WHITEPAPER

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Earning Incentives, Avoiding Penalties: 5 Keys to Success with PQRS and Beyond

athenahealth

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Executive Summary

If health care providers have felt extra weight on their shoulders lately, it's due in part to the pressure from new care-related government regulations.

Despite the frustrations of keeping up with each new mandate, there is an intended goal in sight: Improve the quality of care while lowering costs. The principle strategy involves replacing traditional fee-for-service reimbursement, which rewards volume, with new payment models that reward the delivery of value. Without this kind of reform, spending will continue to skyrocket toward an untenable, unaffordable future.

As a central element of this change, the Centers for Medicare and Medicaid Services (CMS) now requires providers to deliver value via the Physician Quality Reporting System (PQRS) and Value-Based Modifier Program (VM). In 2016, this initiative will apply to practically every health care provider in the country.

The penalties for non-compliance are substantial – but the incentives and long-term rewards are there for the taking.

> **CMS plans to tie 30% of all provider payments to quality initiatives by 2016. By 2018, that rises to 50%.**[1]

Providers who failed to report PQRS in 2013 face a 1.5% Medicare payment reduction in 2015. In 2017, that penalty will be as high as 6% for practices of 10 or more providers.

The 2015 Penalty Outlook:

- **PQRS:** More than 469,000 providers already face a payment reduction based on 2013 reporting.[2]
- **Meaningful Use:** More than 30% of providers will be penalized in 2015 for not meeting requirements in 2013 and 2014, with total penalties reaching $200 million.[3]

Practices that do well with PQRS and other quality programs will have the foundation to thrive as value-based payments become a bigger piece of the reimbursement pie. athenahealth data illustrates that past performance does, in fact, reflect future success. In a recent study, practices already excelling at Meaningful Use were more likely to perform well on PQRS.

5 Keys to PQRS Success

As an experienced industry leader in satisfying quality programs – with a 98.2% attestation rate for Stage 2 Meaningful Use in 2014 – we have established the following steps to help practices meet PQRS and VM requirements, and create the framework for success with value-based care:

1. Assess your PQRS starting point.
2. Determine the best reporting approach.
3. Select the right quality measures.
4. Optimize practice performance.
5. Implement an effective patient engagement strategy.

Breaking Down the Numbers: PQRS Penalties and Incentives

Taking part in the transition to value-based care is no longer merely encouraged, it's required, with the CMS planning to tie 50% of all provider payments to quality initiatives by 2018. Additionally, the total payment cut for Medicare fee-for-service reimbursement is expected to double between 2015 and 2018.[3]

The PQRS program, which focuses on promoting and measuring quality outcomes, has already progressed beyond the initial incentive phase and is now levying penalties for non-participation [see Figure 1].

