier (NPI) number and the Taxpayer Identification Number (TIN) under which they billed for services; this is commonly referred to as a "TIN/NPI" (please see the Appendix for more detail). Findings reported at the practice level include both eligible professionals participating individually, summarized at the practice level, as well as practices that participated through the group practice reporting option (GPRO). For PQRS, the results include eligible professionals reporting (for the purposes of PQRS) through a Medicare Accountable Care Organization (ACO) under the Shared Savings Program (SSP), eligible professionals reporting through a Medicare ACO participating in the Pioneer ACO Model, and eligible professionals participating in the Comprehensive Primary Care (CPC) Initiative. Eligible professionals participating via the Pioneer ACO Model or the CPC initiative are summarized in this report as individual participants. While reporting through the GPRO or

[12] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS and http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive

through a Medicare ACO participating under the SSP are not individual participation options, unless otherwise noted, the participation information from these options were combined with participation information from the individual participation options to describe the total number of individual eligible professionals that participated in the programs.

The information and data in this report generally addresses PQRS and eRx Incentive Program, but also include certain PQRS data related to eligible professionals within Medicare ACOs under the Shared Savings Program (SSP), Pioneer ACO Model, and the Comprehensive Primary Care (CPC) initiative, given that eligible professionals within ACOs must report through the ACO for the purposes of earning a PQRS incentive and CPC participants can also earn a PQRS incentive. However, such eligible professionals participating in such initiatives outside the traditional PQRS are subject to the reporting, participation, and program requirements specific to that program. Unless otherwise indicated, the program requirements discussed below (e.g. reporting options, mechanisms, periods, criteria, measures, participation rules, etc.) pertain to PQRS.

III. PHYSICIAN QUALITY REPORTING SYSTEM

A. Background

Program Description

The information in this section primarily addresses the PQRS. In some places, however, we have included results related to the Medicare Shared Savings Program, the Pioneer ACO Model, and the CPC Initiative, given that EPs report through the program or these models for purposes of earning PQRS incentives. However, EPs participating in such initiatives outside of the traditional PQRS are subject to reporting, participation, and program requirements specific to the Shared Savings Program, Pioneer ACO Model, or CPC Initiative, as applicable (not the traditional PQRS). Unless otherwise indicated, the program requirements discussed here (e.g., reporting options, mechanisms, periods, criteria and measures; participation rules, etc.) generally pertain to the PQRS.

The Physician Quality Reporting System is part of an overall effort to move toward a value-based purchasing (VBP) system that aims to reward the value of care provided, rather than the quantity of services. To this end, PQRS quality measures are intended to define, standardize and drive improvement in the quality of health care. A payment adjustment, applicable to professionals who do not satisfy the criteria for reporting quality data under PQRS, is intended to encourage professionals to adopt evidence-based, outcomes-driven healthcare delivery practices.

The authorizing legislation for the program is contained in Section 101(b) of Division B (Medicare Improvements and Extension Act of 2006 [MIEA]) of the TRHCA, which was enacted on December 20, 2006. Section 101(b) of the MIEA-TRHCA added subsection K to section 1848 of the Social Security Act and required the establishment of a quality reporting system. CMS initially referred to the Physician Quality Reporting System as the Physician Quality Reporting Initiative or PQRI.

Section 101(c) of MIEA-TRHCA established a financial incentive for professionals to participate in a voluntary quality reporting program, which has been amended by subsequent legislation. An eligible professional who chose to participate in the 2007 program and satisfied the reporting criteria on a set of quality measures was eligible for an incentive, subject to a cap, equal to 1.5 percent of the total estimated Part B MPFS charges for covered professional services furnished by the eligible professional during the reporting period.

Program Evolution

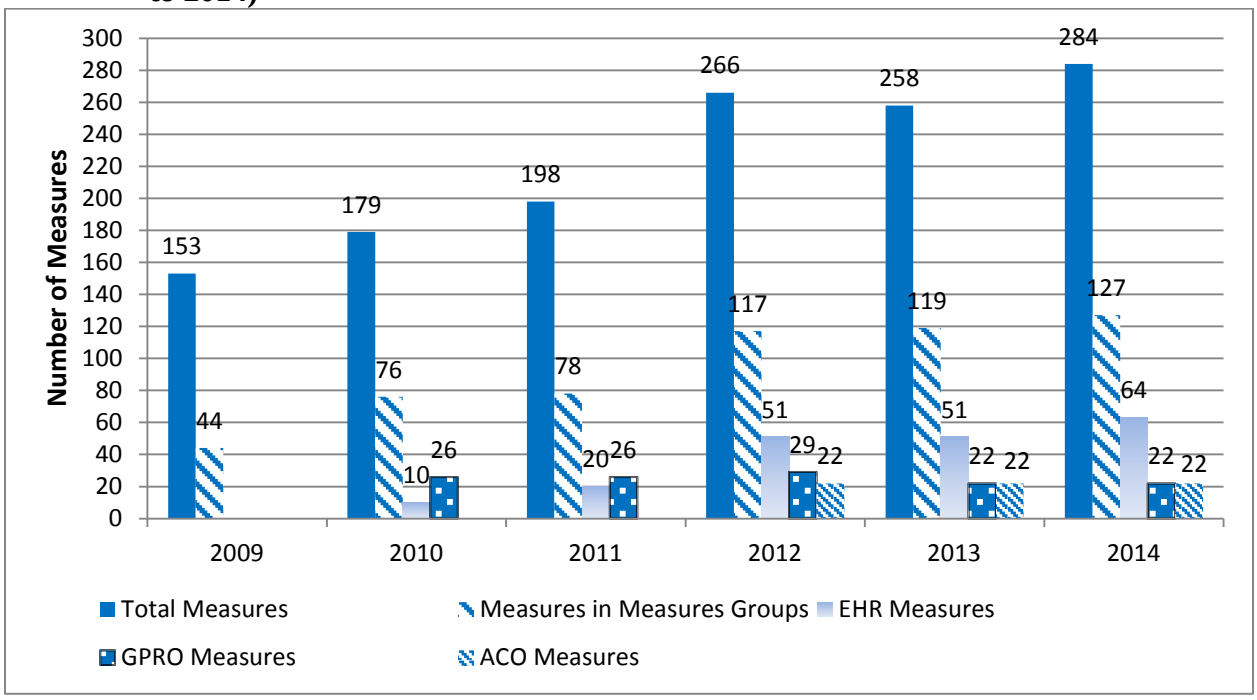
Measures for the 2007 program were defined by the TRHCA as quality measures that were developed under the Physician Voluntary Reporting Program (PVRP) and published on the CMS website as of the date of enactment of the TRHCA. The statute also provided that measures could be changed by the Secretary through a consensus-based process if such changes were published on the CMS website by a specified date. A portion of the 74 measures and their specifications were developed by the American Medical Association-Physician Consortium for Performance Improvement (AMA-PCPI), physician specialty organizations, and the National Committee for Quality Assurance (NCQA). The AMA-PCPI collaborated with CMS on defining reporting specifications for measures used in the 2007 program and developed instructions on

how data would be captured through a claims-based reporting process using quality data codes (QDCs) based on either Current Procedural Terminology (CPT) II codes or G-codes. QDCs indicate performance of a quality action, non-performance of the action, or an exclusion from performing the action. The Appendix to this report provides a description of how eligible professionals submit quality measure data to CMS.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), enacted on December 29, 2007 (Pub. Law 110-173), extended the quality reporting system through 2008 and 2009. The MMSEA authorized incentive payments for 2008 and removed the cap on the total earned incentive amount previously mandated by TRHCA. Additionally, the MMSEA required that CMS establish alternative reporting periods, criteria for reporting groups of clinically-related measures, and collecting quality information through a clinical data registry. Registries do not require QDCs to accept clinical data. In 2008, MIPPA (Pub. Law 110-275, section 131(b)) made changes to the quality measure requirements as well as authorized incentives through 2010. In 2009 and 2010, the applicable quality percent for the incentive was set at two percent; it was decreased to one percent in the 2011 program year and to one-half percent for the 2012 and 2013 program years. The Patient Protection and Affordable Care Act, Pub. Law 111-148, enacted on March 23, 2010, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. Law 111-152, and collectively known as the Affordable Care Act, made a number of changes to the PQRS, including authorizing incentive payments through 2014 and requiring a penalty, beginning in 2015, for eligible professionals and group practices who do not meet reporting requirements, described in more detail below. The Affordable Care Act also authorized an additional incentive (an additional one-half percent of MPFS allowed charges) for 2011 through 2014 for eligible professionals who satisfactorily report data on quality measures under PQRS and satisfy certain requirements related to participation in a Maintenance of Certification Program Incentive (MOCP); MOCP requirements are described in more detail in section III.B. Section 601(b) of the American Taxpayer Relief Act of 2012 (Pub. Law 112-240, enacted January 2, 2013) included an amendment to Section 1848 (m)(3) of the Social Security Act which would expand quality reporting options to include QCDRs for 2014 and subsequent years.

CMS has continued to expand the number of measures and reporting options and mechanisms for PQRS each year (Figure 11). For example, the total number of measures available was 153 in 2009, 179 in 2010, 198 in 2011, and 266 in 2012. The 2013 program has 258 total measures; 10 measures were added and 18 measures were retired. The 2014 program further expanded the number of measures to 284. Appendix Table A1 lists all individual measures that could be reported in the program during 2013.

Figure 11: Number of Individual PQRS Measures by Reporting Mechanism/Option (2009 to 2014)



Notes for Figure 11: Categories are not mutually exclusive; for example, an individual measure can also be part of a measures group. GPRO counts for PQRS in 2011 do not include the GPRO II reporting option and GPRO counts in 2013 and 2014 include web interface measures only. The number of measures also includes measures reported by EPs through Medicare ACOs participating in the SSP and Pioneer ACO Model and measures reported by EPs through the CPC Initiative.

Measures groups were introduced to PQRS in the 2008 program year and expanded each year thereafter.[13] For program years from 2008 through 2014, measures groups are a subset of four or more clinically-related measures; in 2015, measures groups contain six or more clinically-related measures. The 2008 program included four measures groups that could be reported via the claims or the registry mechanisms. The 2009 program added four measures groups and retired one, for a total of seven measures groups, one of which was reportable via the registry mechanism only. The 2010 program added six measures groups, three of which were reportable via registry only, for a total of 13 measures groups. The 2011 program added one additional measures group for a total of 14, and the 2012 program added eight new measures groups (six registry only) for a total of 22. The 2013 program added one measure group and retired one group to maintain a total of 22, and the 2014 program added three groups for a total of 25 measures groups.

CMS has revised measure group reporting requirements over the years to simplify measure group reporting. Beginning in 2009, CMS introduced a new QDC that allowed eligible professionals reporting on measures groups to use a single code to indicate if all recommended quality actions were performed for each measure in the group. That is, eligible professionals could report a single QDC—referred to as a composite G-code—for the entire measures group. Before this code existed, eligible professionals reported one QDC for each measure within the

[13] Measures groups do not apply to reporting by ACOs participating in the SSP and Pioneer ACO Model or to the CPC Initiative.

measures group. Moreover, in an effort to simplify measures group reporting, the 2009 program year requirement to report on consecutive patients was removed. That is, beginning in the 2010 program year, eligible professionals could report a measures group measure on 30 non-consecutive beneficiaries—appropriate for the measures group—during the reporting period. This change applied to reporting measures groups through both claims and a registry. The 2013 program lowered the required patient count from 30 to 20 patients.

The available measures groups in 2013 were:

- Asthma (four measures)
- Back pain (four measures) – measures group only
- Cataracts (four measures) – registry only
- Chronic kidney disease (CKD) (four measures)
- Chronic obstructive pulmonary disease (COPD) (five measures)
- Cardiovascular prevention (CVP) (six measures)
- Coronary artery bypass graft (CABG) surgery (10 measures) – registry only
- Coronary artery disease (CAD) (four measures) – registry only
- Dementia (nine measures)
- Diabetes mellitus (six measures)
- Heart failure (four measures) – registry only
- Hepatitis C (eight measures)
- HIV/AIDS (six measures) – registry only
- Hypertension (eight measures) – registry only
- Inflammatory bowel disease (IBD) (eight measures) – registry only
- Ischemic vascular disease (IVD) (four measures)
- [New] Oncology (eight measures) – registry only
- Parkinson's disease (six measures) – registry only
- Perioperative care (four measures)
- Preventive care (nine measures)
- Rheumatoid arthritis (six measures)
- Sleep apnea (four measures) – registry only

As seen in Figure 11, the number of measures reportable via the EHR mechanism has expanded from ten measures in 2010 to 51 measures in 2013 and 63 in 2014. The measures under the

GPRO web interface grew modestly from 26 in 2010 and 2011 to 29 in 2012 and in 2013 were reduced to 22 measures and aligned with the ACO GPRO measures.

In addition to expanding the available measures, CMS has continued to refine the avenues for participation in the PQRS, as shown in Table 6. Reporting via a qualified EHR vendor directly was added to the program in 2010. In 2012, CMS added an EHR data submission vendor reporting mechanism, under which eligible professionals could work with an approved data submission vendor to submit EHR data on their behalf, rather than directly submitting EHR data. Beginning in 2014, the claims-based measures group reporting mechanism was no longer available, although measures groups continued to be reportable via registry.

Table 6: Summary of PQRS Reporting Mechanisms and Alternative Programs (2007 to 2014)

Reporting Mechanisms or Alternative Programs	2007	2008	2009	2010	2011	2012	2013	2014
Claims Individual Measures	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Claims Measures Groups	No	Yes	Yes	Yes	Yes	Yes	Yes	No
Registry Individual Measures	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Registry Measures Groups	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Electronic Health Record (EHR) Individual Measures	No	No	No	Yes	Yes	Yes	Yes	Yes
GPRO Web Interface	No	No	No	Yes	Yes	Yes	Yes	Yes
GPRO Claims	No	No	No	No	Yes	No	No	No
GPRO Registry	No	No	No	No	Yes	No	Yes	Yes
GPRO EHR	No	No	No	No	No	No	No	Yes
ACO via GPRO Web Interface	No	No	No	No	No	Yes	Yes	Yes
CPC	No	No	No	No	No	No	Yes	Yes
QCDR	No	No	No	No	No	No	No	Yes

Notes for Table 6: GPRO was a reporting option for practices with 200 or more professionals in 2010. In 2011, the GPRO II option was added for practices with 2 to 199 professionals. In 2012, GPRO I and GPRO II were replaced with Large (100+ NPIs) and Small GPRO (25-99 NPIs). In 2013 and 2014, the GPRO includes Small (2-24 NPIs), Medium (25-99 NPIs), and Large (100+ NPIs).

The group reporting option was introduced in 2010 for practices with 200 or more eligible professionals. GPRO reporting differs from reporting for individually participating eligible professionals. To participate through the GPRO, a group practice self-nominates with CMS.[14] Among practices that met requirements and were approved to participate through the GPRO, CMS provided a web interface containing a pre-selected sample of patients with select patient demographic and utilization characteristics.[15] The practices were responsible for completing data

[14] For more information see: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html

[15] In the 2011 program, GPRO I used the web interface for reporting; GPRO II practices used claims, registry, or EHR reporting. In both 2010 and 2012, group practices could report via one method, a database tool and an online web interface, respectively. In 2013, Small GPRO practices could only report via registry, while those participating in the Medium and Large GPRO could report via web interface or registry.

fields to report specific quality actions for GPRO measures for the selected patients. The GPRO was expanded in 2011 to include "GPRO I" for practices with 200 more eligible professionals and "GPRO II" for practices with 2 to 199 eligible professionals. In 2012, GPRO I and GPRO II were replaced with Small GPRO for practices with 25 to 99 eligible professionals and Large GPRO for practices with 100 or more eligible professionals. In 2013, the GPRO option was further refined to include: Small GPRO (2 to 24 eligible professionals), Medium GPRO (25 to 99 eligible professionals, and Large GPRO (100 or more eligible professionals); these groups were maintained for the 2014 program year. Figure 12 presents a summary of GPRO options over time.

Figure 12: Group Practice Reporting Options (2010 – 2013)

<table>
<tr><th>GROUP SIZE</th><th>2010</th><th>2011</th><th>2012</th><th>2013</th></tr>
<tr><td>2-24</td><td>N/A</td><td rowspan="3">GPRO II</td><td>N/A.</td><td>SMALL GPRO</td></tr>
<tr><td>25-99</td><td>N/A</td><td>SMALL GPRO</td><td>MEDIUM GPRO</td></tr>
<tr><td>100-199</td><td>N/A</td><td rowspan="2">LARGE GPRO</td><td rowspan="2">LARGE GPRO</td></tr>
<tr><td>200+</td><td>GPRO</td><td>GPRO I</td></tr>
</table>

In 2010, the GPRO web interface quality measures included four disease modules (coronary artery disease, diabetes mellitus, heart failure, and hypertension) and four preventive care measures for 26 total measures. In 2012, CMS expanded this set by adding three disease modules (care coordination, chronic obstructive pulmonary disease, and ischemic vascular disease), adding preventive measures, and retiring certain other measures, resulting in a total of 29 quality measures for group practices to report under the GPRO in 2012. In 2013, the required GPRO web interface measures were reduced to 22 and aligned with the ACO GPRO measures. In 2013, ACOs and practices who reported via the web interface under the Large GPRO had to report a minimum of 411 patients per GPRO web interface measure or all eligible patients if fewer were available; practices participating under the Medium GPRO were required to report a minimum of 218 patients per GPRO web interface measure or all eligible patients if fewer were available. Beginning in 2013, a registry option was available as the only reporting mechanism for practices participating through the Small GPRO and an alternative participation mechanism for Medium and Large GPRO. Also beginning in 2013, practices with 100 or more NPIs reporting via the web interface were required to supplement PQRS reporting with the Consumer Assessment of

Healthcare Providers and Systems (CAHPS) survey. The CAHPS for PQRS survey includes the core questions contained in the CAHPS Clinician & Group Survey (Version 2.0), plus additional questions for a total of 12 patient experience of care summary survey measures.[16]

The satisfactory reporting criteria for the 2013 PQRS remained relatively consistent between 2012 and 2013 (Table 7). The requirements for measures groups reporting were simplified, removing the patient percentage options and reducing the patient count from 30 to 20 patients. The six-month reporting option was removed from the registry measures groups option. Measures with a zero (0) percent performance rate (or 100 percent for inverse measures[17]) continued to not count toward requirements for satisfactory reporting for any individual reporting method. Individual eligible professionals who reported individual measures through claims had to report at least 50 percent of eligible instances; for measures groups they had to report on at least 20 patients. The Measures Applicability Validation (MAV) process continued in 2013, which determines if eligible professionals satisfactorily reported despite reporting fewer measures (e.g., less than three). As in prior years, the MAV was applied for eligible professionals who satisfied the reporting criteria (e.g., 50 percent for claims-based measures in 2013) for one or two individual measures and did not report other measures. See Appendix A for more details on the MAV process.

As shown in Table 7, for eligible professionals who earned an incentive, the payment in the 2013 program year continued to be one-half percent of total estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional in the applicable reporting period.[18] The applicable quality percent will remain one-half percent for the 2014 program.

Table 7: Summary of PQRS Incentives, Measures and Reporting Criteria for Eligible Professionals Participating as Individuals (2011 to 2014)[19]

Statistic	2011	2012	2013	2014
Applicable Quality Percent[a]	1% of MPFS allowed charges	0.5% of MPFS allowed charges	0.5% of MPFS allowed charges[b]	0.5% of MPFS allowed charges[b]
Number of Measures and Measures Groups	198 Total Measures 14 Measures groups	266 Total Measures 22 Measures groups	258 Total Measures 22 Measures groups	284 Total Measures 25 Measures groups

[16] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/CMS-Certified-Survey-Vendor.html

[17] Inverse measures are measures for which a lower performance rate indicates better performance.

[18] As required by law, President Obama issued a sequestration order on March 1, 2013. Under these mandatory reductions, PQRS incentive payments made to eligible professionals and group practices have been reduced by two percent. This two percent reduction affected PQRS incentive payments for reporting periods that ended on or after April 1, 2013. All 2014 incentive payments are subject to sequestration.

[19] For further details, see the Medicare Physician Fee Schedule (PFS) Final Rules for each calendar year. 2011: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS1240932.html. 2012: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS1253669.html. 2013: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1590-FC.html. 2014: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-FC.html.

Statistic	2011	2012	2013	2014
Individual Measures Reporting Criteria	· Claims: 3 measures (or 1-2 measures subject to MAV) and 50% of eligible instances · Registry & EHR: report a minimum of 3 measures and 80% of eligible instances	· Claims: 3 measures (or 1-2 measures subject to MAV) and 50% of eligible instances · Registry: report a minimum of 3 measures and 80% of eligible instances · EHR: Option 1: report a minimum of 3 measures and 80% of eligible instances. Option 2: report all 3 PQRS EHR measures that are also Medicare EHR Incentive Program core measures; if the denominator for one or more of the Medicare EHR Incentive Program core measures is 0, report on up to 3 PQRS EHR measures that are also Medicare EHR Incentive Program alternate core measures AND report on 3 additional PQRS EHR measures that are also available for the Medicare EHR Incentive Program	· Claims: 3 measures (or 1-2 measures subject to MAV) and 50% of eligible instances · Registry: report a minimum of 3 measures and 80% of eligible instances · EHR: Option 1: report a minimum of 3 measures and 80% of eligible instances Option 2: report all 3 PQRS EHR measures that are also Medicare EHR Incentive Program core measures; if the denominator for one or more of the Medicare EHR Incentive Program core measures is 0, report on up to 3 PQRS EHR measures that are also Medicare EHR Incentive Program alternate core measures AND report on 3 additional PQRS EHR measures that are also available for the Medicare EHR Incentive Program	· Claims and registry: 9 measures for at least 3 NQS domains (or 1-8 measures covering 1-3 NQS domains, subject to MAV) and 50% of eligible instances · EHR: 9 measures for at least 3 NQS domains. If an EP's CEHRT does not contain 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 at least 1 measure for which there is Medicare patient data. ·QCDR: at least 9 measures, of which 1 must be an outcome measure, available for submission under the QCDR, covering at least 3 NQS domains, and at least 50% of eligible instances
Measures Group (MG) Reporting Criteria[c]	Report on all measures in at least 1 MG for: · Claims: 50% eligible Medicare patients (min of 8 or 15 patients) · Registry: 80% eligible Medicare patients (min of 8 or 15 patients) or 30 patients	Report on all measures in at least 1 MG for: · Claims: 50% eligible Medicare patients (min of 8 or 15 patients) via Claims · Registry: 80% eligible Medicare patients (min of 8 or 15 patients) or 30 patients	Claims and registry: Report on all measures in at least 1 MG for: · 20 patients. A majority of patients (11 out of 20) must be Medicare Part B FFS patients.	Registry: Report on all measures in at least 1 MG for: · 20 patients. A majority of patients (11 out of 20) must be Medicare Part B FFS patients. Measure Groups containing a measure with a 0% performance rate will not be counted.

