PQRS Guide for ASA Members – Webcast Script

Chapter 1

(Slide 1) Hello and welcome to this guide to the Physician Quality Reporting System for ASA members.

The Physician Quality Reporting System, or PQRS, formerly known as the Physician Quality Reporting Initiative, is a reporting program that uses a combination of incentive payments and negative payment adjustments to promote reporting of quality measures by eligible professionals.

(Slide 2) This training is an introduction to the PQRS system and will address:

- What is PQRS?
- Who is eligible to participate,
- Why participation is important,
- First steps for physicians who want to participate,
- Individual and group reporting options through PQRS,
- And some tools and resources to help aid in participation,

(Slide 3) The Physician Quality Reporting System is an initiative developed by the Centers for Medicare and Medicaid Services, or CMS, to provide information about the quality of care across many different health care settings.

The reporting program uses both incentive payments and negative payment adjustments to promote quality reporting by eligible professionals.

The Affordable Care Act seeks to increase access to high-quality, affordable health care for all Americans. To achieve this goal, the Secretary of Health and Human Services established a National Strategy for Quality Improvement in Health Care, also known as the National Quality Strategy or NQS.

(Slide 4) PQRS quality measures address various aspects of care, including prevention, chronic and acute care management, procedure related care, resource utilization, and care coordination.

(Slide 5) Each of the PQRS measures is assigned to one of six National Quality Strategy domains. The six NQS domains are:

- Patient Safety
- Person and Caregiver Experiences and Outcomes
- Care Coordination
- Clinical Care

- Population Health
- and Efficiency and Cost Reduction.

There are a few examples of types of quality measures that fit within each of these NQS domains.

For example, the Patient Safety domain includes measures related to:

- Patient safety
- Health care acquired infections and conditions and
- Provider safety
- Note that all three anesthesia care measures are found under the Patient Safety domain.

(Slide 6) The Person and Caregiver-Centered Experience and Outcomes domain includes measures related to:

- Patient experience
- Caregiver experience and
- Patient-reported and functional outcomes
- One example are measures reported under the Clinical and Group Consumer Assessment of Healthcare Providers and Systems also known as the (CG CAHPS) Survey

(Slide 7) The Care Coordination domain includes measures related to:

- Transition of care
- Admission and readmission and
- Provider communication

(Slide 8) The Clinical Care domain includes measures related to:

- Acute care
- Chronic care
- Prevention and
- Clinical effectiveness

(Slide 9) The Population Health domain includes measures related to:

- Health behaviors
- Access to care
- Social and economic factors
- Physical environment and

- Disparities in care

(Slide 10) The Efficiency and Cost Reduction domain includes measures related to:

- Annual spending—for example per capita spending
- Episode costs and
- The quality to cost ratio.

(Slide 11) A key component of PQRS is determining who is eligible to participate in the reporting process.

An eligible professional is a health care provider who performs professional services that are paid under, or based on the Medicare Physician Fee Schedule. Under PQRS, eligible professionals, also known as EPs, report data on quality measures for covered Physician Fee Schedule services furnished to Medicare Part B Fee-for-Service patients.

(Slide 12) Anesthesiologists are among the eligible professionals.

(Slide 13) In the 2011 reporting period, anesthesiologists had the second highest participation rate among physician specialties. However, anesthesiologists received the one of the lower incentive payments among participating physician specialties.

(Slide 14) In that reporting year 54 percent of eligible anesthesiologists participated in PQRS. However, 46 percent of eligible anesthesiologists did not participate. Out of 42,936 eligible anesthesiologists, 23,210 participated. Of those participating, 19,480 earned an incentive payment. As the payment adjustment under PQRS increases, it becomes even more important for eligible anesthesiologists to participate in PQRS reporting. And there is still room for increased participation in our specialty.

(Slide 15) There a few key reasons why participation in PQRS is important. First, there are incentive payment opportunities for delivering quality care and, participation also allows EPs to avoid negative payment adjustments in the future.

