2014 Reporting Experience

Including Trends (2007-2015)

Physician Quality Reporting System

April 15, 2016

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I. EXECUTIVE SUMMARY

In 2007, the Centers for Medicare & Medicaid Services (CMS) implemented the Physician Quality Reporting System (PQRS), a pay-for-reporting program for eligible professionals[1] that has grown substantially from its inception. The program (formerly, Physician Quality Reporting Initiative or PQRI) was 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), and entered its eighth year in 2014. PQRS encourages eligible professionals to report clinical quality data by providing a payment incentive 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 a payment adjustment for unsuccessful reporters, based on a percent reduction in MPFS payment amounts. The first year of the payment adjustment applied adjustments to 2015 payments, based on 2013 PQRS program year reporting. PQRS reporting in the 2014 program year forms the basis for the 2016 payment adjustment. The 2014 program year was also the last year in which eligible professionals could earn an incentive for PQRS reporting.

This report summarizes the historical reporting experience of eligible professionals in the PQRS program through program year 2014. Unless otherwise noted, all tables and figures are based on data reported for calendar year 2014. Findings in this report summarized at the practice level include both eligible professionals participating individually, 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] For brevity, the tables and figures in this report present the SSP and Pioneer model ACO programs and CPC as "participation options" under PQRS; however, they are alternative programs and eligible professionals must meet all requirements under those programs. In addition, 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 program.

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

[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 incentive payments 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 incentive payments and avoid the PQRS payment adjustment.

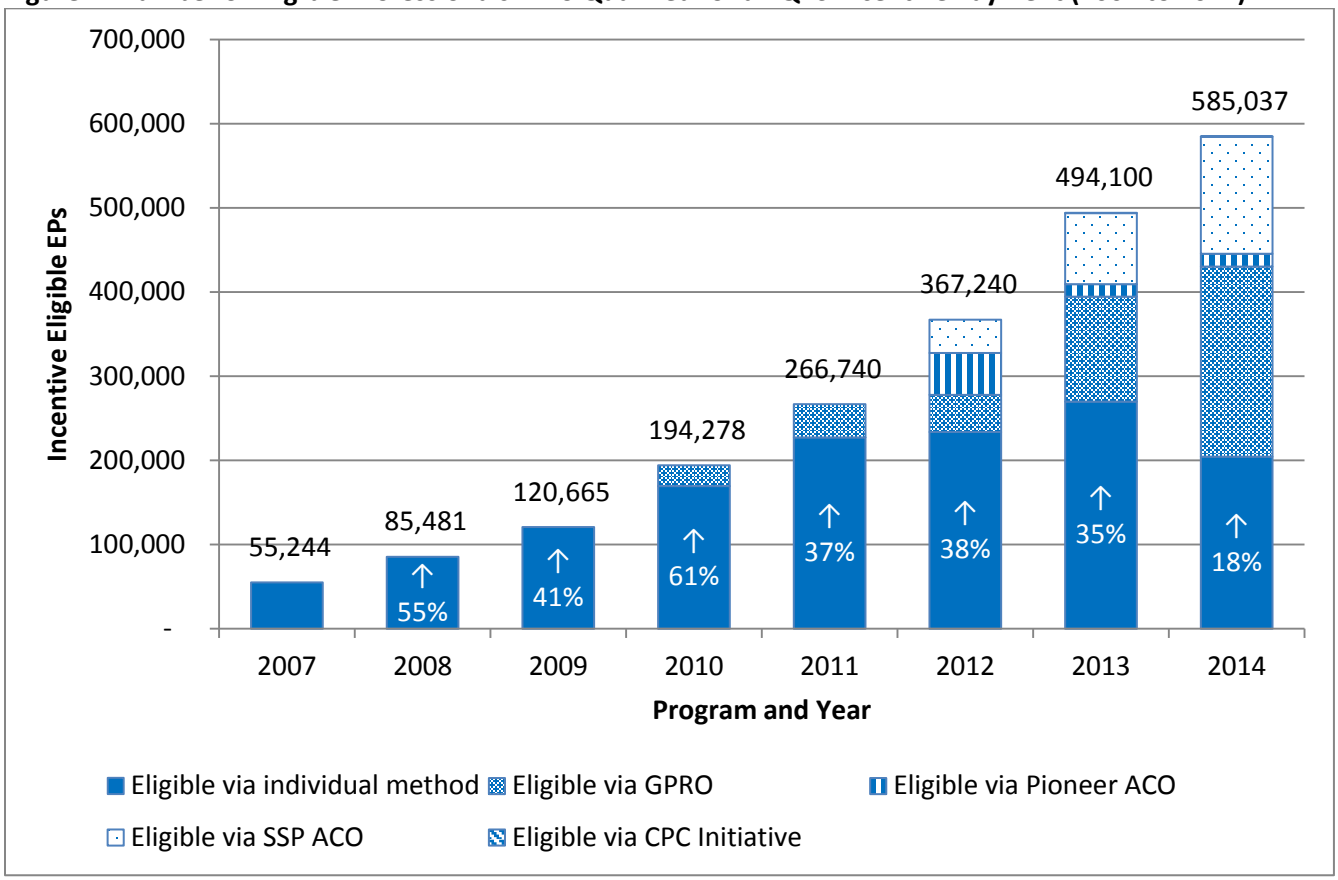
[3] As required by law, President Obama issued a sequestration order on March 1, 2013. Under these mandatory reductions, PQRS incentive payments made to eligible professionals and group practices have been reduced by two percent. This two percent reduction affected PQRS incentive payments for reporting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

professionals that meet requirements related to participation in Maintenance of Certification Program Incentive (MOCP), although some tables present the MOCP incentive results separately.[4]

Incentive Payments

- The number of eligible professionals who qualified for an incentive payment under PQRS has increased each year, particularly among those eligible under a practice participating via the GPRO or SSP (Figure 1).

Figure 1: Number of Eligible Professionals Who Qualified for a PQRS Incentive Payment (2007 to 2014)

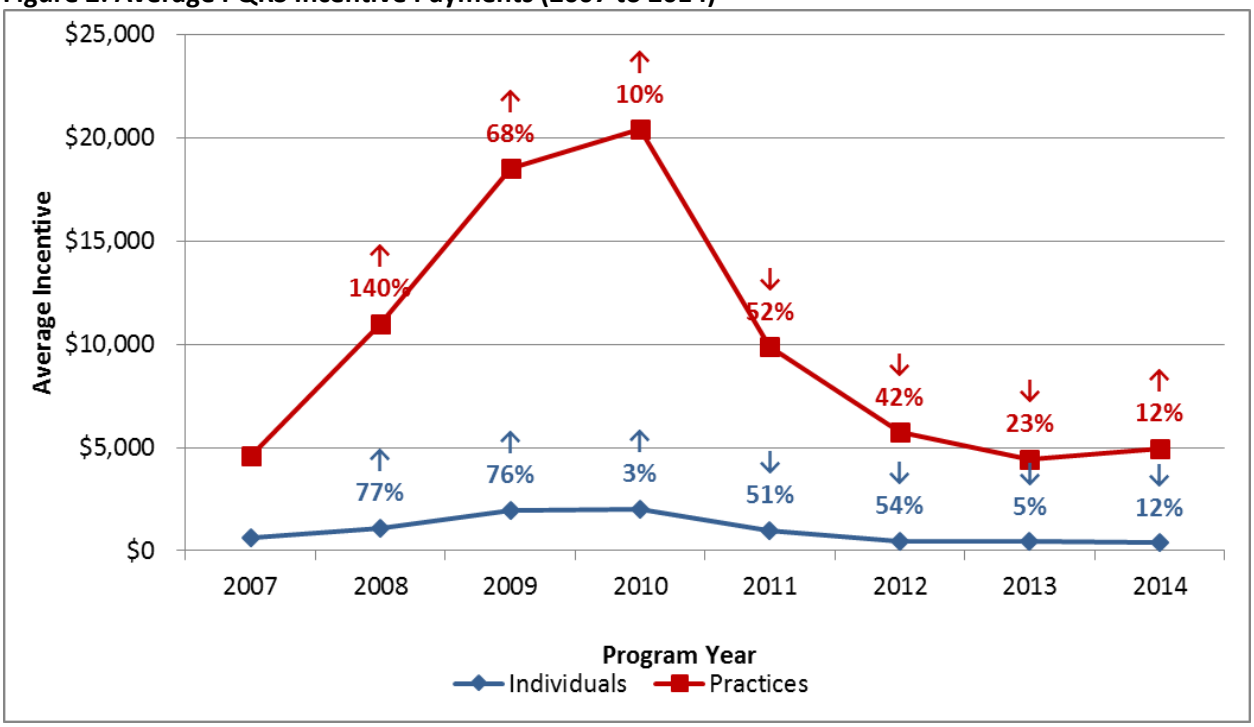


Note for Figure 1: Results include all participation options (i.e. individual, GPRO, SSP and Pioneer ACOs, and the CPC initiative).

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

- A total of $224,088,411 in PQRS incentive payments were earned in the 2014 program year after sequestration, which reflects successful participation of 585,037 eligible professionals within 45,273 practices (Table 3).[5]
    - The number of eligible professionals who qualified for an incentive for PQRS in 2014 increased by 18 percent from 2013 (N=494,100).
    - The number of practices that received an incentive for the 2014 program year (N=45,273) decreased by six percent from 2013 (N=48,313) (Table 3).
    - The average incentive was $383 per eligible professional and $4,950 per practice; the average incentive per eligible professional decreased by 12 percent from 2013 (Figure 2).
- The 2014 program year was the last year eligible professionals could earn a PQRS incentive payment. However, a total of $1,627,613,994 was paid over the eight years (2007 – 2014) that CMS provided PQRS incentive payments.

Figure 2: Average PQRS Incentive Payments (2007 to 2014)



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

[5] 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.

Expansion of Participation Mechanisms and Program Eligibility

- In program year 2014, CMS expanded the PQRS reporting mechanisms by adding the Qualified Clinical Data Registry (QCDR) individual mechanism and EHR reporting for practices participating as part of the GPRO. The claims-based measures group reporting mechanism was removed in 2014. The program will retain the same reporting mechanisms and options for 2015.

Table 1: Summary of Reporting Options, Mechanisms, and Alternative Programs for PQRS (2007 to 2015)

Reporting Options and Mechanisms	2007	2008	2009	2010	2011	2012	2013	2014	2015
Individual Participation	--	--	--	--	--	--	--	--	--
Claims-based: Individual Measures	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Claims-based: Measures Groups	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Registry: Individual Measures	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Registry: Measures Groups	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
EHR: Individual Measures	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Qualified Clinical Data Registry (QCDR)	No	No	No	No	No	No	No	Yes	Yes
GPRO	--	--	--	--	--	--	--	--	--
GPRO I Web Interface	No	No	No	Yes	Yes	No	No	No	No
GPRO II Claims	No	No	No	No	Yes	No	No	No	No
GPRO II Registry	No	No	No	No	Yes	No	No	No	No
GPRO II EHR	No	No	No	No	No	No	No	No	No
Small GPRO Web Interface	No	No	No	No	No	Yes	No	No	No
Small GPRO Registry	No	No	No	No	No	No	Yes	Yes	Yes
Small GPRO EHR	No	No	No	No	No	No	No	Yes	Yes
Medium GPRO Web Interface	No	No	No	No	No	No	Yes	Yes	Yes
Medium GPRO Registry	No	No	No	No	No	No	Yes	Yes	Yes
Medium GPRO EHR	No	No	No	No	No	No	No	Yes	Yes
Large GPRO Web Interface	No	No	No	No	No	Yes	Yes	Yes	Yes
Large GPRO Registry	No	No	No	No	No	No	Yes	Yes	Yes
Large GPRO EHR	No	No	No	No	No	No	No	Yes	Yes
Accountable Care Organizations (ACO)	--	--	--	--	--	--	--	--	--
SSP ACO via Web Interface	No	No	No	No	No	Yes	Yes	Yes	Yes
Pioneer ACO via GPRO Web Interface	No	No	No	No	No	Yes	Yes	Yes	Yes
Comprehensive Primary Care Initiative (CPC)	No	No	No	No	No	No	Yes	Yes	Yes

Notes for Table 1: In 2010, PQRS 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 became available.

- The number of quality measures from which eligible professionals could choose to participate in the PQRS increased in program year 2014—due to increases in measures reportable via measures groups and via EHR (Table 2).

Table 2: Number of PQRS Quality Measures (2011 to 2015)

Mechanism, Option, or Alternative Program	2011	2012	2013	2014	2015
Total number of measures	198	266	258	284	253
Number of measures groups [a]	14	22	22	25	22
Number of measures within measures groups [a]	78	117	119	127	108
Number of measures reportable via claims	131	143	137	110	72
Number of measures reportable via registry	186	208	203	201	175
Number of measures reportable via EHR	20	51	51	64	64
Number of measures reportable via QCDR [b]	N/A	N/A	N/A	284	253
Number of measures reportable via GPRO web interface	26	29	22	22	17
Number of measures reportable by ACOs via the GPRO web interface	N/A	22	22	22	17
Number of measures reportable under the CPC Initiative	N/A	N/A	14	11	13

Notes for Table 2: Total number of measures reflects all measures, including all possible reporting mechanisms and options. Refer to Section III.B for more information about how the GPRO has changed over time. [a] Measures groups were available to report via Claims or Registry until 2013, and only via Registry starting 2014. [b] Any PQRS measure can be reported via QCDR; in addition, each QCDR registry can submit up to 20 custom, non-PQRS measures.

- 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 (Table 15).

- CMS strives to include quality measures that are applicable to a wide range of specialties and annually requests suggestions for measures to be included in PQRS. Appendix Table A1 presents a list of PQRS measures in program year 2014.

- Over 1.32 million professionals were eligible to participate in the 2014 program year PQRS—including those participating through the PQRS GPRO, those participating in Medicare ACOs under the SSP or Pioneer ACO Model and the CPC initiative—compared to 1.25 million eligible professionals in 2013 (Figure 3).

- Specialties with the largest numbers of eligible professionals who were eligible to participate in PQRS during program year 2014 included internal medicine, family practice, nurse practitioner, physician assistant, and emergency medicine.

- Nearly 3,000 practices (1,545 Small GPRO, 855 Medium GPRO, and 585 Large GPRO) self-nominated or registered to participate via the PQRS GPRO in program year 2014, a large increase compared to 677 total practices that self-nominated for the GPRO in 2013 (data not shown).

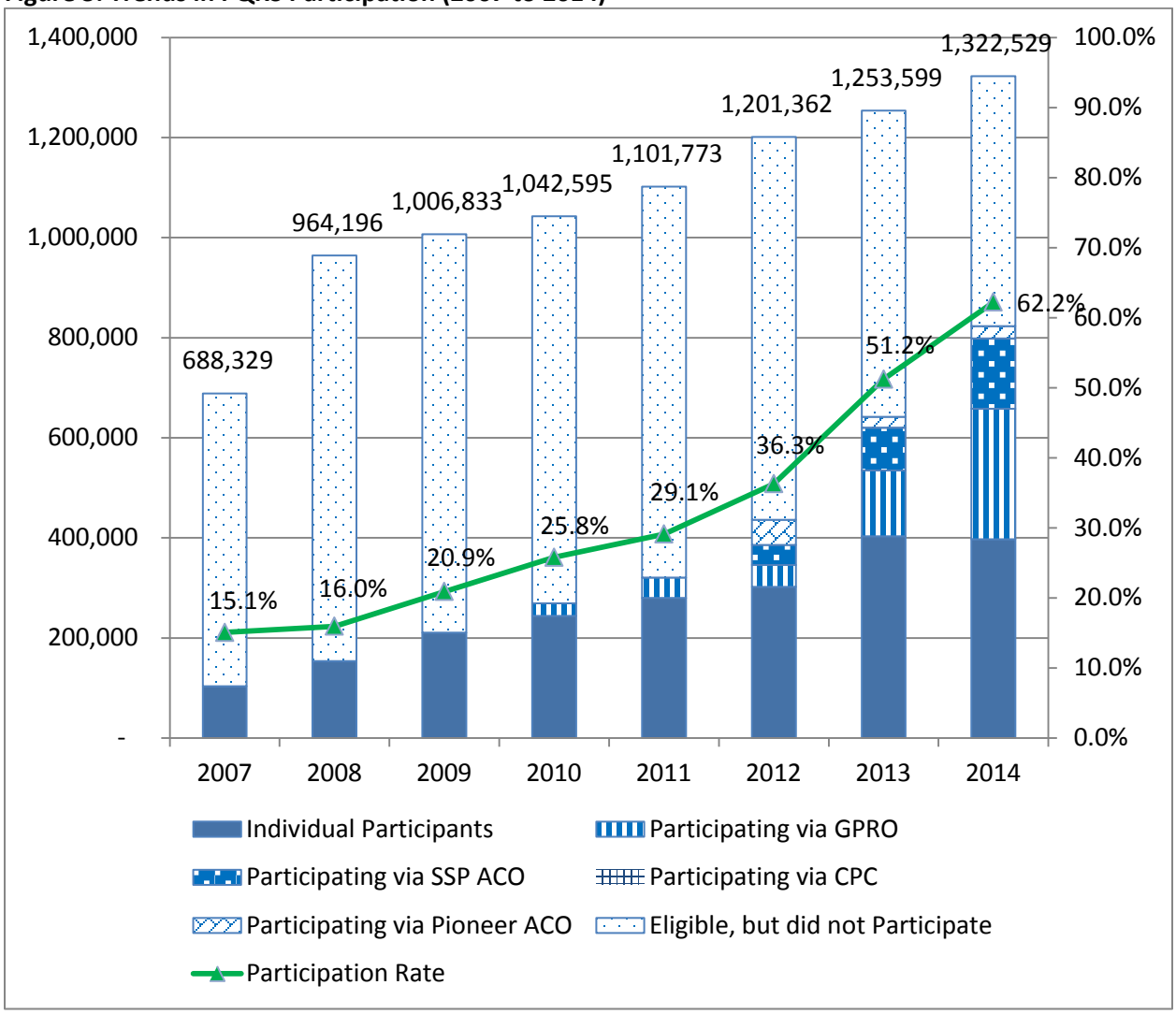
    - Another 337 practices were Medicare ACOs that were eligible for PQRS under the SSP, 20 practices were eligible under the Pioneer ACO Model, and 192 practices were eligible through the CPC program (data not shown).

Participation[6]

- Participation in PQRS has increased every year, especially among eligible professionals within practices participating via a group reporting option (Figure 3).
    - The number of participating eligible professionals increased by 28 percent between 2013 and 2014 from 642,114 to 822,810.
    - In 2014, 261,156 eligible professionals participated in PQRS as part of practices electing to participate under the GPRO (Table 3).
    - Another 139,921 eligible professionals participated as part of a Medicare ACO participating under the SSP.
    - 24,144 eligible professionals participated as part of a practice under the Pioneer ACO model, and 453 participated under the CPC initiative.
- The participation rate among all eligible professionals using any method to participate in PQRS increased from 15 percent to 62 percent between 2007 and 2014.
- Of the 2,985 practices that self-nominated to participate under the PQRS GPRO, 2,425 participated:
    - 1,161 practices encompassing 17,232 eligible professionals participated via Small GPRO,
    - 726 practices encompassing 41,516 eligible professionals participated via the Medium GPRO, and
    - 538 practices encompassing 202,408 eligible professionals participated via the Large GPRO (Table 3).
- There were 332 practices encompassing 139,921 eligible professionals that, for the purpose of earning a PQRS incentive, reported under the SSP.
- There were 20 practices with eligible professionals participating via the Pioneer ACO Model and out of 192 practices eligible to participate via the CPC initiative, 75 actually did participate (that is, the practices were able to take advantage of the PQRS waiver).

[6] Unless otherwise noted, all participation results include eligible professionals 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.