Statistic	2011	2012	2013	2014
Group Reporting Criteria	· GPRO I (200 or more EPs) web interface: At least 411 patients per GPRO measure. · GPRO II (2 – 199 EPs) claims and registry (varied by practice size): submit a specified number of patients for one to four measures groups as well as at least 50 percent of patients for 3 to 6 individual measures via claims and 80 percent of patients via registry.	· Large GPRO (100 or more EPs) web interface: At least 411 patients per GPRO measure. · Small GPRO (25 – 99 EPs) web interface: At least 218 patients per GPRO measure.	· Large GPRO (100 or more EPs) web interface: At least 411 patients per GPRO measure and report CAHPS for PQRS. · Medium GPRO (25 – 99 EPs) web interface: At least 218 patients per GPRO measure. · GPRO (2 or more EPs) registry: Report a minimum of 3 measures and 80% of eligible instances.	· Large GPRO (100 or more EPs) web interface: At least 411 patients per GPRO measure and report CAHPS for PQRS. · Medium GPRO (25 – 99 EPs) web interface: At least 218 patients per GPRO measure. · GPRO (2 or more EPs) registry: 9 measures across 3 NQS domains (or MAV if fewer than 9 measures or fewer than 3 domains) for at least 50% of eligible instances. · GPRO (2 or more EPs) EHR: 9 measures for at least 3 NQS domains. If a group's CEHRT does not contain data for at least 9 measures covering at least 3 domains then the group must report the measures for which there is Medicare patient data. A group must report at least 1 measure for which there is Medicare patient data.

Notes for Table 7: Information in this table does not apply to EPs participating in Medicare ACOs under the SSP or the Pioneer ACO Model, nor does it apply to those participating under the CPC Initiative. [a]*Applicable Quality Percent is applied to estimated allowed charges for covered professional services furnished by the eligible professional in the applicable reporting period.*
[b]*For 2013, Incentive payments made through PQRS are subject to the mandatory reductions in federal budgetary resources known as sequestration, required by the Budget Control Act of 2011. The American Taxpayer Relief Act of 2012 postponed sequestration for 2 months. As required by law, President Obama issued a sequestration order on March 1, 2013. Under these mandatory reductions, PQRS incentive payments made to eligible professionals and group practices will be reduced by 2%.*
[c]*Minimums of 8 and 15 patients apply to 6-month and 12-month reporting periods, respectively.*

Eligible professionals continued to have the opportunity to receive an additional incentive based on a quality percent of one-half percent in 2013 by participating in a MOCP and by meeting all of the following requirements:

- Satisfactorily report quality measures under PQRS either individually or as part of a selected group practice, AND
- More frequently than is required to qualify for or maintain board certification, participate in a MOCP, AND
- More frequently than is required to qualify for or maintain board certification, successfully complete a qualified MOCP practice assessment.

In 2014, CMS introduced numerous changes to reporting requirements and mechanisms to further align with national quality goals and other programs. The biggest change in 2014 is a new satisfactory reporting requirement requiring eligible professionals using any mechanism to submit *nine* measures across three National Quality Strategy (NQS) domains. Other changes to the 2014 program include: the number of available measures was increased to 284; the measure-applicability validation (MAV) process was expanded to registry reporting; and there are 25 measures groups available in 2014, but reporting via measures groups is available for the registry mechanism only. In addition, a new qualified clinical data registry (QCDR) reporting method is available for individual participants in 2014 and can also be used to meet Medicare EHR Incentive Program requirements.[20] Finally, as noted above, group practices reporting via the GPRO are able to report via EHR in addition to registry and web interface, and groups of 100 or more EPs reporting via web interface are required to report CAHPS for PQRS survey measures.

PQRS Payment Adjustment

As mandated by the Affordable Care Act, a payment adjustment for the PQRS program was implemented in 2015, based on 2013 reporting. Eligible professionals and groups who did not meet reporting requirements in 2013 are subject to a 1.5 percent reduction in their MPFS allowed charges in 2015. To avoid the PQRS payment adjustment for 2015, individual eligible professionals and group practices had to meet the following requirements:

- Meet the requirements for satisfactory reporting for incentive eligibility for the 2013 PQRS program, for the applicable participation option and mechanism, or
- Report at least one valid measure via the mechanisms available[21], or
- Elect to participate in the administrative claims-based reporting option via the Physician Value-PQRS (PV-PQRS) Registration System between July 15, 2013 and October 15, 2013.

Other reasons for avoiding the payment adjustment included not being eligible for PQRS: not having at least one eligible denominator claim, not meeting the definition of an eligible professional for the PQRS payment adjustment, or not having any MPFS charges in 2013. Individual eligible professionals or group practices that have been notified that they are subject to the 2015 PQRS payment adjustment are able to request an informal review, as described in Section E.

CMS implemented further changes to the payment adjustment for 2016, based on 2014 reporting. The administrative claims method was eliminated as a method to avoid the 2016 PQRS payment adjustment; to avoid an adjustment of two percent of MPFS allowed charges in 2016, eligible professionals and groups will have to meet more stringent criteria than needed to avoid the 2015

[20] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Qualified-Clinical-Data-Registry-Reporting.html

[21] Practices reporting via the GPRO web interface (i.e. practices reporting under the GPRO and Medicare ACOs reporting through the SSP or Pioneer ACO Model) had to report at least one patient for a measure; eligible professionals in CPC practice sites who were in a position to take advantage of the waiver had to meet reporting requirements under CPC; EHR participants had to submit data with at least one valid HIC number.

adjustment. The PQRS Payment Adjustment is described in more detail in section III.E of this report.

B. Incentive Payments

The incentive for the 2013 PQRS was equal to one-half percent of estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional (professional and technical services) during the applicable reporting period. We have included results for eligible professionals within Medicare ACOs reporting under the SSP and Pioneer ACO Model given EPs participating in these ACOs must report through those initiatives for the sake of earning PQRS incentives, as well as for eligible professionals within practices participating in the CPC initiative and earning a PQRS incentive for meeting electronic Clinical Quality Measure (eCQM) reporting requirements under that program. This section reports the incentives earned by eligible professionals and groups, prior to a two percent reduction in payments from sequestration.[22]

Overall, a total of $218,930,348 in incentive payments (excluding additional MOCP incentive payments) were earned by 494,619 eligible professionals for the 2013 program year, with an average payments of $443 (Table 5).[23] This includes incentives earned by 48,313 practices (including individually participating eligible professionals, summarized at the practice level, as well as practices that earned an incentive under the GPRO or as practice participating as an ACO or in the CPC initiative), with an average incentive payment of $4,531 per practice for the 2013 program year.

Over two thirds (68 percent) of total incentives were earned by eligible professionals qualifying for an incentive through an individual reporting mechanism (claims, registry, or EHR) (Appendix Table A41). A total of $35,998,218 was earned by 516 practices qualifying for an incentive via the GPRO; most GPRO incentives were earned by 253 practices participating via the Large GPRO (Appendix Table A41). An additional $33,017,405 was earned by the 214 practices qualifying for an incentive as a Medicare ACO participating under the SSP, and $6,719,135 was earned by 22 practices qualifying for an incentive as a Pioneer ACO. Average incentives earned by group reporting practices were larger than those earned by practices of individual participants; for example, the average practice-level incentive earned by practices participating via the Large GPRO was $126,916 compared to an average of $4,531 per incentive-eligible practice overall.

As seen in Figure 1, the numbers of eligible professionals and practices earning PQRS incentives grew between 2007 and 2013. The average incentive payments increased from 2007 to 2010 but have since decreased due to the decrease in the applicable quality incentive percent from two percent in 2010 to one percent in 2011 to one-half percent in 2012 and 2013 (Figure 2).

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[22] As required by law, President Obama issued a sequestration order on March 1, 2013. Under these mandatory reductions, PQRS incentive payments made to eligible professionals and group practices have been reduced by two percent. This two percent reduction affected PQRS incentive payments for reporting periods that ended on or after April 1, 2013. All 2014 incentive payments are subject to sequestration.

[23] Eligible professionals who met incentive eligibility criteria but had no Part B MPFS charges for covered professional services furnished by the eligible professional during the reporting period had an incentive amount of $0.00. These eligible professionals were not included in counts of those who were paid an incentive in this report. For additional explanation, please see the Appendix.

Incentive Payments by Specialty

Total incentive payments by specialty under the PQRS are determined both by the number of eligible professionals within the specialty who qualify for an incentive and by total Part B MPFS allowed charges for covered professional services furnished by those eligible professionals during the applicable reporting period. Therefore, variations in total incentive payments by specialty reflect differences both in incentive eligibility rates (number of eligible professionals who received an incentive divided by the number of eligible professionals who participated) and in Part B MPFS allowed charges for covered professional services furnished by the eligible professionals during the applicable reporting period. Appendix Table A2 displays the distribution of incentive payments by specialty and shows that there was a wide range in average incentive payments across specialties from $8 for Certified Nurse Midwives to $1,937 for Radiation Oncologists.

Appendix Table A3 presents the average potential incentive that could have been earned if 100 percent of individual eligible professionals participated and qualified for an incentive during a 12-month reporting period. This was calculated by summing the total 2013 Part B MPFS allowed charges for covered professional services furnished during the 12-month reporting period by all eligible professionals who could have participated in 2013, dividing by the number of those individual eligible professionals, and taking one-half percent of this value. Overall, the average potential incentive was $343 for all specialties, but exceeded $1,000 for six specialties.

Additional Incentive Payments for Participation in Maintenance of Certification Program Incentive (MOCP)

As in 2011 and 2012, in 2013 eligible professionals who qualified for a PQRS incentive based on a 12-month reporting period could earn an additional incentive of one-half percent of total Part B MPFS allowed charges by meeting reporting and participation requirements related to MOCPs. To be eligible for the additional incentive payment (referred to in this report as the MOCP incentive), an incentive eligible professional had to be a physician. For the purposes of this program, the term “physician” was limited to doctors of medicine; doctors of osteopathy; doctors of dental surgery or of dental medicine; doctors of podiatric medicine; doctors of optometry; and doctors of chiropractic. In 2013, 18 boards were qualified for the MOCP incentive, compared to seven boards in 2011 and 13 in 2012. These boards collected and reported data to CMS on behalf of participating eligible professionals. Thirty-nine specialties earned MOCP incentives in 2013, compared to 28 in 2012, and only eight in 2011.

Tables 8 and 9 show MOCP incentives earned by participation mechanism and specialty. In the 2013 program, 9,091 eligible professionals earned an MOCP incentive payment, compared to 5,600 in 2012. Most eligible professionals earning an MOCP incentive payment qualified for an incentive through the claims reporting mechanism (Table 8). However, registry and EHR reporters earned a higher MOCP median incentive payment ($1,251 and $1,001, respectively) compared for claims reporters ($396). As seen in Table 9, the majority of eligible professionals earning an incentive payment were in emergency medicine (52 percent), followed by radiology (26 percent), pathology (three percent) and ophthalmology and ‘other eligible professional’ (two percent).

Table 8: PQRS MOCP Incentive Amounts by Participation Mechanism or Option (2013)

Level and Mechanism/Option	Number Eligible for MOCP Incentive	MOCP Median Incentive Payment	MOCP Mean Incentive Payment	MOCP Total Incentive Payments
Eligible Professional Level	--	--	--	--
Pioneer ACO	100	$404	$734	$73,373
CPC	--	--	--	--
Claims	6,723	$396	$571	$3,836,486
Registry	646	$1,251	$2,070	$1,337,124
EHR	83	$1,001	$1,176	$97,633
Small GPRO	36	$335	$773	$27,828
Medium GPRO	839	$270	$403	$338,284
Large GPRO	680	$294	$561	$381,687
SSP ACO	680	$294	$561	$381,687
Total (Unduplicated)	9,091	$398	$646	$5,870,627
Practice Level	--	--	--	--
Pioneer ACO	100	$404	$734	$73,373
CPC	--	--	--	--
Claims	6,723	$396	$571	$3,836,486
Registry	646	$1,251	$2,070	$1,337,124
EHR	83	$1,001	$1,176	$97,633
Small GPRO	36	$335	$773	$27,828
Medium GPRO	178	$495	$677	$120,501
Large GPRO	839	$270	$403	$338,284
SSP ACO	680	$294	$561	$381,687
Total (Unduplicated)	9,091	$398	$646	$5,870,627

Table 9: Eligible Professional MOCP Incentive Amounts by Specialty for Individual Participation Options (2011 to 2013)

Specialty	Number of Eligible Professionals who Earned MOCP Incentive in 2011	Total MOCP Incentive payments in 2011	Number of Eligible Professionals who Earned MOCP Incentive in 2012	Total MOCP Incentive payments in 2012	Number of Eligible Professionals who Earned MOCP Incentive in 2013	Total MOCP Incentive payments in 2013
MD/DO	--	--	--	--	--	--
Allergy/Immunology	0	$0	3	$897	3	$883
Anesthesiology	1	$231	0	$0	55	$15,544
Cardiology	0	$0	80	$178,739	83	$204,732
Colon/Rectal Surgery	0	$0	0	$0	27	$17,002
Critical Care	0	$0	4	$885	1	$350
Dermatology	35	$111,378	83	$255,750	77	$244,466
Emergency Medicine	1	$534	3,267	$1,074,165	4,718	$1,550,057
Endocrinology	0	$0	7	$4,795	7	$3,934
Family Practice	0	$0	5	$2,330	43	$23,705
Gastroenterology	0	$0	1	$712	12	$11,012
General Practice	0	$0	11	$2,130	8	$2,480
General Surgery	0	$0	0	$0	241	$175,707
Geriatrics	0	$0	3	$2,123	2	$2,288
Hand Surgery	0	$0	0	$0	1	$322
Infectious Disease	0	$0	1	$202	2	$1,062
Internal Medicine	8	$3,406	88	$76,002	122	$103,455
Interventional Radiology	60	$56,394	82	$85,605	112	$91,546
Nephrology	0	$0	19	$41,324	33	$56,184
Neurology	1	$0	0	$0	2	$958
Neurosurgery	0	$0	3	$1,854	0	$0
Nuclear Medicine	4	$2,464	2	$1,495	9	$5,377
Obstetrics/Gynecology	0	$0	4	$141	4	$2,094
Oncology/Hematology	1	$2,780	5	$8,578	20	$47,430
Ophthalmology	0	$0	115	$406,895	170	$548,418
Orthopaedic Surgery	0	$0	0	$0	1	$302
Other MD/DO	1	$17	3	$695	13	$13,901
Pathology	3	$395	0	$0	310	$144,953
Pediatrics	0	$0	2	$278	5	$1,154
Plastic Surgery	1	$2,491	0	$0	7	$2,448
Pulmonary Disease	0	$0	10	$20,890	10	$17,368
Radiation Oncology	71	$518,156	59	$188,499	143	$349,336
Radiology	833	$754,672	1,510	$1,243,332	2,406	$1,746,600
Rheumatology	0	$0	4	$5,205	5	$7,514
Thoracic/ Cardiac Surgery	0	$0	0	$0	25	$24,637
Vascular Surgery	0	$0	0	$0	66	$167,338
Other Eligible Professionals	--	--	--	--	--	--
Agencies/Hospitals/ Nursing and Treatment Facilities	0	$0	3	$255	13	$3,017

Specialty	Number of Eligible Professionals who Earned MOCP Incentive in 2011	Total MOCP Incentive payments in 2011	Number of Eligible Professionals who Earned MOCP Incentive in 2012	Total MOCP Incentive payments in 2012	Number of Eligible Professionals who Earned MOCP Incentive in 2013	Total MOCP Incentive payments in 2013
Nurse Practitioner	2	$1,355	0	$0	2	$310
Optometry	25	$12,797	45	$24,399	51	$22,586
Other Eligible Professional	19	$84,006	132	$119,847	221	$223,663
Physician Assistant	2	$726	0	$0	0	$0
Podiatrist	31	$18,882	50	$34,703	61	$36,495
Total (Unduplicated)	**1,099**	**$1,570,682**	**5,601**	**$3,782,726**	**9,091**	**$5,870,627**

Note for Table 9: Specialties not shown in Table 9 did not earn a MOCP incentive payment.

C. Participation

How to Participate

CMS provides multiple resources on the PQRS website to assist eligible professionals who choose to participate in the program.[24] The *2013 Measure List and Implementation Guide* gave guidance on how to determine which measures to report, the reporting method, and claims-based reporting principles. CMS also provides Frequently Asked Questions (FAQ's) covering a wide range of topics regarding the program.

In 2013, there were eight individual participation options and three participation group options for submitting measure data to PQRS. Unless otherwise noted, each mechanism applied to a 12-month period from January 1 to December 31, 2013:

1. Claims-Based Individual Measures. Eligible professionals could report QDCs for 137 individual measures via claims. To qualify for an incentive, eligible professionals had to report on at least three measures (or, if fewer than three apply, one or two measures, subject to a MAV review) for at least 50 percent of reporting opportunities.

2. Claims-Based Measures Group –Patient Count. Eligible professionals could report all applicable measures within at least one measures group available for claims reporting. To be incentive eligible, eligible professionals had to report all applicable measures for at least one measures group on at least 20 Medicare Part B FFS patients.

3. Registry-Based Reporting – Individual Measures. Eligible professionals could submit data on 203 measures through a qualified registry. To be incentive eligible, eligible professionals had to report three or more measures for at least 80 percent of their applicable Medicare Part B FFS patients.

[24] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/.

4. Registry-Based Reporting – Measures Groups Patient Count. Eligible professionals could submit data through a qualified registry. To be incentive eligible, eligible professionals had to report all applicable measures for at least one measures group on at least 20 patients (11 out of 20 patients had to be Medicare Part B FFS patients).

5. EHR – Direct Submission PQRS Only. Eligible professionals could submit data directly through a qualified EHR product. To be incentive eligible, eligible professionals had to report at least three of 51 available EHR measures for at least 80 percent of applicable Medicare Part B FFS patients.

6. EHR – Direct Submission PQRS/Medicare EHR Incentive Pilot. Alternatively, eligible professionals could align with the Medicare EHR Incentive Program by reporting all three EHR Incentive Program Core Measures (or, if the denominator for one or more of these is zero, report up to three of the 38 EHR Incentive Program alternate core measures) AND report three additional measures available for the Medicare EHR Incentive Program, via direct EHR submission.

7. EHR – Data Submission Vendor (DSV). Eligible professionals could submit data through a qualified data submission vendor. To be incentive eligible, eligible professionals had to report at least three of 51 available EHR measures for at least 80 percent of applicable Medicare Part B FFS patients seen by the eligible professional.

8. EHR – Data Submission Vendor PQRS/Medicare EHR Incentive Pilot. Eligible professionals could align with the Medicare EHR Incentive Program by reporting all three EHR Incentive Program Core Measures (or, if the denominator for one or more of these is zero, report up to three EHR Incentive Program alternate core measures) AND report three additional measures available for the Medicare EHR Incentive Program, via data submission vendor.

9. GPRO Registry Reporting. Practices with two or more NPIs that self-nominated and were selected for Small, Medium, or Large GPRO had to report on at least three measures for at least 80 percent of the practice's Medicare Part B FFS patients.

10. Medium GPRO – Web Interface. Practices with 25 to 99 NPIs that self-nominated and were selected by CMS had to complete all 22 measures in the GPRO web interface for a pre-populated patient sample of 218 patients.

11. Large GPRO – Web Interface. Practices with 100 or more NPIs that self-nominated and were selected by CMS had to complete all 22 measures in the GPRO web interface for a pre-populated patient sample of 411 patients.

In addition to the participation options for the traditional PQRS described above, Medicare ACOs participating in the SSP or Pioneer ACO Model were required to submit the same 22 quality measures via the GPRO web interface. EPs participating in ACOs could earn a PQRS incentive if the ACO met the same requirements as applicable to the Large GPRO. For further information on how EPs participating in a Medicare ACO under the SSP or Pioneer ACO Model, CMS provides multiple resources on its website. Practices that were part of the CPC and electing a PQRS waiver were required to meet the eCQM reporting requirements under that program to

qualify for a PQRS incentive. The CMS website includes further information on these programs and initiatives.[25]

Participation Results

In 2013, there were 1,253,595 professionals eligible to participate in PQRS, including 221,500 eligible professionals who were part of a group practice that self-nominated under the GPRO or as part of a Medicare ACO participating under the SSP (Appendix Table A4). Appendix Table A5 presents characteristics of eligible professionals that were eligible to participate in the 2013 PQRS. Most eligible professionals eligible for individual participation were in solo or relatively small practices and were in a primary care or other non-surgical specialty. Most eligible professionals eligible for group reporting (because their practice self-nominated) were in large practices (200 or more eligible professionals).

A broad range of specialties were eligible to report PQRS measures. Appendix Table A6 presents the number of eligible professionals who could have participated in PQRS through any reporting option by specialty for the 2010 to 2013 program years. As in prior years, internal medicine and family practice were the specialties with the largest number of eligible professionals who could have participated in the program in 2013 (over 100,000 each). Nurse practitioner and physician assistant also had large numbers eligible to participate (82,560 and 67,222, respectively). Almost all specialties had an increase in the number eligible to participate in the program between 2012 and 2013.

As shown in Figure 6 in the Executive Summary, each year of program operation has seen growth in participation across all reporting options except for a decline in registry reporting from 2011 to 2012.[26] Overall, 424,905 eligible professionals (41 percent of those eligible) participated individually in the 2013 PQRS (Appendix Table A4). In addition, 131,690 eligible professionals within 550 practices that participated under the GPRO and 85,059 eligible professionals participated through 220 Medicare ACOs participating under the SSP. Including all reporting options and participation in other programs for the sake of earning a PQRS incentive, the overall participation rate was 51.2 percent, and the total number participating in the PQRS increased 47 percent from 2012. Early data from the first half of 2014 show that the number of eligible professionals submitting data via the claims mechanism alone was close to the number in 2013 (Figure 5).