In addition, participation in PQRS will become even more beneficial to eligible professionals in the coming years as the Value-Based Payment Modifier is implemented. We will discuss that implementation shortly.

(Slide 16) Participation in PQRS also has benefits beyond the financial. According to CMS, quality initiatives like PQRS aim to empower providers and consumers with information that supports the overall delivery and coordination of care.

PQRS is a first step toward linking Medicare health professionals' payments to quality, which is consistent with Medicare's ongoing transformation from passive payer to active purchaser of high-value healthcare.

(Slide 17) This simple graph demonstrates the impact of incentive payments and adjustments over the next few years. It is worth noting that the current 2014 reporting cycle offers the last opportunity for a payment incentive through PQRS.

Also, please note the 2014 reporting year will count toward incentives and payment adjustments in 2016. In the 2014/2016 reporting cycle there is a 0.5 percent incentive opportunity and a potential 2 percent negative payment adjustment. This reporting period began January 1, 2014 and ends December 31, 2014. In the 2015/2017 reporting cycle there are no incentive payments, only negative payment adjustments.

(Slide 18) If you are eligible for an incentive payment, you would receive that payment in the fall after the reporting period concludes. For example, An EP reporting during 2014 would receive an incentive payment in the fall of 2015.

(Slide 19) Similarly, payment adjustments are made one year after the end of the reporting cycle. For example, an EP reporting during the 2014 cycle would see their Medicare Part B payments adjusted in 2016.

(Slide 20) We have already talked a few times about the Value-Based Payment Modifier or VBM, but a few additional details are necessary. The Value-Based Payment Modifier provides for differential payments to a physician or group of physicians under the Medicare Physician Fee Schedule. The differential payment is based on the quality of care furnished, compared to the cost of that care during a given reporting cycle. The VBM is based on participation in PQRS.

(Slide 21) For purposes of Value-Based modifier, CMS defines "eligible professionals" as not only physicians, but physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians/nutrition professionals, physical and occupational therapists, qualified speech-language pathologists, and qualified audiologists.

Though this broader definition is used to determine initial targets of the modifier, the payment adjustment itself will apply only to items and services billed by physicians in that group.

While EPs may participate in PQRS as individuals or as a group practice, the VBM is only considered on a group basis. However, if a group of physicians does not register for PQRS reporting as a group, that group can avoid the VBM payment adjustment as long as 50 percent of EPs within that group satisfactorily report via any method available to individual EPs.

(Slide 22) The Value-Based Payment Modifier affects more physicians each reporting cycle. In the 2013 performance period, the VBM applies to groups of 100 or more eligible professionals, affecting payment adjustments in calendar year 2015.

In the 2014 reporting period the VMB will apply to practice groups of 10 or more eligible professionals, affecting payment adjustments in calendar year 2016. In 2015 groups of 100 or more EPs are subject to upward, downward or neutral adjustments; groups of 10-99 EPs are eligible for upward or neutral adjustments only.

By the 2015 reporting cycle, which affects payment adjustments in calendar year 2017, all physicians who participate in Medicare Part B fee-for-service practices will be affected by the Value-based payment modifier.

Solo practitioners and EPs in smaller group practices are encouraged to become familiar with the VBM and to begin participating in PQRS, which CMS will use as the basis for calculating the

quality component of the modifier.

(Slide 23) There are a few more specific details about the implementation of the VBM in the coming year. For calendar year 2016, which is based on the 2014 reporting cycle, the VBM will apply to groups of physicians with 10 or more eligible professionals. Physician groups are divided into two categories:

Category one includes groups that participate in PQRS, meaning groups that register for PQRS as a group and report at least one measure, or groups where at least 50 percent of the EPs meet satisfactory reporting requirements through PQRS as individual EPs.

Category two includes groups that do not register for PQRS as a group and do not report on any measures.

Groups in category one will be evaluated based on quality-tiering that depends upon comparison to other participating groups. Quality-tiering will determine if a group's performance is statistically better, the same, or worse than the national mean based on both quality and cost measures.