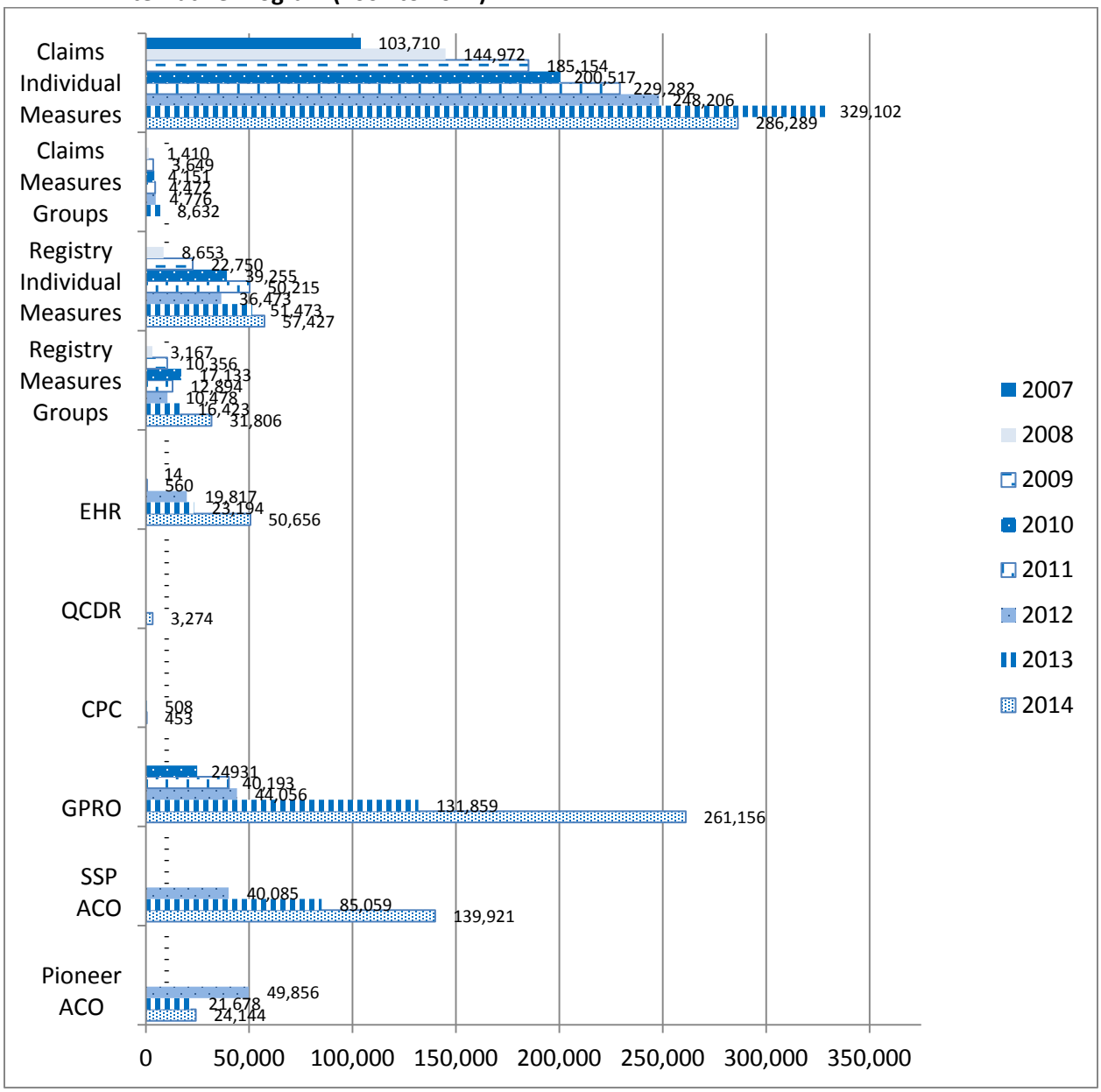
Figure 3: Trends in PQRS Participation (2007 to 2014)



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

- The most common participation method in PQRS in program year 2014 continued to be reporting individual measures through claims, though use of this mechanism fell slightly between 2013 and 2014 (Figure 4).
    - Registry reporting increased in program year 2014, particularly the use of registry measures groups; however, participation via the new QCDR mechanism was relatively low compared with other registry reporting mechanisms (only 3,274 eligible professionals).
    - EHR reporting also showed continued strong growth in 2014, surpassing 50,000 eligible professionals, more than double the number who reported via EHR during the previous program year.

Figure 4: Total Number of Eligible Professionals Participating in PQRS, by Reporting Mechanism or Alternative Program (2007 to 2014)



Note for Figure 4: 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.

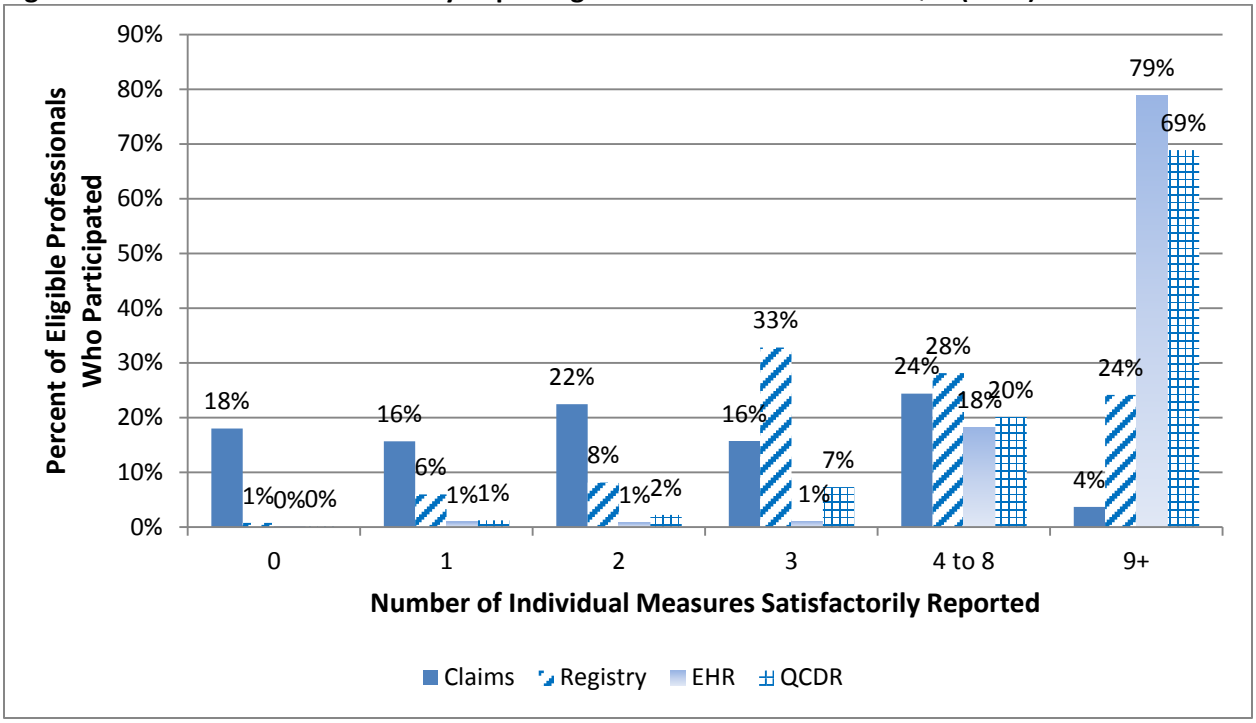
- Some specialties participated in greater numbers and/or at higher rates in the 2014 programs than others (Appendix Table A8).
    - Internal medicine, family practice, nurse practitioner, physician assistant, and emergency medicine had the largest numbers of overall participants.

- Pathology and radiology had the highest participation rates of any specialty (80 percent or above). The registry and QCDR reporting mechanisms were more likely to include non-primary care specialties in the top ten specialties compared to other mechanisms (Table 9 – Table 14).

Satisfactory Reporting and Challenges to Reporting

- Rates of satisfactory reporting of at least one measure in PQRS varied by participation method. Over eight in ten (82 percent) eligible professionals who participated through claims satisfactorily reported at least one measure, compared to 99 percent for registry participants, and 100 percent for EHR or QCDR participants (Figure 5).
    - That is, 18 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, and less than one percent using an EHR or QCDR.
- The average number of satisfactorily reported measures varied by submission mechanism as well: eligible professionals reporting via EHR and QCDR were most likely to report 9 or more measures (79 percent of those using EHR and 69 percent for QCDR), compared to only 24 percent of those participating via registry and 4 percent of those reporting via claims (Figure 5).
- The most common reporting errors via registry were submitting data for an eligible professional that had no Part B MPFS allowed charges and submitting data for an eligible professional who was in a practice participating under the GPRO, as part of an ACO, or as part of a practice participating under the CPC Initiative.
- The most common calculation issue for QCDR was miscalculated reporting and performance rates of greater than 100 percent; CMS has reached out to entities reporting data under this new mechanism to help improve future submissions.
- Within the EHR mechanism, the most common errors were either a performance rate greater than 100 percent or a reporting rate greater than 100 percent.

Figure 5: Distribution of Satisfactorily Reporting Individual Measures for PQRS (2014)



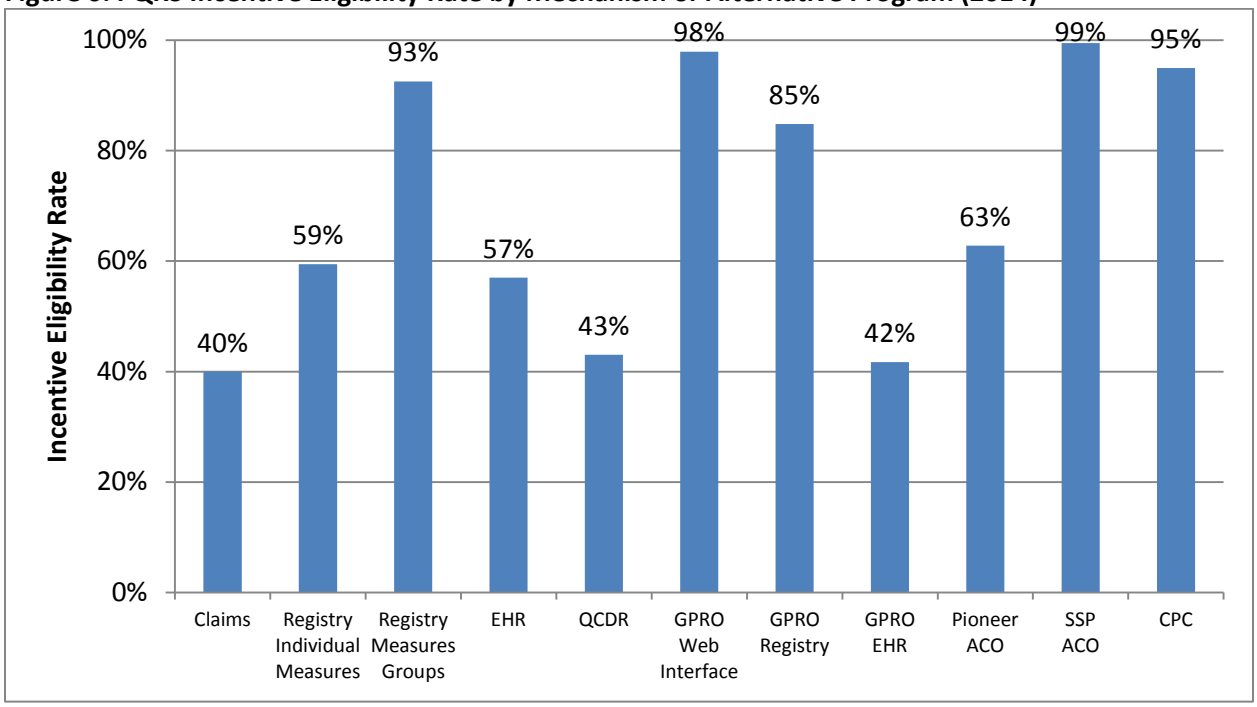
Note for Figure 5: Satisfactory reporting required reporting at least 50 percent of eligible instances. The results for '0' above indicate that no measures were reported satisfactorily.

Incentive Eligibility

- Across all reporting options, just over two-thirds (71 percent) of participants in the 2014 program year PQRS met the criteria for incentive eligibility, and 44 percent of all those eligible earned an incentive.[7]
- Incentive eligibility rates varied by reporting option and mechanism:
    - Among individual participants, incentive eligibility rates were 93 percent among those using registry measures groups, 59 percent for registry individual measures, 57 percent for EHR, 43 percent for QCDR, and 40 percent among eligible professionals participating via claims (Figure 6 and Appendix Table A4).
    - Within the GPRO, the incentive eligibility rate was 98 percent for GPRO web interface, 85 percent for GPRO registry, and 42 percent for GPRO EHR.
    - Among eligible professionals in Medicare ACOs participating under the SSP, 99 percent were incentive eligible, compared to 63 percent of eligible professionals in Pioneer ACOs and 95 percent among those in CPC practices.

[7] Section III.B describes the criteria to qualify for an incentive payment. 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.

Figure 6: PQRS Incentive Eligibility Rate by Mechanism or Alternative Program (2014)



Note for Figure 6: Individual eligible professionals could be counted under more than one method if they participated and were incentive eligible under more than one method.

- Table 3 presents a summary of eligibility, participation, and incentive eligibility in the PQRS in 2014, at the level of eligible professional and practice.

Table 3: Eligible Professionals' and Practices' Reporting Results for PQRS (2014)

Outcome and Mechanism	Eligible Professionals	Eligible Practices
Eligible	1,322,529	272,544
Participated via Any Method	822,810	91,531
Participated via Claims	286,289	65,184
Participated via Registry	88,623	23,202
Participated via EHR	50,656	8,185
Participated via QCDR	3,274	482
Participated via Small GPRO	17,232	1,161
Participated via Medium GPRO	41,516	726
Participated via Large GPRO	202,408	538
Participated via SSP ACO	139,921	332
Participated via Pioneer ACO	24,144	20
Participated via CPC	453	75
Incentive Eligible	585,037	45,273
Total Incentives Earned	$224,088,411	$224,088,411
Average Incentives Earned	$383	$4,950

Notes for Table 3: (1) Results include eligible professionals who were part of a practice that participated under the PQRS GPRO, as part of a Medicare ACO participating under the SSP or Pioneer ACO Model, or through the CPC initiative. (2) Some eligible professionals participated in more than one reporting method.

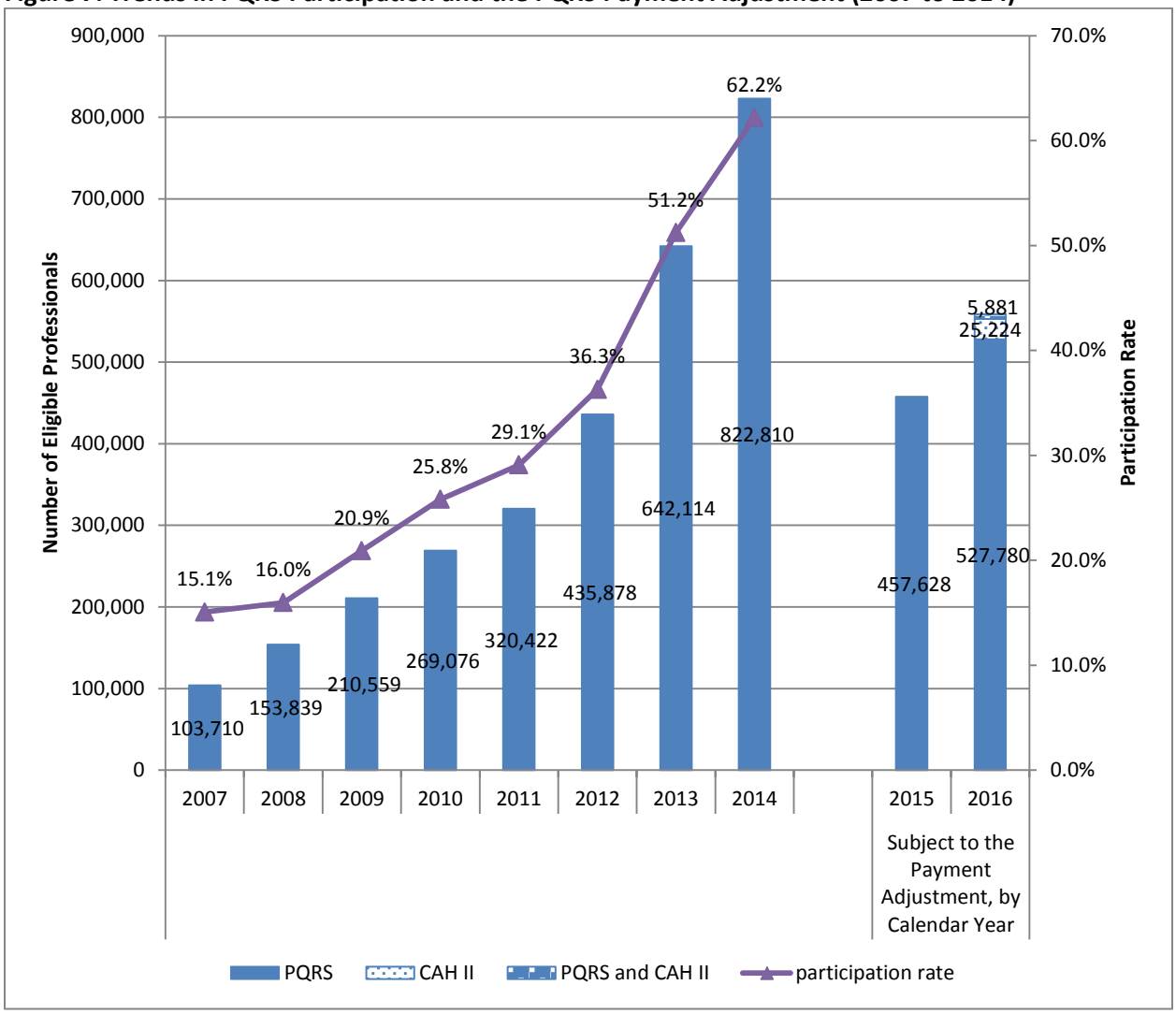
2016 PQRS Payment Adjustment

- More than half of all eligible professionals avoided the reduction of 2.0 percent of their 2016 Part B MPFS charges, based on 2014 PQRS reporting; this left 558,885 eligible professionals who were subject to the adjustment (Figure 7 and Table 22).[8]
    - Over eight in ten (83 percent) of those subject to the adjustment did not attempt to participate in PQRS, while one percent attempted participation but were not successful because they submitted only invalid QDCs and did not avoid the 2016 PQRS payment adjustment for any other reason (Table 22).[9]

[8] See section IIIC of this report for more information on the PQRS payment adjustment.

[9] For more information on various types of QDC errors, please refer to the section on Challenges to Successful Reporting in Section V.D of this report.

Figure 7. Trends in PQRS Participation and the PQRS Payment Adjustment (2007 to 2014)



- Eligible professionals who avoided the 2016 PQRS payment adjustment did so most often by reporting the required data (Table 25):
    - Eighty-six percent of eligible professionals avoiding the payment adjustment (N=654,059), who did not avoid the payment adjustment for any other reason, avoided it by actively reporting in PQRS and meeting the reporting requirements.
    - About 11 percent of eligible professionals avoided the adjustment because they did not meet the definition of an eligible professional for the PQRS payment adjustment, had no 2014 MPFS charges, or did not have at least one denominator-eligible claim.
    - Finally, four percent of those avoiding the 2016 payment adjustment did so based on informal reviews.