Eligible professionals who chose to participate in the 2013 PQRS using the registry or EHR-based reporting mechanisms contacted the CMS-qualified registries or EHR vendors listed in the posted CMS qualified lists.[27] In 2013, there were 70 qualified registries that could submit data on behalf of eligible professionals, 55 of which submitted quality measure information. There were

[25] Information on the SSP can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html; information on the Pioneer ACO Model can be found at http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/; and information on the CPC Initiative can be found at http://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/.

[26] Participation here includes participation in the traditional PQRS as well as participation in other programs for the purposes of earning a PQRS incentive and avoiding the PQRS payment adjustment (i.e. the SSP, Pioneer ACO Model, and CPC Initiative).

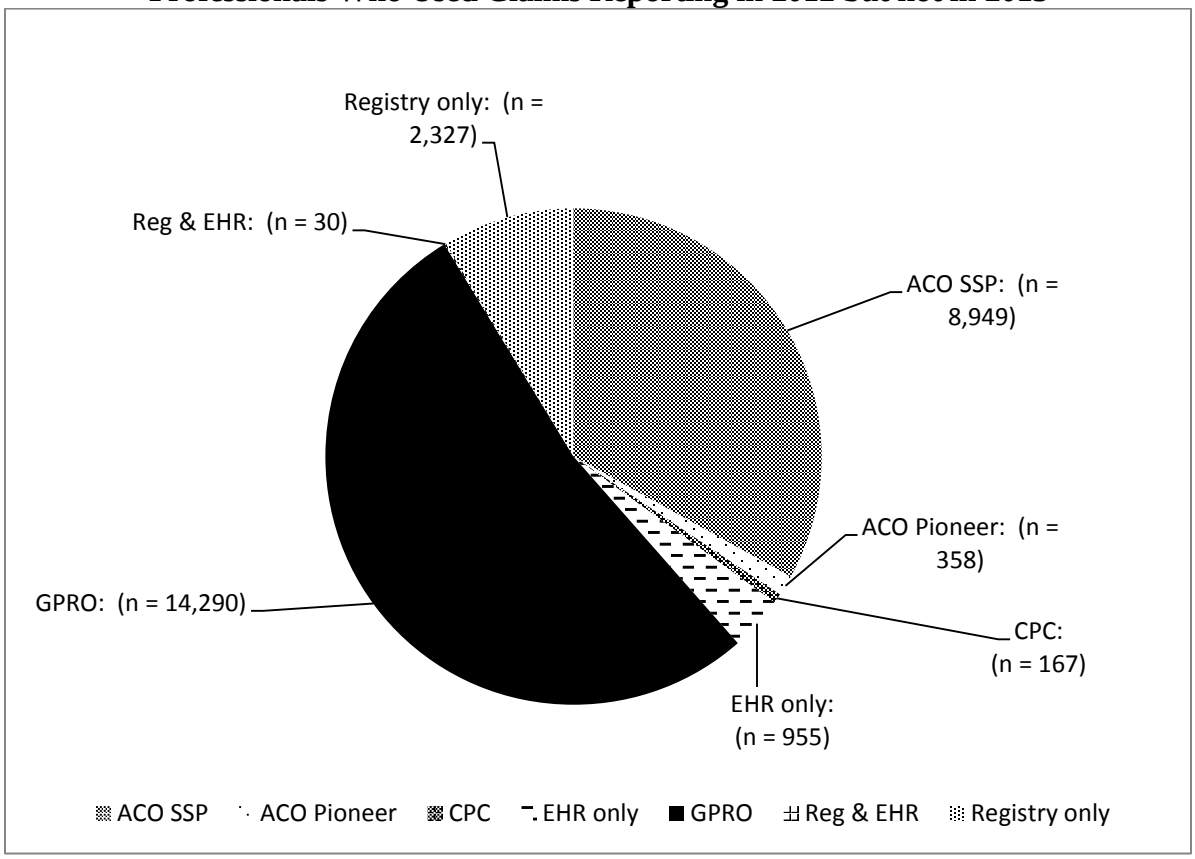
[27] Both lists can be found at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/2013-Physician-Quality-Reporting-System.html

24 approved EHR products for those choosing Direct EHR submission (of which 12 were used) and 53 approved EHR data submission vendors qualified by CMS to submit EHR data on behalf of participants (22 of these vendors submitted data).

Within the individual reporting option, 78 percent of participants used the claims mechanism (n=331,668), while 16 percent (n=67,631) used registry reporting, and five percent (n=23,194) participated via EHR (Appendix Table A4). Participation in the EHR option increased moderately from 19,817 in 2012, while use of registry reporting increased by 45 percent from 2012, after a decline between 2011 and 2012. Most claims and registry participants participated via individual measures, although those using measures groups accounted for nearly one-quarter of registry participants. Within the EHR mechanism, over three-quarters of participants submitted via the Data Submission Vendor option. About five percent of individual participants participated via more than one participation mechanism: four percent of individual participants participated via claims and registry, one percent participated via claims and EHR, and 0.2 percent participated via registry and EHR (data not shown).

Most participants using the claims-reporting mechanism in 2013 had also used the claims reporting mechanism in 2012. Among the 347,249 eligible professionals who participated in the program in both 2012 and 2013, 50 percent (n=174,450) used claims reporting in both years (including those who participated through more than one reporting mechanism), and 47 percent used claims reporting only in both years (data not shown). Figure 13 presents the distribution among 27,076 participants in both 2012 and 2013 who elected to report via claims in 2012 but used alternative mechanisms or programs for the purpose of earning a 2013 PQRS incentive (i.e. through registry, EHR, through the CPC Initiative, or through the web interface as part of a practice that participated under the GPRO or a Medicare ACO participating under the SSP or Pioneer ACO Model). Over half (53 percent) of these eligible professionals who used a mechanism other than claims in 2013 were in a practice participating via the GPRO in 2013, followed by 33 percent in an SSP ACO, nine percent reporting via registry only, four percent through EHR only, one percent participating via a Pioneer ACO or as part of the CPC initiative, and less than one percent using both registry and EHR.

Figure 13: Reporting Mechanisms/Options/Alternative Programs Used in 2013 by Eligible Professionals Who Used Claims Reporting in 2012 but not in 2013

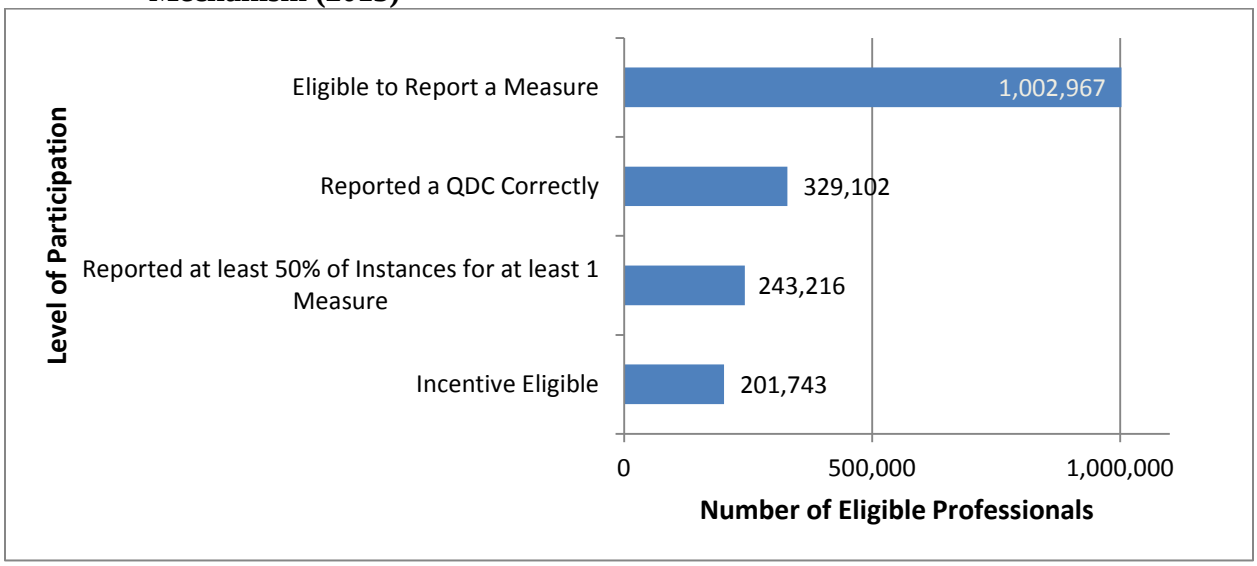


Note for Figure 13: This chart represents the 27,076 eligible professionals that switched from claims reporting in 2012 to other forms of reporting in 2013.

Figure 14 summarizes participation through the claims-based individual measure reporting mechanisms in 2013. Over one million professionals were eligible to participate individually in PQRS in 2013, and one third of these professionals participated by submitting at least one QDC without error via claims. Among all eligible professionals attempting to submit a QDC (n=344,282), about four percent submitted all invalid QDCs (n=15,180) (data not shown). Ultimately, one fifth of professionals eligible to submit claims-based individual measures to PQRS qualified for an incentive in 2013.

Figure 14 presents a summary of participation via the individual claims mechanism in 2013. Out of the 1,002,967 eligible professionals who could have participated individually via claims, 329,102 submitted at least one QDC correctly and were counted as participating. Among those, 243,216 (74 percent) submitted data for at least 50 percent of eligible instances for at least one measure, and 201,743 did so for enough measures to earn an incentive.

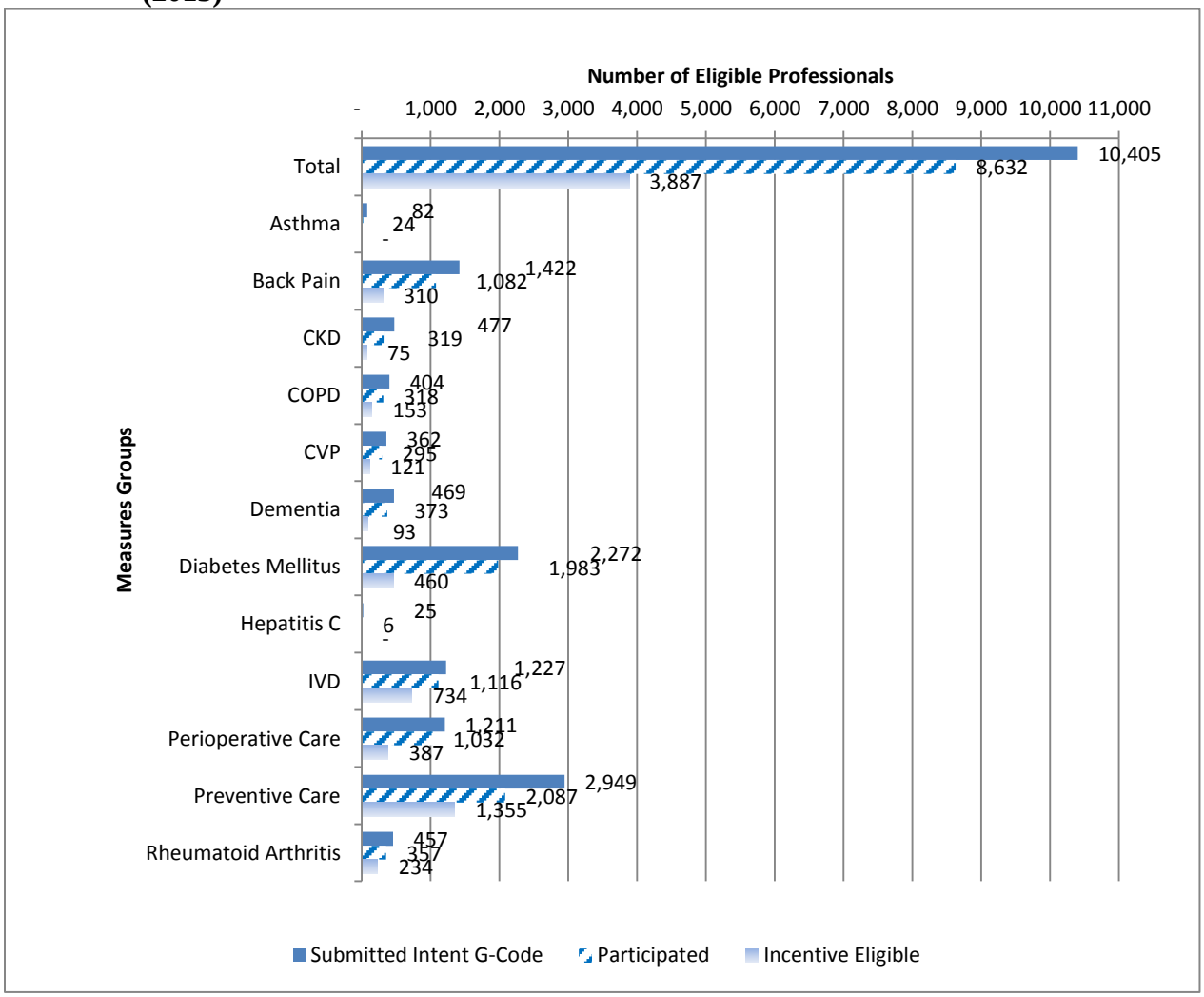
Figure 14: Summary of Individual Measures Reported through the PQRS Claims Mechanism (2013)



Use of Measures Groups and Registries

The number of measures groups available for reporting under PQRS expanded from four to 22 between 2008 and 2013 (one was added and one was retired for 2013). The number of eligible professionals who participated via the claims-based measures groups reporting mechanism grew modestly between 2009 and 2012, and by 81 percent between 2012 and 2013, though this was still a very small proportion of claims-based reporting (Appendix Table A10). Claims-based measures group reporting was concentrated in family practice and internal medicine, followed by cardiology, and orthopaedic surgery (Table 11). Figure 15 shows the number of eligible professionals signaling their intention to participate in the claims-based measures group reporting option by submitting intent G-codes, submitting QDCs, and attaining incentive eligibility within each claims-based measures group. The preventive care measures group was reported the most by eligible professionals, followed by the diabetes, ischemic vascular disease (IVD), and back pain measures groups.

Figure 15: Summary of Measures Groups Reported through the PQRS Claims Mechanism (2013)



Note for Figure 15: Results do not include data for eligible professionals who were part of a practice that participated under the PQRS GPRO, through the CPC Initiative, or as part of a Medicare ACO under the Shared Savings Program or the Pioneer ACO Model.

Participation in the registry-based measures group reporting option was more common than participation through claims-based measures groups; 16,423 eligible professionals used a registry-based measures group in 2013 compared to 8,632 using claims-based measures groups. However, this still represented a minority of registry reporters (Appendix Table A12). The number of eligible professionals participating using registry measures groups increased noticeably in 2013, following declines in 2011 and 2012. Use of registry measures group reporting was concentrated within family practice, internal medicine, cardiology, and nephrology (Table A12).

The number of registries submitting data on behalf of eligible professionals has fluctuated over time. In 2008, 31 qualified registries submitted PQRS data on behalf of eligible professionals, compared to 87 in 2011, 56 in 2012, and 55 in 2013 (data not shown). Table 10 displays the registries that submitted data for the most eligible professionals in 2013; this reflects data from

both PQRS and the eRx Incentive programs.[28] Some registries are more specific to a certain specialty and, therefore, might not have a high volume of eligible professionals to report measures via their registry.

Table 10: Registries that Submitted Data on Behalf of the Most Eligible Professionals for PQRS or the eRx Incentive Program (2013)

Registry Name	Eligible Professionals Submitted by Registry
NextGen_Registry	9,195
CECity	7,980
Covisint Corporation, ReqSelfNom	5,745
WebPT Inc.	4,525
NetHealth	4,321
Central Utah Informatics	4,024
WellCentive	3,693
Outcome(TM) PQRI Registry	3,526
Alere Analytics Inc	2,935
MDinteractive	2,794

Challenges to Participation and Satisfactory Reporting

Different reporting methods had different challenges to reporting. For the claims reporting mechanism, the main challenges to satisfactory reporting in PQRS included: (1) failure to identify eligible patients or claims, (2) failure to submit QDCs for at least 50 percent of eligible instances (for claims reporting), and (3) QDC submission errors. For example, QDC submission errors encompass submitting a QDC on a claim that did not have a qualifying diagnosis or the appropriate patient age, or submitting the QDC on an incorrect Healthcare Common Procedure Coding System (HCPCS) code. For certain satisfactory reporting criteria, eligible professionals who submitted data for fewer than three claims-based individual measures also had to pass the MAV process to confirm they were eligible for fewer than three measures. About 21 percent of eligible professionals submitting claims data were subject to MAV in 2013 (data not shown).[29] In 2013, roughly seven percent of those eligible professionals subject to the MAV process were not incentive eligible, which was less than one percent of all eligible professionals who participated.

QDC submission errors occurred when a QDC was submitted on a claim that did not have required information (e.g., diagnosis, procedures, and gender) for that measure. An invalid QDC could occur, for example, if an eligible professional submits a QDC on a claim that lacks the necessary combination of diagnosis and procedure codes to identify the measure denominator.

[28] A complete listing of qualified registries available for the 2013 PQRS can be found at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013ParticipatingRegistryVendors_05172013.pdf.

[29] More information on the MAV process is available on the Physician Quality Reporting System website under the Analysis and Payment page: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html.

Because ineligible claims are not included in the measure's denominator, QDC errors do not adversely affect an eligible professional's reporting rate.[30]

The most common QDC error was reporting a QDC on a claim that did not also have the required denominator eligible procedure code (HCPCS or CPT). Among 90,757,480 QDC submissions for all measures in 2013, nine percent were invalid: eight percent had an incorrect procedure code and/or an incorrect diagnosis code, two percent had an incorrect age and/or gender, and less than one-half of one percent were reported on instances with a missing procedure code (data not shown).

Though most measures reported had low rates of QDC errors, some measures reported had relatively high QDC error rates. Appendix Tables A17 through A19 highlight measures with high rates (greater than 20 percent) of specific QDC errors. For example, 69 percent of QDCs reported for measure #40 (Osteoporosis: Management Following Fracture of Hip, Spine, or Distal Radius for Men and Women Aged 50 Years or Older) had a mismatch between the QDC and the required diagnosis on the claim (Appendix Table A17). Nine measures had this type of mismatch for over one-half of submissions. It is recommended that eligible professionals double check the measure specifications to ensure accurate submission, especially if they are submitting measures with higher rates of submission errors.

Some PQRS participants who used a registry or EHR experienced submission problems. About 23 percent of registries submitted incorrect reporting rates based on the submitted numerators and denominators, affecting just over 2,000 eligible professionals (data not shown). About 25 percent of registries submitted performance rates which did not equal rates calculated from the submitted numerator and denominator values, affecting about 3,000 eligible professionals. About 86 percent of registries submitted data for eligible professionals who did not have any MPFS charges; in total, 5,352 eligible professionals fell into this category. The most common errors for EHR reporting were: 13 percent of eligible professionals using Direct EHR submissions were missing status codes on at least one file; nine percent of EPs did not have MPFS charges; and 3.4 percent of Direct EHR files were submitted with invalid HIC numbers (data not shown).

In addition, there were challenges for those who submitted data through the web interface (i.e. practices participating under the GPRO and eligible professionals participating as part of a Medicare ACO under the SSP or Pioneer ACO Model). These included a lack of understanding about the assignment and/or sampling methodology and inexperience using the web interface which resulted in some users not inputting the data properly.

Participation by Specialty

The measures in PQRS apply to a broad range of specialties, providing numerous opportunities for eligible professionals in all specialties to report on their Medicare patients.[31] Appendix Table A8 shows eligibility and participation rates by specialty across all reporting options from 2010 to

[30] The reporting rate is the number of instances an eligible professional reported (e.g., a valid QDC) divided by the number of eligible instances.

[31] In this section, "specialty" was determined based on the primary specialty that was listed for the NPI in the National Provider and Plan Enumeration System (NPPES); please see the Appendix for details.

2013. Participation rates by specialty and submission mechanism for 2010 through 2013 can be found in Appendix Tables A9 through A13.

As shown in the top panel of Table 11, of eligible professionals who participated through the claims-based individual measures reporting option, several hospital-based specialties were among the top ten specialties using this reporting mechanism. For example, emergency physicians had the largest representation among all specialties and also had a high rate of participation in this mechanism (69 percent), followed by anesthesiology, which had the second highest number of participants and a 66 percent participation rate. Nurse anesthetist and radiology had the fourth and seventh highest number of participants in claims-based individual measures. Hospital-based practices may have processes in place to capture clinical data, facilitating quicker uptake of reporting quality measure data. Eligible professionals in the fields of physical and occupational therapy, family practice, internal medicine, physician assistant, and nurse practitioner also had a relatively large number of professionals who participated in the 2013 program; however, with the exception of physician and occupational therapy, these specialties had lower than average participation rates. (Appendix Table A9 presents results for all specialties.)

The specialties with the largest number of eligible professionals who submitted data through the claims-based measures groups option are listed in the bottom panel of Table 11. (Appendix Table A10 presents results for all specialties.) As in prior years, family practice and internal medicine had the largest number of eligible professionals submitting via claims-based measures groups, though this submission mechanism had relatively low participation and will no longer be available in the 2014 program year.

Table 11: Specialties with the largest Number of Eligible Professionals Participating in PQRS through Claims Reporting (2013)

Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
Claims Individual Measures	--	--	--
Emergency Medicine	50,051	34,292	68.5%
Anesthesiology	40,527	26,914	66.4%
Physical/Occupational Therapy	49,006	24,308	49.6%
Nurse Anesthetist	46,266	23,484	50.8%
Family Practice	78,441	22,631	28.9%
Internal Medicine	76,041	21,695	28.5%
Radiology	31,213	19,980	64.0%
Physician Assistant	50,626	15,383	30.4%
Nurse Practitioner	62,216	13,100	21.1%
Optometry	33,698	12,646	37.5%
Claims Measures Groups	--	--	--
Family Practice	78,441	1,474	1.9%
Internal Medicine	76,041	1,429	1.9%
Cardiology	18,851	764	4.1%
Orthopaedic Surgery	18,384	602	3.3%
Nurse Practitioner	62,216	512	0.8%
Physical/Occupational Therapy	49,006	387	0.8%

Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
Other Eligible Professional	38,052	387	1.0%
Physician Assistant	50,626	323	0.6%
Rheumatology	3,520	285	8.1%
Nephrology	7,202	264	3.7%

Note for Table 11: Results exclude eligible professionals who are part of a group practice that participate under the PQRS GPRO, eligible professionals participating as part of a Medicare ACO under the Shared Savings Program or the Pioneer ACO Model, or eligible professionals participating through the CPC initiative.