As this is a budget neutral program, there will be some winners and losers; some groups will receive an upward adjustment based on their comparative performance to other participating groups, while others will receive a downward or neutral adjustment.

However, a positive or negative 2016 payment adjustment will be applied to a relatively small number of groups with cost and quality performance indicators that vary substantially from the mean. The majority of groups would have no adjustment as a result of quality-tiering—only the outliers.

All groups in category two will receive a two percent downward payment adjustment in 2016.

Groups of physicians with between 10 and 99 eligible professionals will be subject only to any upward or neutral adjustment determined under the quality-tiering methodology.

Groups of physicians with 100 or more EPs will be subject to upward, neutral, or downward adjustments determined by quality-tiering.

(Slide 24) There are a few key steps to take before participating in PQRS reporting. First, an individual or group should register for a CMS Individual Authorized Access to CMS Computer Services account, also known as an IACS account. The link on this slide (http://1.usa.gov/1cUwBho) will take you to a website offering more information about IACS and where to sign up.

An EP or group should also determine which method of reporting is best for you or your practice, and which quality measures or measure groups to report on through your chosen reporting method.

(Slide 25) When selecting which PQRS measures to report on you should consider: the clinical conditions you or your group usually treat; the types of care you or your group most often provide—for example preventive, chronic, or acute care; and the setting in which you deliver care—for example in an office, emergency department, or surgical suite. You should also consider your quality improvement goals for 2014.

(Slide 26) There are currently three PQRS measures specific to anesthesia care:

- Measure number 30 addresses the "Timely Administration of Prophylactic Parenteral Antibiotics,"
- Measure number 44 addresses "Coronary Artery Bypass Graft (CABG) in the case of Preoperative Beta-Blocker in Patients with Isolated CABG Surgery,"
- Measure number 76 addresses the "Prevention of Catheter-related Bloodstream Infections during Central Venus Catheter Insertion," and
- Measure number 193 addresses "Perioperative Temperature Management."

(Additional information on 2014 Individual Measures specifications can be found in the zip file here: http://go.cms.gov/1kEFbWF.*)*

(Slide 27) A few of the PQRS reporting methods also allow for reporting on measures groups. A measures group is a group of clinically related measures identified by CMS for use in PQRS.

One example of a measures group is the low back pain measures group available to pain physicians for reporting through PQRS. You can see here the specific clinically related measures that are a part of this measures group.

(Additional information on 2014 Measures Groups specifications can be found in the zip file here: http://go.cms.gov/1nvW5Uy*)*

(Slide 28) PQRS offers several different ways to report on quality measures depending on the size, specialty, and nature of your practice.

Eligible professionals can report as individuals, or, if practicing with one or more other eligible professionals, as a group. Different reporting methods and requirements are available depending on the size of your practice.

Chapter 2

(Slide 29) First we will take a look at individual reporting options.

Eligible professionals participating in PQRS as individuals have four different reporting options: claims-based reporting, registry-based reporting, Electronic Health Record reporting and, new in 2014, reporting through a Qualified Clinical Data Registry. The reporting period for each option is 12 months. The current reporting period began January 1, 2014 and will end December 31, 2014. Measures with a 0% reporting rate will not be counted.

We will start off exploring Claims-based reporting.

(Slide 30) When using claims based reporting, quality measures are reported through an eligible professional's Medicare Part B claims. If you are considering using this reporting method, please note that some measures may be unavailable for reporting through your Medicare Part B claims.

In the 2014 reporting period, if you use the claims based method, you must report data on nine

measures covering 3 National quality strategy domains. An EP should report on at least 50 percent of all applicable Medicare Part B fee-for-service patients for each measure. If an EP reports on at least nine measures covering three NQS domains, that EP is considered a satisfactory reporter and will avoid the payment adjustment and be eligible for an incentive payment.

If fewer than nine PQRS measures covering less than the required three NQS domains apply to an eligible professional's practice, the EP must report on one to eight measures covering at least one NQS domain, and report each measure for at least 50 percent of the Medicare Part B fee-for-service patients seen during the reporting period.