II. INTRODUCTION

In 2007, the Centers for Medicare & Medicaid Services (CMS) implemented the Physician Quality Reporting System (PQRS), a pay-for-reporting program for eligible professionals that has grown substantially from its inception.[10] The program (formerly, Physician Quality Reporting Initiative or PQRI) was 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), and entered its eighth year in 2014. The program rewards eligible professionals with a payment incentive—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 applies a payment adjustments based on whether eligible professionals meet applicable requirements for reporting information on standardized clinical quality measures. The last year in which eligible professionals could earn an incentive payment was 2014. In 2015, eligible professionals will need to meet reporting requirements in order to avoid a payment adjustment on their 2017 MPFS allowed charges.

This report summarizes the 2014 and historical reporting experience of eligible professionals in PQRS. Section III of this report presents background on the evolution of the PQRS program and payment adjustment and describes data and methods used for this report. Sections IV - VIII detail findings for PQRS incentive payments, participation, incentive eligibility, payment adjustment, and clinical performance rates. Sections IX and X describe information about feedback reports available under PQRS and the services available from the Help Desk. Section XI concludes. The Appendix is a separate MS Excel document for interested readers, which contains detailed tables of results.

This report uses the term "eligible professional" to describe physicians and other health care professionals who could participate in PQRS. The health care professionals who are eligible to participate in the program are precisely identified on the CMS website.[11] 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) 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 Section III for more details). 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). 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. For brevity, the tables and figures in this report present the SSP and Pioneer model ACO programs and CPC as "participation options" under PQRS; however, we note that they are alternative programs and eligible professionals must meet all requirements under those programs. 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 through a Medicare ACO participating under the SSP are not individual participation options, unless otherwise noted, the participation information from these options were

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

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

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 address PQRS, 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. BACKGROUND AND METHODS

A. Program Origins

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.

B. 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 original 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 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 program years 2012 through 2014.

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 payment adjustment (penalty), beginning in 2015, for eligible professionals and group practices who do not meet reporting requirements, described in more detail below.

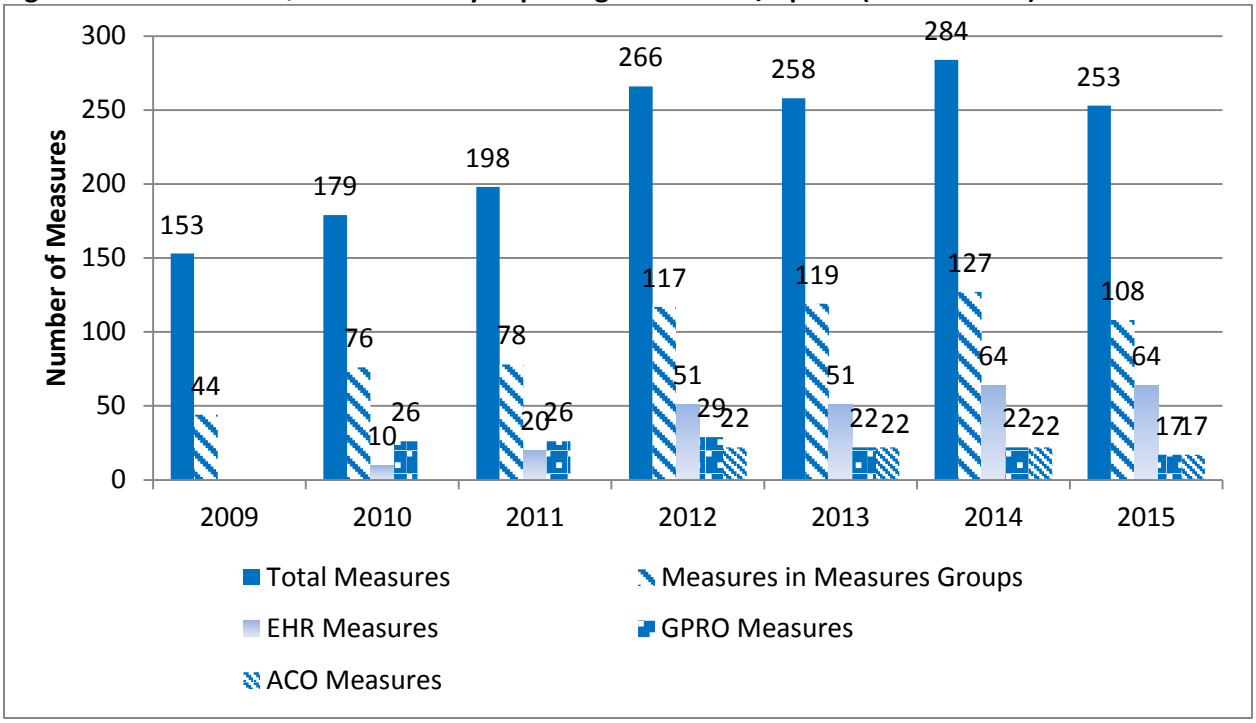
The Affordable Care Act also authorized an additional incentive (an additional one-half percent of MPFS allowed charges) for 2011 through 2014 for eligible professionals who satisfactorily report data on quality measures under PQRS and satisfy certain requirements related to participation in a Maintenance of Certification Program Incentive (MOCP); MOCP requirements are described in more detail below. Finally, 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 qualified clinical data registries (QCDRs) for 2014 and subsequent years.

PQRS Measures

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. CMS has generally expanded the number of measures and reporting options and mechanisms for PQRS each year (Figure 8). 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 2014. In 2015, the total measures will decline slightly to 253.

As seen in Figure 8, the number of measures reportable via the EHR mechanism has expanded from ten measures in 2010 when the reporting mechanism was first introduced to 51 measures in 2013, and 64 in 2014 and 2015. The measures under the GPRO web interface grew modestly from 26 in 2010 and 2011 to 29 in 2012, were reduced to 22 measures in 2013 and 2014, and to 17 in 2015, to align with the ACO GPRO web interface measures.

Figure 8: Number of PQRS Measures by Reporting Mechanism/Option (2009 to 2015)



Notes for Figure 8: 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-to 2015 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.[12] 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. Measures groups were reportable by claims or registry when first introduced, and from 2014 on are reportable via registry only. The number of measures groups has increased steadily: four measures groups in 2008, seven in 2009, 13 in 2010, 14 in 2011, 22 in 2012 and 2013, and 25 groups in 2014, though was reduced to 22 in 2015. Some measures groups are made up of measures reportable only via measures groups as noted below; although, beginning in 2014, eligible professionals reporting via the QCDR mechanism could report these "measures groups only" measures as individual measures.

CMS has also 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 via claims 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 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—

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

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 2014 program removed the claims-based measure group reporting option. The available measures groups in 2014 were:

- Asthma (four measures)
- Back pain (four measures) – measures group only
- Cataracts (four measures)
- 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)
- Coronary artery disease (CAD) (four measures)
- Dementia (nine measures)
- Diabetes mellitus (five measures)
- [New] General Surgery (five measures)
- Heart failure (four measures)
- Hepatitis C (four measures)
- HIV/AIDS (seven measures)
- Hypertension (nine measures)
- Inflammatory bowel disease (IBD) (eight measures)
- Ischemic vascular disease (IVD) (four measures)
- Oncology (eight measures)
- [New] Optimizing Patient Exposure to Ionizing Radiation (six measures) – measures group only
- Parkinson's disease (six measures) – measures group only
- Perioperative care (four measures)
- Preventive care (nine measures)
- Rheumatoid arthritis (six measures)
- Sleep apnea (four measures) – measures group only
- [New] Total Knee Replacement (four measures) – measures group only

Participation Options and Mechanisms

In addition to expanding the available measures, CMS has continued to refine the avenues for participation in the PQRS, as shown in Table 1. Individual 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. In addition, a new qualified clinical data registry (QCDR) reporting method was available for individual participants in 2014.[13] Beginning in 2014, the claims-based measures group reporting mechanism was no longer available, as noted above.

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 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 and 2015 program years. Figure 9 presents a summary of GPRO options over time.

[13] Eligible professionals submitting via the QCDR mechanism and using the QRDA III format could also be used to meet Medicare EHR Incentive Program requirements. See the CMS website for more information: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Qualified-Clinical-Data-Registry-Reporting.html

[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. In 2014, all sizes of GPRO practices could also report via EHR.

Figure 9. Group Practice Reporting Options (2010 – 2015)

<table>
<tr><th>GROUP SIZE</th><th>2010</th><th>2011</th><th>2012</th><th>2013 - 2015</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>

Satisfactory Reporting and Incentive Eligibility Requirements

The satisfactory reporting criteria for the PQRS remained relatively consistent between 2012 and 2013, but changed substantially in 2014 (Table 4). Prior to 2014, individual eligible professionals generally had to report at least 3 measures for a percentage of patients (50% for claims and registry measures groups, and 80% for registry individual measures and EHR) or a patient count for registry measures groups. If eligible professionals reporting via claims individual measures did not report three measures they were subject to a measures applicability validation (MAV) process, described below, that checked for available eligible measures.

The biggest change in 2014 was the requirement for eligible professionals using any mechanism to submit 9 measures across three National Quality Strategy (NQS) domains. However, eligible professionals reporting via claims or registry individual measures could report fewer than 9 measures or fewer than 3 NQS domains subject to the measures applicability validation (MAV) process, described below. For those reporting via EHR, if an eligible professional's certified electronic health record technology (CEHRT) does not contain data for at least 9 measures covering at least 3 domains then the eligible professional must report the measures for which there is Medicare patient data (and an eligible professional must report at least 1 measure for which there is Medicare patient data). For the QCDR, an eligible professional must report 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.

Prior to 2014, measures with a zero (0) percent performance rate (or 100 percent for inverse measures[16]) did not count toward requirements for satisfactory reporting for individual claims or

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

registry reporting; beginning in 2014, a zero percent performance rate also did not count toward satisfactory reporting for EHR. Individual eligible professionals who reported individual measures through claims or registry 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 for claims reporting and was expanded to registry individual measures reporting in 2014. MAV determines if eligible professionals or groups reporting under the GPRO via registry satisfactorily reported despite reporting fewer measures than required under the incentive eligibility rules.[17] In 2014, MAV was applied for eligible professionals or groups participating under the GPRO via registry who satisfied the reporting criteria (i.e., for 50 percent of eligible instances) for fewer than 9 measures or fewer than 3 NQS domains.

In 2014, 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 than 411 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 than 218 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, Large GPRO practices 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.[18] Finally, in 2014 practices of all sizes reporting via the GPRO were able to report via EHR, and groups of 100 or more EPs reporting via web interface were required to report CAHPS for PQRS survey measures. In 2014, Medium and Large GPRO practices reporting via registry or EHR had the option to report CAHPS measures.

Under PQRS, eligible professionals (or group practices) who were incentive eligible qualify for an incentive payment equal to a percentage of their estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professionals (or group practice) during the reporting period. The applicable incentive percentage has varied across program years. The applicable percentage was 1.5 percent in 2007 and 2008, and was raised to 2.0 percent in 2009 and 2010, lowered to 1.0 percent in 2011, and then to 0.5 percent for 2012 through 2014 (Table 4).[19] The incentive payment was

[17] The MAV process determines whether eligible professionals could have reported additional clinically-related measures through two tests. First, the clinical relation test checks for any eligible instances on measures related to those reported. Second, the minimum threshold test checks for a certain number of eligible instances for those measures the eligible professional could have reported based on the clinical relation test. Eligible professionals who satisfied the reporting criteria for less than nine individual measures but did not satisfy the MAV process did not earn an incentive because they could have reported additional measures. Conversely, eligible professionals who satisfied both the reporting criteria for less than nine individual measures and the MAV process would qualify for an incentive. 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.

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

[19] 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

no longer available beginning in the 2015 program year; see the payment adjustment section below for requirements to avoid the payment adjustment by year.

Table 4: Summary of PQRS Incentives, Measures and Reporting Criteria for Eligible Professionals Participating as Individuals (2011 to 2014)[20]

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
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

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.

[20] 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
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.
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, for program years 2011 and 2012.*

Maintenance of Certification Program Requirements

Eligible professionals continued to have the opportunity to receive an additional incentive based on a quality percent of one-half percent in 2014 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.

C. 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 were subject to a 1.5 percent reduction in their MPFS allowed charges in 2015; the adjustment increased to 2.0 percent reduction in MPFS allowed charges for 2016 and 2017, based on reporting years 2014 and 2015, respectively.

CMS implemented changes to requirements for avoiding the payment adjustment for 2016. 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 compared to prior program years (Table 5). For program year 2014, eligible professionals that assigned their reimbursement and billing to a critical access hospital under Method II (CAHs) also had to meet reporting requirements, or be subject to a two percent reduction in their 2016 CAH II charges.

Individual eligible professionals could avoid the PQRS payment adjustment for 2016, if they:

- Met the requirements for satisfactory reporting for incentive eligibility for the 2014 PQRS program, for the applicable participation option and mechanism as described in Table 4; or
- Reported at least 3 measures covering 1 NQS domain for at least 50% of the individual eligible professionals Medicare Part B fee-for-service (FFS) patients via claims or qualified registry (or fewer than 3 measures subject to MAV); or
- Participated via a QCDR that selects measures for the individual eligible professionals, including at least 3 measures covering a minimum of 1 NQS domain and submitted measures for at least 50% of applicable patients seen during the participation period in which the measure applies.

Group practices[21] could avoid the 2016 payment adjustment if they:

- Met requirements for satisfactorily reporting for incentive eligibility for GPRO as described in Table 4; or
- Reported at least 3 measures covering 1 NQS domain for at least 50% of the group practice's Medicare Part B FFS patients via qualified registry (or fewer than 3 measures subject to MAV).

Other reasons for avoiding the payment adjustment were related to not being eligible for PQRS:

- Not having at least one eligible denominator claim; or
- Not meeting the definition of an eligible professional for the PQRS payment adjustment; or
- Not having any MPFS charges in 2014.

In addition, individual eligible professionals or groups participating via GPRO, ACO, or CPC were able to request an informal review of their negative payment determination between September 9, 2015 and December 16, 2015, for the 2014 PQRS program year.

[21] All eligible TIN/NPI under a TIN electing GPRO reporting receive the payment adjustment if the TIN does not meet these requirements, provided the eligible TIN/NPI meets the definition of an eligible professional for the purposes of the payment adjustment, has MPFS allowed charges, and has at least one eligible denominator instance. Practices reporting PQRS data through the SSP, Pioneer ACO model, or CPC must meet that program's requirements for information on how to report quality data to avoid the PQRS payment adjustment.

Table 5. Summary of the PQRS Payment Adjustment, By Program Year

Statistic	2015 Program Year Adjustment	2016 Program Year Adjustment	2017 Program Year Adjustment
Applicable Payment Adjustment Percentage Amount [a]	1.5% of MPFS allowed charges	2.0% of MPFS allowed charges [b]	2.0% of MPFS allowed charges [b]
Program Year Evaluated to Determine Applicability	2013	2014	2015
How Individual Participants Can Avoid the Payment Adjustment	· Meet requirements to satisfactorily participate for incentive eligibility · Report at least one valid measure via claims, participating registry, or participating/qualified Electronic health Record (EHR, including Data Submission Vendors and Direct EHR vendors) OR report at least one valid measures group via claims or participating registry. · Elect to participate in the CMS-calculated administrative claims-based reporting mechanism.	· Meet requirements to satisfactorily participate for incentive eligibility · Report at least 3 measures covering 1 NQS domain for at least 50 percent of the individual EP's Medicare Part B fee-for-service (FFS) patients via claims or qualified registry. Note that an individual EP that reported fewer than 3 measures covering at least 1 NQS domain via claims or qualified registry is subject to MAV. ·Participate via a qualified clinical data registry (QCDR) that selects measures for the individual EP, including at least 3 measures covering a minimum of 1 NQS domain AND submitted measures for at least 50% of applicable patients seen during the participation period in which the measure applies.	· Claims and registry: Satisfactorily report at least 9 measures covering at least 3 NQS domains and satisfactorily report at least 1 cross-cutting measure when required; if the EP reported on fewer than 9 measures and/or fewer than 3 domains, then they must pass MAV. · Registry measures groups: Satisfactorily report all measures within a measures group, at least one measure in the measures group must be reported for at least 20 patients, and at least one measure in the measures group must be reported for at least 11 beneficiaries. · EHR: Report at least 9 measures across at least 3 domains and at least one of those measures must include Medicare patient data (if data do not contain at least 9 measures across at least 3 domains, then must report all of the measures for which there is Medicare patient data). · QCDR: Satisfactorily report on at least 9 measures across at least 3 domains AND at least 2 of the satisfactorily reported measures are from the Outcome NQS domain OR at least 1 of the satisfactorily reported measures is from the Outcome NQS domain and at least one of the satisfactorily reported measures is from the Person and Caregiver Experience and outcomes, Efficiency and Cost reduction or Patient Safety NQS domains.

Statistic	2015 Program Year Adjustment	2016 Program Year Adjustment	2017 Program Year Adjustment
How Group Participants Can Avoid the Payment Adjustment	· Meet requirements to satisfactorily participate for incentive eligibility · Report at least one valid measure via web interface (only available to practices of 25 or more EPs) or participating registry (available to all PQRS GPRO sizes) · Elect to participate in the CMS-calculated administrative claims-based reporting mechanism.	· Meet requirements for satisfactorily reporting for incentive eligibility · Report at least 3 measures covering 1 NQS domain for at least 50% of the group practice's Medicare Part B FFS patients via qualified registry or EHR. Note that a practice that reported fewer than 3 measures covering at least 1 NQS domain qualified registry is subject to MAV.	· Web interface: Submit all web interface measures for the required population (at least one measure must have data for a Medicare patient). · Registry: If the group is required or elected to report CAHPS, they must satisfactorily report on at least 6 measures across 2 domains; if they reported on fewer than 6 measures or across only 1 domain then they must pass MAV. If the group is not reporting CAHPS data then they must satisfactorily report on 9 measures across 3 domains (or they can report on fewer than 9 measures and/or fewer than 3 domains, provided they pass MAV) · EHR: If the group has elected or is required to report CAHPS, then they must report at least 6 measures across at least 2 domains; of these data at least 1 measure must include Medicare patient data. If the group is not reporting CAHPS, they must report at least 9 measures across at least 2 domains

(1) 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] In 2013, incentive payments made through PQRS became 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 are reduced by 2%.

D. Data and Methods

Data

This report draws on multiple sources of data: (1) Medicare Part B claims data; (2) data submitted by qualified registries and QCDRs; (3) data submitted by qualified EHR vendors; (4) PQRS measure data submitted through an online web interface by practices that were approved to participate in the GPRO and by eligible professionals participating via the SSP and the Pioneer ACO Model; and (5) Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS data submitted by practices participating in the Medium and Large GPRO. In addition, the report uses MOCP data reported by participating specialty boards for the 2014 program year. Data on the 2016 PQRS payment adjustment were from the PQRS Payment Adjustment file dated March 3, 2016.

Claims data encompassed services within the respective program years and must have been processed by the last Friday in February of the following year to be included in analyses. For example, the analysis of the 2014 program year encompassed claims with service dates from January 1, 2014 through December 31, 2014 and processed by February 27, 2015. Similar to claims data, data collected from the registry, QCDR, and EHR mechanisms as well as the GPRO web interface aligns with the program year and must have been received by CMS by the established deadline for the reporting option.

Information on physician specialty and location was obtained from the National Plan and Provider Enumeration System (NPPES), which is publicly available data and downloadable from the NPPES website.[22]

Unit of Analysis

The most common unit of analysis in the report is the individual eligible professional. The National Provider Identifier number (NPI) within a billing unit (i.e., the Taxpayer Identification Number [TIN]) defined an eligible professional; the NPI was the *performing* NPI.[23] All analyses regarding individual eligibility, participation, and incentive eligibility were performed at the NPI level within a TIN (referred to as TIN/NPI). Consequently, a single eligible professional could be counted more than once if he/she worked for multiple practices (i.e., single NPI and more than one TIN).