Internal medicine, physical/occupational therapy, and family practice had the highest numbers of eligible professionals participating via the registry mechanism in 2013 (Table 12). (See Appendix Table A11 and A12 for results for all specialties.) Relative to the number eligible, dermatology had the highest rate of participation via registry individual measures (37 percent). Family practice, internal medicine, cardiology, and nephrology were the specialties with the highest number of participants reporting via the registry measures groups mechanism, although nephrology had the highest participation rate (21 percent).

Table 12: Specialties with the largest Number of Eligible Professionals Participating in PQRS through Registry Reporting (2013)

Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
Registry Individual Measures	--	--	--
Internal Medicine	76,041	5,942	7.8%
Physical/Occupational Therapy	49,006	5,499	11.2%
Family Practice	78,441	4,566	5.8%
Dermatology	9,791	3,617	36.9%
Nurse Practitioner	62,216	3,050	4.9%
Physician Assistant	50,626	2,664	5.3%
Other Eligible Professional	38,052	2,599	6.8%
Radiology	31,213	2,284	7.3%
Ophthalmology	17,468	1,604	9.2%
Cardiology	18,851	1,530	8.1%
Registry Measures Groups	--	--	--
Family Practice	78,441	2,893	3.7%
Internal Medicine	76,041	2,395	3.1%
Cardiology	18,851	1,658	8.8%
Nephrology	7,202	1,502	20.9%
Other Eligible Professional	38,052	864	2.3%
Orthopaedic Surgery	18,384	789	4.3%
Nurse Practitioner	62,216	657	1.1%
Physician Assistant	50,626	442	0.9%
Pulmonary Disease	7,993	440	5.5%
Oncology/Hematology	9,118	436	4.8%

Note for Table 12: Results exclude eligible professionals who are part of a group practice that participate under the PQRS GPRO, eligible professionals participating as part of a Medicare ACO under the Shared Savings Program or the Pioneer ACO Model, or eligible professionals participating through the CPC initiative.

Family practice and internal medicine also topped the list for the specialties with the most eligible professionals participating in PQRS via the EHR mechanism, followed by nurse practitioner, cardiology, obstetrics/gynecology, and physician assistant. However, the rate of participation among these specialties using the EHR mechanism was relatively low (highest for cardiology at 10 percent). See Appendix Table A13 for more detail.

The specialties with the most eligible professionals who were part of practices participating via the GPRO or as part of a Medicare ACO under the SSP were concentrated among primary care (internal medicine, family practice, nurse practitioner, and physician assistant (Table 14).

Table 13: Specialties with the Largest Number of Eligible Professionals Participating in PQRS through the EHR Mechanism (2013)

Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
Family Practice	78,441	4,929	6.3%
Internal Medicine	76,041	3,218	4.2%
Nurse Practitioner	62,216	2,060	3.3%
Cardiology	18,851	1,828	9.7%
Obstetrics/Gynecology	25,840	1,470	5.7%
Physician Assistant	50,626	1,319	2.6%
Orthopaedic Surgery	18,384	938	5.1%
General Surgery	18,341	844	4.6%
Other Eligible Professional	38,052	757	2.0%
Gastroenterology	10,296	591	5.7%

Note for Table 13: Results exclude eligible professionals who are part of a group practice that participate under the PQRS GPRO, eligible professionals participating as part of a Medicare ACO under the Shared Savings Program or the Pioneer ACO Model, or eligible professionals participating through the CPC initiative.

Table 14: Specialties with the Largest Number of Eligible Professionals Participating in PQRS through the GPRO and SSP ACO (2013)

Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
GPRO	--	--	--
Internal Medicine	17,396	16,847	96.8%
Family Practice	12,764	12,425	97.3%
Nurse Practitioner	11,518	11,178	97.0%
Physician Assistant	9,669	9,452	97.8%
Emergency Medicine	5,727	5,540	96.7%
Radiology	5,656	5,459	96.5%
Obstetrics/Gynecology	5,052	4,755	94.1%
Cardiology	4,605	4,511	98.0%
Anesthesiology	4,263	3,953	92.7%
Nurse Anesthetist	3,965	3,715	93.7%
SSP ACO	--	--	--
Internal Medicine	12,488	12,488	100.0%
Family Practice	10,917	10,917	100.0%
Nurse Practitioner	7,223	7,223	100.0%
Physician Assistant	5,947	5,947	100.0%
Cardiology	3,812	3,812	100.0%
Emergency Medicine	3,589	3,589	100.0%
Obstetrics/Gynecology	2,997	2,997	100.0%
Other Eligible Professional	2,683	2,683	100.0%
Radiology	2,461	2,461	100.0%
Anesthesiology	2,160	2,160	100.0%

Among eligible professionals who were participating in a Pioneer ACO or as part of practices participating in the CPC initiative the most common specialties were also internal medicine, family practice, nurse practitioner, and physician assistant (Table 15).

Table 15: Specialties with the Largest Number of Eligible Professionals Participating in PQRS as part of a Pioneer ACO or the CPC Initiative (2013)

Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
Pioneer ACO	--	--	--
Internal Medicine	4,160	4,160	100.0%
Family Practice	2,729	2,729	100.0%
Nurse Practitioner	1,556	1,556	100.0%
Physician Assistant	933	933	100.0%
Cardiology	883	883	100.0%
Obstetrics/Gynecology	768	768	100.0%
Emergency Medicine	762	762	100.0%
Radiology	753	753	100.0%
Other Eligible Professional	707	707	100.0%
Pediatrics	605	605	100.0%
CPC	--	--	--
Family Practice	746	300	40.2%
Internal Medicine	299	93	31.1%
Nurse Practitioner	118	47	39.8%
Physician Assistant	110	47	42.7%
Other Eligible Professional	11	5	45.5%
Pediatrics	7	4	57.1%
General Practice	12	4	33.3%
Other MD/DO	4	2	50.0%
Cardiology	1	1	100.0%
Emergency Medicine	3	1	33.3%

Participation by Beneficiary Volume and Specialty

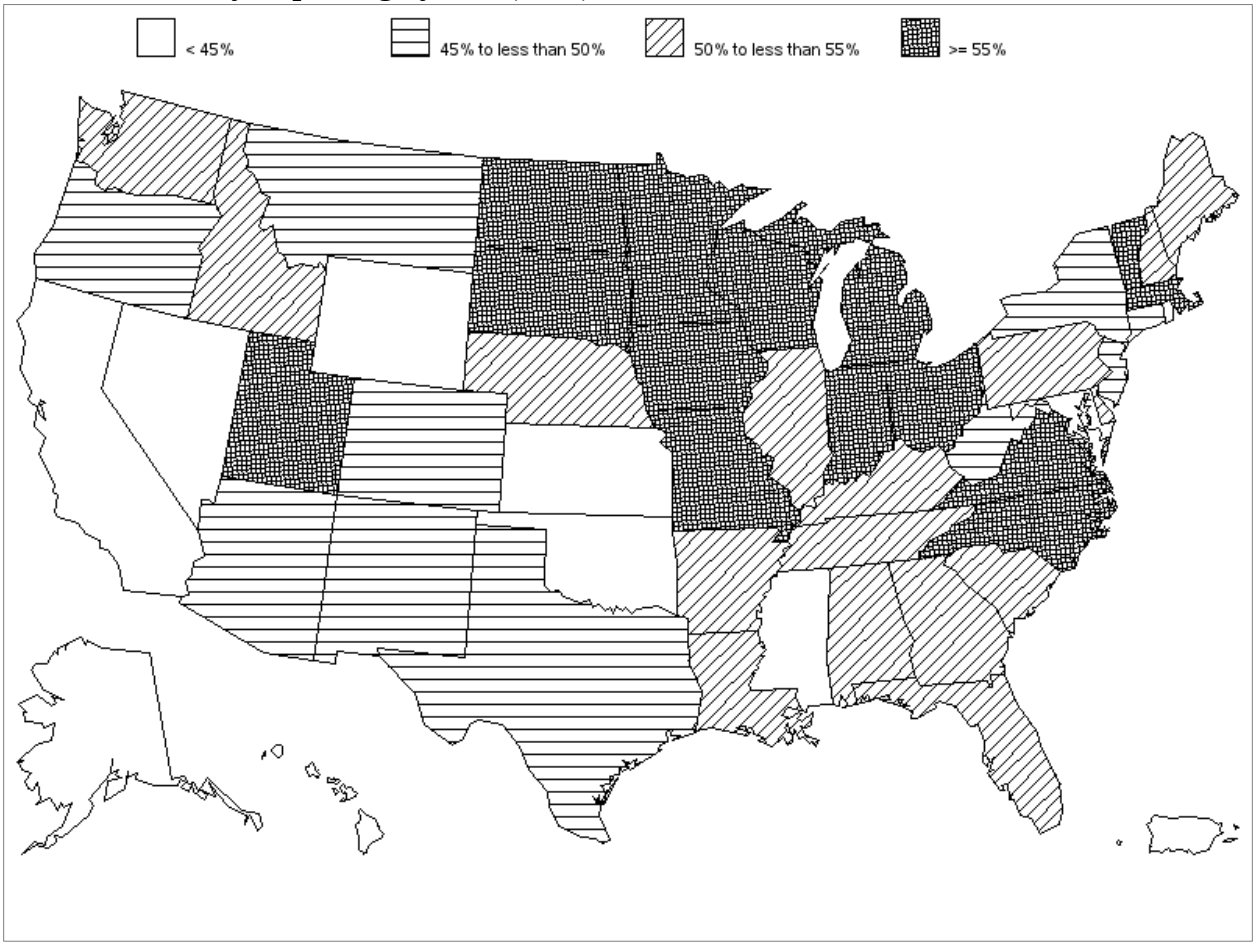
Participation rates among eligible professionals generally increased by beneficiary volume—defined as the number of beneficiaries who had an eligible claim for at least one PQRS measure—but patterns varied by specialty. Among all specialties, eligible professionals with 25 or fewer patients had a participation rate of 30 percent, compared to 46 percent among those with 26 to 100 patients, 58 percent among those with 101 to 200 patients, and 69 percent among those with more than 200 patients (Appendix A14). This general pattern was present for almost all specialties, especially MD/DOs and those with larger numbers of participants overall. Within family practice and internal medicine, the participation rate within the largest two beneficiary volume groups (more than 100 beneficiaries) was over twice the rate among eligible professionals treating fewer than 25 beneficiaries. Among emergency medicine and radiology, eligible professionals with larger beneficiary volume (over 200 patients) had a participation rate of 87 percent and 86 percent, respectively (Appendix Table A14). Some specialties had relatively high rates of participation among eligible professionals with low beneficiary volume

(fewer than 25 patients) including: pathology (70 percent), physical/occupational therapy (53 percent), radiology (51 percent), and anesthesiology (50 percent).

Geographic Variation in Participation

Figure 16 demonstrates the geographic variation in participation rates for the 2013 PQRS.[32] Detailed state-by-state participation results are available in Appendix Table A15. Participation was generally highest in states in the East and Midwest. Participation rates were highest in Minnesota (65 percent), Wisconsin and Vermont (64 percent), Utah (62 percent), Massachusetts (59 percent), Iowa (58 percent) and Virginia (58 percent). Participation was lowest (below 30 percent) in Puerto Rico, Virgin Islands, and Alaska.

Figure 16: Geographic Distribution of Eligible Professionals Participating in the Physician Quality Reporting System (2013)



Notes for Figure 16: Results include all individual participation PQRS mechanisms (i.e., claims, registry, and EHR) as well as eligible professionals who belong to a practice that participated under the PQRS GPRO, eligible professionals participating as part of a Medicare ACO under the Shared Savings Plan or Pioneer ACO Model, and eligible professionals participating through the CPC initiative. The data used to populate this map can be found in Appendix Table A15.

[32] State was identified by the eligible professional in the National Plan and Provider Enumeration System (NPPES). Please see Appendix for details.

Participation by Measure

Many measures in PQRS were selected because they were applicable to a wide range of eligible professionals and Medicare beneficiaries. The measures applicable to the largest number of eligible professionals in 2013 were those related to participation in a clinical database registry, pain assessment and follow-up, documentation of medications, and preventive care (Table 16).

Table 16: Individual Measures Reportable by the Largest Number of Eligible Professionals for PQRS (2013)

Measure Number	Measure Description	Eligible Professionals
321	Participation by a Hospital, Physician or Other Clinician in a Systematic Clinical Database Registry that Includes Consensus Endorsed Quality	701,240
131	Pain Assessment and Follow-Up	664,919
130	Documentation of Current Medications in the Medical Record	663,342
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	639,568
317	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	634,348
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	604,015
134	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	595,868
173	Preventive Care and Screening: Unhealthy Alcohol Use - Screening	592,534
47	Advance Care Plan	584,942
154	Falls: Risk Assessment	566,477

Note for Table 16: Results include the claims, registry, and EHR mechanisms, exclude results for eligible professionals who are part of a practice that participated under the PQRS GPRO, eligible professionals participating as part of a Medicare ACO under the Shared Savings Program or the Pioneer ACO Model, and eligible professionals participating through the CPC initiative.

Table 17 lists the ten measures reported by the largest number of eligible professionals in 2013. While the top reported measures include four of the measures with the most eligible professionals able to report, they also include two emergency medicine measures, one perioperative care, and other preventive care measures related to pneumococcal and influenza vaccination, and colorectal cancer screening. Although a relatively large number of eligible professionals reported these measures, several measures were submitted by ten percent or fewer of those to which the measure was applicable: #111 (Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years or Older), #131 (Pain Assessment and Follow Up), #110 (Preventive Care and Screening: Influenza Immunization), and #113 (Preventive Care and Screening: Colorectal Cancer Screening). Appendix Table A16 displays the percentage of eligible professionals who reported each measure and the average reporting rate (total instances reported for a measure divided by total eligible instances for the measure) for each measure reported through claims.

Table 17: Measures Reported by the Largest Numbers of Eligible Professionals under PQRS (2013)

Measure Number	Measure Description	Participated	Percent of Eligible
130	Documentation of Current Medications in the Medical Record	111,655	16.8%
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	82,638	13.7%
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	68,260	10.7%
111	Preventive Care and Screening: Pneumococcal Vaccination for Patients 65 Years and Older	50,538	9.5%
30	Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics	49,103	60.5%
131	Pain Assessment and Follow-Up	48,896	7.4%
54	Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	45,123	67.7%
110	Preventive Care and Screening: Influenza Immunization	44,359	8.1%
56	Emergency Medicine: Community-Acquired Pneumonia (CAP): Vital Signs	43,275	25.2%
113	Preventive Care and Screening: Colorectal Cancer Screening	42,245	8.2%

Note for Table 17: Results include the claims, registry, and EHR mechanisms, exclude results for eligible professionals who are part of a practice that participated under the PQRS GPRO, eligible professionals participating as part of a Medicare ACO under the Shared Savings Program or the Pioneer ACO Model, and eligible professionals participating through the CPC initiative.

Table 18 presents information on the top five measures submitted by each specialty, identified by measure number. Overall, among eligible professionals with an MD/DO, the top five measures reported in 2013 were: #130 (Documentation of Current Medications in the Medical Record), #226 (Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention), #128 (Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up), #111 (Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years or Older), and #110 (Preventive Care and Screening: Influenza Immunization).

Table 18: Five Most Frequently Reported Individual Measures by Specialty for PQRS (2013)

Specialty	#1 (Top)	#2	#3	#4	#5
MD/DO	130	226	128	111	110
Allergy/Immunology	130	226	111	110	128
Anesthesiology	30	193	76	130	226
Cardiology	226	130	204	6	201
Colon/Rectal Surgery	130	113	226	128	23
Critical Care	47	111	130	226	31
Dermatology	137	224	138	130	265
Emergency Medicine	56	54	55	59	28
Endocrinology	1	2	130	3	226
Family Practice	226	1	111	130	128

Specialty	#1 (Top)	#2	#3	#4	#5
Gastroenterology	130	113	226	128	111
General Practice	130	128	226	1	2
General Surgery	130	226	128	113	112
Geriatrics	110	130	111	1	226
Hand Surgery	130	226	128	131	111
Infectious Disease	130	226	111	110	128
Internal Medicine	226	111	130	1	128
Interventional Radiology	145	195	76	147	146
Nephrology	130	110	121	226	122
Neurology	130	226	128	111	110
Neurosurgery	130	226	128	21	20
Nuclear Medicine	147	226	130	6	128
Obstetrics/Gynecology	130	112	226	128	113
Oncology/Hematology	130	69	70	226	71
Ophthalmology	12	14	117	18	140
Oral/Maxillofacial Surgery	128	130	226	173	111
Orthopaedic Surgery	130	226	128	21	20
Other MD/DO	47	31	130	111	32
Otolaryngology	130	226	128	91	111
Pathology	99	100	249	251	250
Pediatrics	130	110	128	226	317
Physical Medicine	130	226	131	128	154
Plastic Surgery	130	226	128	111	110
Psychiatry	130	226	9	128	107
Pulmonary Disease	226	130	111	110	51
Radiation Oncology	194	226	104	156	130
Radiology	145	195	146	147	225
Rheumatology	130	108	226	39	128
Thoracic/Cardiac Surgery	43	44	45	321	226
Urology	226	48	130	49	50
Vascular Surgery	130	226	21	20	22
Other Eligible Professionals	130	131	182	128	226
Agencies/Hospitals/Nursing and Treatment Facilities	130	128	226	131	111
Audiologist	130	261	134	188	226
Certified Nurse Midwives	130	226	128	112	110
Chiropractor	131	182	128	111	113
Clinical Nurse Specialists	130	226	128	110	111
Counselor/Psychologist	134	130	226	173	107
Dentist	130	226	128	110	111
Dietitian/Nutritionist	1	2	130	128	3

Specialty	#1 (Top)	#2	#3	#4	#5
Nurse Anesthetist	30	193	76	130	128
Nurse Practitioner	130	226	128	111	110
Optometry	117	12	14	140	18
Other Eligible Professional	130	226	128	111	110
Physical/Occupational Therapy	131	130	154	182	155
Physician Assistant	130	54	226	56	128
Podiatrist	126	127	163	130	226
Registered Nurse	30	193	130	226	128
Social Worker	130	134	226	107	173
Unknown/Missing	130	226	30	110	145
Total	130	226	128	111	131

Note for Table 18: Please refer to Appendix Table A1 for measure descriptions; results include claims, registry, and EHR. Results do not include data for eligible professionals who belong to a practice that participates under the PQRS GPRO, eligible professionals participating as part of a Medicare ACO under the Shared Savings Program or Pioneer ACO Model, and eligible professionals participating through the CPC initiative.

D. Incentive Eligibility

To qualify for an incentive under PQRS, eligible professionals must meet the criteria for satisfactory reporting applicable to the submission method and reporting period. An individual eligible professional was eligible for an incentive under the 2013 program if the eligible professional met one of the satisfactory reporting criteria applicable for at least one individual reporting option. Unless otherwise noted, the reporting mechanisms pertain to a 12-month period (January 1 through December 31, 2013. The criteria discussed below pertain to the reporting requirements under the traditional PQRS; eligible professionals reporting as part of a Medicare ACO participating in the SSP or Pioneer ACO Model and eligible professionals participating through the CPC Initiative were subject to the satisfactory reporting criteria established under those programs/initiatives. The three basic criteria were:

- Percentage Method:
    - 50 percent of patients, individual measures option: An eligible professional must report at least 50 percent of eligible instances for at least three measures; this criterion applied to the individual measures option for the claims mechanism only. An eligible professional could qualify for an incentive by reporting at least 50 percent of eligible instances on one or two measures (i.e. less than three) if the MAV process was passed; the MAV process checked to ensure there were no other measures the eligible professional could have reported.
    - 80 percent of patients, individual measures option: An eligible professional must report at least 80 percent of eligible instances for at least three measures; this criterion applied to the individual measures option for the registry and EHR reporting mechanisms.

- Patient Count Method: An eligible professional must report at least one measures group for at least 20 patients; this criterion applied to the claims and registry measures group mechanisms. For claims-based measures groups, all 20 patients had to be Medicare Part B FFS patients; for registry-based measures groups, 11 out of 20 patients had to be Medicare Part B FFS.

- Align with EHR incentive Program: For EHR reporters choosing to align with the EHR Incentive Program (Meaningful Use), an eligible professional must report on all three Medicare EHR Incentive Program core measures (or, if the denominator for one or more of the Medicare EHR Incentive Program core measures is zero, the eligible professional must report on up to three Medicare EHR Incentive Program alternate core measures) AND report on three additional measures available for the Medicare EHR Incentive Program.

In addition to the incentive eligibility criteria listed above, measures submitted via any individual participation method with a performance rate of zero percent were not used to calculate incentive eligibility; inverse measures are an exception since a zero percent performance rate indicates the desired performance on these measures. Therefore, inverse measures with 100 percent performance rates were likewise not used to calculate incentive eligibility.

Practices participating via the web interface for group reporting had to report on a minimum of 411 consecutively assigned Medicare beneficiaries (from a maximum patient sample of 616) per disease module (or preventive care measure) for Large GPRO and ACOs and 218 for Medium GPRO (from a maximum patient sample of 327). If a practice had fewer than the required number of patients who were eligible for the module, the practice was required to report on 100 percent of assigned beneficiaries. The consecutively assigned Medicare beneficiaries are selected from those for whom services were furnished during the 2013 reporting period (January 1, 2013 to December 31, 2013).

Eligible professionals meeting the requirements for satisfactory reporting qualified for an incentive payment equal to one-half percent of the estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional or group practice during the applicable reporting period in 2013. Additional detail about incentive eligibility is described in the Appendix.

Incentive Eligibility by Reporting Approach

Over three-quarters of eligible professionals who participated in the 2013 PQRS qualified for an incentive (77 percent), a slight decrease from 2012 (84 percent) but still larger than in earlier years (72 percent in 2010 and 57 percent in 2009) (Appendix Table A20). In the 2013 program, the percentage of eligible professionals who qualified for an incentive continued to vary by reporting option. As shown in Figure 8, the percentage of individual participants who qualified for an incentive payment was highest among EHR participants (84 percent). Incentive eligibility rates were lowest among those participating individually via registry individual measures (71 percent), the claims-based measures (61 percent), and 45 percent for claims-based measures groups. Among those reporting under the GPRO or as an ACO under the MSSP or Pioneer ACO Model, GPRO registry and SSP ACO participants had the highest incentive eligibility rate (99 percent), followed by GPRO web interface (93 percent) and Pioneer ACO (69 percent).