(Slide 31) In the case of EPs who satisfactorily submit data for fewer than nine PQRS measures, a measure-applicability validation, or MAV, process will determine whether they should have submitted data on additional measures.

The MAV is a two-part test used to determine whether there are other measures a participating EP should have reported in the PQRS reporting process.

First, CMS will examine whether other measures were clinically related and therefore potentially applicable.

CMS has identified two anesthesia clusters, or clinically related measures, that are subject to MAV. The first cluster consists of PQRS Measure #30 ("Timely Administration of Prophylactic Parenteral Antibiotics) and PQRS Measure #76 (Prevention of Catheter Related Bloodstream Infection). The second cluster includes PQRS Measure #76 and Measure #193.

Step two of the MAV process is a minimum threshold test that is applied ***only*** if step one identifies that additional measures could have been reported. Step two specifies that an EP is only required to submit a closely related measure if the EP has treated a certain number of Medicare cases applicable to that measure.

During the reporting period, CMS will determine a minimum threshold for each individual PQRS measure based on analysis of Part B claims data. No threshold will fall below the common threshold of 15 patients or encounters.

If it is determined that an eligible professional could not have reported on additional measures, that EP will not be subject to the payment adjustment and will be eligible for the 2016 incentive payment.

(Slide 32) A second option for EPs reporting as individuals is registry-based reporting.

(Slide 33) Through this method, an eligible professional reports PQRS data through a CMS-certified registry. CMS approved registries are allowed to submit PQRS data on behalf of eligible individual professionals. An EP using registry-based reporting has two options: The first option is to report on individual PQRS measures.

If an EP chooses to report on individual measures via a registry, the EP must report on at least nine individual PQRS measures covering at least three of the National Quality Strategy domains for the 12-month reporting period. The EP must submit data on at least 50 percent of applicable Medicare

Part B fee-for-service patients for each measure.

If an EP does not have nine measures applicable to his or her practice, the EP may report on one to eight applicable measures covering at least one NQS domain, and like those reporting on nine or more measures, must provide data on 50 percent of eligible Medicare Part B fee-for-service patients for each measure.

Those eligible professionals reporting on fewer than nine measures will be subject to a one-step MAV process that is similar to the clinical relation test used in the MAV process for claims based reporting. If the MAV process determines that the EP could not have reported on additional measures, then the EP will avoid a payment adjustment, but will not be eligible for an incentive payment.

(Slide 34) An eligible professional choosing to report through a registry can also report on measures groups through a registry. A measures group is a group of clinically-related quality measures identified by CMS for use in PQRS. If an EP chooses to report on Measures Groups through a CMS-certified registry, an EP must submit data on at least one Measures Group for the 12-month reporting period. The current reporting period is January 1, 2014 through December 31, 2014.

The EP must submit data for at least 20 applicable patients per measures group. However, only a majority of the patients must be Medicare fee-for-service patients. Measures groups with a zero percent performance rate on a measure will not be counted.

Reporting on measures groups through a registry is unique in that a six-month reporting option is also available. CMS believes that data submitted via qualified registries for a six-month period will be sufficiently reliable to base a physician or group of physicians' quality composite score.

EPs reporting on measures groups via Registry may report for a six-month period. This year, that reporting period is July 1 through December 31, 2014.

During the six-month reporting period, eligible professionals must report on at least one measures group, and report on each measures group for at least 20 patients, a majority of which must be Medicare Part B fee-for-service patients. Satisfactorily reporting for the six-month reporting period will allow an EP to avoid the payment adjustment, and will make an EP eligible for an incentive.

(Slide 35) The Anesthesia Quality Institute, or AQI, is one example of a CMS-qualified PQRS registry and is now accepting PQRS reporting for the 2014 reporting period. Please visit the AQI website, the link for which you can see here: http://www.aqihq.org/PQRSReporting.aspx, for more information about registry-based reporting through AQI.

(Slide 36) AQI is also a participating registry vendor. Reporting through AQI is only available for AQI members, and there is no charge for AQI participants in 2014.