An additional unit of analysis presented in the report is the group practice level, which was defined by a TIN. Practices that participated under the GPRO and SSP ACO were analyzed at the practice (i.e., TIN) level. In addition to summarizing group reporting information at the TIN level, this report also aggregates information from individual eligible professionals to the practice (TIN) level for descriptive purposes. For these descriptions, a practice was defined as eligible, participating, or incentive eligible if at least one eligible professional associated with that practice was eligible, participating, or incentive eligible.

This report also describes counts of individual eligible professionals who belong to a practice that participated under group reporting options (including those in practices participating via the GPRO and eligible professionals within SSP ACOs reporting PQRS data).[24] For example, unless otherwise noted, tables and figures that present counts of total eligible professionals also include the number of eligible professionals within practices participating under group reporting options. For the purposes of summarizing participation and incentive eligibility, all eligible professionals that are part of a practice that participates or is incentive eligible under a group reporting option are assumed to have participated or been incentive eligible. Eligible professionals that participated in PQRS as part of the Pioneer ACO model or by accepting the PQRS waiver as part of CPC practices are reported as individual participants in this report.

[22] http://download.cms.gov/nppes/NPI_Files.html

[23] There are multiple NPIs associated with a service (performing, referring, and ordering); the performing NPI identifies the eligible professional who actually performed the service.

[24] As part of their quality reporting requirements, practices within Medicare ACOs reporting PQRS data under the Medicare Shared Savings Program and Pioneer ACO models submitted data on 22 measures via the GPRO web interface.

The specialty and state for eligible professionals was obtained from NPPES. Region was based on CMS carrier regions on claims. In tables that provide regional breakouts, information on the Railroad Retirement Board (RRB) carrier is not provided. This is due to the RRB not being based on geographical location of the eligible professional.

IV. INCENTIVE PAYMENTS

Under PQRS, eligible professionals or group practices who were incentive eligible qualified for an incentive payment equal to a percentage of their estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional (or group practice) during the reporting period. The applicable incentive percentage varied across program years as described in Section III.B. The incentive for the 2014 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, and was the last year the PQRS program provided an incentive payment. This report includes results for eligible professionals within Medicare ACOs reporting under the SSP and Pioneer ACO Model given eligible professionals 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, after a two percent reduction in payments from sequestration.[25]

Overall, a total of $224,088,411 in incentive payments (excluding additional MOCP incentive payments) were earned by 585,037 eligible professionals for the 2014 program year, with an average payment of $383 (Table 3).[26] This includes incentives earned by 45,273 practices (including individually participating eligible professionals, summarized at the practice level, as well as practices that earned an incentive under the GPRO, as a practice participating as an ACO, or in the CPC initiative), with an average incentive payment of $4,950 per practice for the 2014 program year.

Just under half (48 percent) of total incentives were earned by eligible professionals qualifying for an incentive through an individual reporting mechanism (claims, registry, EHR, or QCDR) (Appendix Table A36). A total of $62,863,190 was earned by 1,817 practices qualifying for an incentive via the GPRO; most GPRO incentives were earned by 460 practices earning an incentive via the Large GPRO (Appendix Table A36). An additional $49,711,537 was earned by the 328 practices qualifying for an incentive as a Medicare ACO participating under the SSP, and $6,124,293 was earned by 19 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 $102,442 compared to an average of $4,950 per incentive-eligible practice overall.

As seen in Figure 1, the numbers of eligible professionals and practices earning PQRS incentives grew between 2007 and 2014. The average incentive payments for individual participants 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 through 2014 (Figure 2). Incentive payments ended with the 2014 program year.

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[25] 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.

[26] 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.

A. 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 A3 displays the distribution of incentive payments by specialty and shows that there was a wide range in average 2014 incentive payments across specialties from $6 for Certified Nurse Midwives to $1,823 for Radiation Oncologists. Six specialties had average incentive payments of at least $1,000: cardiology, dermatology, nephrology, ophthalmology, radiation oncology, and vascular surgery. Medial doctors/doctors of osteopathy (MD/DOs) earned $484 on average, compared to $158 on average among non-MD/DOs.

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

As in 2011 to 2013, in 2014 eligible professionals who qualified for a PQRS incentive 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. Twenty entities qualified for the MOCP program in 2014, compared to 18 in 2013, and 13 in 2012. These boards collected and reported data to CMS on behalf of participating eligible professionals.

Forty specialties earned MOCP incentives in 2014, compared to 39 in 2013, 29 in 2012, and eight in 2011. Tables 6 and 7 present the MOCP incentives earned by participation mechanism and specialty. In the 2014 program, 9,482 eligible professionals earned an MOCP incentive payment, compared to 9,102 eligible professionals in 2013. Most eligible professionals earning an MOCP incentive payment qualified for an incentive through the claims reporting mechanism, followed by Large GPRO and ACO SSP (Table 6). However, QCDR, EHR, registry, and Small GPRO reporters earned a higher MOCP average incentive payment (all over $1,400) compared to claims reporters ($456). At the practice level, the six practices participating via QCDR had much higher average MOCP incentive payments compared to other mechanisms; the average MOCP incentive across the 1,832 practices earning an MOCP incentive was $3,103. As seen in Table 7, the majority of eligible professionals earning an incentive payment were in emergency medicine (47 percent of eligible professionals earning an MOCP incentive), followed by radiology (34 percent), pathology (three percent) and radiation oncology and ‘other eligible professional’ (two percent).

Table 6: PQRS MOCP Incentive Amounts by Participation Mechanism or Option (2014)

Level and Mechanism/Option	Number Eligible for MOCP Incentive	MOCP Median Incentive Payment	MOCP Mean Incentive Payment	MOCP Total Incentive Payments
Eligible Professional Level	--	--	--	--
Claims	5,108	$348	$456	$2,327,099
Registry	1,021	$842	$1,417	$1,446,826
EHR	112	$1,101	$1,742	$195,116
QCDR	63	$1,316	$1,466	$92,334
Small GPRO	104	$829	$1,609	$167,340
Medium GPRO	422	$271	$474	$199,962
Large GPRO	1,345	$272	$437	$587,498
SSP ACO	1,431	$315	$586	$837,937
Pioneer ACO	89	$364	$591	$52,594
CPC	0	$0	$0	$0
Total (Unduplicated)	**9,482**	**$358**	**$599**	**$5,684,141**
Practice Level	--	--	--	--
Claims	947	$699	$2,457	$2,327,099
Registry	387	$1,695	$3,739	$1,446,826
EHR	75	$1,566	$2,602	$195,116
QCDR	6	$6,311	$15,389	$92,334
Small GPRO	47	$544	$3,560	$167,340
Medium GPRO	78	$210	$2,564	$199,962
Large GPRO	188	$415	$3,125	$587,498
SSP ACO	140	$1,429	$5,985	$837,937
Pioneer ACO	12	$2,236	$4,383	$52,594
CPC	0	$0	$0	$0
Total (Unduplicated)	**1,832**	**$910**	**$3,103**	**$5,684,141**

Table 7: Eligible Professional MOCP Incentive Amounts by Specialty for Individual Participation Options (2012 to 2014)

Specialty	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	Number of Eligible Professionals who Earned MOCP Incentive in 2014	Total MOCP Incentive payments in 2014
MD/DO	**5,371**	**$3,603,521**	**8,732**	**$5,476,409**	**9,174**	**$5,467,839**
Allergy/Immunology	3	$897	3	$865	1	$307
Anesthesiology	0	$0	55	$15,233	12	$5,059
Cardiology	80	$178,739	82	$200,608	94	$214,958
Colon/Rectal Surgery	0	$0	27	$16,662	22	$13,041
Critical Care	4	$885	1	$343	2	$1,761
Dermatology	83	$255,750	78	$250,410	53	$150,055
Emergency Medicine	3,267	$1,074,165	4,718	$1,519,056	4,426	$1,291,323
Endocrinology	7	$4,795	7	$3,855	3	$2,481
Family Practice	5	$2,330	43	$23,231	45	$18,025
Gastroenterology	1	$712	12	$10,792	25	$27,967
General Practice	11	$2,130	8	$2,430	5	$1,762
General Surgery	0	$0	239	$171,513	41	$22,251
Geriatrics	3	$2,123	2	$2,242	5	$4,398
Hand Surgery	0	$0	1	$316	0	$0
Infectious Disease	1	$202	2	$1,041	3	$3,319
Internal Medicine	88	$76,002	122	$101,386	127	$131,492
Interventional Radiology	82	$85,605	111	$89,276	143	$88,350
Nephrology	19	$41,324	33	$55,060	62	$101,466
Neurology	0	$0	2	$939	5	$2,159
Neurosurgery	3	$1,854	0	$0	0	$0
Nuclear Medicine	2	$1,495	9	$5,270	10	$9,686
Obstetrics/Gynecology	4	$141	4	$2,052	9	$2,735
Oncology/Hematology	5	$8,578	20	$46,481	114	$114,850
Ophthalmology	115	$406,895	170	$537,449	134	$408,673
Orthopaedic Surgery	0	$0	1	$296	6	$5,316
Other MD/DO	3	$695	13	$13,623	7	$11,830
Otolaryngology	0	$0	0	$0	4	$3,634
Pathology	0	$0	310	$142,054	237	$104,725
Pediatrics	2	$278	5	$1,131	1	$275
Plastic Surgery	0	$0	7	$2,399	5	$4,077
Psychiatry	0	$0	0	$0	5	$4,682
Pulmonary Disease	10	$20,890	10	$17,020	49	$68,824
Radiation Oncology	59	$188,499	143	$342,349	215	$422,758
Radiology	1,510	$1,243,332	2,398	$1,705,527	3,234	$2,082,870
Rheumatology	4	$5,205	5	$7,364	9	$11,057
Thoracic/Cardiac Surgery	0	$0	25	$24,144	5	$7,105
Vascular Surgery	0	$0	66	$163,991	56	$124,563
Other Eligible Professionals	**230**	**$179,205**	**370**	**$296,477**	**306**	**$215,450**

Specialty	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	Number of Eligible Professionals who Earned MOCP Incentive in 2014	Total MOCP Incentive payments in 2014
Agencies/Hospitals/ Nursing and Treatment Facilities	3	$255	13	$2,956	6	$2,486
Nurse Practitioner	0	$0	2	$303	0	$0
Optometry	45	$24,399	51	$22,135	27	$15,045
Other Eligible Professional	132	$119,847	220	$218,648	197	$160,120
Podiatry	50	$34,703	84	$52,434	73	$37,698
Registered Nurse	0	$0	0	$0	3	$100
Unknown/Missing	0	$0	0	$0	2	$851
Total	**5,601**	**$3,782,726**	**9,102**	**$5,772,885**	**9,482**	**$5,684,141**

Note for Table 7: Specialties not shown in Table 7 did not earn a MOCP incentive payment in any year.

V. PARTICIPATION

A. How to Participate

CMS provides multiple resources on the PQRS website (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/) to assist eligible professionals who choose to participate in the program. The *2014 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 2014, there were six individual participation options and five participation group options (plus one additional requirement for large groups submitting via web interface) for submitting measure data to PQRS. Unless otherwise noted, each mechanism applied to a 12-month period from January 1 to December 31, 2014:

1. Claims-Based Individual Measures. Eligible professionals could report QDCs for measures via claims. To qualify for an incentive, eligible professionals had to report on at least 9 measures from 3 NQS domains (or fewer than 9 measures or fewer than 3 NQS domains, subject to a MAV review) for at least 50 percent of reporting opportunities.

2. Registry-Based Reporting – Individual Measures. Eligible professionals could submit measures through a qualified registry. To qualify for an incentive, eligible professionals had to report on at least 9 measures from 3 NQS domains (or fewer than 9 measures or fewer than 3 NQS domains, subject to a MAV review) for at least 50 percent of reporting opportunities.

3. Registry-Based Reporting – Measures Groups Patient Count. Eligible professionals could submit data through a qualified registry. To qualify for an incentive, eligible professionals had to report all applicable measures for at least 1 measures group on at least 20 patients (11 out of 20 patients had to be Medicare Part B FFS patients).

4. Qualified Clinical Data Registry (QCDR). Eligible professionals could submit measures through a CMS-approved entity that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care furnished to patients. To qualify for an incentive, eligible professionals had to report at least 9 measures across 3 NQS domains for at least 50 percent of reporting opportunities, including at least 1 outcome measure; QCDRs are not limited to PQRS measures or Medicare beneficiaries.

5. EHR – Direct Submission. Eligible professionals could submit data directly through a qualified EHR product. To qualify for an incentive, eligible professionals had to report on at least 9 EHR measures across 3 NQS domains for at least 50 percent of reporting opportunities via a direct EHR-based product that is CEHRT; if an eligible professional's CEHRT does not contain patient data for at least 9 measures and 3 domains, he or she must report the measures for which there is Medicare patient data. Successful submission of CQM data and one measure with at least one Medicare beneficiary will qualify eligible professionals for the PQRS incentive and meet the CQM component of the Medicare EHR Incentive Program.

6. EHR – Data Submission Vendor (DSV). Eligible professionals could submit data through a qualified data submission vendor. To qualify for an incentive, eligible professionals had to meet

the same requirements as described for EHR – Direct Submission except submitted via an approved data submission vendor that is CEHRT.

7. GPRO Registry Reporting. Practices with two or more NPIs that self-nominated and were selected for Small, Medium, or Large GPRO could report via a qualified registry. To earn an incentive, practices had to report on at least 9 measures across 3 NQS domains (or fewer than 9 measures or fewer than 3 NQS domains, subject to a MAV review) for at least 50 percent of the practice's eligible Medicare Part B FFS patients. (Note: under the GPRO registry mechanism and the GPRO EHR mechanisms, Medium GPRO practices had the option to report CAHPS data in addition to registry/EHR; the measure criteria for when practices report CAHPS data is described under that mechanism below.)

8. GPRO – EHR Direct Submission. Practices with two or more NPIs that self-nominated and were selected for Small, Medium, or Large GPRO could report through a qualified EHR product. Practices had to report on at least 9 EHR measures across 3 NQS domains for at least 50 percent of reporting opportunities via a direct EHR-based product that is CEHRT. If a practice's CEHRT does not contain patient data for at least 9 measures and 3 domains, it must report all measures for which there is Medicare patient data; it must report at least one measure with at least one Medicare beneficiary.

9. GPRO – EHR Data Submission Vendor (DSV). Same as GPRO EHR – Direct Submission except submitted via an approved data submission vendor that is CEHRT.

10. GPRO – Web Interface. Practices with 25 or more NPIs that self-nominated and were selected for Medium or Large GPRO could report the GPRO web interface for a pre-populated patient sample of 218 patients (Medium GPRO) or 411 patients (Large GPRO).

11. GPRO – CAHPS Certified Survey Vendor. Practices with more than 100 eligible professionals that reported via the web interface had to have all CAHPS for PQRS summary survey modules reported on the group's behalf via a CMS-certified survey vendor. Medium and Large GPRO practices who reported via registry or EHR had the option of reporting CAHPS data; if they reported CAHPS data, they were required to report at least 6 measures across 2 NQS domains for at least 50% of reporting opportunities.

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. Eligible professionals participating in ACOs could earn a PQRS incentive if the ACO met the same requirements as applicable to the Large GPRO, in addition to meeting the requirements for successful participation in the ACO program. For further information on how eligible professionals 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.[27]

[27] 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/.

To participate through the claims reporting mechanism, eligible professionals submitted the specified Quality Data Code(s) (QDC) for a given measure on a Medicare Part B professional services claim that met the denominator criteria for that measure. QDCs indicate that a specific quality action or outcome was or was not met, or that exclusion criteria for the measure were met. QDCs are entered on a line item on the claim, similar to procedure codes. A QDC for a given quality measure must be entered on a claim that also has all the required denominator criteria for that measure. For example, a measure could require a specific combination of diagnosis, procedure codes, and beneficiary age to be an 'eligible instance'; to report the measure validly, the eligible professional had to submit the required QDC(s) on line items for that claim.

To report measures through the registry, EHR, and QCDR mechanisms, eligible professionals submitted performance data via an approved vendor (for registry, QCDR, and EHR data submission vendor), or via an approved EHR product for each measure—such as number of eligible instances (denominator), instances of quality service performed (numerator), number of performance exclusions, reporting rates, and performance rates—in a file format specified by CMS.

B. Overall Participation Results

Eligibility

A professional was defined as eligible to participate individually in PQRS if he/she had at least one MPFS professional services claim that contained the denominator criteria of the applicable quality measure for any PQRS measure, respectively, and was not part of a TIN electing group reporting for that program. Eligible practices (TINs) that chose to report under the GPRO applied and met requirements for participation.[28] A practice could participate under the GPRO under PQRS. Eligible professionals were not eligible to participate individually in PQRS if they participated as a group practice. All eligible professionals that were part of a practice self-nominating to participate via the GPRO or that were part of an SSP ACO were considered eligible under those reporting options only. Eligible professionals were considered eligible via the Pioneer ACO or CPC mechanism if they elected to participate via these programs.

In 2014, there were 1,322,529 professionals eligible to participate in PQRS, including 422,842 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). Among the 899,687 professionals eligible to participate individually, 843,668 were eligible to participate via claims, 875,090 through registry, EHR, or QCDR,[29] 24,144 were eligible under the Pioneer ACO program and 1,215 as part of a CPC practice. Within those eligible as part of a practice self-nominating for GPRO, over half (212,558) were part of a practice nominating for Large GPRO, compared to 47,739 under Medium GPRO and 22,204 under Small GPRO. Finally, 140,341 eligible professionals were eligible as part of an SSP ACO.

[28] GPRO eligibility criteria varied by program year. In 2010, practices with at least 200 NPIs could participate in the GPRO option; in 2011, practices with 200+ NPIs could participate in "GPRO I" and those with 2-199 NPIs could participate in the GPRO II option; in 2012, practices with 25-99 NPIs could participate in the "Small GPRO" option, while practices with 100+ NPIs could participate in the "Large GPRO" option; and in 2013, Small GPRO (2-24 NPIs), Medium GPRO (25-99 NPIs), and Large GPRO (100+ NPIs) were available.

[29] These figures are based on all eligible professionals that were not part of practices self-nominating for group reporting or SSP ACO; they do not reflect the number that actually had access to a registry, EHR, or QCDR.

Appendix Table A5 presents characteristics of eligible professionals that were eligible to participate in the 2014 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. The majority of eligible professionals eligible for group reporting (because their practice self-nominated) were in large practices (100 or more eligible professionals). Among individuals not part of a practice self-nominating for GPRO, in an SSP ACO, Pioneer ACO, or CPC, most were eligible to report six or more measures; however, 27 percent were eligible to report from one to five measures.

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 2011 to 2014 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 2014 (116,740 and 114,585, respectively). Nurse practitioner and physician assistant also had large numbers eligible to participate (99,917 and 75,749, respectively). With the exception of registered nurse, 'agencies/hospitals/nursing and treatment facilities', chiropractor, dentist, and 'other eligible professionals', all specialties had an increase in the number eligible to participate in the program between 2013 and 2014 (Appendix Table A6).