Incentive Eligibility by Specialty

The specialties with the most eligible professionals who qualified for an incentive follow the same pattern as participation. Across all reporting options, internal medicine, family practice, and emergency medicine had the largest number of eligible professionals who earned an incentive (Appendix Table A2). Appendix Tables A21 through A25 present the percentage of eligible professionals from each specialty who qualified for an incentive by program year for each individual reporting mechanism. Tables 19 through 21 display the top ten specialties with the most eligible professionals who earned an incentive for each reporting mechanism.

Among the specialties with the most eligible professionals who qualified for an incentive through the claims-based individual measures mechanism, emergency medicine, anesthesiology, nurse anesthetist, radiology, and physician assistant also had relatively high rates of incentive eligibility (70 percent or above) (Table 19). Nurse practitioner, optometry, family practice, and internal medicine also had large numbers of eligible professionals earning an incentive via claims-based individual reporting, but relatively lower incentive eligibility rates (56, 53, 52, and 49 percent, respectively).

Table 19: Top 10 Specialties Earning a PQRS Incentive – Claims-Based Individual Measures (2013)

Specialty	Eligible Professionals who Participated	Eligible Professionals who Qualified for an Incentive	Percent Who Qualified for an Incentive
Emergency Medicine	34,292	31,033	90.5%
Anesthesiology	26,914	20,630	76.7%
Nurse Anesthetist	23,484	17,864	76.1%
Physical/Occupational Therapy	24,308	15,939	65.6%
Radiology	19,980	14,562	72.9%
Family Practice	22,631	11,792	52.1%
Physician Assistant	15,383	10,856	70.6%
Internal Medicine	21,695	10,697	49.3%
Nurse Practitioner	13,100	7,330	56.0%
Optometry	12,646	6,742	53.3%

Note for Table 19: Results do not include data for eligible professionals who belong to a practice that participates under the PQRS GPRO, eligible professionals participating as part of a Medicare ACO under the SSP or Pioneer ACO Model, or eligible professionals participating through the CPC initiative.

As seen in Table 20, the number of incentive eligible professionals and incentive eligibility rates among the specialties that participated in the claims-based measures groups reporting mechanism were lower than other reporting mechanism; however, cardiology and rheumatology had a relatively high proportion of eligible professionals who qualified for an incentive within this method (72 and 70 percent, respectively).

Table 20: Top 10 Specialties Earning a PQRS Incentive – Claims-Based Measures Groups Reporting Option (2013)

Specialty	Eligible Professionals who Participated	Eligible Professionals Who Qualified for an Incentive	Percent Who Qualified for an Incentive
Internal Medicine	1,429	749	52.4%
Family Practice	1,474	651	44.2%
Cardiology	764	548	71.7%
Orthopaedic Surgery	602	269	44.7%
Rheumatology	285	199	69.8%
Other Eligible Professional	387	175	45.2%
Nurse Practitioner	512	165	32.2%
Nephrology	264	133	50.4%
Pulmonary Disease	205	119	58.0%
Physician Assistant	323	117	36.2%

Note for Table 20: Results do not include data for eligible professionals who belong to a practice that participates under the PQRS GPRO, eligible professionals participating as part of a Medicare ACO under the SSP or Pioneer ACO Model, or eligible professionals participating through the CPC initiative.

The incentive eligibility rates for eligible professionals who used registry-based reporting were relatively high compared to claims reporting mechanisms, for most specialties. For example, eligible professionals in family practice and internal medicine using this reporting mechanism had relatively high incentive eligibility rates (87 and 79 percent, respectively) than those in these same specialties reporting via claims (Table 21).

Table 21: Top 10 Specialties Earning a PQRS Incentive – Reporting via Registries (2013)

Specialty	Eligible Professionals who Participated	Eligible Professionals Who Qualified for an Incentive	Percent Who Qualified for an Incentive
Internal Medicine	8,299	6,539	78.8%
Family Practice	7,373	6,437	87.3%
Physical/Occupational Therapy	5,599	3,873	69.2%
Dermatology	3,629	2,527	69.6%
Cardiology	3,172	2,505	79.0%
Other Eligible Professional	3,451	2,505	72.6%
Nurse Practitioner	3,698	2,430	65.7%
Physician Assistant	3,103	2,039	65.7%
Nephrology	2,160	1,975	91.4%
Orthopaedic Surgery	1,982	1,649	83.2%

Note for Table 21: Results do not include data for eligible professionals who belong to a practice that participates under the PQRS GPRO, eligible professionals participating as part of a Medicare ACO under the SSP or Pioneer ACO Model, or eligible professionals participating through the CPC initiative.

As seen in Appendix Table A25, family practice and internal medicine had the largest number of eligible professionals earning incentive payments under the EHR mechanism, followed by nurse practitioner, cardiology, obstetrics/gynecology, and physician assistants. All specialties reporting via this mechanism had relatively high incentive eligibility rates.

E. PQRS Payment Adjustment

In 2015, eligible professionals who are eligible for PQRS but who do not meet the reporting requirements described below will be subject to a 1.5 percent payment reduction on all of their Part B Medicare PFS charges. In subsequent years, the payment reduction will be equal to two percent. Eligible professionals who are part of a practice that self-nominated to participate via the GPRO will be evaluated at TIN level; all others will be evaluated individually.

To avoid the PQRS payment adjustment for 2015, individual participants had to meet at least one of the following criteria, for each TIN they report under:

- Meet the requirements for satisfactory reporting for incentive eligibility for the 2013 PQRS program, described above; or
- Report at least one valid measure via claims, registry, or EHR (direct submission or data submission vendor) or report at least one valid measures group via registry; or
- Elect to participate in the administrative claims-based reporting option via the web portal between July 15, 2013 and October 15, 2013.

Practices reporting as a group could avoid the payment adjustment as follows:

- Meet the requirements for satisfactory reporting for incentive eligibility for the 2013 PQRS program, described above; or
- Report at least one valid measure via registry or the GPRO web interface (for practices with at least 25 eligible professionals), or for certain CPC practices, meet the eCQM reporting requirements under that program; or
- Elect to participate in the administrative claims-based reporting option via the web portal between July 15, 2013 and October 14, 2013 (not available for SSP ACOs).

Other reasons for not being subject to the payment adjustment were related to not being eligible for PQRS: not having at least one eligible denominator claim, not meeting the definition of an eligible professional for the 2015 PQRS payment adjustment, or not having any MPFS charges in 2013. Individual eligible professionals or groups participating via GPRO, ACO, or CPC will be able to request an informal review of their negative payment determination between January 1, 2015 through February 28, 2015, for the 2013 PQRS program year; this report presents payment adjustment results prior to that informal review process.

As seen in Table 22, 469,755 eligible professionals in total will be subject to the 2015 PQRS payment adjustment based on their 2013 reporting experience, prior to the results from informal reviews; this table includes eligible professionals who participated in a Medicare ACO under the SSP or Pioneer ACO Model as well as eligible professionals who participated through the CPC Initiative. This represents 40 percent of the 1,174,364 eligible professionals who did not

automatically avoid the adjustment due to specialty. The majority (98 percent) of eligible professionals who were subject to the adjustment did not submit any PQRS data in 2013 and did not avoid the adjustment for any other reason, while two percent attempted participation but were not successful because they submitted only invalid QDCs, and 0.1 percent of those subject to the adjustment were individual participants (Table 22).[33] At the practice level, nine percent of practices subject to the adjustment were considered participating. Only 4,325 eligible professionals who were subject to the 2015 adjustment were part of practices self-nominating under the GPRO; none of these practices participated in 2013.

By region, the distribution of eligible professionals subject to the 2015 PQRS payment adjustment was similar to the geographical distribution of participants in PQRS in 2013; however, compared to the geographical distribution of PQRS participants, both New York and San Francisco had higher concentrations of those subject to the payment adjustment, and Atlanta and Chicago had a slightly lower concentration of those subject to the adjustment (Table 22).

Eligible professionals were more likely to be subject to the payment adjustment if they were part of smaller practices, had lower MPFS allowed charges, lower beneficiary volume, and were in practices with fewer specialties. For example, 72 percent of the eligible professionals subject to the payment adjustment were individuals in practices with fewer than 25 NPIs, compared to only 46 percent among the PQRS-eligible population. In particular, solo practitioners represented 31 percent of those subject to the adjustment, but only 16 percent of the total eligible for PQRS (Table 22).

Table 22: Physician Quality Reporting System 2015 Payment Adjustment

Eligible Professional (EP) Characteristics	Number EPs (TIN/NPI) Subject to Payment Adjustment	Percent of EPs Subject to Payment Adjustment	Number TIN Subject to Payment Adjustment	Percent of TIN Subject to Payment Adjustment
Participation Option	--	--	--	--
Non-participants[a]	461,417	98.2%	181,957	89.7%
Attempted participation, but were not successful[b]	7,772	1.7%	3,040	1.5%
Individual Participants[c]	566	0.1%	17,851	8.8%
Small GPRO	--	--	--	--
Medium GPRO	--	--	--	--
Large GPRO	--	--	--	--
Geography (Regions) [d,e,f]	--	--	--	--
1 - Boston	31,823	6.8%	12,852	6.3%
2 - New York	61,810	13.2%	32,147	15.8%
3 - Philadelphia	45,735	9.7%	19,046	9.4%
4 - Atlanta	81,442	17.3%	35,127	17.3%
5 - Chicago	75,527	16.1%	29,645	14.6%
6 - Dallas	48,053	10.2%	21,129	10.4%

[33] Individual participants include any eligible professionals who submitted PQRS data from 1/1/2013 to 12/31/2013 and did not avoid the PQRS payment adjustment for any reason. This includes any eligible professional who used the registry or EHR reporting mechanisms, but did not have any valid measures.

Eligible Professional (EP) Characteristics	Number EPs (TIN/NPI) Subject to Payment Adjustment	Percent of EPs Subject to Payment Adjustment	Number TIN Subject to Payment Adjustment	Percent of TIN Subject to Payment Adjustment
7 - Kansas City	21,334	4.5%	8,255	4.1%
8 - Denver	16,309	3.5%	6,881	3.4%
9 - San Francisco	65,461	13.9%	29,008	14.3%
10 - Seattle	20,879	4.4%	8,158	4.0%
Unknown	10	0.0%	-	0.0%
Practice Size (# NPIs)	--	--	--	--
Individual Participants	--	--	--	--
1	146,171	31.1%	146,171	72.1%
2-4	75,129	16.0%	34,351	16.9%
5-10	59,327	12.6%	12,216	6.0%
11-24	58,812	12.5%	6,023	3.0%
25-50	44,180	9.4%	2,635	1.3%
51-99	30,963	6.6%	1,003	0.5%
100-199	19,078	4.1%	238	0.1%
200+	31,770	6.8%	92	0.0%
Unknown	--	--	--	--
Group Participants	--	--	--	--
1-24	550	0.1%	83	0.0%
25-50	195	0.0%	7	0.0%
51-99	894	0.2%	14	0.0%
100-199	1,741	0.4%	13	0.0%
200+	945	0.2%	2	0.0%
Total MPFS charges per EP	--	--	--	--
Individual Participants	--	--	--	--
less than or equal to $2,500	117,409	25.0%	59,983	29.6%
$2,501 - $10,000	102,374	21.8%	34,176	16.8%
$10,001 - $40,000	121,379	25.8%	48,340	23.8%
$40,001 - $100,000	61,400	13.1%	28,999	14.3%
over $100,000	62,868	13.4%	31,231	15.4%
Group Participants	--	--	--	--
less than or equal to $2,500	863	0.2%	3	0.0%
$2,501 - $10,000	768	0.2%	2	0.0%
$10,001 - $40,000	1,160	0.2%	14	0.0%
$40,001 - $100,000	876	0.2%	16	0.0%
over $100,000	658	0.1%	84	0.0%
Individual Participants (TIN level)	--	--	--	--
less than $10,000	117,409	25.0%	59,983	29.6%
$10,001 - $25,000	102,374	21.8%	34,176	16.8%
$25,001 - $100,000	121,379	25.8%	48,340	23.8%
$100,001 - $250,000	61,400	13.1%	28,999	14.3%
over $250,000	62,868	13.4%	31,231	15.4%
Group Participants (TIN level)	--	--	--	--

Eligible Professional (EP) Characteristics	Number EPs (TIN/NPI) Subject to Payment Adjustment	Percent of EPs Subject to Payment Adjustment	Number TIN Subject to Payment Adjustment	Percent of TIN Subject to Payment Adjustment
less than $10,000	863	0.2%	3	0.0%
$10,001 - $25,000	768	0.2%	2	0.0%
$25,001 - $100,000	1,160	0.2%	14	0.0%
$100,001 - $250,000	876	0.2%	16	0.0%
over $250,000	658	0.1%	84	0.0%
Beneficiary Volume	--	--	--	--
Individual Participants	--	--	--	--
1-25	200,449	42.7%	63,604	31.4%
26 - 100	121,569	25.9%	47,299	23.3%
101 - 200	61,035	13.0%	26,558	13.1%
201+	82,367	17.5%	65,264	32.2%
Unknown	10	0.0%	4	0.0%
Group Participants	--	--	--	--
1-25	1,288	0.3%	1	0.0%
26-100	1,099	0.2%	6	0.0%
101-200	765	0.2%	1	0.0%
201+	1,173	0.2%	111	0.1%
Unknown	--	--	--	--
Specialties (# per practice)	--	--	--	--
1	206,195	43.9%	168,115	82.9%
2 - 5	146,878	31.3%	30,771	15.2%
>5	116,681	24.8%	3,961	2.0%
Unknown	1	0.0%	1	0.0%
Provider Age	--	--	--	--
44 and younger	52,019	11.1%	-	0.0%
45 to 54	85,661	18.2%	-	0.0%
55 to 65	101,279	21.6%	-	0.0%
66 to 80	46,391	9.9%	-	0.0%
Older than 80	2,909	0.6%	-	0.0%
Unknown	181,496	38.6%	-	0.0%
Total (Unduplicated)	**469,755**	**100.0%**	**202,848**	**100.0%**

[a] *Non-participants include any EPs who did not submit any PQRS data from 1/1/2013 to 12/31/2013 and did not avoid the 2015 PQRS payment adjustment for any reason.*

[b] *Attempted participation but were not successful means the eligible professional submitted only invalid QDCs and did not avoid the 2015 PQRS payment adjustment for any other reason.*

[c] *Individual participants include any EPs who submitted PQRS data from 1/1/2013 to 12/31/2013 and did not avoid the 2015 PQRS payment adjustment for any reason. This includes any eligible professional who used the registry or EHR reporting mechanisms, but did not have any valid measures (e.g. data were received, but not on eligible instances).*

[d] *See Appendix A for definition of regions.*

[e] *Some practices (TIN) encompassed more than one state/region; consequently, sums across categories within the Geography results do not equal totals.*

[f] *Information about the RRB carrier is not displayed in Table 22 due to the RRB not being based on the geographical location of the eligible professional.*
Notes on Table 22: Individual Participants are measures at the TIN/NPI level and exclude TIN/NPIs that are part of a practice participating under the GPRO. Results could include eligible professionals participating in a Medicare ACO that participates under the SSP or Pioneer ACO Model as well as eligible professionals participating under the CPC Initiative.

Eligible professionals who were MD/DOs were less likely than those in non-MD/DO specialties to be subject to a 2015 payment adjustment based on 2013 reporting (Table 23). For example, 33 percent of MD/DOs were subject to the adjustment compared to 41 percent of the non-MD/DO specialties (nurse practitioner, physician assistant, and podiatrist).

Within MD/DO specialties, the percent of eligible professionals who will receive an adjustment based on 2013 reporting ranged from 15 percent to 72 percent (Table 23). Specialties with a relatively small proportion of eligible professionals subject to the adjustment included: pathology (15 percent), and radiology, interventional radiology, emergency medicine, oncology/hematology (all 20 percent). On the other hand, specialties with relatively high proportions of eligible professionals subject to the adjustment included oral/maxillofacial surgery (72 percent), psychiatry (67 percent), general practice (65 percent), and plastic surgery (60 percent).

Table 23: Eligible Professionals Subject to the 2015 PQRS Payment Adjustment, by Specialty

Eligible Professional (EP) Specialty	(A) Number of EPs (TIN/NPIs) who were Eligible for the 2015 PQRS Payment Adjustment	(B) Number EPs (TIN/NPI) Subject to 2015 PQRS Payment Adjustment	(C) Percent of EPs Subject to 2015 PQRS Payment Adjustment (Column %)	(D) = (B)/(A) Percent of EPs Eligible for the 2015 PQRS Payment Adjustment Who Are Subject
MD/DO	**730,273**	**240,482**	**51.2%**	**32.9%**
Allergy/Immunology	3,867	1,936	0.4%	50.1%
Anesthesiology	47,398	10,942	2.3%	23.1%
Cardiology	28,144	6,962	1.5%	24.7%
Colon/Rectal Surgery	1,357	420	0.1%	31.0%
Critical Care	2,925	965	0.2%	33.0%
Dermatology	11,898	4,340	0.9%	36.5%
Emergency Medicine	60,108	12,275	2.6%	20.4%
Endocrinology	6,213	1,617	0.3%	26.0%
Family Practice	105,117	39,852	8.5%	37.9%
Gastroenterology	13,931	3,923	0.8%	28.2%
General Practice	6,083	3,979	0.8%	65.4%
General Surgery	24,772	9,150	1.9%	36.9%
Geriatrics	4,699	1,698	0.4%	36.1%
Hand Surgery	1,923	717	0.2%	37.3%
Infectious Disease	6,511	2,315	0.5%	35.6%
Internal Medicine	110,134	35,882	7.6%	32.6%
Interventional Radiology	2,051	410	0.1%	20.0%

Eligible Professional (EP) Specialty	(A) Number of EPs (TIN/NPIs) who were Eligible for the 2015 PQRS Payment Adjustment	(B) Number EPs (TIN/NPI) Subject to 2015 PQRS Payment Adjustment	(C) Percent of EPs Subject to 2015 PQRS Payment Adjustment (Column %)	(D) = (B)/(A) Percent of EPs Eligible for the 2015 PQRS Payment Adjustment Who Are Subject
Nephrology	9,743	2,700	0.6%	27.7%
Neurology	15,145	4,783	1.0%	31.6%
Neurosurgery	5,165	1,669	0.4%	32.3%
Nuclear Medicine	710	221	0.0%	31.1%
Obstetrics/Gynecology	34,644	15,406	3.3%	44.5%
Oncology/Hematology	13,163	2,674	0.6%	20.3%
Ophthalmology	20,485	5,697	1.2%	27.8%
Oral/Maxillofacial Surgery	404	290	0.1%	71.8%
Orthopaedic Surgery	23,371	8,432	1.8%	36.1%
Other MD/DO	13,071	4,873	1.0%	37.3%
Otolaryngology	9,712	3,591	0.8%	37.0%
Pathology	10,795	1,628	0.3%	15.1%
Pediatrics	10,284	3,334	0.7%	32.4%
Physical Medicine	9,254	4,314	0.9%	46.6%
Plastic Surgery	4,767	2,856	0.6%	59.9%
Psychiatry	32,347	21,719	4.6%	67.1%
Pulmonary Disease	11,511	3,409	0.7%	29.6%
Radiation Oncology	5,147	1,282	0.3%	24.9%
Radiology	40,064	7,921	1.7%	19.8%
Rheumatology	4,955	1,266	0.3%	25.5%
Thoracic/Cardiac Surgery	4,224	955	0.2%	22.6%
Urology	10,494	2,951	0.6%	28.1%
Vascular Surgery	3,687	1,128	0.2%	30.6%
Other Eligible Professionals	**167,990**	**69,145**	**14.7%**	**41.2%**
Agencies/Hospitals/ Nursing and Treatment Facilities	145	60	0.0%	41.4%
Audiologist	7,280	3,545	0.8%	48.7%
Certified Nurse Midwives	2,038	717	0.2%	35.2%
Chiropractor	46,946	36,537	7.8%	77.8%
Clinical Nurse Specialists	2,748	1,509	0.3%	54.9%
Counselor/Psychologist	33,614	25,531	5.4%	76.0%
Dentist	3,101	2,637	0.6%	85.0%
Dietitian/Nutritionist	3,157	1,865	0.4%	59.1%
Nurse Anesthetist	52,097	17,610	3.7%	33.8%
Nurse Practitioner	82,547	35,552	7.6%	43.1%
Optometry	34,725	20,326	4.3%	58.5%
Other Eligible Professional	4,129	2,010	0.4%	48.7%
Physical/Occupational Therapy	51,861	18,633	4.0%	35.9%

Eligible Professional (EP) Specialty	(A) Number of EPs (TIN/NPIs) who were Eligible for the 2015 PQRS Payment Adjustment	(B) Number EPs (TIN/NPI) Subject to 2015 PQRS Payment Adjustment	(C) Percent of EPs Subject to 2015 PQRS Payment Adjustment (Column %)	(D) = (B)/(A) Percent of EPs Eligible for the 2015 PQRS Payment Adjustment Who Are Subject
Physician Assistant	67,214	24,593	5.2%	36.6%
Podiatrist	18,229	9,000	1.9%	49.4%
Registered Nurse	133	63	0.0%	47.4%
Social Worker	34,089	29,073	6.2%	85.3%
Unknown/Missing	38	12	0.0%	31.6%
Total (Unduplicated)	**1,174,364**	**469,755**	**100.0%**	**40.0%**

Note for Table 23: This table includes individual eligible professionals as well as those in groups eligible for the PQRS GPRO, eligible professionals participating as part of a Medicare ACO participating under the Shared Savings Program or the Pioneer ACO Model, and eligible professionals participating through the CPC Initiative who were subject to the payment adjustment.

Among the 783,849 eligible professionals avoiding the 2015 payment adjustment, 48 percent were individual participants, 38 percent were part of a practice self-nominating to participate via the GPRO, 11 percent were part of an SSP ACO, and three percent were in a Pioneer ACO (Table 24). Comparing participation and incentive eligibility for those who avoided the 2015 PQRS payment adjustment (Table 24) with participation and incentive eligibility for the program overall (Appendix Table A4), eligible professionals who avoided the payment adjustment had a higher PQRS participation rate (82 percent) than in the overall program (51 percent), but had an incentive eligibility rate (77 percent) similar to the overall participant population.