(Slide 37) However, AQI only reports on measures for anesthesia – measure numbers 30, 44, 76, and 193, which we referenced earlier in this training. Therefore, AQI does not report on measures groups, GPRO, or eRx. AQI is working with ASA on additional anesthesia applicable measures for 2014.

(Slide 38) When available, eligible professionals may also report PQRS measures through an Electronic Health Record, also known as EHR.

(Slide 39) To report through EHR, eligible professionals can submit their data to CMS in three different ways.

First, in some cases, measure data can be submitted directly through an EP's EHR system. Using this method EPs will need to report on at least nine measures covering three NQS domains and report each measure for at least one Medicare Part B fee-for-service patient.

In the second case, eligible professionals can use a Data Submission Vendor, which is a vendor that collects an EPs clinical data directly from the his or her EHR system, then delivers that data to CMS in a CMS-specified format.

Like the first option, EPs using this reporting method must report on at least nine individual PQRS measures covering at least three NQS domains, and submit data on at least one applicable Medicare Part B fee-for-service patient.

The final option for individual EHR reporting is to submit data through the joint PQRS-Medicare EHR Incentive pilot program. In this case, EPs must submit information on three core measures and three additional clinical quality measures available for reporting. In addition, participating EPs must use a certified system and meet all core objectives as well as the required menu objectives.

(Slide 40) Now we will take a look at the fourth and final reporting option for individual eligible professionals participating in PQRS. In 2014, CMS is proposing a new individual reporting option—the Qualified Clinical Data Registry or QCDR.

(Slide 41) A QCDR is a CMS-approved entity, such as a registry, certification board or collaborative 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.

This option is different from the above-mentioned qualified registry in that each QCDR has the flexibility to develop measures that will best achieve the goal of improving the quality of care provided by EPs participating in a QCDR. QCDR specific measures, in addition to existing PQRS measures, are available to eligible professionals utilizing the QCDR reporting option.

(Slide 42) To meet the criteria for satisfactory participation, individuals must report on at least nine QCDR measures, covering at least three of the National Quality Strategy domains. An EP must report each measure for at least 50 percent of the EP's applicable patients.

QCDR may report on existing PQRS measures, as well as QCDR specific measures. A QCDR will submit data on greater than nine, but no more than 20, quality measures on behalf of an eligible professional.

It is worth noting that reporting on process measures alone only allows an EP to avoid a payment adjustment. You must report on at least one outcome measure in order to be eligible for the incentive payment.

Chapter 3

(Slide 43) If an eligible professional practices with at least one other EP, they can participate in PQRS as a group.

CMS defines a group practice as a single Tax Identification Number with two or more individual eligible professionals, as identified by the Individual National Provider Identifier, who have reassigned their billing rights to that Tax Identification Number, or TIN. Please take note that if an organization or EP changes its TIN, the participation under the old TIN does not carry over to the new tax ID, nor is it combined for final analysis.

(Slide 44) Groups have three different reporting options: the GPRO Web Interface; registry-based reporting, and Electronic Health Record reporting. A supplemental reporting option is the Consumer Assessment of Healthcare Providers and Systems survey, known as CAHPS.

(Slide 45) We will start off by looking at the GPRO Web Interface option. The GPRO Web Interface is a program that attributes Medicare beneficiaries to a group practice and pre-populates the system with their patient data.

Group practices of 25 or more EPs can use the GPRO Web Interface for their PQRS reporting. Group practices may register to use the GPRO web interface through the CMS portal shown here: https://portal.cms.gov.

Once a group practice has registered, or self-nominated, to participate in the PQRS GPRO Web Interface, it is the only PQRS submission method available to the group and all individual EPs who bill Medicare under the group's Tax ID Number.

Group practices must register with CMS by September 30, 2014 to participate in the GPRO Web Interface, as well as any other group reporting option. All registrants will be considered a PQRS GPRO participant and will be analyzed at the TIN level.