Participation

Eligible professionals were defined as participating in PQRS if they had a complete and valid submission of data on quality measures through claims or a valid submission from a qualified registry, EHR (via direct submission or the data submission vendor mechanism), or QCDR. Eligible professionals who are part of a practice participating under the GPRO are considered participating if the TIN submitted data through the web interface, registry, or EHR. A practice was defined as participating in the PQRS GPRO or SSP ACO if the practice submitted data for an assigned sample of patients through a web interface provided by CMS (or a registry or EHR for PQRS GPRO). A practice was defined as participating in PQRS as a Pioneer ACO if the TIN elected to participate in the Pioneer ACO model; note that some of these TINs are "split TINs" in which only some of the NPIs are participating in the Pioneer ACO model; in these cases, the non-ACO NPIs can only participate in PQRS through the usual individual participation mechanisms (i.e. claims, registry, EHR, or QCDR). Eligible professionals were considered participating in PQRS via the CPC if they were eligible to participate in this program and had submitted a PQRS waiver.[30]

As shown in Figure 4 in the Executive Summary, each year of program operation has seen growth in participation across most reporting options except for a decline in registry reporting from 2011 to 2012, a decline in Pioneer ACO participation from 2012 to 2013, and a decline in claims reporting from 2013 to 2014.[31] Overall, 421,733 eligible professionals (47 percent of those eligible) participated individually in the 2014 PQRS (Appendix Table A4). In addition, 261,156 eligible professionals within 2,425 practices participated under the GPRO and 139,921 eligible professionals participated through 332 Medicare ACOs participating under the SSP (Table 3). Including all reporting options and participation in other programs for the sake of earning a PQRS incentive, the overall participation rate was 62 percent, and the total number participating in the PQRS increased 28 percent from 2013.

[30] TIN/NPI that were on the CPC finder file but did not submit a PQRS waiver and submitted PQRS data via the claims, registry, or EHR submission mechanisms are counted under those mechanisms.

[31] 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).

Eligible professionals who chose to participate in the 2014 PQRS using the registry, EHR, or QCDR-based reporting mechanisms contacted the CMS-qualified registries, EHR, or QCDR vendors listed in the posted CMS qualified lists.[32] In 2014, there were 87 qualified registries that could submit data on behalf of eligible professionals, compared to 70 in 2013; 69 registries submitted quality measure information in 2014. In 2014 there were also 36 qualified clinical data registries, 15 of which submitted data. In 2014, CMS discontinued the PQRS qualification process for EHR data submission vendors and direct EHR vendors. The Office of the National Coordinator for Health Information Technology (ONC) certification process has established standards and other criteria for structured data that EHRs must use.

As seen in Appendix Table A4, within the individual reporting option:

- 68 percent of participants used the claims mechanism (N=286,289)
- 21 percent used registry reporting (N=88,623)
- 12 percent participated via EHR (N=50,656)
- 6 percent participated as part of a Pioneer ACO (N=24,144)
- 1 percent participated via the QCDR (N=3,274)
- <1 percent participated as part of the CPC (N=453)

Participation in the EHR option more than doubled from 23,194 in 2013, while use of registry reporting increased by 31 percent from 2013. Most registry participants (65 percent) participated via individual measures. Within the EHR mechanism, 95 percent of participants submitted via the QRDA III option, with only 4 percent reporting via the QRDA I option, and 1 percent using both formats.

About eight percent of individual participants used more than one participation mechanism. For example, five percent of individual participants used claims and registry, two percent used claims and EHR, and less than one percent used other combinations such as claims and QCDR (0.2 percent) or claims/registry/EHR (0.04 percent) (data not shown).

Within the group reporting option, participation by mechanism varied by practice size (Appendix Table A4). Within Small GPRO practices, 79 percent of eligible professionals reported via registry, compared to 21 percent via QRDA III; no Small GPRO practices used QRDA I. Within Medium GPRO, 71 percent of eligible professionals were in a practice reporting via registry (with or without CAHPS), compared to 14 percent using web interface, and 15 percent using QRDA III. Finally, among Large GPROs, most eligible professionals were in practices reporting via the web interface (53 percent), compared to 39 percent using registry, and 8 percent using QRDA III.

Appendix Table A5 presents information on the characteristics of eligible professionals who were eligible and participating in the 2014 PQRS. As with the distribution of those eligible, the Atlanta and Chicago regions had the most participating eligible professionals. Among individual participants, over half could report on 15 or fewer measures. About one-quarter of individual participants were in a practice with fewer than 5 NPIs, compared to more than one-third of those eligible. Individual participants were also disproportionately likely to have larger MPFS allowed charges and beneficiary volume. The distribution of participants in practices under group reporting options was similar to that among those eligible, and was concentrated among those in larger practices.

[32] Lists can be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/2014_Physician_Quality_Reporting_System.html

C. Use of Measures Groups and Registries

The number of measures groups available for reporting under PQRS expanded from four to 25 between 2008 and 2014 (three were added for 2014). Although it had experienced growth over time, claims-based measure groups was a small portion of claims reporting and was no longer available in 2014. In 2014, one-third of eligible professionals reporting via registry (N=31,806) reported via registry measures groups (Appendix Table A4). The number of eligible professionals participating using registry measures groups almost doubled in 2014 (Figure 4). Use of registry measures group reporting was concentrated within family practice, internal medicine, cardiology, nurse practitioner, and nephrology (Table A11).

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, 55 in 2013, and 69 in 2014 (data not shown). Table 8 displays the registries that submitted data for the most eligible professionals in 2014.[33] 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 8: Registries that Submitted Data on Behalf of the Most Eligible Professionals for PQRS (2014)

Rank	Registry Name	EPs Submitted	Practices Submitted
--	**Individual Participants**	--	--
1	CECity	16,703	N/A
2	NextGen_Registry	9,266	N/A
3	NetHealth	9,101	N/A
4	WebPT Inc.	6,827	N/A
5	Covisint Corporation, ReqSelfNom	6,431	N/A
6	MDinteractive	6,167	N/A
7	Central Utah Informatics	5,095	N/A
8	WellCentive	3,985	N/A
9	KHC Registry	2,997	N/A
10	Ingenious Med, Inc.	2,911	N/A
--	**Group Participants**	--	--
1	CECity	21,722	477
2	PQRS Solutions	19,891	305
3	HCFS Health Care Financial Services Inc	9,349	132
4	Covisint Corporation, ReqSelfNom	8,289	133
5	MDinteractive	6,822	59
6	NextGen_Registry	6,041	79
7	Massachusetts General Physicians Organization	5,815	7
8	WellCentive	5,669	64
9	Crimson Care Registry	5,631	10

[33] A complete listing of qualified registries available for the 2014 PQRS can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2014QualifiedRegistries.pdf.

Rank	Registry Name	EPs Submitted	Practices Submitted
10	EClinicalWeb	4,459	98

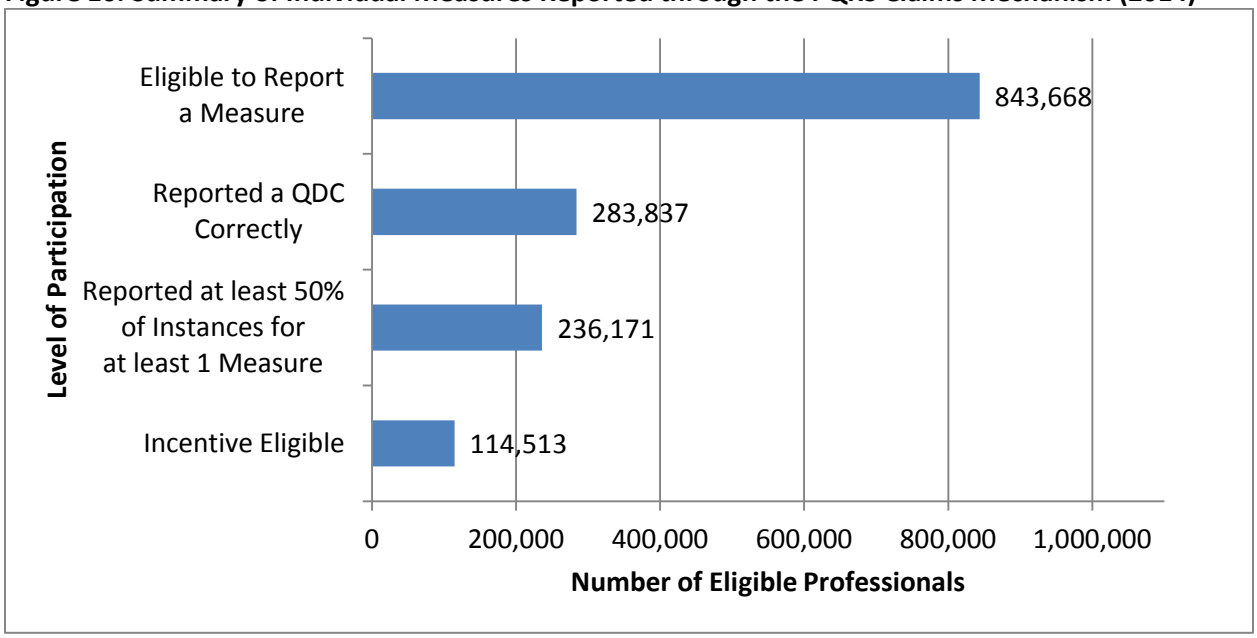
D. Challenges to Participation and Satisfactory Reporting

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) QDC submission errors; and (3) failure to submit QDCs for at least 50 percent of eligible instances (for individual measures reporting). 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. 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. Because ineligible claims are not included in the measure's denominator, QDC errors do not adversely affect an eligible professional's reporting rate.[34] An individual measure was satisfactorily reported when there were valid submissions for at least 50 percent of patients. As was seen in Figure 5, 18 percent of eligible professionals reporting via claims reported no (zero) measures satisfactorily, compared to only 1 percent of those reporting via registry, and zero percent for EHR and QCDR.

Figure 10 summarizes participation through the claims-based individual measure reporting mechanism in 2014: 843,668 eligible professionals were eligible to participate individually via claims in PQRS in 2014, and one third of these professionals participated by submitting at least one QDC without error via claims (N=283,837). Among all eligible professionals attempting to submit a QDC (N=293,621), 97.5 percent of them had at least one valid QDC (data not shown). Over 83 percent of those submitting at least one correct QDC were able to report at least 50 percent of instances for at least one measure. Ultimately, 14 percent of professionals eligible to submit claims-based individual measures to PQRS qualified for an incentive in 2014.

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

Figure 10. Summary of Individual Measures Reported through the PQRS Claims Mechanism (2014)



Note: The counts for who reported a QDC correctly and who reported at least 50% of instances for at least 1 measure are derived after the application of our hierarchy in performance data.

Some PQRS participants who used a registry, QCDR, or EHR experienced submission problems. About 50 percent of registries incorrectly submitted data for individual eligible professionals who are in a practice participating under the GPRO, as part of an ACO, or as part of a practice participating under the CPC Initiative; this affected 4,547 eligible professionals. Eighty-two percent of registries submitted data for eligible professionals who did not have Part B PFS charges; this affected 5,599 eligible professionals. For EHR, nine percent of QRDA I submissions had an error, compared to 90 percent of QRDA III submissions. About 67 percent of QRDA III submissions had either a performance numerator greater than the reporting denominator or (performance numerator + exclusions) greater than the reporting denominator, affecting 41,930 eligible professionals. Of the eligible professionals who submitted through QCDR, five percent were part of a practice that participated under the GPRO, nine percent were part of a practice that participated as an SSP ACO, and another two percent were part of a practice participating as a Pioneer ACO. The most prevalent calculation issue for QCDR was miscalculated reporting rates, which appeared on 32 percent of submissions. CMS has communicated with the registries, QCDRs, and EHR vendors about these issues, so that they can improve on these submissions in future program years.

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, inexperience using the web interface, and challenges with the layers between those providing care and those abstracting the data for submission, which resulted in some users not inputting the data properly.

E. 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.[35] Appendix Table A8 shows participation rates by specialty across all reporting options from 2011 to 2014. Participation rates by specialty and submission mechanism for 2011 through 2014 can be found in Appendix Tables A9 through A13.

As shown in Table 9, of eligible professionals who participated through the claims-based reporting option, several hospital-based specialties were among the top ten specialties using this reporting mechanism. For example, nurse anesthetist had the largest representation among all specialties and also had a high rate of participation in this mechanism (67 percent), followed by emergency medicine and anesthesiology, which had participation rates of 68 and 71 percent respectively. Radiology had the fifth highest number of participants via claims. 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 therapy, internal medicine, family practice, optometry, chiropractor, and physician assistant also had a relatively large number of professionals who participated in the 2014 program via claims; however, with the exception of physical therapy, these specialties had participation rates of less than 50 percent. (Appendix Table A9 presents results for all specialties reporting via claims.)

Table 9: Specialties with the largest Number of Eligible Professionals Participating in PQRS through Claims Reporting (2014)

Rank	Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
1	Nurse Anesthetist	41,182	27,555	66.9%
2	Emergency Medicine	39,939	27,184	68.1%
3	Anesthesiology	36,583	26,085	71.3%
4	Physical Therapy	46,470	25,521	54.9%
5	Radiology	26,814	18,681	69.7%
6	Internal Medicine	58,642	15,277	26.1%
7	Family Practice	60,113	14,278	23.8%
8	Optometry	34,036	13,586	39.9%
9	Chiropractor	45,834	12,725	27.8%
10	Physician Assistant	40,159	12,253	30.5%

Notes for Table 9: 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.

Physical therapy, internal medicine, dermatology, and family practice had the highest numbers of eligible professionals participating via the registry individual measures mechanism in 2014 (Table 10). Within the registry measures group mechanism, the top specialties included family practice, internal medicine, cardiology, and nurse practitioner (See Appendix Tables A10 and A11 for results for all specialties). Among the specialties with the most participants, dermatology had the highest rate of

[35] 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).

participation via registry individual measures (45 percent), and nephrology had the highest participation rate (28 percent) in registry measures groups.

Table 10: Specialties with the largest Number of Eligible Professionals Participating in PQRS through Registry Reporting (2014)

Rank	Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
--	**Registry Individual Measures**	--	--	--
1	Physical Therapy	46,487	6,164	13.3%
2	Internal Medicine	60,844	5,243	8.6%
3	Dermatology	9,131	4,115	45.1%
4	Family Practice	66,514	4,043	6.1%
5	Nurse Practitioner	58,275	3,691	6.3%
6	Physician Assistant	42,399	3,353	7.9%
7	Radiology	27,516	2,803	10.2%
8	Other Eligible Professional	30,181	2,327	7.7%
9	Emergency Medicine	42,877	1,937	4.5%
10	Ophthalmology	16,625	1,912	11.5%
--	**Registry Measures Groups**	--	--	--
1	Family Practice	66,514	3,988	6.0%
2	Internal Medicine	60,844	3,891	6.4%
3	Cardiology	15,571	2,046	13.1%
4	Nurse Practitioner	58,275	1,968	3.4%
5	Nephrology	6,705	1,849	27.6%
6	Oncology/Hematology	6,902	1,571	22.8%
7	Other Eligible Professional	30,181	1,569	5.2%
8	Orthopaedic Surgery	16,256	1,508	9.3%
9	Physical Therapy	46,487	1,379	3.0%
10	General Surgery	15,562	1,201	7.7%

Note for Table 10: 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 11 presents the specialties with the most eligible professionals reporting via EHR in 2014. Family practice and internal medicine topped the list for the specialties with the most eligible professionals participating in PQRS via the EHR mechanism, followed by nurse practitioner, physician assistant, and obstetrics/gynecology. However, the rate of participation among these specialties using the EHR mechanism was relatively low (highest for obstetrics/gynecology at 13.2 percent). See Appendix Table A12 for more detail.

Table 11: Specialties with the Largest Number of Eligible Professionals Participating in PQRS through the EHR Mechanism (2014)

Rank	Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
1	Family Practice	66,514	7,957	12.0%
2	Internal Medicine	60,844	6,179	10.2%
3	Nurse Practitioner	58,275	4,921	8.4%
4	Physician Assistant	42,399	2,929	6.9%
5	Obstetrics/Gynecology	21,195	2,797	13.2%
6	Ophthalmology	16,625	2,141	12.9%
7	Orthopaedic Surgery	16,256	1,969	12.1%
8	Cardiology	15,571	1,795	11.5%
9	General Surgery	15,562	1,782	11.5%
10	Other Eligible Professional	30,181	1,641	5.4%

Notes 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.

Table 12 presents the specialties with the most eligible professionals reporting via the new QCDR mechanism in 2014. Cardiology had the most eligible professionals reporting via this mechanism, followed distantly by thoracic/cardiac surgery, radiology, physician assistant and nurse practitioner. Thoracic/cardiac surgery had a relatively high rate of participation in this mechanism (19 percent) compared to 6 percent for cardiology and one percent or less for the other specialties in Table 12. See Appendix Table A13 for more detail on all specialties.

Table 12. Specialties with the Largest Number of Eligible Professionals Participating in PQRS through the QCDR Mechanism (2014)

Rank	Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
1	Cardiology	15,571	986	6.3%
2	Thoracic/Cardiac Surgery	2,241	421	18.8%
3	Radiology	27,516	295	1.1%
4	Physician Assistant	42,399	232	0.5%
5	Nurse Practitioner	58,275	222	0.4%
6	Internal Medicine	60,844	201	0.3%
7	General Surgery	15,562	171	1.1%
8	Other Eligible Professional	30,181	139	0.5%
9	Orthopaedic Surgery	16,256	121	0.7%
10	Family Practice	66,514	82	0.1%

Notes 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.

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 13).

Table 13. Specialties with the Largest Number of Eligible Professionals Participating in PQRS through the GPRO and SSP ACO (2014)

Rank	Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
--	**GPRO**	--	--	--
1	Internal Medicine	31,852	30,061	94.4%
2	Nurse Practitioner	26,838	24,812	92.5%
3	Family Practice	26,532	24,494	92.3%
4	Physician Assistant	22,146	20,763	93.8%
5	Emergency Medicine	16,916	15,108	89.3%
6	Nurse Anesthetist	10,323	9,516	92.2%
7	Radiology	10,365	9,515	91.8%
8	Obstetrics/Gynecology	9,897	9,080	91.7%
9	Cardiology	9,196	8,659	94.2%
10	Anesthesiology	8,572	8,032	93.7%
--	**SSP ACO**	--	--	--
1	Internal Medicine	19,862	19,779	99.6%
2	Family Practice	18,545	18,470	99.6%
3	Nurse Practitioner	12,923	12,910	99.9%
4	Physician Assistant	10,031	10,014	99.8%
5	Cardiology	6,324	6,318	99.9%
6	Emergency Medicine	5,409	5,407	100.0%
7	Obstetrics/Gynecology	4,907	4,901	99.9%
8	Radiology	4,244	4,240	99.9%
9	Other Eligible Professional	3,612	3,590	99.4%
10	General Surgery	3,562	3,556	99.8%

Finally, 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 14).

Table 14. Specialties with the Largest Number of Eligible Professionals Participating in PQRS as part of a Pioneer ACO or the CPC Initiative (2014)

Rank	Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
--	**Pioneer ACO**	--	--	--
1	Internal Medicine	4,093	4,093	100.0%
2	Family Practice	2,727	2,727	100.0%
3	Nurse Practitioner	1,836	1,836	100.0%
4	Physician Assistant	1,137	1,137	100.0%
5	Cardiology	1,024	1,024	100.0%
6	Obstetrics/Gynecology	903	903	100.0%

Rank	Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
7	Radiology	890	890	100.0%
8	Pediatrics	728	728	100.0%
9	Other Eligible Professional	684	684	100.0%
10	Emergency Medicine	643	643	100.0%
--	**CPC**	--	--	--
1	Family Practice	604	267	44.2%
2	Internal Medicine	315	89	28.3%
3	Nurse Practitioner	120	45	37.5%
4	Physician Assistant	112	36	32.1%
5	Geriatrics	19	5	26.3%
6	General Practice	10	3	30.0%
7	Gastroenterology	2	2	100.0%
8	Pediatrics	7	2	28.6%
9	Other Eligible Professional	9	2	22.2%
10	Other MD/DO	6	1	16.7%

F. 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 40 percent, compared to 60 percent among those with 26 to 100 patients, 70 percent among those with 101 to 200 patients, and 77 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 about twice the rate among eligible professionals treating fewer than 25 beneficiaries. Within emergency medicine, radiology, radiation oncology, and interventional radiology, eligible professionals with larger beneficiary volume (over 200 patients) had a participation rate of 89 percent and above (Appendix Table A14). Some specialties had relatively high rates of participation among eligible professionals with low beneficiary volume (fewer than 25 patients) including: pathology (82 percent), certified nurse midwives (65 percent), nurse anesthetist (64 percent), radiology (64 percent), and anesthesiology (60 percent).