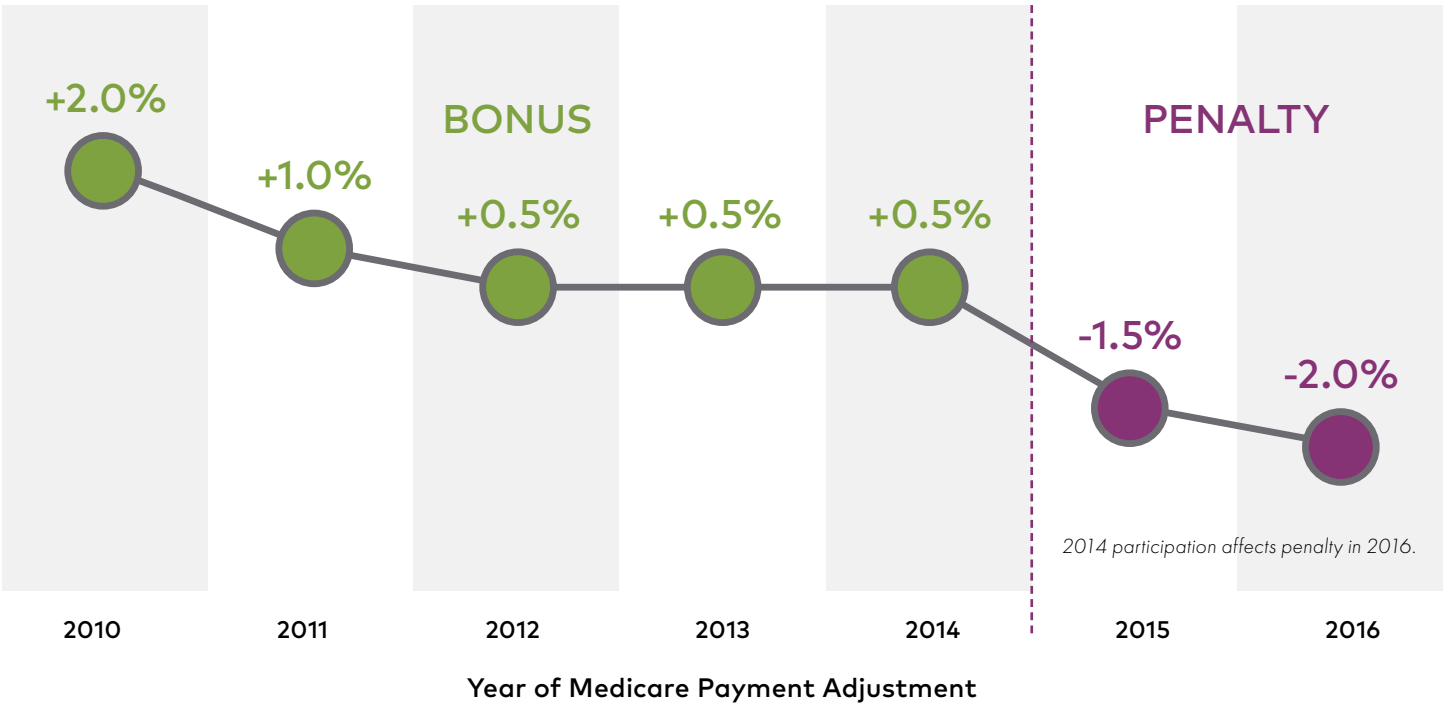
Much like Meaningful Use, PQRS requires providers to report data to CMS on certain quality measures for their Medicare patients. Eligible providers can report PQRS as an individual provider or as a group practice.

Mandatory PQRS Participation Expands Significantly

However providers choose to report, they face a new level of accountability with the 2015 reporting period. That's when the VM program becomes mandatory for an unprecedented number of providers. The VM program uses PQRS data to assess performance based on quality and cost, resulting in Medicare payment adjustments.

Providers who do not report PQRS in 2015 will automatically receive a minimum 4% reduction on their Medicare Part B payments in 2017 – that's 2% for failing to report PQRS and 2% for not participating in VM. For practices of 10 or more providers, that automatic penalty is 6%.

Figure 1. From Perk to Penalty: The Rapid PQRS Transition



Reducing Your Revenue: How Medicare Penalties Can Add Up Fast

The penalties for not participating in the lineup of CMS programs can be significant, regardless of your financial health. If you're already doing well, you need to continue keeping margins up in an increasingly competitive landscape. If you're struggling, you can't afford to lose a cent. A ding here, a ding there, and it adds up quickly.

Adjustment Year		2015	2016	2017	2018	2019* -2020*
Performance Year		2013	2014	2015	2016	2017-2018
Program	Physician Quality Reporting System (PQRS)	-1.5%	-2%	-2%	-2%	–
	Value-Based Modifier Program (VM)	-1%	-2% (practices with 100+ EPs only)	-2% (practices with 1-9 EPs) -4% (practices with 10+ EPs)	TBD	–
	Meaningful Use/EHR Incentive Program	-1% (-2% for those who did not participate in 2014)	-2%	-3%	-4%	–
Total Potential Penalty		-3.5% or -4.5%	-6%	-7% (1-9 EPs) -9% (10+ EPs)	TBD	-4% (2019) -5% (2020)

(Note: The 1% automatic VM penalty in 2015 affects non-reporting practices with 100+ EPs only or practices with 100+ EPs who did not elect Administrative Claims or report with the Group Practice Reporting Option [GPRO].)

**2019 is the first year that adjustments will be based on the Merit-Based Incentive Payment System (MIPS), a consolidation of the PQRS, VM and Meaningful Use programs. The first performance year for MIPS will be 2017. See "On the Horizon" on page 5 for more information.*

The Value-Based Modifier Program

The Value-Based Modifier (VM) program requires providers to meet goals related to quality and cost, and uses PQRS reported data. 2015 marks a significant expansion of this initiative, with potential penalties and incentives for practices with 10 or more providers.

How the program works: Providers reporting PQRS don't need to report additional data. The Value Modifier, based on a combination of CMS calculations and quality measures reported through PQRS, determines a composite score for each practice, reflecting the quality and cost of care compared against national benchmarks. Depending on whether the performance is above the benchmark, below it, or average, CMS calculates a penalty or an incentive.