(Slide 46) Groups of 25 or more eligible professionals who elect to report via the GPRO Web Interface must report on all PQRS GPRO measures included in the Web Interface.

The group must also populate data fields for a specified number of consecutively ranked and assigned beneficiaries. Groups of 25 – 99 EPs using the Web Interface need to provide data for the first 218 consecutively ranked and assigned beneficiaries.

If the pool of eligible assigned beneficiaries is less than 218, the group must report on 100 percent of their assigned beneficiaries.

For each module or patient care measure, information should be reported on the assigned patients in the order in which they appear in the sample.

(Slide 47) Groups of 100 or more EPs choosing to report through the GPRO Web Interface must also submit data on all the measures included in the web interface.

Group practices of this size must provide data for the first 411 consecutively ranked Medicare beneficiaries. Similar to the requirements for groups of 99 EPs and under, should the number of

eligible assigned beneficiaries be few than 411, the group must report on 100 percent of the eligible beneficiaries for a given module or measure.

Also in the case of groups this size, information on each module or patient care measure should be reported in the order in which assigned patients appear in the sample.

However, an additional requirement for groups of 100 or more eligible professionals is that they must report on all Consumer Assessment of Healthcare Providers and Systems survey measures through a certified survey vendor.

(Slide 48) Group practices with two or more EPs have the option to report through a qualified registry.

(Slide 49) Note that registry reporting is the one of the two reporting methods available to group practices made up of between two and 24 eligible professionals.

To be eligible for an incentive, a group must submit data on at least nine PQRS measures covering three NQS domains, while reporting on at least 50 percent of the group's applicable Medicare Part B fee-for-service patients for those measures.

(Slide 50) If fewer than nine measures apply to a practice, the group practice must report on one to eight measures covering at least one NQS domain to avoid the 2016 payment adjustment. The Measure Applicability Validation or MAV process would apply in this case.

(Slide 51) Group practices also have the option to report through Electronic Health Records or EHR. Just as in individual reporting, groups may report directly from their EHR system or through a data submission vendor.

(Slide 52) If reporting directly from the EHR product, a group practice must report on at least nine measures covering at least three NQS domains during the 12-month reporting cycle.

If a practice's Certified EHR Technology (CERHT) doesn't contain patient data for at least nine measures covering at least three NQS domains, then the practice must report on all measures for which there is a Medicare patient. A group practice must report on at least one measure for which there is Medicare patient data.

(Slide 53) Those groups reporting through an EHR data submission vendor must also report at least nine measures covering three or more NQS domains during the 12-month reporting cycle. Again, if a practice's Certified EHR Technology doesn't contain patient data for at least nine measures covering at least three NQS domains, then the practice must report all measures for which there is a Medicare patient. A group practice must report on at least one measure for which there is Medicare patient data.

(Slide 54) While it is required for group practices of more than 100 eligible professionals, Group practices of 25 or more EPs also have to option to report on CG CAHPS survey measures.

(Slide 55) The Consumer Assessment of Healthcare Providers and Systems or CAHPS program is a multi-year initiative of the Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of consumers' experiences with health care.

Reporting on Clinical & Groups CAHPS (CG CAHPS) survey measures are allowed under PQRS and counts toward the PQRS reporting requirement of at least nine quality measures and one NQS domain.

Groups choosing to report on the CG CAHPS survey must also report on six other PQRS measures covering two National Quality Strategy domains.

Groups of 25 or more EPs can report on survey measures. However, the data collected on these CAHPS survey measures must be transmitted through a separate certified survey vendor, instead of through the previously established PQRS group practice reporting mechanism.

At this time no other survey measures are available for reporting under PQRS.

If you are considering reporting through CG CAHPS do note that this method focuses on assigning beneficiaries to a group based on whether the group provided the plurality of primary care services. Because beneficiaries are assigned to a group based on the provision of primary care services, this survey is not an appropriate option for groups of physicians that do not provide primary care services.