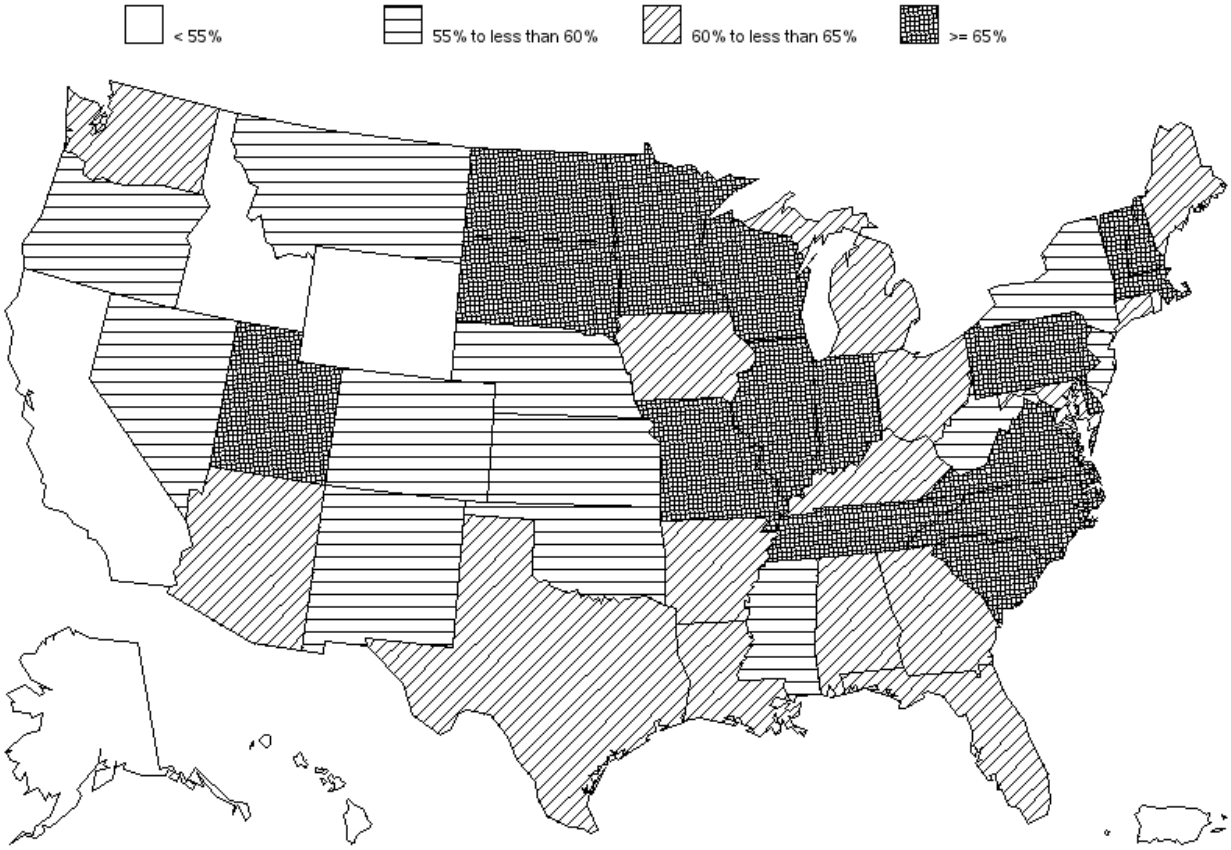
G. Geographic Variation in Participation

Figure 11 demonstrates the geographic variation in participation rates for the 2014 PQRS.[36] Detailed state-by-state participation results are available in Appendix Table A15. Participation was generally highest in states in the Southeast, Midwest, and New England. Participation rates were highest in Vermont and Wisconsin (76 percent), Minnesota (73 percent), North Carolina (71 percent), Missouri (69 percent), and Indiana and South Dakota (69 percent). Participation was lowest (below 45 percent) in

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

Puerto Rico, Virgin Islands, Wyoming, Alaska, Hawaii, and Rhode Island. New York and California had the largest absolute number of eligible professionals who participated, although participation rates in these states were below 60 percent.

Figure 11. Geographic Distribution of Eligible Professionals Participating in PQRS (2014)



Notes for Figure 12: Results include all individual participation PQRS mechanisms (i.e., claims, registry, EHR, and QCDR) 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.

H. 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 2014 were those related to preventive care for high blood pressure, documentation of current medications, body mass index (BMI) screening, tobacco use, and clinical depression, as well as pain assessment and follow-up (Table 15).

Table 15: Individual Measures Reportable by the Largest Number of Eligible Professionals for PQRS (2014)

Rank	Measure Number	Measure Description	Eligible Professionals
1	317	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	632,586
2	130	Documentation of Current Medications in the Medical Record	610,925
3	131	Pain Assessment and Follow-Up	573,233
4	128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	549,115
5	226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	512,970
6	134	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	505,431
7	181	Elder Maltreatment Screen and Follow-Up Plan	483,020
8	47	Advance Care Plan	471,699
9	154	Falls: Risk Assessment	471,568
10	110	Preventive Care and Screening: Influenza Immunization	428,410

Notes for Table 15: Results include the claims, registry, EHR, and QCDR mechanisms, and 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 16 lists the ten measures reported by the largest number of eligible professionals in 2014. The top reported measures include five of the measures with the most eligible professionals able to report: #130, #226, #128, #131, and #110. They also include a number of other preventive measures—for Pneumonia Vaccination (#111), Controlling high blood pressure (#236), and Colorectal Cancer Screening (#113)—as well for Diabetes- Hemoglobin A1c Poor Control (#1), and perioperative measure, Timing of Prophylactic Antibiotic-Administering Physician (#30).

Although a relatively large number of eligible professionals reported these measures, several measures were submitted by 15 percent or fewer of those to which the measure was applicable: #111 (Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years or Older), #110 (Preventive Care and Screening: Influenza Immunization), #113 (Preventive Care and Screening: Colorectal Cancer Screening), and #131 (Pain Assessment and Follow Up). 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 16: Measures Reported by the Largest Numbers of Eligible Professionals under PQRS (2014)

Rank	Measure Number	Measure Description	Participated	Percent of Eligible
1	130	Documentation of Current Medications in the Medical Record	156,727	25.7%
2	226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	111,522	21.7%
3	128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	104,996	19.1%
4	131	Pain Assessment and Follow-Up	61,385	10.7%
5	111	Pneumonia Vaccination Status for Older Adults	60,235	14.3%

Rank	Measure Number	Measure Description	Participated	Percent of Eligible
6	1	Diabetes: Hemoglobin A1c Poor Control	58,708	18.5%
7	110	Preventive Care and Screening: Influenza Immunization	57,809	13.5%
8	236	Controlling High Blood Pressure	53,291	25.8%
9	113	Colorectal Cancer Screening	53,106	12.5%
10	30	Perioperative Care: Timing of Prophylactic Antibiotic-Administering Physician	51,909	73.3%

Notes for Table 16: Results include the claims, registry, EHR, and QCDR mechanisms, and 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 presents information on the top five measures submitted by each specialty, identified by measure number in 2014. Overall, among eligible professionals with an MD/DO, the top five measures reported in 2014 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), #1 (Diabetes: Hemoglobin A1c Poor Control), and #111 (Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years or Older). These measures were among the top five for most specialties.

Table 17: The Five Most Frequently Reported Individual PQRS Measures, by Specialty, for PQRS (2014)

Specialty	#1 (Top)	#2	#3	#4	#5
MD/DO	**130**	**226**	**128**	**1**	**111**
Allergy/Immunology	130	226	111	128	110
Anesthesiology	30	193	76	130	226
Cardiology	226	130	128	236	6
Colon/Rectal Surgery	113	130	226	128	112
Critical Care	130	47	226	111	76
Dermatology	137	224	138	130	226
Emergency Medicine	54	56	59	55	28
Endocrinology	1	130	2	226	128
Family Practice	130	1	226	128	111
Gastroenterology	130	113	226	128	111
General Practice	130	128	1	226	2
General Surgery	130	226	128	113	111
Geriatrics	130	110	128	226	1
Hand Surgery	130	226	128	131	113
Infectious Disease	130	226	128	111	110
Internal Medicine	130	1	226	128	2
Interventional Radiology	145	195	76	147	146
Nephrology	130	226	128	236	110
Neurology	130	226	128	111	236
Neurosurgery	130	226	128	111	110
Nuclear Medicine	147	195	145	226	130
Obstetrics/Gynecology	130	226	128	112	110
Oncology/Hematology	130	226	110	71	72
Ophthalmology	12	117	14	18	130

Specialty	#1 (Top)	#2	#3	#4	#5
Oral/Maxillofacial Surgery	226	130	128	112	111
Orthopaedic Surgery	130	128	226	113	110
Other MD/DO	130	47	31	32	226
Otolaryngology	130	226	128	91	111
Pathology	99	100	249	251	250
Pediatrics	110	130	379	134	226
Physical Medicine	130	128	131	226	154
Plastic Surgery	130	226	128	111	110
Psychiatry	130	226	128	107	134
Pulmonary Disease	130	226	128	111	110
Radiation Oncology	194	226	130	128	110
Radiology	195	145	146	147	225
Rheumatology	130	226	128	111	110
Thoracic/Cardiac Surgery	130	20	226	43	21
Urology	130	226	128	48	111
Vascular Surgery	130	226	128	111	204
Other Eligible Professionals	**130**	**131**	**128**	**182**	**226**
Agencies/Hospitals/Nursing and Treatment Facilities	130	131	128	182	154
Audiology	130	261	134	317	111
Certified Nurse Midwives	130	226	128	112	110
Chiropractor	131	182	317	130	128
Clinical Nurse Specialists	130	226	128	111	110
Counselor/Psychologist	134	130	226	107	106
Dentist	130	128	226	111	131
Dietitian/Nutritionist	130	128	1	2	181
Nurse Anesthetist	193	30	76	44	130
Nurse Practitioner	130	226	128	111	1
Occupational Therapy	131	130	182	154	128
Optometry	117	12	14	226	140
Other Eligible Professional	130	226	128	111	113
Physical Therapy	131	182	130	154	128
Physician Assistant	130	226	128	54	111
Podiatry	163	226	128	130	317
Registered Nurse	30	193	130	226	128
Social Worker	130	134	226	107	106
Unknown/Missing	**130**	**226**	**128**	**193**	**131**
Total	**130**	**226**	**128**	**131**	**111**

Notes for Table 17: Please refer to Appendix Table A1 for measure descriptions; results include claims, registry, EHR, and QCDR. 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.

VI. 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 2014 program if the eligible professional met one of the reporting criteria applicable for at least one individual reporting option, as detailed in Section III.B. In addition to the incentive eligibility criteria, measures submitted via any participation method with a performance rate of zero percent were not used to calculate incentive eligibility in program year 2014; 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. Finally, eligible professionals who met incentive eligibility criteria for PQRS but had no Part B MPFS allowed charges on which to calculate an incentive payment had an incentive amount of $0.00; these participants are not included in the counts of eligible professionals who were incentive eligible. Potentially, this was because an eligible professional or the vendor submitting data on behalf of the eligible professional provided an incorrect TIN or NPI.

When comparing incentive eligibility results across years, it is important to note the incentive eligibility requirements can be different in different years. See Table 4 of the main text for a summary of the PQRS incentive eligibility criteria across the years.

A. Incentive Eligibility by Reporting Approach

The percent of eligible professionals participating in PQRS who qualified for an incentive decreased from 77 percent in 2013 to 71 percent in 2014 (Appendix Table A17). As in prior years, incentive eligibility varied by reporting option. As shown in Figure 6, the percentage of individual participants who qualified for an incentive payment was highest among CPC participants (95 percent) and registry measures group participants (93 percent). Incentive eligibility rates were lower among those participating individually via registry individual measures (59 percent), EHR (57 percent), QCDR (43 percent), and claims-based measures (40 percent). Among those reporting under the GPRO or as an ACO under the SSP or Pioneer ACO Model, SSP participants had the highest incentive eligibility rate (99 percent), followed by GPRO web interface (98 percent), GPRO registry (85 percent), Pioneer ACO (63 percent), and GPRO EHR (42 percent).

B. Incentive Eligibility by Specialty

The specialties with the most eligible professionals who qualified for an incentive follow the same patterns as participation. Across all reporting options, internal medicine, family practice, nurse practitioner, physician assistant, and emergency medicine had the largest number of eligible professionals who earned an incentive (Appendix Table A3). Appendix Tables A18 through A22 present the percentage of eligible professionals from each specialty who qualified for an incentive by program year for each individual reporting mechanism. Tables 18 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, pathology, anesthesiology, and nurse anesthetist also had relatively high rates of incentive eligibility (75 percent or above) (Table 18). Physician assistant, family practice, internal medicine, and physical therapy also had relatively large numbers of eligible professionals earning an incentive via claims-based individual reporting, but relatively lower incentive

eligibility rates (46, 24, 21, and 18 percent, respectively). See Appendix Table A18 for results for all specialties reporting via claims.

Table 18: Top 10 Specialties Earning a PQRS Incentive via Claims (2014)

Rank	Specialty	Eligible Professionals who Participated	Eligible Professionals who Qualified for an Incentive	Percent Who Qualified for an Incentive
1	Nurse Anesthetist	27,555	21,295	77.3%
2	Anesthesiology	26,085	20,260	77.7%
3	Emergency Medicine	27,184	15,589	57.3%
4	Radiology	18,681	11,629	62.3%
5	Chiropractor	12,725	6,804	53.5%
6	Physician Assistant	12,253	5,647	46.1%
7	Physical Therapy	25,521	4,678	18.3%
8	Pathology	4,889	4,036	82.6%
9	Family Practice	14,278	3,375	23.6%
10	Internal Medicine	15,277	3,258	21.3%

Notes for Table 18: 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 (80 and 69 percent, respectively) compared to those in these same specialties reporting via claims (Table 19). See Appendix Tables A19 and A20 for more detail.

Table 19: Top 10 Specialties Earning a PQRS Incentive via Registry (2014)

Rank	Specialty	Eligible Professionals who Participated	Eligible Professionals Who Qualified for an Incentive	Percent Who Qualified for an Incentive
1	Family Practice	8,000	6,426	80.3%
2	Internal Medicine	9,101	6,266	68.8%
3	Physical Therapy	7,527	5,134	68.2%
4	Nurse Practitioner	5,554	3,761	67.7%
5	Cardiology	3,478	2,915	83.8%
6	Other Eligible Professional	3,868	2,847	73.6%
7	Physician Assistant	4,493	2,756	61.3%
8	Dermatology	4,163	2,664	64.0%
9	Radiology	2,942	2,497	84.9%
10	Nephrology	2,533	2,186	86.3%

Notes 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, family practice and internal medicine had the largest number of eligible professionals earning incentive payments under the EHR mechanism, followed by nurse practitioner, ophthalmology, obstetrics/gynecology, and physician assistant. Most of the top specialties reporting via this mechanism had incentive eligibility rates between 50 and 60 percent; ophthalmology had a notably higher rate (90 percent). See Appendix Table A21 for more detail.

Table 20: Top 10 Specialties Earning a PQRS Incentive via EHR (2014)

Rank	Specialty	Eligible Professionals who Participated	Eligible Professionals Who Qualified for an Incentive	Percent Who Qualified for an Incentive
1	Family Practice	7,957	4,730	59.4%
2	Internal Medicine	6,179	3,328	53.9%
3	Nurse Practitioner	4,921	2,581	52.4%
4	Ophthalmology	2,141	1,925	89.9%
5	Obstetrics/Gynecology	2,797	1,813	64.8%
6	Physician Assistant	2,929	1,657	56.6%
7	Orthopaedic Surgery	1,969	1,133	57.5%
8	Cardiology	1,795	1,017	56.7%
9	General Surgery	1,782	1,010	56.7%
10	Other Eligible Professional	1,641	905	55.1%

Notes 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.

Table 21 presents the top ten specialties earning an incentive using the new QCDR mechanism in 2014. Cardiology had the most eligible professionals earning an incentive using this mechanism compared to all other specialties, and had a relatively high (88 percent) incentive eligibility rate. See Appendix Table A22 for results for all specialties.

Table 21. Top 10 Specialties Earning a PQRS Incentive via QCDR (2014)

Rank	Specialty	Eligible Professionals who Participated	Eligible Professionals Who Qualified for an Incentive	Percent Who Qualified for an Incentive
1	Cardiology	986	863	87.5%
2	Internal Medicine	201	152	75.6%
3	Radiology	295	114	38.6%
4	Nurse Practitioner	222	107	48.2%
5	Physician Assistant	232	49	21.1%
6	Other Eligible Professional	139	33	23.7%
7	Family Practice	82	27	32.9%
8	Thoracic/Cardiac Surgery	421	17	4.0%
9	Vascular Surgery	25	8	32.0%
10	General Surgery	171	7	4.1%

Notes 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.

VII. PQRS PAYMENT ADJUSTMENT

In 2016, eligible professionals who are eligible for PQRS but who did not meet the 2014 reporting requirements will be subject to a 2.0 percent payment reduction on all of their Part B Medicare PFS charges, an increase from 1.5 percent for the 2015 payment adjustment. 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. Eligible professionals who bill under the CAH II method are also subject to the payment adjustment beginning with the 2016 adjustment.

To avoid the PQRS payment adjustment for 2016, individual participants had to meet the criteria described in Section III.C and Table 5. 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 2016 PQRS payment adjustment, or not having any MPFS charges in 2014. Individual eligible professionals or groups participating via GPRO, ACO, or CPC were also able to request an informal review of their negative payment determination between September 9, 2015 and December 16, 2015, for the 2014 PQRS program year; this report presents payment adjustment results prior to the conclusion of the informal review process.

As seen in Table 22, 558,885 eligible professionals in total will be subject to the 2016 PQRS payment adjustment based on their 2014 reporting experience, prior to the final results from informal reviews. This count 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. The majority (83 percent) of eligible professionals who were subject to the adjustment did not submit any PQRS data in 2014. A limited number of eligible professionals subject to the payment adjustment attempted participation but were not successful because they submitted only invalid QDCs, and 15 percent of those subject to the 2016 adjustment were individual participants (compared to less than one percent who were subject to the 2015 payment adjustment) (Table 22).[37] At the practice level, 21 percent of practices subject to the adjustment were considered participating. A total of 20,125 eligible professionals were part of a GPRO practice that was subject to the payment adjustment. Among these, 2,520 eligible professionals were part of practices that participated, while 17,605 eligible professionals were part of practices that did not participate at all in 2014 (data not shown).

The regional distribution of eligible professionals subject to the 2016 PQRS payment adjustment was similar to the geographical distribution of participants in PQRS in 2014 (Table 22 and Appendix Table A5). As with the 2015 payment adjustment, 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, 65 percent of the eligible professionals subject to the payment adjustment were individuals in practices with fewer than 25 NPIs, compared to only 42 percent among the PQRS-eligible population (Appendix Table A5). In particular, solo practitioners represented 28 percent of those subject to the adjustment, but 15 percent of the total eligible for PQRS (Table 22).

[37] Individual participants include any eligible professionals who submitted PQRS data from 1/1/2014 to 12/31/2014 and did not avoid the PQRS payment adjustment for any reason. This includes any eligible professional who used the registry, EHR, or QCDR reporting mechanisms, but did not have any valid measures.

