Physician Quality Reporting System (PQRS) Facts

PQRS History
On December 20, 2006, President Bush signed PL 109-432, the Tax Relief and Health Care Act of 2006 (TRHCA). Division B, Title I, Section 101 of Title I of TRHCA authorized the establishment of a physician quality reporting system by CMS. Formerly known as PQRI, this incentive began July 1, 2007.

Under the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), the PQRS program was made permanent and increased PQRS incentive payments for 2009 and 2010. Several PQRS program changes were included in health care reform legislation enacted in 2010. The Affordable Care Act (ACA) requires the implementation of timely feedback and the establishment of an informal appeals process by 2011. The ACA also calls for PQRS payment penalties starting in 2015. CMS finalized in its 2012 Medicare Physician Fee Schedule rule that 2015 program penalties are based on 2013 performance. Therefore, those physicians who elect not to participate or are found unsuccessful during the 2013 program year, will receive a 1.5 percent payment penalty, and 2 percent thereafter. In the 2014 Medicare Physician Fee Schedule Rule, CMS finalized its proposal to base 2016 PQRS penalties off of 2014 reporting. Therefore, physicians who do not participate in PQRS in 2014 will receive a 2 percent penalty in 2016.

<table>
<thead>
<tr>
<th>Year</th>
<th>Penalty</th>
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<tbody>
<tr>
<td>2013</td>
<td>0.5% (performance year for 2015 penalty)</td>
</tr>
<tr>
<td>2014</td>
<td>0.5% (performance year for 2016 penalty)</td>
</tr>
<tr>
<td>2015</td>
<td>-1.5%</td>
</tr>
<tr>
<td>2016</td>
<td>-2%</td>
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Participation
Why should you participate in PQRS? Advantages of participation include:

- Improved quality of care for patients.
- Increased Medicare reimbursement (versus payment reductions).
- Better prepared for future Medicare changes in reporting.
Improved Quality of Care

PQRS gives eligible professionals the opportunity to assess the quality of care they are providing to their patients, helping to ensure that patients get the right care at the right time.

Eligible professionals (EPs) include:

**Medicare physicians:**
- Doctor of medicine.
- Doctor of osteopathy.
- Doctor of podiatric medicine.
- Doctor of optometry.
- Doctor of oral surgery.
- Doctor of dental medicine.
- Doctor of chiropractic.

**Practitioners:**
- Physician assistant.
- Nurse practitioner.
- Clinical nurse specialist.
- Certified registered nurse anesthetist (and anesthesiologist assistant).
- Certified nurse midwife.
- Clinical social worker.
- Clinical psychologist.
- Registered dietitian.
- Nutrition professional.
- Audiologists (as of January 1, 2009).
- Physical Therapist (PT)/Occupational Therapist (OT)/Speech-Language Pathologist (SLP).

Increased Medicare Reimbursement (versus Payment Reductions)

This is the last year EPs can earn an incentive payment for satisfactorily reporting PQRS quality data to CMS, and this year’s participation in PQRS will also determine the 2016 PQRS payment adjustment. The reporting period for 2014 began January 1 and will end December 31, 2014. To receive the .05% incentive, EPs must report on nine quality measures, with three being from the National Quality Strategy (NQS) domain, on 50% of their Medicare patients.

Each practitioner will be identified and scored individually using his/her National Provider Identifier (NPI) number. Each NPI with greater than 50% reporting on nine or more measures will be awarded a PQRS bonus. The aggregate funds of the individual providers will be paid to the Tax Identification Number (TIN) or Employer Identification Number (EIN) of the reporting entity.
To avoid the 2% reduction in CY 2016, EPs must report (in 2014) on at least three quality measures, with one being from the NQS domain.

The below table provides examples of PQRS measures that are performed in Indian Health Service (IHS) and Tribal facilities.

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure Title</th>
<th>Reporting</th>
<th>Denominator</th>
<th>Numerator</th>
<th>MU</th>
<th>NQSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus</td>
<td>Once per reporting period.</td>
<td>Ages 18–75. Diabetes diagnosis. E/M service.</td>
<td>3046F A1c &gt;9.0 Append 8P to 3046F if not performed during performance period</td>
<td>0059</td>
<td>Effect. Clinical Care</td>
</tr>
<tr>
<td>130</td>
<td>Documentation of current medications in medical record.</td>
<td>Each visit during 12 month reporting period.</td>
<td>Age 18 and older. No specific diagnosis. E/M service.</td>
<td>G8427</td>
<td>0419</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>225</td>
<td>Radiology: Reminder system for screening mammogram</td>
<td>Each time a screening mammogram performed during reporting period.</td>
<td>Age 40 and older. Diagnosis: V7611 &amp; V7612. (after 10/1/14 diagnosis Z1231) CPT or HCPCS: 77057, G0202</td>
<td>7025F</td>
<td>0509</td>
<td>Communication</td>
</tr>
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Better Prepared for Future Medicare Changes in Reporting and Reimbursement

The future of Medicare payments (both Part A and B) will be linking quality reporting and services with payment. The following are quality reporting programs where incentive payments (or payment reductions) are assessed based on performance and reporting.

**PQRS**

Part B incentive (and reductions) to eligible professionals for performing and reporting quality measures. CY 2014 is the last year to receive incentive. Reductions (1.5%) for not reporting will begin in 2015 with 2016 and later applying a 2% reduction.
**E-prescribing**

Part B incentive (and reduction) to eligible professionals for using certified e-prescribing system and reporting. CY 2014 is the last year to receive an incentive (based on 2013 reporting) but reductions will be applied if EPs failed to report eRx in 2013.

**ASC Quality Reporting**

Under this program, ASCs report quality of care data for standardized measures to receive the full annual update to their ASC annual payment rate, beginning with CY 2014 payments.

**Meaningful Use**

Program that provides EPs and hospitals incentive to adopt, implement, upgrade and demonstrate “meaningful use” of certified electronic health record technology. Payment adjustments begin in 2015 for EPs that chose not to participate.

**Hospital Value Based Purchasing**

The Hospital VBP Program, implements a pay-for-performance approach to the payment system that accounts for the largest share of Medicare spending – affecting payment for inpatient stays in approximately 3,000 hospitals across the country.

Under Hospital VBP, Medicare is adjusting a portion of payments to hospitals beginning in Fiscal Year (FY) 2013 based on either:

- How well they perform on each measure compared to all hospitals, or
- How much they improve their own performance on each measure compared to their performance during a prior baseline period.

The Hospital VBP Program is designed to promote better clinical outcomes for hospitalized patients and improve their experience of care during hospital stays.

**RESOURCES:**

**CMS PQRS:**

**CMS ASC Quality Reporting:**

**CMS Hospital Value Based Purchasing:**