(Slide 56) Here is a quick review of the different group reporting options and what size groups are eligible for each: Groups of two to 25 EPs may report through a registry, and electronic health records, but not the GPRO web interface or CG CAHPS. Groups of 25-99 EPs may report via the GPRO web interface, Electronic Health Records, or a registry. Reporting of CG CAHPS is optional. Groups of 100 or more EPs may report via the GPRO web interface, Electronic Health Records or registry reporting. Reporting of CG CAHPS survey measures is mandatory.

Chapter 4

(Slide 57) We also want to take a few minutes to highlight the steps and requirements for satisfactory reporting through PQRS. If an individual EP or group satisfactorily submits data though claims, registry, EHR or GPRO reporting methods, the EP or group will be eligible for a PQRS incentive payment.

(Slide 58) If an EP or group reports at least nine PQRS measures covering three NQS domains via claims, registry, EHR or GPRO that EP or group will be considered a satisfactory reporter.

(Slide 59) If an eligible professional or group reports fewer than nine PQRS measures covering three NQS domains, but successfully completes the MAV process, that EP or group will also be considered a satisfactory reporter.

(Slide 60) An EP is also eligible for a PQRS incentive if he or she satisfactorily participates via QCDR. In order to satisfactorily participate via QCDR, the EP must report on at least nine QCDR measures covering three NQS domains and at least one measure must be an outcomes measure.

A few examples might offer additional understanding of what is involved in satisfactory PQRS reporting.

(Slide 61) In our first example, during the 2014 reporting period an eligible professional has zero measures available for reporting. The EP confirms with the CMS QualityNet Help Desk that no measures apply to his or her practice and participates in PQRS with zero measures. The MAV process confirms that the EP could not have reported any measures. This EP will avoid the 2016 payment adjustment, but will not be eligible for a 2016 incentive payment.

(Slide 62) In our second example, during the 2014 reporting period an EP only has one measure, which covers one NQS domain, available for reporting. The EP reports the measure through claims-based reporting and successfully completes the MAV process. This EP will be considered a satisfactory reporter. As such, the EP will avoid the 2016 payment adjustment and is eligible for the 2016 incentive payment.

(Slide 63) In the third and final example, during the 2014 reporting period an EP has five measures covering two NQS domains available for reporting. The EP reports on all five measures covering two NQS domains via registry and successfully completes the registry MAV process. This EP will be considered a satisfactory reporter and as such, the EP will avoid the 2016 payment adjustment and will be eligible for the 2016 incentive payment.

(Slide 64) As we are close to wrapping up this training, we want to highlight again a few of the key steps to take in order to participate in PQRS reporting.

- First, register or update your IACS account (http://1.usa.gov/1cUwBho)
- Determine which measures or measures groups apply to your practice.
- Determine which reporting method works best for you or your practice
- Register for your chosen reporting method if necessary
- Just as a reminder, the deadline for group registration is September 30, 2014. Please note that regardless of reporting method, all groups must register with CMS in order to participate in the 2014 PQRS reporting process.
- Utilize the various resources available, some of which we'll list for you, to stay up to date on any news, updates, and changes to PQRS reporting and dependent programs.

(Slide 65) Here are a few tools and resources to assist you in getting started in the reporting process and help you stay up to date on PQRS news, updates, and changes. Where we can, we have tried to include web addresses where you can view and sign up for these resources, which include:

- The PQRS listserv (http://bit.ly/1gyV9fV)
- The CMS Quality Net Help Desk (Qnetsupport@sdps.org)
- The CMS twitter feed (https://twitter.com/cmsgov)
- The CMS "How to Get Started" guide (http://go.cms.gov/1dnCoNy)
- CMS's answers to frequently asked questions about PQRS (http://1.usa.gov/1c1GdqI)
- and our announcement about the 2014 changes to PQRS (http://bit.ly/1fjC13k)

In addition, a glossary of some of the PQRS relevant terms used here can be found at the end of this video.

(Slide 64) Thank you for taking the time to use this training on the Physician Quality reporting system. If you have any additional questions regarding PQRS, please contact ASA's Quality and Regulatory Affairs team.