Table 22. 2015 and 2016 PQRS Payment Adjustment

Eligible Professional (EP) Characteristics	EPs Subject to 2015 Payment Adjustment	Percent of Total EPs Subject to 2015 Payment Adjustment	EPs Subject to 2016 Payment Adjustment	Percent of Total EPs Subject to 2016 Payment Adjustment
Participation Option [a]	--	--	--	--
Non-participants	448,872	98.1%	466,351	83.4%
Attempted participation, but were not successful	7,638	1.7%	5,802	1.0%
Individual Participants	359	0.1%	83,596	15.0%
Small GPRO	62	0.0%	168	0.0%
Medium GPRO	41	0.0%	183	0.0%
Large GPRO	656	0.1%	2,169	0.4%
SSP ACO	0	0.0%	616	0.1%
Geography (Regions) [b]	--	--	--	--
1 – Boston	30,518	6.7%	36,983	6.6%
2 - New York	61,379	13.4%	69,783	12.5%
3 - Philadelphia	45,141	9.9%	55,389	9.9%
4 – Atlanta	79,844	17.4%	96,562	17.3%
5 – Chicago	71,870	15.7%	89,625	16.0%
6 – Dallas	47,458	10.4%	59,879	10.7%
7 - Kansas City	19,697	4.3%	28,620	5.1%
8 – Denver	15,438	3.4%	20,632	3.7%
9 - San Francisco	64,964	14.2%	74,930	13.4%
10 – Seattle	19,895	4.3%	26,555	4.8%
Unknown	108	0.0%	86	0.0%
Practice Size (# of NPIs)	--	--	--	--
Individual Participants	--	--	--	--
1	145,669	31.8%	155,094	27.8%
2-4	74,441	16.3%	84,273	15.1%
5-10	57,295	12.5%	63,565	11.4%
11-24	55,631	12.2%	62,729	11.2%
25-50	41,717	9.1%	52,340	9.4%
51-99	30,158	6.6%	43,669	7.8%
100-199	18,713	4.1%	33,456	6.0%
200+	29,840	6.5%	42,630	7.6%
Group Participants	--	--	--	--
1-24	531	0.1%	4,680	0.8%
25-50	239	0.1%	2,456	0.4%
51-99	954	0.2%	2,826	0.5%
100-199	1,599	0.3%	4,036	0.7%
200+	841	0.2%	7,131	1.3%
Total MPFS charges per EP	--	--	--	--
Individual Participants	--	--	--	--
less than or equal to $2,500	113,692	24.8%	139,982	25.0%
$2,501 - $10,000	99,619	21.8%	111,581	20.0%

Eligible Professional (EP) Characteristics	EPs Subject to 2015 Payment Adjustment	Percent of Total EPs Subject to 2015 Payment Adjustment	EPs Subject to 2016 Payment Adjustment	Percent of Total EPs Subject to 2016 Payment Adjustment
$10,001 - $40,000	118,098	25.8%	140,385	25.1%
$40,001 - $100,000	60,281	13.2%	74,638	13.4%
over $100,000	61,774	13.5%	71,170	12.7%
Group Participants	--	--	--	--
less than or equal to $2,500	925	0.2%	4,709	0.8%
$2,501 - $10,000	793	0.2%	4,213	0.8%
$10,001 - $40,000	1,207	0.3%	5,692	1.0%
$40,001 - $100,000	763	0.2%	3,648	0.7%
over $100,000	476	0.1%	2,867	0.5%
Beneficiary Volume	--	--	--	--
Individual Participants	--	--	--	--
1-25	194,949	42.6%	223,665	40.0%
26-100	118,165	25.8%	140,691	25.2%
101-200	59,518	13.0%	73,063	13.1%
201+	80,831	17.7%	99,400	17.8%
Unknown	1	0.0%	937	0.2%
Group Participants	--	--	--	--
1-25	1,299	0.3%	6,880	1.2%
26-100	1,074	0.2%	5,570	1.0%
101-200	777	0.2%	3,545	0.6%
201+	907	0.2%	5,008	0.9%
Unknown	107	0.0%	126	0.0%
Specialty	--	--	--	--
MD/DO	--	--	--	--
Primary Care	78,981	17.3%	96,924	17.3%
Surgery	24,669	5.4%	30,699	5.5%
Other Specialties	128,595	28.1%	162,363	29.1%
Other Eligible Professionals	--	--	--	--
Physicians	68,301	14.9%	80,366	14.4%
Physician Assistant	23,550	5.1%	28,313	5.1%
Nurses	53,060	11.6%	67,621	12.1%
Other Eligible Professionals	80,470	17.6%	92,599	16.6%
Unknown/Missing	2	0.0%	0	0.0%
Provider Age	--	--	--	--
44 and younger	51,132	11.2%	56,452	10.1%
45 to 54	79,305	17.3%	100,089	17.9%
55 to 65	91,009	19.9%	116,911	20.9%
66 to 80	37,450	8.2%	51,035	9.1%
Older than 80	2,078	0.5%	2,875	0.5%
Unknown	196,654	43.0%	231,523	41.4%
Total (Unduplicated)	**457,628**	**100.0%**	**558,885**	**100.0%**

[a] *Non-participants include any EPs who did not submit any PQRS data and did not avoid the PQRS payment adjustment for any reason. Attempted participation but were not successful means the eligible professional submitted only invalid QDCs and did not avoid the payment adjustment for any other reason. Individual participants include any EPs who submitted PQRS data and did not avoid the payment adjustment for any reason.*

[b] *Regions are based on the CMS regions for Carrier code from the claims data. Some practices (TIN) encompassed more than one state/region; consequently, sums across categories within the Geography results do not equal totals. 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 measured at the TIN/NPI level and exclude TIN/NPIs that are part of a practice participating under the GPRO. Results 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.

The number of eligible professionals subject to the 2016 payment adjustment represents 44 percent of the 1,276,654 eligible professionals who did not automatically avoid the adjustment because they did not meet the CMS definition for eligible professionals subject to the payment adjustment (data not shown). Eligible professionals who were MD/DOs were less likely than those in non-MD/DO specialties to be subject to a 2016 payment adjustment based on 2014 reporting (Table 23). For example, 37 percent of MD/DOs were subject to the adjustment compared to 56 percent of the non-MD/DO specialties.

Within these two groups, the percent of eligible professionals subject to the payment adjustment varied widely, following the same trends as PQRS participation. Among the MD/DO specialties, the percent of eligible professionals who will receive an adjustment based on 2014 reporting ranged from 16 percent to 72 percent (Table 23). MD/DO specialties with a relatively small proportion of eligible professionals subject to the adjustment included pathology (16 percent), and oncology/hematology, radiology, cardiology, and thoracic/cardiac surgery (all less than 28 percent). On the other hand, MD/DO specialties with relatively high proportions of eligible professionals subject to the adjustment included oral/maxillofacial surgery and general practice both 72 percent), and psychiatry (71 percent).

Among other non-MD/DO eligible professionals, the percent of eligible professionals who will receive an adjustment based on 2014 reporting ranged from 10 percent to 88 percent. Specialties with a relatively small proportion of eligible professionals subject to the adjustment included registered nurse (10 percent) and agencies/hospitals/nursing and treatment facilities (13 percent), compared to specialties with a relatively high proportion of eligible professionals subject to the adjustment included social worker (88 percent), dentist (84 percent), chiropractor (84 percent), and counselor/psychologist (82 percent).

Table 23. Eligible Professionals Subject to the 2015 and 2016 PQRS Payment Adjustment, by Specialty

Specialty	EPs Subject to 2015 Payment Adjustment	Percent of EPs Subject to 2015 Payment Adjustment	EPs Subject to 2016 Payment Adjustment	Percent of EPs Subject to 2016 Payment Adjustment
MD/DO	**232,245**	**31.8%**	**289,986**	**36.8%**
Allergy/Immunology	1,917	49.6%	2,092	52.5%
Anesthesiology	10,744	22.7%	15,087	30.6%
Cardiology	6,790	24.1%	8,518	26.7%
Colon/Rectal Surgery	407	30.0%	473	32.2%

Specialty	EPs Subject to 2015 Payment Adjustment	Percent of EPs Subject to 2015 Payment Adjustment	EPs Subject to 2016 Payment Adjustment	Percent of EPs Subject to 2016 Payment Adjustment
Critical Care	936	32.0%	1,159	35.4%
Dermatology	4,285	36.0%	4,645	37.2%
Emergency Medicine	11,482	19.1%	18,448	28.3%
Endocrinology	1,588	25.6%	2,059	30.2%
Family Practice	37,066	35.3%	46,619	40.9%
Gastroenterology	3,808	27.3%	4,922	32.4%
General Practice	3,885	63.9%	4,606	72.2%
General Surgery	8,640	34.9%	10,731	39.7%
Geriatrics	1,650	35.1%	1,883	38.6%
Hand Surgery	710	36.9%	917	41.9%
Infectious Disease	2,274	34.9%	2,609	37.5%
Internal Medicine	34,740	31.5%	41,410	35.7%
Interventional Radiology	398	19.4%	678	28.7%
Nephrology	2,662	27.3%	3,468	31.8%
Neurology	4,720	31.2%	5,840	34.9%
Neurosurgery	1,635	31.7%	2,239	38.4%
Nuclear Medicine	214	30.1%	240	31.7%
Obstetrics/Gynecology	15,211	43.9%	16,382	44.6%
Oncology/Hematology	2,576	19.6%	3,705	25.1%
Ophthalmology	5,634	27.5%	7,413	34.3%
Oral/Maxillofacial Surgery	288	71.3%	328	72.2%
Orthopaedic Surgery	8,098	34.6%	10,267	39.8%
Other MD/DO	4,733	36.2%	5,945	39.7%
Otolaryngology	3,537	36.4%	4,279	41.1%
Pathology	1,562	14.5%	1,914	16.2%
Pediatrics	3,290	32.0%	4,289	33.9%
Physical Medicine	4,271	46.2%	4,896	49.7%
Plastic Surgery	2,840	59.6%	3,102	60.6%
Psychiatry	21,651	66.9%	23,665	70.7%
Pulmonary Disease	3,360	29.2%	4,202	32.8%
Radiation Oncology	1,249	24.3%	1,607	29.1%
Radiology	7,324	18.3%	10,998	25.7%
Rheumatology	1,219	24.6%	1,667	30.2%
Thoracic/Cardiac Surgery	942	22.3%	1,248	27.5%
Urology	2,800	26.7%	4,042	34.2%
Vascular Surgery	1,109	30.1%	1,394	34.8%
Other Eligible Professionals	**225,380**	**50.8%**	**268,059**	**55.7%**
Agencies/Hospitals/Nursing and Treatment Facilities	60	40.5%	19	13.3%
Audiology	3,505	48.1%	4,268	57.8%
Certified Nurse Midwives	703	34.5%	799	33.4%
Chiropractor	36,476	77.7%	38,884	84.2%
Clinical Nurse Specialists	1,494	54.4%	1,644	55.2%

Specialty	EPs Subject to 2015 Payment Adjustment	Percent of EPs Subject to 2015 Payment Adjustment	EPs Subject to 2016 Payment Adjustment	Percent of EPs Subject to 2016 Payment Adjustment
Counselor/Psychologist	25,478	75.8%	27,801	81.9%
Dentist	2,633	84.9%	2,574	83.8%
Dietitian/Nutritionist	1,830	58.0%	1,815	55.7%
Nurse Anesthetist	16,235	31.2%	20,281	36.6%
Nurse Practitioner	34,566	41.9%	44,888	45.0%
Occupational Therapy	2,523	44.5%	3,073	48.2%
Optometry	20,282	58.4%	25,682	71.8%
Other Eligible Professional	2,014	48.5%	1,546	43.8%
Physical Therapy	15,997	34.6%	21,808	42.7%
Physician Assistant	23,550	35.0%	28,313	37.4%
Podiatry	8,910	48.9%	13,226	70.0%
Registered Nurse	62	45.9%	9	10.0%
Social Worker	29,062	85.3%	31,429	88.1%
Unknown/Missing	**3**	**9.1%**	**840**	**56.5%**
Total	**457,628**	**39.0%**	**558,885**	**43.9%**

Notes 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 763,644 eligible professionals avoiding the 2016 payment adjustment, 44 percent were eligible to participate as individuals, 34 percent were part of a practice self-nominating to participate via the GPRO, 18 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 2016 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 (96 percent) than in the overall program (62 percent), and also had an incentive eligibility rate (79 percent) slightly higher than the overall participant population.

Table 24. Eligible Professionals Who Avoided the 2016 PQRS Payment Adjustment

Method of Participation	Eligible Count	Participating Count	Participation Rate	Incentive Eligible Count	Incentive Eligibility Rate
Individual Participants	336,693	312,968	92.95%	204,011	65.19%
GPRO	262,376	258,636	98.57%	225,842	87.32%
Pioneer ACO	24,144	24,144	100.00%	15,167	62.82%
SSP ACO	139,337	139,305	99.98%	139,148	99.89%
CPC	1,094	1,025	93.69%	869	84.78%
Total	**763,644**	**736,078**	**96.39%**	**585,037**	**79.48%**

Notes on Table 24: This table provides an unduplicated count of eligible professionals avoiding the PQRS payment adjustment, including CAH II eligible professionals.

Table 25 provides more detail on how eligible professionals and practices avoided the 2015 and 2016 PQRS payment adjustments. Eligible professionals participating individually avoided the 2016 PQRS

payment adjustment most often by reporting the required data (80 percent of those avoiding the adjustment), as seen in the rightmost column of Table 25, which applies a hierarchy to reasons for avoidance from top to bottom so each reason is represented as mutually exclusive. About 17 percent of individual eligible professionals avoided the adjustment because they did not meet the definition of an eligible professional for the 2016 PQRS payment adjustment, had no 2014 MPFS charges, or did not have at least one denominator-eligible claim. Finally, three percent avoided the 2016 adjustment after an informal review. Among eligible professionals who were part of a GPRO, 89 percent of those avoiding the adjustment did so because the practice met reporting requirements, while only four percent avoided the adjustment because they did not meet the definition of an eligible professional for the purposes of the 2016 PQRS Payment Adjustment, and seven percent did so based on informal review. Among those in an SSP ACO, 97 percent avoided the adjustment did so by meeting reporting requirements; however, among those in Pioneer ACOs, 39 percent of eligible professionals who avoided the adjustment did so because they did not have any MPFS charges in 2014.

Table 25 also highlights that eligible professionals met multiple conditions to avoid the adjustment. For example, 20,544 individually-participating eligible professionals in total avoided the 2016 adjustment because they did not have at least one denominator eligible claim, but over 6,000 of these also did not meet the definition of an eligible professional for the PQRS payment adjustment or did not have MPFS charges, and therefore only 14,323 are counted as avoiding the payment adjustment because they did not have at least one denominator eligible claim after applying the hierarchy used in the right-most column of the table. Many eligible professionals who met the reporting requirements also met one of the other conditions for avoiding the adjustment, especially among individual eligible professionals and those in a Pioneer ACO.

Table 25. How Eligible Professionals Avoided the 2015 and 2016 PQRS Payment Adjustment, in Total and by Hierarchy

Reason for Avoiding Payment Adjustment	EPs Avoiding 2015 Payment Adjustment, Total	EPs Avoiding 2015 Payment Adjustment, After Hierarchy	EPs Avoiding 2016 Payment Adjustment, Total	EPs Avoiding 2016 Payment Adjustment, After Hierarchy
Individual Participants	**387,502**	**387,502**	**336,693**	**336,693**
Did Not Meet the Definition of an Eligible Professional for the PQRS Payment Adjustment	65,709	65,709	36,305	36,305
Did Not Have MPFS Charges	36,116	5,946	6,379	6,370
Did Not Have at least 1 Denominator Eligible Claim	6,269	470	20,544	14,323
Elected Administrative Claims	1,079	1,031	N/A	N/A
Met Reporting Requirements	321,354	302,418	294,620	269,991
Informal Review	11,928	11,928	9,726	9,704
GPRO	**304,613**	**304,613**	**262,376**	**262,376**
Did Not Meet the Definition of an Eligible Professional for the PQRS Payment Adjustment	9,899	9,899	9,424	9,424
Did Not Have MPFS Charges	1,539	1,357	14	13
Did Not Have at least 1 Denominator Eligible Claim	7,430	5,819	168	168
Elected Administrative Claims	172,336	164,646	N/A	N/A
Met Reporting Requirements	214,915	121,972	242,136	234,392

Reason for Avoiding Payment Adjustment	EPs Avoiding 2015 Payment Adjustment, Total	EPs Avoiding 2015 Payment Adjustment, After Hierarchy	EPs Avoiding 2016 Payment Adjustment, Total	EPs Avoiding 2016 Payment Adjustment, After Hierarchy
Informal Review	920	920	18,395	18,379
Pioneer ACO	**17,743**	**17,743**	**24,144**	**24,144**
Did Not Meet the Definition of an Eligible Professional for the PQRS Payment Adjustment	697	697	538	538
Did Not Have MPFS Charges	5,842	5,631	9,380	9,380
Did Not Have at least 1 Denominator Eligible Claim	6,108	260	9,521	141
Elected Administrative Claims	0	0	N/A	N/A
Met Reporting Requirements	17,743	11,155	24,144	14,085
Informal Review	0	0	0	0
SSP ACO	**85,059**	**85,059**	**139,337**	**139,337**
Did Not Meet the Definition of an Eligible Professional for the PQRS Payment Adjustment	2,899	2,899	4,584	4,584
Did Not Have MPFS Charges	0	0	24	24
Did Not Have at least 1 Denominator Eligible Claim	3,766	3,606	89	89
Elected Administrative Claims	0	0	N/A	N/A
Met Reporting Requirements	85,059	78,554	139,214	134,635
Informal Review	0	0	5	5
CPC	**1,054**	**1,054**	**1,094**	**1,094**
Did Not Meet the Definition of an Eligible Professional for the PQRS Payment Adjustment	15	15	12	12
Did Not Have MPFS Charges	105	102	93	91
Did Not Have at least 1 Denominator Eligible Claim	109	4	34	7
Elected Administrative Claims	4	3	N/A	N/A
Met Reporting Requirements	942	901	995	956
Informal Review	29	29	28	28
Total	**795,971**	**795,971**	**763,644**	**763,644**

Notes on Table 25: (1) The first and third columns of data provide total counts of eligible professionals who avoided the PQRS payment adjustment for the reason cited; the second and fourth columns of data provide an unduplicated count of eligible professionals avoiding the PQRS payment adjustment based on the application of a hierarchy of exemption reason in the order given. (2) Eligible professionals (TIN/NPI) in the Pioneer finder file and TINs on the SSP ACO finder file are used to identify EPs eligible for these programs. (3) Administrative claims was only an option in program year 2013 (2015 payment adjustment) and does not apply to program year 2014 (2016 payment adjustment).

VIII. 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 was used to determine a Physician Value-Based Modifier beginning in 2015, based on performance in the 2013 program year. 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. Performance on a measure was calculated as the number of times the eligible professional reported that the recommended quality action for that measure was performed (numerator), divided by the number of instances they could have performed the quality action (denominator), multiplied by 100. For example, under claims-based reporting options, the numerator was the number of times the eligible professional reported the measure-specific QDC indicating the quality action was met and the denominator was the number of eligible instances for that measure identified through claims. Instances that did not apply (i.e., reported as exclusions) were excluded from performance rate calculations.

The following hierarchy was applied if an eligible professional participated through more than one reporting mechanism: (1) QCDR, (2) EHR (QRDA III, then QRDA I)[38], (3) claims, and (4) registry. The hierarchy ensured only one performance rate for each measure for an eligible professional is displayed in results. For program year 2014, there were situations in which eligible professionals and practices submitted data indicating reporting or performance rates greater than 100 percent; in order to keep these anomalies from distorting results, this report removed measures data with rates greater than 100 percent. This issue was most common with measures submitted via the QCDR (7 percent of records), with smaller numbers for measures submitted via QRDA III, QRDA I, and registry (less than one percent of records in each group).