CMS has been phasing in the VM over time and has taken an enormous step in expanding the program. In 2016, possible program penalties will affect not just physicians – all eligible professionals will face VM adjustments.

A practice that doesn't report PQRS is penalized at the highest possible rate, combining automatic penalties for PQRS and VM (as high as 6% in 2017).

Figure 2. When and How the Value Modifier (VM) Adjustment Affects You

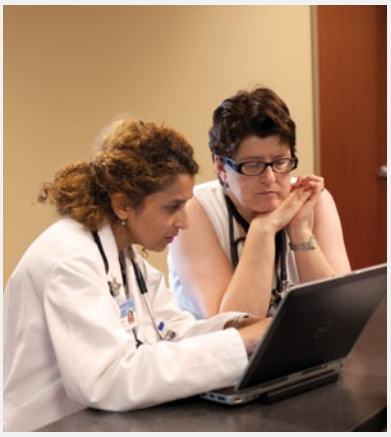
Performance Year/Payment Adjustment Year	Group Size (Eligible Providers)	Possible Value Modifier (VM) Outcomes
2014 / 2016	100+	• **Non-reporting:** Total penalty of 4% (PQRS + VM) • **Reporting:** Upward, neutral, or downward payment adjustment
	10-99	• **Non-reporting:** Total penalty of 2% • **Reporting:** Upward or neutral payment adjustment only
2015 / 2017	10+	• **Non-reporting:** Total penalty of 6% (PQRS + VM) • **Reporting:** Upward, neutral, or downward payment adjustment, ranging from -4% to +4%
	1-9	• **Non-reporting:** Total penalty of 4% (PQRS + VM) • **Reporting:** Upward or neutral payment adjustment only, ranging from no change to +2%
2016 / 2018	All EPs, including non-physicians	TBD

Source: Centers for Medicare and Medicaid Services http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

Beyond the Penalties: What You Stand to Gain

Avoiding penalties is a great motivator, but there's also plenty of upside to succeeding with quality programs. Every medical group should understand the full benefits of effective value-focused practice performance.

No Participation in Quality Programs	Successful Participation in Quality Programs
• Full CMS penalties	• No penalties
• No visibility into practice performance	• Full visibility into practice performance
• No benchmark data for quality improvement	• Upward payment adjustment for exceeding Value Modifier (VM) standards
• Less efficient practice workflow	• Optimized practice performance, right person doing the right work
• Not maximizing practice performance for cost and quality	



On the Horizon: A Consolidated Approach

Just when you thought you had sorted out the alphabet soup of program acronyms, here comes another: MIPS.

That's short for the Merit-Based Incentive Payment System program, an upcoming consolidation of current government quality initiatives. Beginning with the 2017 reporting year, the Meaningful Use, PQRS, and VM programs will all merge into MIPS, with adjustments for that year implemented in 2019.