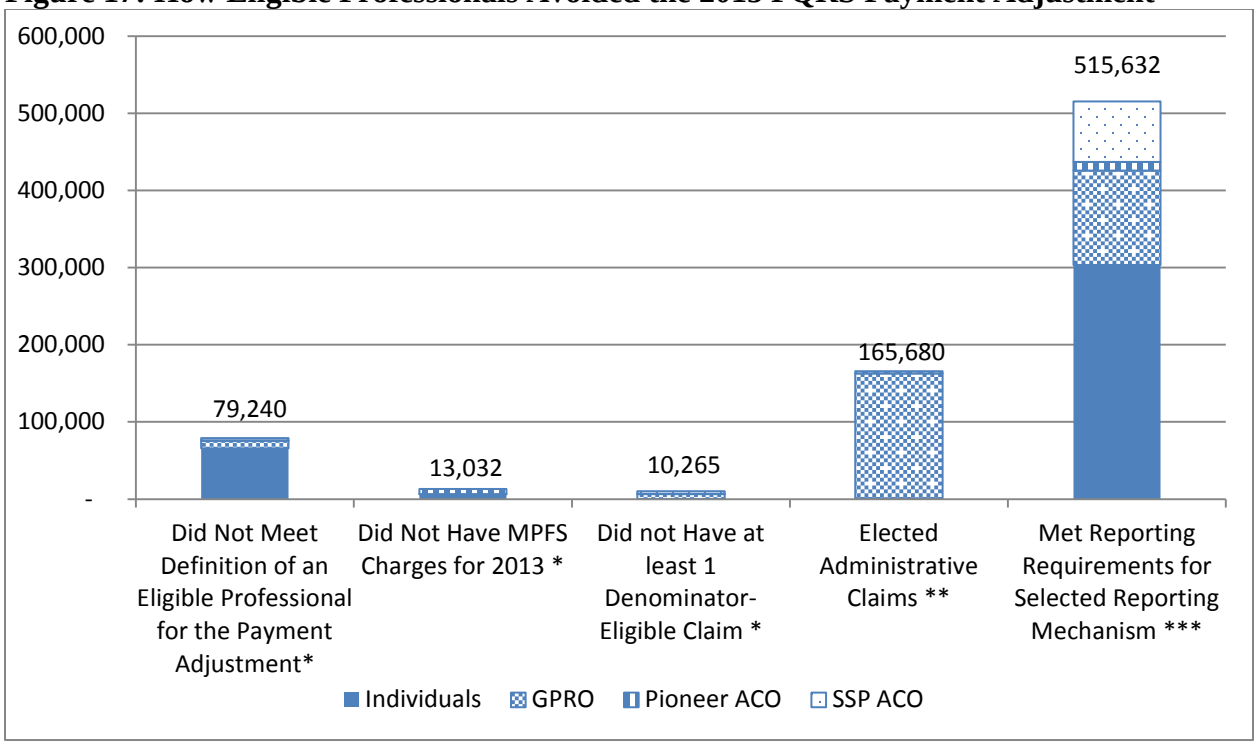
Table 24: Eligible Professionals Who Avoided the 2015 PQRS Payment Adjustment

Type of Participation	Eligible Count	Attempting to Participate but Unsuccessful Count	Eligible Professionals Who Did the Minimum to Avoid the 2015 PQRS Payment Adjustment	Participating Count	Participation Rate	Incentive Eligible Count	Incentive Eligibility Rate
CPC	298	0	0	298	100.00%	261	87.58%
Individual Participants	376,297	406	61,734	322,209	85.63%	208,495	64.71%
GPRO	300,517	1,437	98,718	211,844	70.49%	186,762	88.16%
Pioneer ACO	21,678	0	0	21,678	100.00%	15,007	69.23%
SSP ACO	85,059	0	0	85,059	100.00%	84,094	98.87%
Unduplicated Total	**783,849**	**1,843**	**160,452**	**641,088**	**81.79%**	**494,619**	**77.15%**

Note on Table 24: GPRO includes EPs who belong to a practice that elected administrative claims. These EPs could not participate in PQRS under the GPRO and had to report individually through claims, registry, and/or EHR; they are included in this table under the GPRO category since this is how they avoided the payment adjustment.

Figure 17 and Table 25 provide more detail on how eligible professional and practices avoided the 2015 PQRS payment adjustment. Eligible professionals who avoided the 2015 PQRS payment adjustment did so most often by reporting the required data (two thirds of those avoiding the adjustment) or electing the administrative claims option (one fifth of those avoiding the adjustment), as seen in Figure 17, which applies a hierarchy to reasons for avoidance from left to right so each reason is represented as mutually exclusive. About 13 percent of eligible professionals (individual or group participants) avoided the adjustment because they did not meet the definition of an eligible professional for the 2015 PQRS payment adjustment, had no 2013 MPFS charges, or did not have at least one denominator-eligible claim.

Figure 17: How Eligible Professionals Avoided the 2015 PQRS Payment Adjustment



Notes: These ways of avoiding the payment adjustment are applied as a hierarchy in the order shown, from left to right. Therefore, there is no overlap across these columns. There is further information on how Eligible Professionals avoided the payment adjustment in Table 25.
** These criteria are determined at the TIN/NPI level.*
*** Evaluated at the TIN/NPI level for individual participants; otherwise, evaluated at the TIN level (if the TIN elected Administrative Claims, then all NPIs under the TIN avoid the PQRS payment adjustment).*
**** Meeting reporting requirements is evaluated at the TIN level for PQRS GPRO and SSP ACOs but at the TIN/NPI level for Pioneer ACOs and Individual Participants.*

Table 25 highlights that eligible professionals met multiple conditions to avoid the adjustment. For example, 36,181 individually-participating eligible professionals in total avoided the adjustment because they did not have MPFS allowed charges, but over 30,000 of these also did not meet the definition of an eligible professional for the PQRS payment adjustment, and therefore only 6,009 are counted as avoiding the payment adjustment for lack of MPFS charges after applying the hierarchy used in the right-most column of the table and Figure 17. Many eligible professionals who met the reporting requirements also met one of the other conditions for avoiding the adjustment.

Among the 376,297 individually-participating eligible professional who avoided the adjustment, meeting the reporting requirements for 2013 was the most common way to avoid the adjustment, followed by not meeting the definition of an eligible professional for the PQRS payment adjustment (Table 25). Among GPRO participants, the most common reason for avoiding the adjustment was meeting reporting requirements (N=211,739), followed by electing the administrative claims option (N=168,401). All of the eligible professionals reporting through SSP ACOs avoided the payment adjustment because the ACO met the reporting requirements.

Table 25: How Eligible Professionals Avoided the 2015 PQRS Payment Adjustment, in Total and by Hierarchy

Reason for avoiding the 2015 PQRS Payment Adjustment	Number of EPs Avoiding the Payment Adjustment For This Reason	Number of EPs Avoiding the Payment Adjustment Based on Hierarchy
CPC TIN/NPI (Unduplicated)	**298**	**298**
Did Not Meet the Definition of an Eligible Professional for the PQRS Payment Adjustment	6	6
Did Not Have MPFS Charges for 2013	36	35
Did Not Have at least 1 Denominator Eligible Claim	37	1
Elected Administrative Claims	0	0
Met Reporting Requirements	284	256
Individual TIN/NPI (Unduplicated)	**376,297**	**376,297**
Did Not Meet Definition of an Eligible Professional for the PQRS Payment Adjustment	65,718	65,718
Did Not Have MPFS Charges for 2013	36,181	6,009
Did Not Have at least 1 Denominator Eligible Claim	6,341	473
Elected Administrative Claims	1,083	1,034
Met Reporting Requirements	322,012	303,063
GPRO (Unduplicated)	**300,517**	**300,517**
Did Not Meet Definition of an Eligible Professional for the PQRS Payment Adjustment	9,812	9,812
Did Not Have MPFS Charges for 2013	710	566
Did not Have at least 1 Denominator Eligible Claim	6,679	5,889
Elected Administrative Claims	168,401	161,646
Met Reporting Requirements	211,739	122,604
Pioneer ACO (Unduplicated)	**21,678**	**21,678**
Did Not Meet Definition of an Eligible Professional for the PQRS Payment Adjustment	805	805

Reason for avoiding the 2015 PQRS Payment Adjustment	Number of EPs Avoiding the Payment Adjustment For This Reason	Number of EPs Avoiding the Payment Adjustment Based on Hierarchy
Did Not Have MPFS Charges for 2013	6,671	6,422
Did Not Have at least 1 Denominator Eligible Claim	6,966	296
Elected Administrative Claims	3,935	3,000
Met Reporting Requirements	21,678	11,155
SSP ACO (Unduplicated)	**85,059**	**85,059**
Did Not Meet Definition of an Eligible Professional for the PQRS Payment Adjustment	2,899	2,899
Did Not Have MPFS Charges for 2013	0	0
Did Not Have at least 1 Denominator Eligible Claim	3,766	3,606
Elected Administrative Claims	N/A	N/A
Met Reporting Requirements	85,059	78,554
Unduplicated Total	**783,849**	**783,849**

F. Clinical Performance Rates

Although PQRS focuses on reporting of quality data by eligible professionals, clinical performance rates that use quality data submitted through the program can also be used to make inferences about the quality of care provided to Medicare beneficiaries, and will be used to determine a Physician Value-Based Modifier beginning in 2015.

Eligible professionals reported data on recommended quality actions that were performed, not performed, or did not apply (i.e., exclusions) on eligible instances; this information is used in this report to describe eligible professionals' clinical performance on measures. The following hierarchy was applied if an eligible professional participated through more than one reporting mechanism: (1) EHR[34], (2) claims, and (3) registry. The hierarchy ensured only one performance rate for each measure for an eligible professional is displayed in results. The methods used to calculate performance rates in this report vary from the performance rates used for determining the Physician Value-Based Modifier; for more information, see the Data and Methods section in Appendix A.

This report also presents data on measure performance trends; however, multiple factors should be considered when interpreting performance trends in this report. For example, there have been

[34] EHR performance rates of zero percent have been excluded. CMS has found that the EHR method of reporting has a high instance of zero percent performance rate. We believe this has to do with EHR functionality and submission that can result in a measure being submitted for an EP who did not intend to report the measure. These instances do not give an accurate reflection of performance and are not comparable to other reporting methods where we are certain that an EP has intended to report the measure. Due to our concerns with the reliability of the EHR data for performance measurement, our policy has been to suppress the zero percent performance rates for PQRS measures in our public facing reports until we are more confident with the accuracy of the performance data.

many changes within PQRS across program years. As described above, the participation options have been changed and refined. Individual measures were added, removed, or in some cases their definitions have changed. Moreover, the eligible professionals who participated each year change. As a result, it is unclear the extent to which any observed changes in measure performance were artifacts of the aforementioned changes.

Nonetheless, this section of the report aims to describe clinical performance rates and trends.[35] The Appendix Tables A26 and A27 provide reporting and performance information across program years. Appendix Table A28 shows the number of eligible professionals who consistently reported measures across successive program years. Appendix Tables A29 through A31 also provide total counts and performance rates for eligible professionals who reported a measure for two, three or four consecutive years.

Tables 26 and 27 display the measures with the largest percentage point decline and improvement in performance between 2010 and 2013, among eligible professionals who reported the measure for all four years. While this approach attempts to account for changes in participating eligible professionals, it does not account for other changes. For example, trends in reporting mechanisms—such as a growth in EHR reporting or a measure changing to/from registry reporting only—could cause performance rates to change. Other examples of changes to measures include the addition of new exclusions or changes in thresholds used to define clinical control of a condition. Registries, in some cases, incorporate processes that support eligible professionals' selection of appropriate measures, edits that help to ensure that measures are submitted accurately, and reminders that help providers meet the performance criteria of the measures. In addition, performance rates may be less stable among measures with smaller samples, as is the case with a number of the measures in the following tables. The decrease in performance rates shown in Table 26 do not appear to be linked to major revisions to the measures or changes in reporting mechanisms; however, most measures had drops in the numbers reporting which may reflect the shift to group reporting. Table 27 presents the five measures with the largest improvement in performance. These measures appeared to remain stable for the four program years analyzed and they did not receive any major revisions which could be determined to mean that with practice in reporting the eligible professionals and registries performed better throughout the program years.

Table 26: Individual Measures Reported with the Largest Percentage Point Decrease in Clinical Performance Rate for PQRS (2010 to 2013)

Measure Number	Measure Description	2010 Performance Rate	2013 Performance Rate	Number of Eligible Professionals Reporting the Measure in each year from 2010 to 2013	Percentage Point Change 2010-2013
197	Coronary Artery Disease (CAD): Lipid Control	71.3%	31.3%	23	-40.0%

[35] Please see the Appendix for further description of performance rate calculations.

Measure Number	Measure Description	2010 Performance Rate	2013 Performance Rate	Number of Eligible Professionals Reporting the Measure in each year from 2010 to 2013	Percentage Point Change 2010-2013
116	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use	44.2%	27.3%	17	-17.0%
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	63.4%	46.9%	46	-16.5%
123	Adult Kidney Disease: Patients On Erythropoiesis-Stimulating Agent (ESA) - Hemoglobin Level > 12.0 g/dL	91.0%	23.0%	84	-14.1%
121	Adult Kidney Disease: Laboratory Testing (Lipid Profile)	88.8%	75.0%	147	-13.8%

Notes for Table 26: Results included the claims, registry, and EHR reporting mechanisms. Results are restricted to a group of eligible professionals who reported the same measure from 2010 to 2013. In 2012, measure #123 became an inverse measure where a lower performance rate indicated better performance. This table includes measure performance regardless of whether eligible professionals reporting the measure met the satisfactory reporting requirements or not.

Table 27: Individual Measures Reported with the Largest Percentage Point Increase in Clinical Performance Rate for PQRS (2010 and 2013)

Measure Number	Measure Description	2010 Performance Rate	2013 Performance Rate	Number of Eligible Professionals Reporting the Measure in each year from 2010 to 2013	Percentage Point Change 2010-2013
33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge	69.7%	98.1%	33	28.4%
145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy	49.1%	66.6%	6,635	17.5%
36	Stroke and Stroke Rehabilitation: Rehabilitation Services Ordered	71.5%	88.4%	456	16.9%
3	Diabetes Mellitus: High Blood Pressure Control	57.9%	74.5%	3,357	16.6%

Measure Number	Measure Description	2010 Performance Rate	2013 Performance Rate	Number of Eligible Professionals Reporting the Measure in each year from 2010 to 2013	Percentage Point Change 2010-2013
195	Radiology: Stenosis Measurement in Carotid Imaging Reports	59.9%	75.6%	6,716	15.7%

Notes for Table 27: Results include the claims, registry, and EHR reporting mechanisms. Results were restricted to a group of eligible professionals who reported the same measure from 2010 to 2013. This table includes measure performance regardless of whether eligible professionals who reported the measure met the satisfactory reporting requirement.

For some measures, improvement in measure performance over time was limited by measure performance that 'topped out.' In other words, if performance is at or near 100 percent, the ability to improve performance is limited. Table 28 displays the measures with the highest mean clinical performance rates in 2013.

Table 28: Individual Measures Reported with the Highest Mean Clinical Performance Rates for PQRS (2013)

Measure Number	Measure Description	Mean Performance Rate	Number of Eligible Professionals Submitting
242	Coronary Artery Disease (CAD): Symptom Management	99.9%	26
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge	99.7%	10
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	99.7%	881
45	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Cardiac Procedures)	99.5%	699
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy	99.5%	53
146	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening	0.9%	11,145
250	Radical Prostatectomy Pathology Reporting	99.1%	2,169
224	Melanoma: Overutilization of Imaging Studies in Melanoma	99.0%	3,492
83	Hepatitis C: Testing for Chronic Hepatitis C - Confirmation of Hepatitis C Viremia	98.9%	31
81	Adult Kidney Disease: Hemodialysis Adequacy: Solute	98.8%	15

Note for Table 28: (1) Results include the claims, registry, and EHR reporting mechanisms. In total, there were eight measures with performance rates of 100% in 2013, but these had fewer than 10 eligible professionals submitting. We have limited data here to results for measures that were reported by at least 10 eligible professionals. (2) Measure 146 is an inverse measure where a lower performance rate indicates better performance.

Some measures show particularly high rates of performance across all eligible professionals reporting the measure. Table 29 displays 41 measures for which at least 90 percent of the eligible

professionals who reported the measure achieved performance at or above 90 percent in 2013. Appendix Table A32 is similar and displays the percent of eligible professionals who reported a measure and had a performance rate at or above 90 percent by individual measure.

Table 29: Individual Measures Where at least 90 Percent of Eligible Professionals who Participated had at least a 90 Percent Performance Rate on the Measure (2013)

Measure Number	Measure Description	Percent of Eligible Professionals with At Least 90% Performance Rate
81	Adult Kidney Disease: Hemodialysis Adequacy: Solute	100.0%
82	Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute	100.0%
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation	100.0%
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate	100.0%
166	Coronary Artery Bypass Graft (CABG): Stroke	100.0%
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure	100.0%
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration	100.0%
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge	100.0%
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge	100.0%
213	Functional Communication Measure - Reading	100.0%
234	Thoracic Surgery: Pulmonary Function Tests Before Major Anatomic Lung Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy)	100.0%
242	Coronary Artery Disease (CAD): Symptom Management	100.0%
256	Surveillance after Endovascular Abdominal Aortic Aneurysm Repair (EVAR)	100.0%
303	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	100.0%
325	Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions	100.0%
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	99.4%
146	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening	99.0%
45	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Cardiac Procedures)	98.9%
321	Participation by a Hospital, Physician or Other Clinician in a Systematic Clinical Database Registry that Includes Consensus Endorsed Quality	97.9%
224	Melanoma: Overutilization of Imaging Studies in Melanoma	97.6%
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy	96.2%
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	96.0%
249	Barrett's Esophagus	95.9%
250	Radical Prostatectomy Pathology Reporting	95.9%

Measure Number	Measure Description	Percent of Eligible Professionals with At Least 90% Performance Rate
156	Oncology: Radiation Dose Limits to Normal Tissues	95.6%
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	95.1%
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	94.8%
263	Preoperative Diagnosis of Breast Cancer	94.1%
187	Stroke and Stroke Rehabilitation: Thrombolytic Therapy	93.9%
56	Emergency Medicine: Community-Acquired Pneumonia (CAP): Vital Signs	93.8%
137	Melanoma: Continuity of Care - Recall System	93.7%
83	Hepatitis C: Testing for Chronic Hepatitis C - Confirmation of Hepatitis C Viremia	93.5%
262	Image Confirmation of Successful Excision of Image-Localized Breast Lesion	92.9%
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	92.3%
247	Substance Use Disorders: Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence	92.3%
55	Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Syncope	91.7%
46	Medication Reconciliation	91.4%
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	91.2%
266	Epilepsy: Seizure Type(s) and Current Seizure Frequency(ies)	91.1%
182	Functional Outcome Assessment	90.7%
70	Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry	90.5%

Note for Table 29: Results include the claims, registry, and EHR reporting mechanisms. This table includes measure performance for eligible professionals regardless of whether the eligible professional met the satisfactory reporting requirement.

Group practices reporting under the Medium or Large GPRO web interface or as an ACO (SSP or Pioneer) reported 22 measures covering care coordination/patient safety, coronary artery disease, diabetes mellitus, heart failure, hypertension, ischemic vascular disease, and preventive care. In addition, Large GPRO practices reporting via web interface had to report CAHPS for PQRS survey measures. In 2013, practices participating via the GPRO could also report registry measures; this was the only mechanism available for the Small GPRO. Appendix Tables A33 through A40 summarize quality measure reporting and performance of the practices participating in the 2013 PQRS as a GPRO or ACO.

Among practices participating via the Small GPRO, the most frequently reported registry measures were documentation of current medications (#130) and preventive measures such as tobacco screening and cessation intervention (#226) and BMI screening and follow-up (#128)

(Appendix Table A33). The performance rates across the registry measures varied widely. Performance on many of the preventive screening measures was relatively low (50 percent or below) with the exception of tobacco use screening (86 percent).

Among practices participating via the Medium and Large GPRO submitting data on 22 measures via the web interface, there is similar variation across preventive measures, with most measures having a performance rate between 50 and 60 percent, with the exception of higher rates for tobacco use screening and cessation intervention and a much lower performance rate for the Screening for Clinical depression and Follow-Up Plan measure (Appendix Tables A34 and A36). Performance rates on the CAD and HF measures were relatively high, while performance among the care coordination/patient safety, diabetes, and IVD modules was more varied. Among practices participating in the Medium and Large GPRO via registry, reporting and performance rates showed similar patterns to those among Small GPRO with wide variation across all measures, and relatively low rates among most preventive measures (Appendix Tables A35 and A37). In general, within the GPRO groups, the performance rates on similar measures were higher for those submitted via web-interface compared to those submitted via registry. For example, among practices reporting the tobacco use and cessation intervention under the Large GPRO, the performance rate via web interface was 91 percent compared to 72 percent via registry. Appendix Table A38 presents results for the 22 CAHPS for PQRS survey measures reported by practices who participated in the Large GPRO via the web interface. Results ranged from 26 percent for "stewardship of patient resources" to 93 percent for "how well providers communicate" and "courteous and helpful office staff." Appendix Tables A39 and A40 present web interface results for eligible professionals participating in PQRS through Medicare ACOs participating under the Pioneer ACO Model and the SSP, respectively, which exhibit patterns very similar to that among the practices reporting via Large GPRO (Table A36).

IV. ELECTRONIC PRESCRIBING (ERX) INCENTIVE PROGRAM

A. Background

Program Description

Section 132 of the MIPPA authorized a separate incentive program—the Electronic Prescribing Incentive Program (eRx)—for eligible professionals who are successful electronic prescribers, as defined by the MIPPA. The incentive program began on January 1, 2009 and its last program year was 2013.

Under the eRx Incentive Program, eligible professionals reported data on the electronic prescribing quality measure to describe their use of a qualified electronic prescribing (e-prescribing) system during an eligible visit with a Medicare beneficiary. As defined under the electronic prescribing quality measure, a qualified e-prescribing system is one that is capable of all of the following:[36]

- Generate a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers (PBMs) if available.
- Select medications, print prescriptions, electronically transmit prescriptions, and conduct all alters. [37]
- Provide information related to lower cost and therapeutically appropriate alternatives (if any).
- Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan (if available).