The methods used to calculate performance rates in this report vary from the performance rates used for determining the Physician Value-Based Modifier. Therefore, the performance rates displayed in the 2014 Quality Resource Use Reports (QRURs) may differ from the rates displayed in the 2014 PQRS Experience Report in the following ways: (1) when an eligible professional (EP) reports via multiple reporting methods, the QRURs report a weighted average; (2) this report excludes measures group measures from average performance rates while the QRURs include measures groups measures; (3) the 2014 QRURs did not use data submitted via the GPRO EHR option or, when calculating measures among individual TIN/NPI in a practice, from the individual EHR (QRDA I and III) or the QCDR reporting mechanisms; (4) the QRURs drop any submissions via Registry or Registry Measures Group with a 0% performance rate; and (5) the QRURs handled measures with multiple performance rates on a case by case basis as described in their methodology report, which may differ from this report. For more information on the methodology used for the 2014 QRURs, please see the following link: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html.

[38] 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 rates. 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.

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 many changes within PQRS across program years. As described above, the participation options have been changed and refined. Individual measures have been added, removed, or in some cases their definitions have changed. Moreover, the eligible professionals who participated each year change, and there has been a shift from individual to group reporting. 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. The appendix contains detailed tables on reporting and performance rates; please refer to Appendix Tables A1 and A2 for the full name of measures in these tables. Appendix Table A23 provides eligibility and reporting information across program years for individual measures. Appendix Tables A24 and A25 present the number of eligible professionals reporting by number of measures reported and reporting mechanism, for individual and GPRO participants, respectively.

Appendix Table A26 presents the average number of reported instances and the average performance rate by measure for 2011 through 2014. To provide more context on cohort effects, Appendix Table A27 shows the number of eligible professionals who consistently reported measures across successive program years. Appendix Tables A28 through A30 also provide total counts and performance rates for eligible professionals who reported a measure for two, three or four consecutive years. These tables can provide context for changes in measure performance rates related to how constant the cohort reporting a measure has been over time.

Tables 26 and 27 display the measures with the largest percentage point decline and improvement in performance between 2011 and 2014, among eligible professionals who reported the measure for all four years (2011 to 2014). 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 suggests 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 (2011 to 2014)

Rank	Measure Number	Measure Description	2011 Performance Rate	2014 Performance Rate	EPs Reporting the Measure in each year from 2011 to 2014	Percentage Point Change 2011-2014
1	7	Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)	98.7%	72.2%	31	-26.5%
2	121	Adult Kidney Disease: Laboratory Testing (Lipid Profile)	91.0%	74.7%	156	-16.3%
3	238	Use of High-Risk Medications in the Elderly [a]	0.0%	15.9%	25	-15.9%
4	127	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention - Evaluation of Footwear	95.2%	83.5%	27	-11.7%
5	204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	88.2%	76.8%	807	-11.4%

[a] Inverse measure; lower performance rate indicates better performance.

Notes for Table 26: Results included the claims, registry, EHR, and QCDR reporting mechanisms. Results are restricted to a group of eligible professionals who reported the same measure from 2011 to 2014. Results include measure performance regardless of whether eligible professionals reporting the measure met the satisfactory reporting requirements.

Table 27: Individual Measures Reported with the Largest Percentage Point Increase in Clinical Performance Rate for PQRS (2011 and 2014)

Rank	Measure Number	Measure Description	2011 Performance Rate	2014 Performance Rate	EPs Reporting the Measure in each year from 2011 to 2014	Percentage Point Change 2011-2014
1	33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge	78.4%	100.0%	36	21.6%
2	195	Radiology: Stenosis Measurement in Carotid Imaging Reports	60.8%	82.3%	6,825	21.5%
3	145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy	53.6%	73.6%	6,999	20.1%
4	225	Radiology: Reminder System for Mammograms	67.8%	85.7%	2,858	18.0%
5	147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	56.7%	72.0%	4,291	15.3%

Notes for Table 27: Results include the claims, registry, EHR, and QCDR reporting mechanisms. Results were restricted to a group of eligible professionals who reported the same measure from 2011 to 2014.

Results include 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—mostly QCDR non-PQRS measures—with the highest mean clinical performance rates in 2014.

Table 28: Individual Measures Reported with the Highest Mean Clinical Performance Rates for PQRS (2014)

Rank	Measure Number	Measure Description	Mean Performance Rate	Number of Eligible Professionals Submitting
1	347	Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) Who Die While in Hospital [a]	0.0%	30
2	ACRad 10	Median Size Specific Dose Estimate for CT Chest without contrast (single phase scan)	100.0%	90
3	ACRad 11	Median Dose Length Product for CT Chest without contrast (single phase scan)	100.0%	116
4	ACRad 12	Median Size Specific Dose Estimate for CT Abdomen-Pelvis with Contrast (single phase scan)	100.0%	129
5	ACRad 13	Median Dose Length Product for CT Abdomen-pelvis with contrast (single phase scan)	100.0%	113
6	ACRad 14	Participation in a National Dose Index Registry	100.0%	205
7	ACRad 20	CT IV Contrast Extravasation Rate (Low Osmolar Contrast Media)	100.0%	52
8	ACRad 3	Screening Mammography Cancer Detection Rate (CDR)	100.0%	24
9	ACRad 4	Screening Mammography Invasive Cancer Detection Rate (ICDR)	100.0%	24
10	ACRad 5	Screening Mammography Abnormal Interpretation Rate (Recall Rate)	100.0%	40

[a] Inverse measure; lower performance rate indicates better performance.
Note for Table 28: (1) Results include the claims, registry, EHR, and QCDR reporting mechanisms. (2) Results include measure performance regardless of whether eligible professionals reporting the measure met the satisfactory reporting requirements. (3) Measures are limited to those reported by at least 10 eligible professionals.

Some measures show particularly high rates of performance across all eligible professionals reporting the measure. Table 29 displays 62 measures for which at least 90 percent of the eligible professionals who reported the measure achieved performance at or above 90 percent in 2014. Appendix Table A31 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 (2014)

Measure Number	Measure Description	Percent of Eligible Professionals with At Least 90% Performance Rate
327	Pediatric Kidney Disease: Adequacy of Volume Management	100.0%
335	Maternity Care: Elective Delivery or Early Induction Without Medical Indication at >= 37 and < 39 Weeks	100.0%
342	Pain Brought Under Control within 48 Hours	100.0%
345	Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS) [a]	100.0%
347	Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) Who Die While in Hospital [a]	100.0%
348	HRS-3: Implantable Cardioverter-Defibrillator (ICD) Complications Rate [a]	100.0%
359	Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description	100.0%
363	Optimizing Patient Exposure to Ionizing Radiation: Search for Prior Computed Tomography (CT) Imaging Studies Through a Secure, Authorized, Media-Free, Shared Archive	100.0%
ACRad 10	Median Size Specific Dose Estimate for CT Chest without contrast (single phase scan)	100.0%
ACRad 11	Median Dose Length Product for CT Chest without contrast (single phase scan)	100.0%
ACRad 12	Median Size Specific Dose Estimate for CT Abdomen-Pelvis with Contrast (single phase scan)	100.0%
ACRad 13	Median Dose Length Product for CT Abdomen-pelvis with contrast (single phase scan)	100.0%
ACRad 14	Participation in a National Dose Index Registry	100.0%
ACRad 20	CT IV Contrast Extravasation Rate (Low Osmolar Contrast Media)	100.0%
ACRad 3	Screening Mammography Cancer Detection Rate (CDR)	100.0%
ACRad 4	Screening Mammography Invasive Cancer Detection Rate (ICDR)	100.0%
ACRad 5	Screening Mammography Abnormal Interpretation Rate (Recall Rate)	100.0%
ACRad 6	Screening Mammography Positive Predictive Value 2 (PPV2 - Biopsy Recommended)	100.0%
ACRad 7	Screening Mammography Node Negativity Rate	100.0%
ACRad 8	Screening Mammography Minimal Cancer Rate	100.0%
ACRad 9	Median Dose Length Product for CT Head/Brain without contrast (single phase scan)	100.0%
MBS 2	Surgical Site Complications [a]	100.0%
MBS 3	Serious Complications [a]	100.0%
MBS 4	MBSC Venous Thromboembolism prophylaxis adherence rates for Perioperative Care	100.0%
MBS 5	MBSC Venous Thromboembolism prophylaxis adherence rates for Postoperative Care	100.0%
MBS 8	Unplanned Emergency Room (ER) visits [a]	100.0%
MBS 9	Unplanned Hospital Readmission within 30 Days of Principal Procedure [a]	100.0%
WCHQ 16	Adult Tobacco Use: Screening for Tobacco Use (preventive care)	99.6%
224	Melanoma: Overutilization of Imaging Studies in Melanoma	99.3%
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate [a]	99.1%
146	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening [a]	99.1%
166	Coronary Artery Bypass Graft (CABG): Stroke [a]	98.5%

Measure Number	Measure Description	Percent of Eligible Professionals with At Least 90% Performance Rate
251	Immunohistochemical (IHC) Evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) for Breast Cancer Patients	98.5%
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge	98.4%
250	Radical Prostatectomy Pathology Reporting	98.3%
249	Barrett's Esophagus	97.3%
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	97.1%
263	Preoperative Diagnosis of Breast Cancer	96.8%
168	Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration [a]	96.8%
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge	96.5%
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	96.2%
45	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Cardiac Procedures)	95.5%
378	Children Who Have Dental Decay or Cavities [a]	95.3%
72	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients	95.1%
346	Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Endarterectomy (CEA) [a]	94.9%
334	Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse) [a]	94.9%
339	Prescription of HIV Antiretroviral Therapy	94.6%
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure [a]	94.6%
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	94.2%
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	94.1%
104	Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients	93.1%
182	Functional Outcome Assessment	93.0%
70	Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry	92.6%
52	Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy	92.4%
138	Melanoma: Coordination of Care	92.3%
192	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures [a]	91.9%
262	Image Confirmation of Successful Excision of Image-Localized Breast Lesion	91.6%
246	Chronic Wound Care: Use of Wet to Dry Dressings in Patients with Chronic Skin Ulcers (Overuse Measure)	91.4%
156	Oncology: Radiation Dose Limits to Normal Tissues	91.2%
171	Coronary Artery Bypass Graft (CABG): Anti-Lipid Treatment at Discharge	91.1%
67	Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow	90.6%
22	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)	90.4%
266	Epilepsy: Seizure Type(s) and Current Seizure Frequency(ies)	89.5%

[a] Inverse measure; lower performance rate indicates better performance.

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

Appendix Tables A32 through A35 summarize quality measure reporting and performance of the group practices participating in the 2014 PQRS as a GPRO or ACO, via registry (Table A32), EHR (Table A33), web interface (Table A34), and CAHPS for PQRS (Table A35). Each table presents results separately for the type of group practice that could report via that mechanism.

Among practices participating via the Small GPRO registry mechanism, 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 A32). 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). All of the Small GPRO EHR submissions used the QRDA III format. The measures reported by the most practices under the Small GPRO EHR mechanism were also #226 and #130 (Appendix Table A33).

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. Among practices participating via the Medium and Large GPRO and the SSP and Pioneer ACO model web interface, there is similar variation across preventive measures, with most measures having a performance rate between 55 and 65 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 Table A34). 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.

Performance rates among practices participating in the Medium and Largo GPRO via registry and EHR exhibited similar patterns to those among Small GPRO practices, with wide variation across all measures, and relatively low rates among most preventive measures (Appendix Tables A32 and A33). 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 or EHR. For example, among practices reporting the influenza and pneumococcal vaccination measures under the Large GPRO, the performance rate via web interface was 60 and 61 percent, respectively, compared to 41 and 47 percent via registry (Table A32), and only 31 and 46 percent, respectively, via QRDA III (Table A33).

Appendix Table A35 presents results for the 22 CAHPS for PQRS survey measures reported by practices who participated in the Large GPRO via the web interface, and practices participating in the Medium GPRO via registry or EHR that chose to voluntarily report CAHPS for PQRS. Results ranged from 27 percent for “stewardship of patient resources” to 93 percent for “how well providers communicate” and 92 percent for “courteous and helpful office staff” and “patients ratings of provider.”

IX. FEEDBACK REPORTS

A. Background

CMS provides feedback reports for the Physician Quality Reporting System 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, QCDR, or EHR for a PQRS measure. There are three 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 can obtain an NPI-level feedback report that displays Individual Performance Detail.
- If a practice did not participate under the GPRO in PQRS they can obtain a TIN-level PQRS Feedback Report. The Tax Identification Number (TIN)-Level PQRS Feedback Report provides incentive and payment adjustment information at the TIN-level, with individual-level reporting by National Provider Identifier (NPI), for each EP who reported at least one PQRS quality-data code (QDC) on a claim submitted under that TIN for services furnished during the reporting period.
- 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 and 2014 NPI-level feedback reports are available through the QRUR (Quality Resource and Utilization Report) at the Physician Value Portlet. A new process for requesting 2008-2013 NPI-level feedback reports was established in 2011, allowing report requests to be made through the PQRS Communication Support Page (CSP).[39]

TIN-Level Feedback Report Access

2014 TIN-level (PQRS GPRO/ACO) feedback report data is available within the QRUR (Quality Resource and Utilization Report) at the Physician Value Portlet. TIN-level feedback reports are not available from the PQRS Portal for the PQRS GPRO or eligible professionals participating in Medicare ACOs reporting through the Shared Savings Program or the Pioneer ACO model for purposes of PQRS for 2014.

2014 TIN-level feedback reports for individual participants are available through the QRUR (Quality Resource and Utilization Report) at the Physician Value Portlet. To access these reports, the TIN representative must create an Enterprise Identity Management (EIDM) account, which is required in order for the TIN representative to log on to the QRUR (Quality Resource and Utilization Report) at the Physician Value Portlet. The QRUR (Quality Resource and Utilization Report) at the Physician Value

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

Portlet, accessible via CMS Enterprise Portal, 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.[40]

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 EIDM account. The 2014 NPI-level feedback reports are available through the QRUR (Quality Resource and Utilization Report) at the Physician Value Portlet, and do require an EIDM account. For further information regarding this process, see the Educational Resources page of the PQRS website.

C. Report Content

The 2014 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 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. PQRS participants do not receive claim-level details in the feedback reports.

For PQRS, all Medicare Part B claims submitted and all registry, QCDR, EHR, and GPRO data received for services from January 1, 2014 – December 31, 2014 (for the 12-month reporting period) were analyzed to determine whether the eligible professional or group qualified for an incentive or is subject to the payment adjustment according to the specific reporting criteria for the respective reporting mechanism.

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

X. 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, accounts for Portal access, feedback reports, or payments can contact the appropriate support desk for assistance.

B. Support Desks

1. 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 incentive 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 payment 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 NPI-level feedback reports for the years 2008-2013. The CSP is available through the Portal, and does not require an account login. This alternative was implemented in response to some difficulties eligible professionals were having obtaining their account login. The TIN-level and NPI-level feedback reports for the 2014 PQRS program year is available through the QRUR (Quality Resource and Utilization Report) at the Physician Value Portlet, and do require an EIDM account.

2. 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; Physician Quality Measurement Management (PQMM) handles questions related to measures and Physician Quality Programs Management and Implementation (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. The IACS accounts have now transitioned to EIDM accounts for all of

the above noted access. 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. Starting in 2013, all helpdesk levels began to assist with questions related to the PQRS payment adjustment for the 2015 and 2016 PQRS payment adjustment years.

3. 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 Registry and QCDR vendors, helps train these entities, and assists the aforementioned vendors and MOCP vendors with file submissions at the end of the reporting periods.

    c. The PQMM Support team within the Tier II Help Desk assists with vetting PQRS measures that all Registry and QCDR vendors would like to support for the program year.

    d. 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 SSP or the Pioneer ACO model.

    e. 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.

    f. The Physician Compare Tier II Help Desk assists with questions regarding public reporting of quality care data on Physician Compare data posted in calendar year 2014.

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

XI. CONCLUSION

Participation in PQRS has increased steadily over time, as payment adjustments for this important program 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.[41] PQRS exhibited very strong growth in the 2014 program year, with a 30 percent increase and almost two-thirds of eligible professionals now participating in the program via individual or group reporting options, as part of an ACO, or the CPC initiative. This strong growth was driven by a large increase in the number of practices self-nominating for a group reporting option.

Eligible professionals and practices earned incentive payments for successfully participating in PQRS through 2014. CMS paid over $1.6 billion in total incentives between 2007 and 2014; additional MOCP payments totaled $16.8 million from its start in 2011 through 2014. As PQRS enters a new phase in the transition to pay for performance, eligible professionals and practices will now need to meet requirements for avoiding a payment adjustment. In the second year of the PQRS payment adjustment in 2016, over 763,000 eligible professionals avoided the adjustment with the majority doing so by meeting 2014 reporting requirements. Among those subject to the 2016 adjustment, most continued to be in smaller practices and non-participants; however, an increasing proportion at least tried to participate in the program compared to the 2015 payment adjustment.

All eligible professionals who did not meet the criteria for satisfactory reporting or participating for 2015 PQRS would be subject to the 2017 negative payment adjustment. However, the rate of successful reporting will need to increase from the drop in 2014 for there to be an increase in the number of eligible professionals avoiding the payment adjustment. CMS continues 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. Practices participating in PQRS via the GPRO now have the 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.

In addition, reporting PQRS measures satisfactorily will help eligible professionals and practices avoid a further adjustment under the physician value modifier program. The 2014 performance on PQRS measures in this report will be used for the 2016 Value-based Modifier program. For practices (TINs) that avoid the 2016 PQRS payment adjustment, or in which at least 50 percent of eligible professionals in the TIN met the criteria to avoid the 2016 PQRS payment adjustment as individuals, the 2016 Value Modifier will be calculated based on the practice's quality and cost performance in 2014, using CMS's quality-tiering methodology. Under quality-tiering, all TINs with 10 or more eligible professionals can earn an upward payment adjustment for demonstrating higher quality and/or lower cost.[42] However, practices that do not meet criteria to avoid the 2016 PQRS payment adjustment will also be subject to a 2 percent downward adjustment in addition to the PQRS payment adjustment. The 2016 Value Modifier

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

[42] See https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeedbackprogram/valuebasedpaymentmodifier.html#What is the Value-Based Payment Modifier (Value Modifier) for more information on the physician value modifier program.

applies to physicians in practices with 10 or more eligible individuals, but beginning with the 2017 Value Modifier (based on 2015 PQRS reporting), the program will also apply to physician solo practitioners and physicians in groups with two or more eligible professionals.

ABBREVIATIONS

Table 30: 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
EP	Eligible Professional
EUS	External User Services
FFS	Fee for Service
GPRO	Group Practice Reporting Option
HCPCS	Healthcare Common Procedure Coding System
HCV	Hepatitis C Virus
HIC	Health Insurance Claim number
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
MD/DO	Doctor of Medicine or Doctor of Osteopathy
MG	Measures Groups
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
MOCP	Maintenance of Certification Program
MPFS	Medicare Physician Fee Schedule
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
PCPI	Physician Consortium for Performance Improvement
PECOS	Provider Enrollment, Chain, and Ownership System
PQMM	Physician Quality Measure Management
PQMPI	Physician Quality Programs Management and Implementation
PQRI	Physician Quality Reporting Initiative
PQRS	Physician Quality Reporting System
QCDR	Qualified Clinical Data Registry
QDC	Quality Data Code

Abbreviation	Meaning
QRUR	Quality Resource Use Report
RRB	Railroad Retirement Board
SCHIP	State Children's Health Insurance Program
SSP	Medicare Shared Savings Program
TIN	Taxpayer Identification Number
TRHCA	Tax Relief and Health Care Act of 2006
VBP	Value-Based Purchasing
VM	Value Modifier