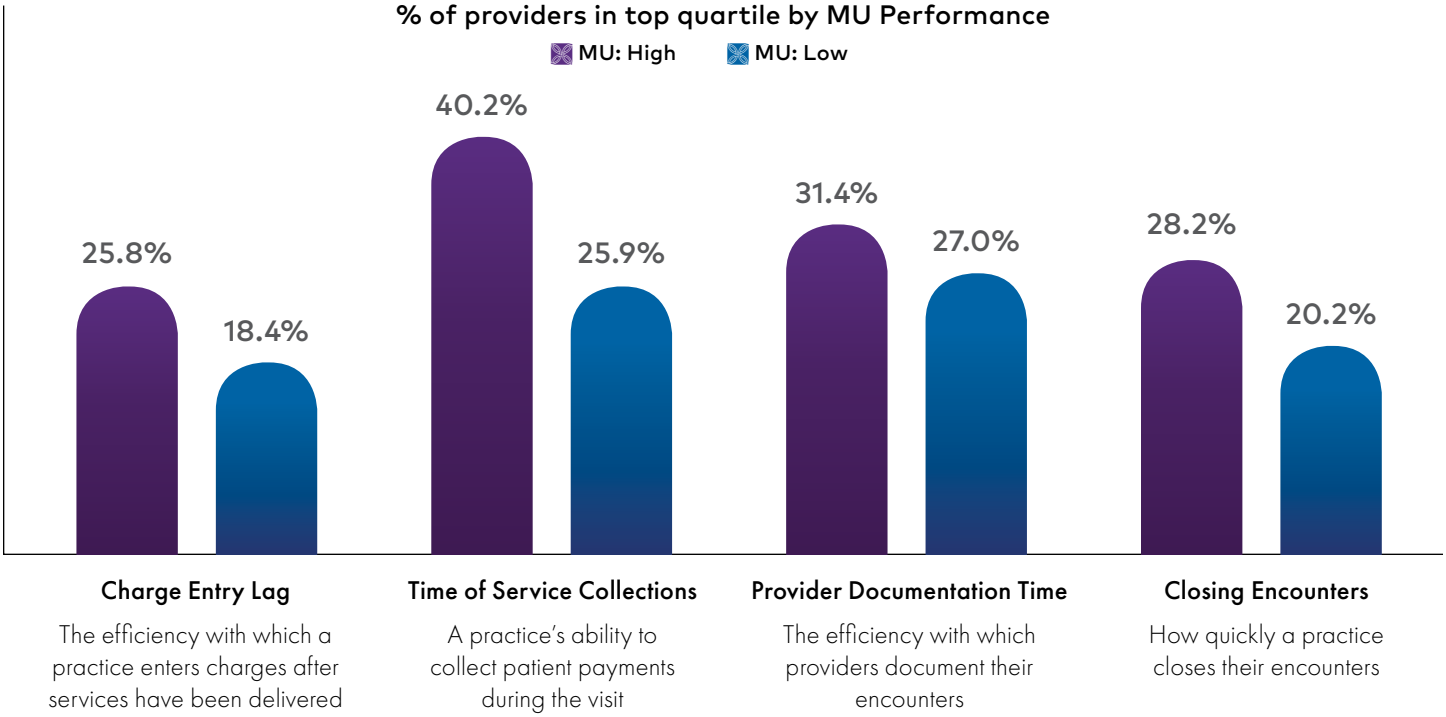
While this streamlines a multitude of programs, the requirements will remain largely unchanged and the emphasis on quality measures will continue to increase. Having the right workflows and tools in place – with full visibility into performance – will become imperative.

The penalties under each current program will be replaced by MIPS payment adjustments, starting with a range of -4% to +12% to be applied in 2019. By 2022, the range of adjustments will be much greater, from a penalty of -9% to an incentive of +27%.

Better Program Performance = Better Practice Performance

In tracking more than 10,000 providers across the athenahealth network, we discovered that practices with high Meaningful Use performance (successful Stage 2 attestation early in 2014) also performed better across metrics related directly to revenue and efficiency, compared to low MU performers (those who attested to Stage 2 later in 2014, or reported Stage 1.) When it comes to collecting payment at the time of service and closing encounters quickly, the difference between high and low MU performers is significant [see Figure 3.]

Figure 3. High Meaningful Use Performers Excel in Other Key Areas



Source: athenahealth, Inc. data, 2015

The above chart illustrates the percentage of providers in each category that perform within the top quartile for each respective metric. For example, 40.2% of "high" MU performers are also in the top quartile of collecting payment at the time of service.

5 Steps to Quality Program Success

What should your practice do now to be successful with PQRS and beyond?

We recommend five areas you should focus on to thrive today and create a foundation to deliver quality, lower-cost care.

1. Assess your PQRS starting point.

If you haven't started with PQRS:

Determine which providers in your practice are eligible to participate in PQRS payment adjustments. Providers are eligible (and may have already seen penalties) if they provide services that are paid under the Medicare Physician Fee Schedule (PFS). By 2016, nearly all health care professionals will be held accountable for PQRS payment adjustments. See our appendix for a current list of eligible medical professionals.

If your practice has participated in PQRS in past years:

Make sure you can easily review providers' performance on each measure. In an ideal situation, your vendor would integrate the current year's benchmark data into your service so you can make a real-time comparison against those benchmarks and determine areas for improvement.

If you've been participating in Meaningful Use, you already have a solid foundation for reporting PQRS data. In a recent athenahealth study of 10,888 practices, 90% of providers who attested relatively early to Stage 2 Meaningful Use (before July 2014) also performed average or above average on PQRS; by comparison, of practices not as proactive in meeting MU requirements, only 59% fared well with PQRS.

Although PQRS has greater complexity than Meaningful Use, this suggests that practices already reporting MU measures are better equipped to participate in other quality programs.

2. Determine the best reporting approach.

First, determine whether you will report as an individual or a group practice, and then select a reporting method.

Individual EPs must report for every Tax Identification Number (TIN) / National Provider Identifier (NPI) combination.