In addition, the system must employ, for the capabilities listed, the e-prescribing standards adopted by the Secretary for Part D. In 2013, the definition of a qualified e-prescribing system continued to include electronic health record systems that are certified by an authorized testing and certification body recognized by the Office of the National Coordinator for Health Information Technology.

Individual eligible professionals did not need to participate in PQRS to participate in the eRx Incentive Program. In all previous years of the eRx Incentive Program, practices could only participate under the GPRO if they were also participating in PQRS under the GPRO. Beginning in 2013, practices wishing to participate under the GPRO in the eRx Incentive Program were no longer required to also participate in the PQRS GPRO. To participate in the eRx Incentive Program, eligible professionals could report data on the eRx quality measure on eligible Medicare Part B claims indicating a qualified eRx system was used. Beginning in 2010,

[36] The eRx measure specification can be found at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive.

[37] Alerts are written or acoustic signals to warn prescribers of possible undesirable or unsafe situations, including potentially inappropriate dose, route of administration, drug-drug interactions, allergy concerns, or warnings and cautions.

individual eligible professionals also could submit data through a qualified registry or a qualified EHR vendor to indicate use of a qualified e-prescribing system. Also beginning in 2010, group practices were eligible to report data on the eRx quality measure under the GPRO if they self-nominated to report the eRx quality measure as a group; the claims, registry, and EHR reporting mechanisms were available. In 2011, the GPRO option for practices with 200 or more eligible professionals was referred to as GPRO I. Smaller group practices (ranging from 2 to 199 eligible professionals) were also eligible to participate under the option referred to as GPRO II. The GPRO II option in 2011 was divided into tiers depending on the number of eligible professionals within the practice: Tier 1 (2-10), Tier 2 (11-25), Tier 3 (26-50), Tier 4 (51-100), and Tier 5 (101-199). The reporting mechanisms available for the GPRO in program year 2011 remained unchanged from 2010 (claims, registry, and EHR). In 2012, the GPRO was refined to include Large GPRO (100 or more eligible professionals) and Small GPRO (25 to 99 eligible professionals). For program year 2012, eRx data could be reported through the claims, registry, and EHR reporting mechanisms. The 2013 eRx Incentive Program GPRO included Large GPRO (100 or more eligible professionals), Medium GPRO (25 to 99 eligible professionals), and Small GPRO (2 to 24 eligible professionals); claims, registry, and EHR reporting were available.

To participate in the 2013 eRx Incentive Program under the claims submission method, eligible professionals reported a QDC, also known as a G-code, for the eRx quality measure on a Part B MPFS claim for an eligible instance. Eligible instances were instances when the measure was applicable, as determined based on the presence of a specific set of procedure codes on a claim.[38] There was one valid QDC for the eRx quality measure in 2013:

- **G8553:** At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system.

In addition to reporting via claims, eligible professionals could report data on the eRx quality measure through a qualified registry or EHR vendor.

To earn the incentive payment for the 2013 eRx Incentive Program, there were two criteria:

1. **Be a Successful Electronic Prescriber.** Individual eligible professionals had to report the eRx measure for at least 25 visits (eligible instances) during the reporting period. For practices participating through the GPRO, the number of reported instances required was 2,500 for Large GPRO, 625 for Medium GPRO, and 75 for Small GPRO.

2. **Meet the 10 Percent Limitation Threshold.** During the reporting period, the allowed charges for Medicare Part B covered professional services furnished by the eligible professional for the codes that appear in the eRx quality measure denominator must comprise at least 10 percent of the total allowed Part B MPFS charges for all such covered professional services furnished by the eligible professional. The same requirement applied to group practices that participated through the GPRO under the eRx Incentive Program.

[38] 2013 denominator codes (CPT/HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109.

The 2013 eRx Incentive Program incentive was 0.5 percent of total estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional or practice during the reporting period, compared to 1.0 percent in 2012.

Program Evolution

With regard to earning an eRx incentive, CMS did not make any changes to the reporting requirements for the eRx Incentive Program for individual eligible professionals for the 2013 program (see Table 30). As noted above, CMS refined the group reporting option to include Large GPRO (practices with 100 or more eligible professionals), Medium GPRO (practices with 25 to 99 eligible professionals), and Small GPRO (practices with 2 to 24 eligible professionals).

Table 30 summarizes changes in the eRx Incentive Program rules for earning an eRx incentive from 2011 to 2013. The main changes over this period were the introduction and refinement of options for reporting under the GPRO, and a reduction in the applicable incentive percentage.

Table 30: Summary of eRx Incentive Program Requirements (2011 to 2013)

Statistic	2011	2012	2013
Applicable Percent [a]	1% of Part B MPFS allowed charges	1% of Part B MPFS allowed charges	0.5% of Part B MPFS allowed charges[b]
Reporting Mechanisms available to Individual eligible professionals and group practices	Claims, Registry, EHR	Claims, Registry[c], EHR[c]	Claims, Registry[c], EHR[c]
Participation Options	Individual Eligible Professionals, Group Practices I (GPRO I), Group Practices II (GPRO II)	Individual Eligible Professionals, Small Group Practices (Small GPRO), Large Group Practices (Large GPRO)[c]	Individual Eligible Professionals, Small Group Practices (Small GPRO), Medium Group practices (Medium GPRO), Large Group Practices (Large GPRO)[c]
Quality-Data Code(s)	G8553	G8553	G8553
Successful Electronic Prescriber Reporting Requirement for Individual Participation	At least 25 eligible events	At least 25 eligible events	At least 25 eligible events

Statistic	2011	2012	2013
Successful Electronic Prescriber Reporting Requirement for Group Practice Reporting Option (GPRO)	GPRO I (200 or more EPs): At least 2,500 eligible events GPRO II (2 – 199 EPs): requirement varied by number of eligible professionals per practice: 2 to 10 (75 events) 11 to 25 (225 events) 26 to 50 (475 events) 51 to 100 (925 events) 101 to 199 (1,875 events)	Small GPRO (25 – 99 EPs): At least 625 eligible events Large GPRO (100 or more EPs): At least 2,500 eligible events	Small GPRO (2 – 24 EPs): At least 75 eligible events Medium GPRO (25 – 99 EPs): At least 625 eligible events Large GPRO (100 or more EPs): At least 2,500 eligible events
Limitation Threshold	10% of Part B MPFS charges	10% of Part B MPFS charges	10% of Part B MPFS charges

Notes for Table 30:
[a] Applicable Quality Percent for the eRx Incentive Program is applied to estimated allowed charges for covered professional services furnished by the eligible professional in the applicable reporting period.
[b] For 2013, Incentive payments made through eRx are subject to the mandatory reductions in federal budgetary resources known as sequestration, required by the Budget Control Act of 2011. The American Taxpayer Relief Act of 2012 postponed sequestration for 2 months. As required by law, President Obama issued a sequestration order on March 1, 2013. Under these mandatory reductions, eRx incentive payments made to eligible professionals and group practices will be reduced by 2%.
[c] Only registries and EHR vendors that qualify may submit data on behalf of eligible professionals, and group practices qualified for the Physician Quality Reporting System GPRO in the given year may participate.

eRx Payment Adjustment

Section 1848(a)(5) of the Social Security Act requires payment adjustments under the eRx Incentive Program for eligible professionals who were not successful electronic prescribers. The 2014 eRx payment adjustment applies a reduction of 2.0 percent, an increase from a reduction of 1.5 percent in 2013, to the MPFS amounts for Medicare Part B services furnished by the eligible professional between January 1 and December 31, 2014.

To avoid the adjustment, eligible professionals had to report the **G8553** code via claims on at least 10 Medicare billable services during the six-month period January 1, 2013 through June 30, 2013, or have been a successful 2012 electronic prescriber. Minimum reporting criteria to avoid the payment adjustment for practices reporting via GPRO depended on the size of the practice. Alternatively, eligible professionals could avoid the payment adjustment by indicating a hardship or lack of prescribing privileges.

B. Incentive Payments

In 2013, 259,401 eligible professionals (representing 54,854 practices) earned $171,732,673 in incentive payments, including eligible professionals who are part of a group practice that was

incentive eligible under the GPRO and eligible professionals receiving an EHR incentive under the Medicare EHR Incentive Program (Table 5).[39] The average incentive payment was $662 per eligible professional and $3,131 per practice, about half of the average 2012 payment following the reduction in the incentive payment percentage from 1.0 to 0.5 percent of total allowed MPFS (Table 31).

Table 31: eRx Incentive Payment (2011 to 2013)

Incentive Description	2011	2012	2013
Average Incentive Payment per Eligible Professional	$1,618	$1,474	$662
Average Incentive Payment per Practice	$6,658	$6,095	$3,131
Total Incentive Amounts	**$287,215,472**	**$335,331,216**	**$171,732,673**

Note for Table 31: Results include eligible professionals who were part of a practice that participated under the GPRO.

Appendix Table A42 presents the distribution of eRx Incentive Program payments by specialty in 2013. The majority of 2013 incentive payments were paid to the top participating specialties – internal medicine, family practice, cardiology, and ophthalmology. Appendix Table A43 shows the average potential incentive by specialty (based on one-half percent of estimated total Part B MPFS allowed charges for covered professional services furnished by eligible professionals during the reporting period) and the participation rate.

For 2013, there were 106,090 eligible professionals who participated individually in the eRx Incentive Program and who were incentive eligible for an eRx incentive, but who received an EHR incentive through the Medicare EHR Incentive Program (data not shown).[40] The total eRx incentive amount for these eligible professionals would have been $97,977,449 (more than half of total incentives earned for the eRx Incentive Program). There were 183 group practices with 28,045 eligible professionals participating in the Medicare EHR Incentive Program; 27,430 were incentive eligible, accounting for total eRx Incentive Program GPRO incentive earnings of $11,116,772.

C. Participation

Participation Findings

The 2013 eRx Incentive Program (reporting in 2013 for the 2013 eRx incentive) consisted of one measure and one reporting period (January 1 through December 31, 2013). Individual eligible professionals did not have to enroll or file any intent to participate in the eRx Incentive Program. Overall, 808,697 eligible professionals could have participated in the eRx Incentive Program in 2013 compared to 778,904 in 2012. In addition, there were 218,607 eligible practices in 2013; 77,708 of these practices participated (Table 5).

[39] Figures include 106,090 individually participating eligible professionals who were incentive eligible for the eRx incentive, but because of the statutory prohibition on receiving an incentive under both the eRx and EHR Incentive Programs, only received an EHR incentive through the Medicare EHR Incentive Program.

[40] Eligible professionals cannot receive an incentive from the e-Prescribing Incentive Program if they receive an incentive under the EHR Incentive Program in a given program year.

Eligible professionals who chose to participate in the 2013 eRx Incentive Program using the registry or EHR-based reporting mechanisms contacted the CMS-qualified registries or EHR vendors listed in the posted CMS qualified lists.[41] In 2013, there were 43 qualified registries, 33 of which submitted eRx quality measure information. There were 17 EHR products approved for direct submission (six of which were used) and 42 EHR vendors qualified by CMS to submit EHR data (nine of which submitted data) (data not shown).

Overall, 377,004 eligible professionals (47 percent of those eligible) participated individually or as part of a group practice in the 2013 eRx Incentive Program (Figure 6), which was a 9 percent increase from the total number of participants in 2012. A total of 208 practices, including 80,009 eligible professionals, participated in the eRx Incentive Program under the GPRO, mostly under the Large GPRO (Appendix Tables A46 and A50). This was a large increase from 66 practices participating under the GPRO in 2012.

In 2013, eligible professionals submitted a total of 33,022,558 eRx QDCs through claims, with an average of 113 QDCs submitted per eligible professional (excluding GPRO data; data not shown). Nearly all (95 percent) of these QDCs were correctly submitted. QDCs were rejected, for example, when an eligible professional used an incorrect procedure code (i.e., HCPCS/CPT code). Among registry reporters, registry data for 865 eligible professionals showed counts of 25 or more eRx instances; however, an examination of Medicare claims for Part B PFS charges for these eligible professionals showed fewer than 25 eligible instances.

MD/DO practitioners were more likely than other types of eligible professionals to participate in the eRx Incentive Program in 2013 (Table 32). Over one-half (53 percent) of MD/DOs participated while roughly one-third of eligible professionals (34 percent) in the "other eligible professionals" category (i.e. non-MD/DOs) participated. This pattern may be due partly to the fact that many non-MD/DO practitioners would not report an e-prescribing measure under this program given the scope of their health care provider license.

Table 32: Number of Eligible Professionals Participating in the eRx Incentive Program by Specialty Category (2013)

Type of Eligible Professional	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
MD/DO	527,701	282,026	53.4%
Other Eligible Professionals	280,181	94,706	33.8%
Unknown/Missing	815	272	33.4%
Total (Unduplicated)	808,697	377,004	46.6%

Note for Table 32: Results include eligible professionals who were part of a practice participated under the GPRO.

Certain specialties were more likely to participate in the 2013 eRx Incentive Program than others (Table 33). Family practice and internal medicine had the largest number of eligible and

[41] EHR: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/Electronic-Health-Record-Reporting.html

Registry: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/Registry-Reporting.html

participating professionals and slightly higher than average participation rates (60 and 58 percent, respectively), although cardiology had the highest participation rate (73 percent). Appendix Table A44 presents participation results for all specialties in 2012 and 2013. Other specialties that had particularly high rates of participation in 2013 but lower overall numbers included: nurse anesthetist (95 percent), physical/occupational therapy (82 percent), and pathology (80 percent).

Table 33: Specialties with the Highest Participation in the eRx Incentive Program (2013)

Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
Family Practice	92,146	55,451	60.2%
Internal Medicine	84,026	48,693	57.9%
Nurse Practitioner	69,064	33,523	48.5%
Physician Assistant	44,187	22,117	50.1%
Cardiology	24,845	18,168	73.1%

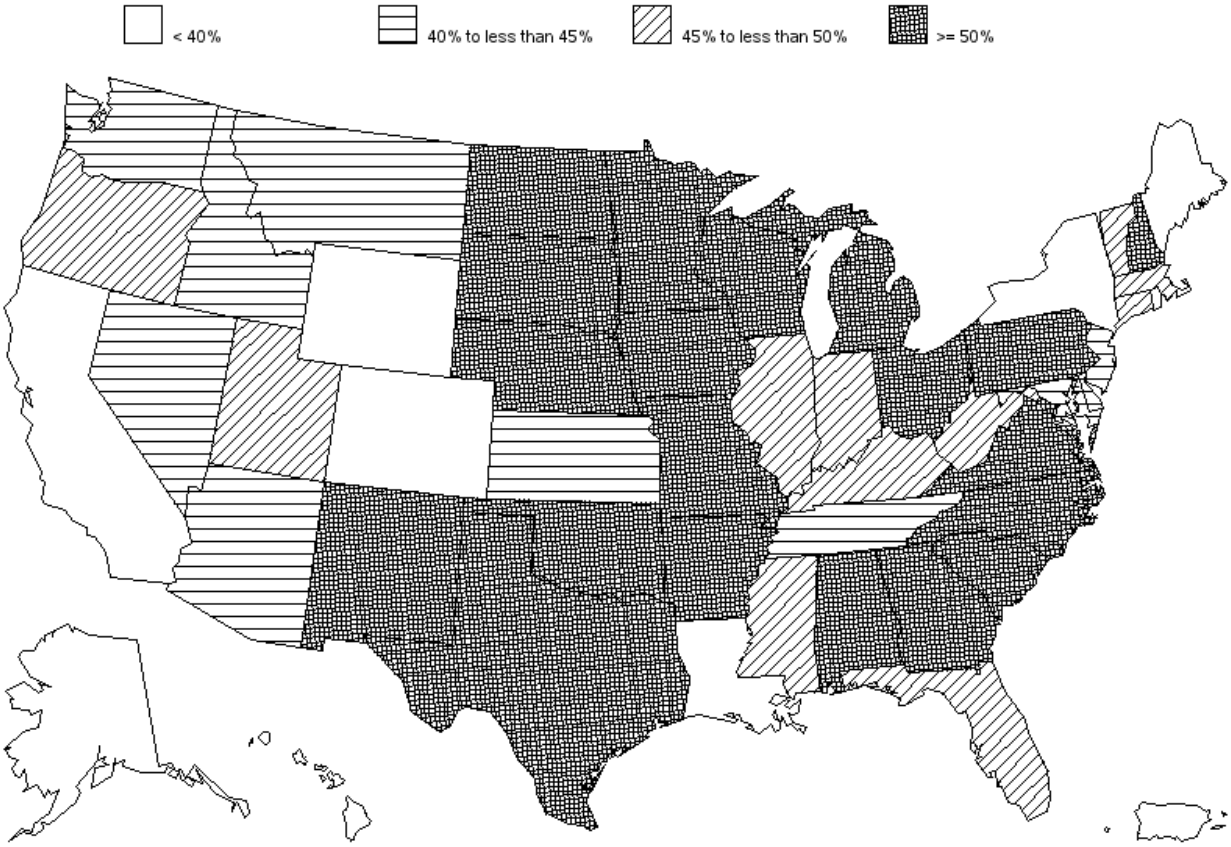
Note for Table 33: Results include eligible professionals who were part of a practice that participated under the GPRO.

Among the 80,009 eligible professionals within practices participating in the 2013 eRx Incentive Program under the GPRO, the specialties with the highest number of participating eligible professionals were internal medicine, family practice, nurse practitioner, physician assistant, and radiology (data not shown).

There was a strong relationship between the number of Medicare beneficiaries seen by an eligible professional and the likelihood of participating in the 2013 eRx Incentive Program (Appendix Table A46). Eligible professionals with more than 200 eligible beneficiaries with an eligible eRx instance had a participation rate of 71 percent, compared to 10 percent among eligible professionals with 25 or fewer beneficiaries on whom to report data, and 35 percent among those with 26 to 100 patients on whom to report data.

Participation rates in the 2013 eRx Incentive Program varied by state. Figure 18 and Appendix Table A47 present the distribution of participation rates across the country. Excluding territories, the participation rate in the 2013 eRx Incentive Program ranged from 26 percent in Alaska (483 eligible professionals) to approximately 67 percent in North Dakota (1,931 eligible professionals). States with the highest participation rates were concentrated in the South and Midwest. The number of eligible professionals participating in the 2013 eRx Incentive Program ranged from below 1,000 in Wyoming, Alaska, and Hawaii to over 20,000 in California, New York, Texas, Florida, and Pennsylvania. It should be noted that some state law limitations on electronic prescribing may affect eligible professionals' participation in the eRx Incentive program.

Figure 18: Geographic Distribution of Eligible Professionals Participating in the eRx Incentive Program (2013)



Note for Figure 18: Results include reporting via the claims, registry, and EHR mechanisms as well as data for eligible professionals who belong to a practice that participated under the GPRO. The data used to populate this map can be found in Appendix Table A47.

D. Incentive Eligibility

To qualify for the 2013 incentive payment equal to 0.5 percent of estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional during the reporting period, an eligible professional or a group practice participating in the eRx Incentive Program must have been a successful electronic prescriber (as described above) and their allowed charges for services identified in the eRx quality measure's denominator must have comprised at least ten percent of the eligible professional's or practice's total 2013 estimated Part B MPFS allowed charges (the 10% limitation threshold).

In 2013, over two-thirds (259,401) of eligible professionals (including eligible professionals within group practices that received an incentive under the GPRO) qualified for an incentive in the eRx Incentive Program (Table 5). Sixty out of seventy practices participating under the Small GPRO qualified for incentives, totaling $536,002. Under the Medium GPRO, 26 of the 27 participating practices earned incentives, totaling $795,175. Under the Large GPRO, 106 of the 111 participating practices earned incentives, totaling $18,543,892 (Appendix Table A50).

Table 34 presents the specialties with the largest number of eligible professionals qualifying for an eRx incentive in 2013. Family practice and internal medicine were among the specialties with the largest number of participants and also had relatively high participation rates of 78 percent.

As seen in Appendix Table A46, incentive eligibility rates were highest among those participating via Medium and Large GPROs (97 percent) compared with claims (61 percent). Incentive eligibility rates were also notably higher among individual participants in practices with at least 200 beneficiary visits (77 percent) compared to those with 26 to 100 beneficiary visits (39 percent).

Table 34: Specialties with the Highest Incentive Eligibility for the eRx Incentive Program (2013)

Specialty	Eligible Professionals who Participated	Eligible Professionals who were Incentive Eligible	Percent of Participating Eligible Professionals who were Incentive Eligible
Family Practice	55,451	43,369	78.2%
Internal Medicine	48,693	38,137	78.3%
Nurse Practitioner	33,523	20,148	60.1%
Cardiology	18,168	13,979	76.9%
Physician Assistant	22,117	13,454	60.8%

Note for Table 34: Results include eligible professionals who were part of a practice that participated under the eRx GPRO.

Though 259,401 eligible professionals qualified for incentives in the 2013 eRx Incentive Program, 261,831 eligible professionals were successful electronic prescribers in 2013 (data not shown). Among successful electronic prescribers, 2,426 did not reach the 10 percent limitation threshold for incentive eligibility (Appendix Table A48). Among eligible professionals with an MD/DO, the specialties with the highest rates of successful electronic prescribers who did not reach the 10 percent threshold (and with more than one eligible professional who did not reach the threshold) included nephrology (six percent) and dermatology (three percent).

E. eRx Payment Adjustment

Beginning in 2012, section 1848(a)(5) of the Social Security Act required CMS to apply a payment adjustment for eligible professionals who were not successful electronic prescribers under the eRx Incentive Program. For the 2014 eRx payment adjustment, eligible professionals who did not meet the requirements described below were subject to a 2.0 percent reduction to the MPFS charges for Medicare Part B services furnished between January 1 and December 31, 2014, an increase from the 1.5 percent reduction imposed for the 2013 eRx payment adjustment with regard to services furnished in 2013.

Certain types of individually participating eligible professionals were not subject to the 2014 eRx payment adjustment:

- Those that were not physicians (MD/DO or podiatrist), nurse practitioners, or physician assistants as of June 30, 2013, based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES).
- Those that did not have at least 100 eligible claims containing an encounter code in the measure denominator during the period from January 1, 2013 to June 30, 2013.
- Those that did not meet the 10% limitation threshold were not eligible for the adjustment.