Regardless of reporting method, practices can report at the TIN level through the Group Practice Reporting Option (GPRO); however, once a group practice decides to participate in the GPRO, this is the only PQRS reporting method available to individual providers who bill Medicare under that group's TIN for the reporting year.

Each reporting method has different criteria for success and failure, and your EHR vendor should help you select the reporting method that's right for you. Before making your final reporting choice:

- Consider the measures you will be reporting (see step #3). Not all measures can be reported via each reporting method.
- If necessary, review options with your vendor to outsource and/or automate the reporting of certain measures.

Reporting Method Considerations

Reporting Method	Considerations
Claims-based Individual EPs submit Quality Data Codes (QDCs) for each of their PQRS measures.	This method tends to be labor-intensive and does not have a high success rate. Additionally, CMS has indicated it will not support claims-based reporting indefinitely.
Qualified PQRS Registry Individual EPs and groups report quality measures data to a participating PQRS registry. Individual EPs determine whether to report individual measures or measures groups.	Unless managed by your vendor, this method requires provider and staff time to establish and maintain data, and ensure appropriate submission.
Qualified Electronic Health Record (EHR) Individual EPs and groups may submit either PQRS quality measure data directly from the practice's certified EHR technology (CEHRT) or a qualified EHR Data Submission.	As with the Qualified PQRS Registry option, this is most effective when your vendor handles submission on your behalf.
Qualified Clinical Data Registry (QCDR) Individual EPs submit to a CMS-approved entity (i.e., registry, certification board, collaborative) that collects medical and/or clinical data for the purpose of patient and disease tracking.	EPs must apply and qualify for this reporting option, and it requires provider and staff time to establish and maintain data, and ensure appropriate submission.

Debunking 3 Myths about PQRS

Myth #1: "We shouldn't bother with PQRS because these programs are always changing."

Reality: Yes, in the ongoing transition to value-based reimbursement, program details will change. But the fundamental capabilities needed for success won't.

In the long term, PQRS, VM and MU will continue—and will combine into one program, the Merit-Based Incentive Payment System (MIPS), beginning with the 2017 reporting year. The reporting emphasis will keep shifting toward quality (rather than just technical capabilities), so participating now is the best way to tighten up workflow and processes at your practice, and be ready for the demands to come.

Myth #2: "PQRS reporting will take too much time away from patient care."

Reality: Depending on your EHR, this could have some truth to it. But it shouldn't. Providers who lack an intelligent, streamlined workflow may very well be frustrated by "yet another measure" to record during office visits. But there are EHR vendors who act as partners in the process, helping practices select the measures they're most likely to perform well (based on specialty and ongoing performance) and ensuring that measures can be captured at the most opportune time possible in the workflow.

athenaResearch data proves that providers can stay efficient even while doing well recording quality measures. According to athenahealth data, 37% of providers who attested to Meaningful Use Stage 2 by September 2014 were also in the top quartile of providers for documentation time.

Myth #3: "Our investment in PQRS won't pay off."

Reality: There is no easy way to calculate a practice's return on investment for participating in PQRS and other quality programs. Yes, doing well now with PQRS and VM means you'll avoid penalties for years to come. But there's a bigger picture to consider.

It's clear that future financial success will be directly related to meeting and reporting on quality measures – not just with Medicare-related reimbursement but with private payer programs as well. With this change well underway, there's no action more powerful than preparation. Those who can deliver now will be well-positioned to do so in the future.

3. Select the right quality measures.

One of the keys to PQRS success is selecting the measures that are most easy to achieve for your practice and specialty. We recommend aligning with a partner who will help you choose measures that are easiest for you to achieve.

When considering your selection, ask yourself which measures...

- Relate directly to your specialty
- Can be met most easily within your workflow
- Are consistent with the care you deliver

Keep in mind that you'll need to review the CMS Measures List every year for changes. Ideally, your vendor should conduct that review for you. You can find detailed PQRS measures lists at the CMS website, with links listed in this paper's appendix.

For Individual Providers

Option 1: From a total of more than 250 measures, providers select nine individual measures ranging across three domains. One of the nine must come from the CMS's new cross-cutting measure list.

Option 2: Providers report on a measures group, a collection of at least six measures that have a common theme. There are 22 measures groups available for 2015 (see below), and reporting must take place via the PQRS registry option.

For Group Practices

Organizations participating as a group practice must select nine individual measures across three domains, just as detailed above, to report on as a group. The measures group option is not available for group practices.