Eligible professionals who did not meet any of the three criteria above could still avoid the 2014 eRx payment adjustment if they:

- Were (1) successful eRx prescribers (as individual eligible professionals) during 2012 eRx Incentive Program year by reporting the G8553 code on at least 25 eligible instances via claims, registry, or EHRs between January 1, 2012 and December 31, 2012; or (2) were successful eRx prescribers (as individual eligible professionals) in 2013 by reporting the G8553 code via claims for at least 10 Medicare billable services (for individual participants) during the six month period from January 1 through June 30, 2013.
    - For practices reporting via GPRO, the minimum reporting criteria to avoid the payment adjustment were 2,500 instances for Large GPRO, 625 for Medium GPRO, and 75 for Small GPRO.
- Reported G-code G8644 (defined as not having prescribing privileges) at least one time on an eligible claim between January 1 and June 30, 2013.
- Reported and were granted a significant hardship exemption via claims between January 1 and June 30, 2013:
    - G8642: The eligible professional practices in a rural area without sufficient high speed internet access indicated a hardship to avoid the payment adjustment under section 1848(a)(5)(A) of the Social Security Act.
    - G8643: The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing indicated a hardship to avoid the payment adjustment under section 1848(a)(5)(A) of the Social Security Act.
- For group practices reporting under the GPRO, indicated a hardship or lack of prescribing privileges to CMS during self-nomination.
- Reported a significant hardship exemption by June 30, 2013 through the Communication Support Page and were approved for any of the following reasons:
    - Inability to electronically prescribe due to local, state, or federal law or regulation (e.g., controlled substances).
    - Limited prescribing activity, defined as an eligible professional generating fewer than 100 prescriptions during the 6-month reporting period.
    - Practicing in an area with limited high speed internet access.
    - Practicing in an area with limited available pharmacies for electronic prescribing.

- Demonstrated meaningful use, as determined by CMS through review of the EHR Incentive Program Attestation and Registration system:
    - Achieved meaningful use in the Medicare or Medicaid EHR Incentive Program and adoption Certified EHR technology in 2012 or the first half of 2013, or
    - Demonstrated intent to participate in the Medicare or Medicaid EHR Incentive Program and adopted certified EHR technology by January 1, 2013.

In total, 49,576 eligible professionals (including those under the GPRO) were subject to the 2014 payment adjustment (Appendix Table A49). Table 35 presents the specialties with the highest number of eligible professionals subject to the 2014 eRx payment adjustment. Appendix Table A49 lists the number of eligible professionals subject to the payment adjustment for all specialties. Family practice and internal medicine had the largest number of eligible professionals (6,915 and 6,097, respectively) subject to the adjustment.

Table 35: Specialties with the Largest Number of Eligible Professionals Subject to the 2014 eRx Payment Adjustment

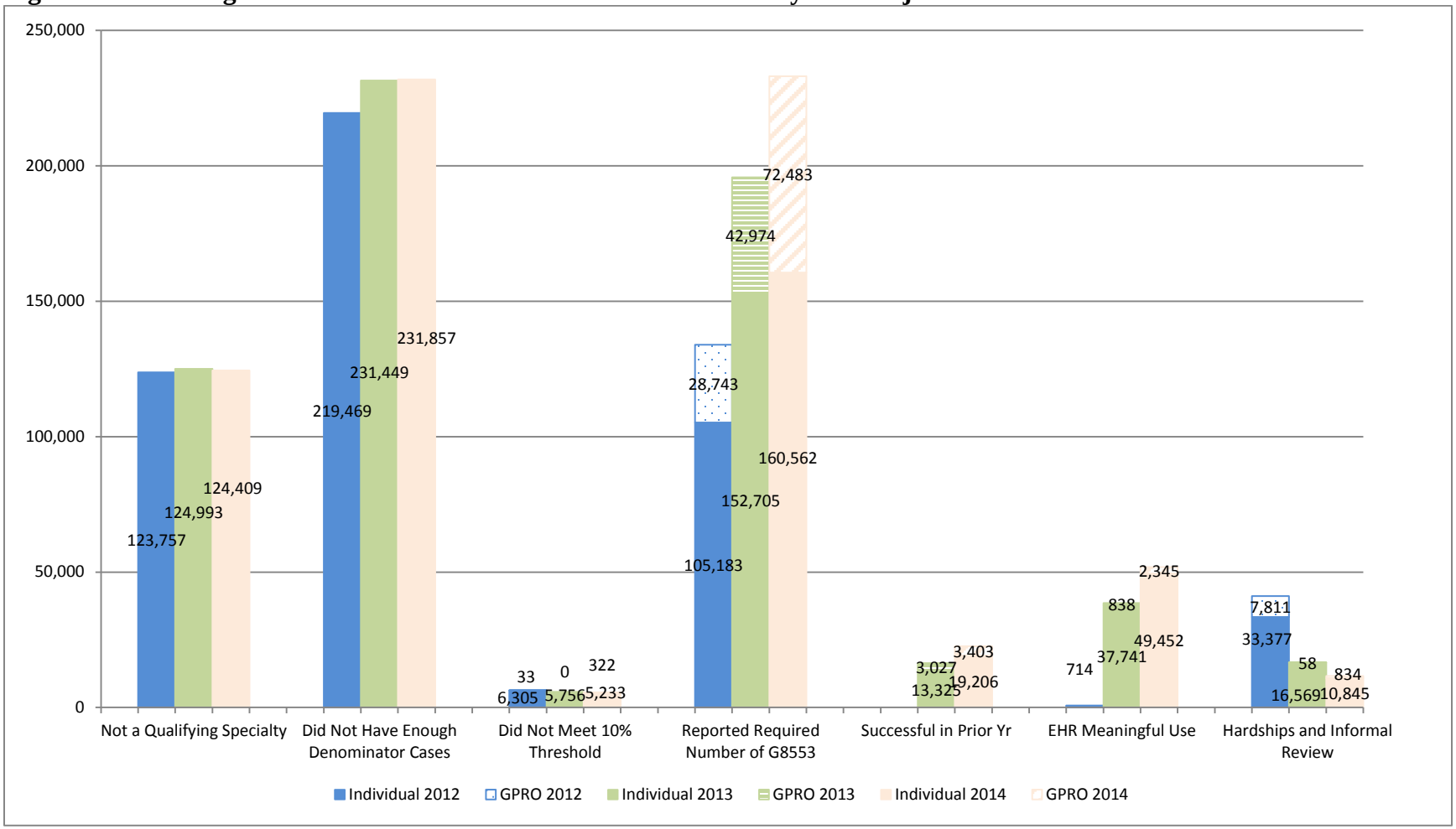
Specialty	Eligible Professionals Subject to the Payment Adjustment	Percent of Eligible Professionals Subject to the Payment Adjustment
Family Practice	6,915	13.9%
Internal Medicine	6,097	12.3%
Nurse Practitioner	5,596	11.3%
Psychiatry	4,208	8.5%
Physician Assistant	3,498	7.1%
Podiatrist	2,350	4.7%
Orthopaedic Surgery	2,095	4.2%
Ophthalmology	1,610	3.2%
Dermatology	1,357	2.7%
Cardiology	1,324	2.7%

Note for Table 35: Results include eligible professionals who were part of a practice that participated under the GPRO.

As seen in Figure 19, the three most common reasons for avoiding the 2014 eRx payment adjustment were: (1) not having enough (at least 100) denominator cases in the 6-month reporting period (N=231,857), (2) reporting the required number of G8553 (N=233,045); and (3) not being a physician, nurse practitioner, or physician assistant (124,409). Another 51,797 avoided the adjustment by meeting the requirements for the EHR Incentive Program (Meaningful Use) and 11,679 avoided the payment adjustment because of a hardship, either through an approved hardship request on the Communication Support Page, a claim hardship, or through an informal review process.

Among the practices reporting under the GPRO that avoided the 2014 payment adjustment, the majority (N=180) reported the required number of QDCs, nine practices did not meet the 10 percent limitation threshold, four practices were successful e-prescribers in 2012, and four practices were granted an exemption after reporting a hardship (data not shown).

Figure 19: How Eligible Professionals Avoided the 2012-2014 eRx Payment Adjustment



Notes for Figure 19: Counts for the five sets of columns on the left are unduplicated and reflect the application of a hierarchy of reasons eligible professionals automatically avoided the eRx payment adjustment in the order shown. Counts for the eligible professionals who avoided the eRx payment adjustment due to hardship requests are also unduplicated within each column, and do not include any eligible professionals who avoided the eRx payment adjustment for any of the reasons in the first five sets of columns (i.e. there is not any overlap with any other columns in the figure).

V. FEEDBACK REPORTS

A. Background

CMS provides feedback reports for the Physician Quality Reporting System and the eRx Incentive Program each year. Although these reports are not provided simultaneously with the incentives, CMS strives to make feedback reports available as closely as possible to delivery of the incentives. CMS does not require that an eligible professional earn an incentive to furnish a feedback report. Instead, TIN-level feedback reports are available for every TIN under which at least one eligible professional (identified by his or her NPI) submitted Part B MPFS claims with at least one QDC or submitted quality data via registry or EHR for either a PQRS measure or the eRx Incentive Program measure. There are four types of feedback reports available, depending on whether participation was on an individual basis or if a group practice self-nominated to participate under the GPRO:

- Individual eligible professionals who participate individually in PQRS or the eRx Incentive Program can obtain an NPI-level feedback report.
- If a practice did not participate under the GPRO in PQRS or the eRx Incentive Program and there was at least one eligible professional who participated in either program, then the practice can obtain TIN-level reports which also include NPI-level data for NPIs within the TIN.
- Group practices that participate under the eRx GPRO are only able to receive TIN-level eRx feedback reports.
- Group practices participating in the PQRS GPRO receive information within their Quality and Resource Use Reports (QRUR).

B. Accessing Feedback Reports

Feedback reports can be accessed through two different processes. TIN-level feedback reports are available from the Physician and Other Health Care Professionals Quality Reporting Portal (Portal). A new process for requesting NPI-level feedback reports was established in 2011, allowing report requests to be made through the PQRS and eRx Incentive Program Communication Support Page (CSP).[42] Feedback reports for multiple program years are available via both of these processes.

TIN-Level Feedback Report Access

2013 TIN-level (PQRS GPRO/ACO) feedback report data is available within the Quality Resource and Utilization Report (QRUR)[43] at the CMS enterprise portal. 2013 QRURs are not

[42] http://www.qualitynet.org/portal/server.pt/community/communications_support_system/234

[43] http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeedbackProgram/2013-QRUR.html

available for TINs with physicians who participated in the Shared Savings Program, the Pioneer ACO Model or the Comprehensive Primary Care initiative in 2013.

2013 TIN-level PQRS feedback reports for eligible professionals who participated in PQRS as an individual are available through the Portal; these reports are not available for eligible professionals who participated through the CPC Initiative. To access these reports, the TIN representative must create an Individuals Authorized Access to the CMS Computer (IACS) account, which is required in order for the TIN representative to log on to the Portal. The Portal, accessible via QualityNet, is the secured entry point to access the reports. Each feedback report is safely stored online and is accessible only to persons specifically authorized by that TIN. For further information regarding this process, see the PQRS website on the Educational Resources page. [44]

NPI-Level Feedback Report Access

In 2011 the CSP was made available so that individual eligible professionals can request 2008-2013 NPI-level feedback reports. The CSP is available through the Portal, and does not require an IACS account. For further information regarding this process, see the Educational Resources page of the PQRS website.

C. Report Content

The 2013 PQRS feedback reports for individual participants were packaged at the TIN-level, with individual-level reporting (or NPI-level) and performance information for each eligible professional who reported under that TIN for services furnished during the reporting period. Reports included information on reporting rates, QDC errors, clinical performance, and incentives earned by eligible professionals, with summary information on reporting success and incentives earned at the practice (TIN) level. Reports also included information on the MAV process and any impact it had on the eligible professional's incentive eligibility. Physician Quality Reporting System and eRx Incentive Program participants do not receive claim-level details in the feedback reports.

For both PQRS and the eRx Incentive Programs, all Medicare Part B claims submitted and all registry, EHR and GPRO data received for services from January 1, 2013 – December 31, 2013 (for the 12-month reporting period) and for services from July 1, 2013 – December 31, 2013 (for the 6-month reporting period) were analyzed to determine whether the eligible professional or group qualified for an incentive according to the specific reporting criteria for the respective reporting mechanism.

An annual eRx payment adjustment Interim Feedback Report is made available to those eligible professionals and group practices reporting under the GPRO who submitted at least one eligible instance and were an MD/DO, Podiatrist, Nurse Practitioner, or Physician Assistant. This reporting includes ten months of Medicare Part B MPFS claims data (from January 1, 2013 – October 31, 2013) to inform the eligible professionals and group practices reporting under the

[44] For more detail, see http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/EducationalResources.html

GPRO of their status in meeting the eRx Incentive Program requirements for being a successful electronic prescriber during the reporting period.

VI. HELP DESK

A. Background

In 2008, CMS recognized the need for a dedicated Physician Quality Reporting System Help Desk to support the reporting efforts of eligible professionals. The QualityNet Help Desk was tasked with providing such support, and began working with the External User Services Help Desk and all of the Medicare A/B Medicare Administrative Contractors (MACs) and carriers. Professionals who have questions on eligibility, reporting, IACS accounts for Portal access, feedback reports, or payments can contact the appropriate support desk for assistance.

B. Support Desks

1. Previously, the External User Services (EUS) Help Desk provided assistance with obtaining an IACS Security Login for access to the PQRS Portal. Near the end of 2010, the IACS support for PQRS was merged with the QualityNet Help Desk to address vetting for the Security Official role in Organizations, IACS account issues, the new Annual Recertification requirement, assistance in obtaining the data submission role, etc. Eligible professionals still need to contact the EUS Help Desk for issues related to Medicare Enrollment and the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).

2. The CMS A/B MAC and Carrier Provider Contact Centers provide Medicare enrollment and claims submission support. This now includes the responsibility of disbursing the PQRS and eRx payments to eligible professionals who earned incentives, paid at the TIN level. They answer questions related to payment disbursement, Remittance Advice, and any offsets or adjustments. The A/B MAC Carriers previously were tasked with accepting request for individual NPI-level feedback reports through the Alternative Feedback Report Request Process. Instead, the CSP was made available in early 2012 as a means for individual eligible professionals to request 2008-2013 NPI-level feedback reports. The CSP is available through the Portal, and does not require an IACS login. This alternative was implemented in response to some difficulties eligible professionals were having obtaining their IACS login.

3. The QualityNet Help Desk initially consisted of one level of support, known as Tier I, which consisted of a team dedicated to issues related to the PQRS and eRx Incentive Programs. This tier handled questions in the summer and fall of 2008 regarding 2007 program year payments and feedback reports, as well as questions regarding 2008 program year reporting. They were available to answer a range of questions on issues such as eligibility, measures, reporting options, portal login, feedback reports, registries, and payments. In the summer of 2009, a second tier was added, known as Inquiry Support, to address specific measure questions and assist CMS with escalated payment or report issues. This tier was able to provide a level of detailed data review to eligible professionals who did not qualify for an incentive and needed information in addition to their feedback report. The Inquiry Support team became the Tier II Inquiry Support level to handle claims detail requests as well as other data specific issues. In 2010, a Tier II

Inquiry Support team was implemented to focus on providing answers to measures questions and program inquiries for both individual measure reporting as well as measures groups reporting, so that eligible professionals could better understand their feedback reports and use that knowledge to be more successful in future years. Currently, there are two Tier II support teams; PQMM handles questions related to measures and PQPMI handles program inquiries. Near the end of 2010, the IACS support for PQRS transitioned to the QualityNet Help Desk (Tier I). This includes vetting for the Security Official role in Organizations, IACS account issues, the new Annual Recertification requirement, assistance in obtaining the data submission role, etc. Eligible professionals still need to contact the EUS Help Desk for issues related to Medicare enrollment and the PECOS system. In 2011, the QualityNet Help Desk at all levels also began to assist with questions related to the eRx payment adjustments for 2012-2014. In 2013, all levels began to assist with questions related to the PQRS payment adjustment.

4. There are additional Support Teams that the QualityNet Help Desk Tiers work with to resolve related issues:

    a. The EHR Meaningful Use Information Center assists with Medicare EHR Incentive Program reporting, as well as with issues stemming from the eRx payment adjustment EHR-related significant hardship exemptions.

    b. The PQPMI Support Team within the Tier II Help Desk assists with vetting new EHR, Registry, and MOCP Vendors, help train these entities, and assist with file submissions at the end of the reporting periods.

    c. The Tier II ACO Help Desk provides guidance related to ACOs that report (via the GPRO Web Interface) on behalf of eligible professionals for purposes of Physician Quality Reporting System reporting under the Medicare Shared Savings Program or the Pioneer ACO model.

    d. The Physician Value Tier II Help Desk assists with Value-Modifier (VM) and QRUR questions, as well as online registration to avoid Physician Quality Reporting System or VM adjustments.

Eligible professionals are encouraged to utilize the services provided by these support desks. The contact information for the support desks follows:

1. External User Services Help Desk for Medicare enrollment and PECOS questions:

    - Phone: 1-866-484-8049
    - TTY/TDD: 1-866-523-4759 (Monday-Friday; 7am-7pm EST)
    - Email: EUSSupport@cgi.com

2. CMS A/B MAC and Carrier Provider Contact Centers:

    - To get information regarding Contact Centers, see the "Provider Compliance Group Interactive Map" by clicking on the following

link: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html.

3. QualityNet Help Desk for first-level questions on IACS, Portal Login, payments, reports, measures, GPRO, ACO, Physician Value, eRx adjustments, file submissions etc. Issues may then be escalated to the appropriate Tier II or Tier III support teams:

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

VII. CONCLUSION

Participation in PQRS and the eRx Incentive Program has increased steadily over time as payment adjustments associated with these important programs have been implemented, on the way toward the use of a value-based payment modifier as authorized under section 3007 of the Affordable Care Act.[45]

Eligible professionals earned over 1.2 billion dollars in incentives during the five program years for the eRx Incentive Program (2009 to 2013). The eRx program exhibited continued growth—primarily from group practices—in its last program year. Close to five out of ten eligible professionals participated and over 14 million beneficiaries received an electronic prescription through the 2013 program. In addition, the number of eligible professionals who were subject to the 2014 eRx payment adjustment continued to fall from the number subject to the 2013 adjustment. The number of eligible professionals avoiding the payment adjustment continued to increase as more eligible professionals met the reporting requirements and/or Medicare EHR Incentive Program meaningful use requirements. Going forward, eligible professionals can continue to earn incentives under the Medicare EHR Incentive Program, in which they must demonstrate as a core measure that more than 40 percent of all permissible prescriptions they write are transmitted electronically using certified EHR technology. Just over half of the eligible professionals earning an eRx incentive in 2013 were already receiving an incentive from the EHR Incentive Program.

The PQRS program exhibited very strong growth in the 2013 program year, with a 47 percent increase and over five out of ten eligible professionals now participating in the program via individual or group reporting options, as part of an ACO, or the CPC initiative. In the first year of the PQRS payment adjustment in 2015, over 780,000 eligible professionals avoided the adjustment with the majority doing so by meeting 2013 reporting requirements.

CMS will continue to foster growth and participation in PQRS and alignment with other programs. First, CMS is actively working to reduce burden on eligible professionals by allowing them to report once for multiple programs. This is accomplished by aligning measures reported through various quality reporting initiatives. For example, under the Medicare EHR Incentive Pilot, eligible professionals will continue to be able to report data on the same set of electronic clinical quality measures (eCQMs) and fulfill the requirements for satisfactory reporting under PQRS as well as meeting the eCQM component of Meaningful Use under the Medicare EHR Incentive Program. Practices participating in PQRS via the GPRO will now have an EHR reporting mechanism available to them. Second, CMS continues to streamline the measures available by eliminating measures that are topped out, redundant, or under-reported. Lastly, CMS continues to align with the National Quality Strategy by streamlining measures across programs as it balances competing goals of establishing parsimonious sets of measures while including sufficient measures to facilitate provider participation. These refinements should enable physicians in groups of 10 or more eligible professionals to avoid the two percent 2016 value modifier, by registering for one of three 2014 PQRS GPRO reporting mechanisms—web interface (for groups with 25 or more NPIs), qualified PQRS Registry, or EHR—and meeting the

[45] See following link for more details: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.

successful reporting criteria for that mechanism; if a group practice does not report quality measures via 2014 PQRS GPRO, CMS will calculate a group quality score if at least 50 percent of the EPs in the group report measures individually and meet the criteria to avoid the 2016 PQRS payment adjustment.

ABBREVIATIONS

Table 36: Abbreviations

Abbreviation	Meaning
ACO	Accountable Care Organization
AMA	American Medical Association
CAP	Community-Acquired Pneumonia
CKD	Chronic Kidney Disease
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CPC	Comprehensive Primary Care Initiative
CPT	Current Procedural Terminology
CSP	Communication Support Page
CVP	Cardiovascular Prevention
eCQM	Electronic Clinical Quality Measure
EHR	Electronic Health Record
eRx	Electronic Prescribing Program
EP	Eligible Professional
EUS	External User Services
FFS	Fee for Service
GPRO	Group Practice Reporting Option
HIC	Health Insurance Claim number
HCPCS	Healthcare Common Procedure Coding System
HCV	Hepatitis C Virus
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
IACS	Individuals Authorized Access to CMS Computer Services
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
IVD	Ischemic Vascular Disease
MAV	Measure Applicability Validation
MG	Measures Groups
MD/DO	Doctor of Medicine or Doctor of Osteopathy
MIEA	Medicare Improvements and Extension Act of 2006
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMSEA	Medicare, Medicaid, and SCHIP Extension Act of 2007
MPFS	Medicare Physician Fee Schedule
NCQA	National Committee for Quality Assurance
NPPES	National Plan and Provider Enumeration System
NPI	National Provider Identifier
PCPI	Physician Consortium for Performance Improvement
PQRI	Physician Quality Reporting Initiative
PQRS	Physician Quality Reporting System
PECOS	Provider Enrollment, Chain, and Ownership System
QCDR	Qualified Clinical Data Registry
QDC	Quality Data Code
QRUR	Quality Resource Use Report
SCHIP	State Children's Health Insurance Program

Abbreviation	Meaning
TRHCA	Tax Relief and Health Care Act of 2006
TIN	Taxpayer Identification Number
VBP	Value-Based Purchasing
VM	Value Modifier