Here are the 22 measures groups for 2015 PQRS:

1. Diabetes
2. Chronic Kidney Disease (CKD)
3. Preventive Care
4. Coronary Artery Bypass Graft (CABG)
5. Rheumatoid Arthritis (RA)
6. Hepatitis C
7. Heart Failure (HF)
8. Coronary Artery Disease (CAD)
9. HIV/AIDS
10. Asthma
11. Chronic Obstructive Pulmonary Disease (COPD)
12. Inflammatory Bowel Disease (IBD)
13. Sleep Apnea
14. Dementia
15. Parkinson's Disease
16. Cataracts
17. Oncology
18. Total Knee Replacement (TKR)
19. General Surgery
20. Optimizing Patient Exposure to Ionizing Radiation (OPEIR)
21. Sinusitis
22. Acute Otitis Externa (AOE)

Once you've selected your reporting option, choose the right measures by following these three steps, which progress from the least amount of additional effort to the most.

Easy: Prioritize measures you're already documenting.

This is the proverbial low-hanging fruit. If there are PQRS measures that align with clinical data you're already collecting (think blood pressure screening and the like), choose those to maximize your efficiency. Consider the clinical conditions you usually treat (as recommended in "Selecting PQRS Measures as a Specialist"), the type of care you typically provide, and the systems and processes already in place for capturing clinical data.

Medium: Consider measures you already capture and can improve upon.

In some cases, it may make sense to select measures already being captured through Meaningful Use or within your workflow—but that need improvement for you to do well with both quality and cost. You should have clear insight into your current performance at the provider and practice level, and have benchmarking data to set improvement goals.

More difficult: Reach for quality improvement measures.

Finally, you may need to select measures that demand more time and effort. Depending on the measure, these may require additional patient communication functionality, such as an enhanced patient portal to help you reach targeted populations. This may require a bit more work, but it's an excellent opportunity to address gaps in care and improve outcomes—exactly the type of changes that position your practice well for the future of payment reform.

As an example of each of the above steps, let's look at how an OB/GYN practice might categorize three individual PQRS measures as "easy," "medium" or "more difficult" to capture. Ideally, most of the measures you select will be in the "easy" or "already documenting" category.

Please keep in mind these are likely samples; as we know from experience with athenahealth clients, a measure sometimes isn't as easy as it looks.

Already Documenting (Easy)
Sample Measure: Documentation of Current Medications in the Medical Record (#130)

Capturing But Need Improvement (Medium)
Sample Measure: Chlamydia Screening for Women (#169)

May Require More Investment (More difficult)
Sample Measure: Maternity Care: Post-Partum Follow-Up and Care Coordination (#191)*

**Percentage of patients, regardless of age, who gave birth during a 12-month period, who were seen for post-partum care within 8 weeks of giving birth who received a breast feeding evaluation and education, post-partum depression screening, post-partum glucose screening for gestational diabetes patients, and family and contraceptive planning.*

4. Optimize practice performance.

Take a look at your practice's ability to support PQRS recording and reporting. That means making sure the processes currently in place enable you to meet quality benchmarks without taking time away from patient care.

Regardless of the PQRS reporting option or measures selected, practices of all sizes need to understand how to improve cost and quality, and how to do so in an efficient manner. Optimizing performance toward those goals is imperative for both current and continued success.

Structure your practice workflow around processes and procedures that improve proficiency and effectiveness. What defines a strong workflow? One that clearly establishes which provider or staff member performs a particular task, at a stage that's easiest and most appropriate for those involved. A predefined workflow for capturing and reporting PQRS measures can save time, ensure successful participation, and help keep providers focused on patients.

As data from athenahealth reinforces [see Figure 3], practices that do well with quality programs also perform better in core efficiency metrics, compared to those practices not as proactive with quality programs.

Regularly review appropriate benchmark data to make sure you're keeping up with the measures you've selected. To start, check CMS reports that establish benchmarks for each quality measure based on the previous year's performance of all providers and groups nationwide.

As an example, the report "Performance Year 2014 Prior Year Benchmarks" lists the means and standard deviations for each quality measure included in the Performance Year 2014 Quality Resource Use Reports (QRURs), which will be used to determine the 2016 value modifier. (QRURs show physicians examples of how the care they delivered compares to the average quality and cost of other physicians with Medicare patients.)

Even better: Any vendor with visibility into their clients' performance should be able to regularly monitor how your practice or group is doing against CMS benchmarks.

Selecting PQRS Measures as a Specialist

By understanding which PQRS measures relate closest to your specialty, and having the right vendor to help you in the process, selecting measures doesn't have to be a time-consuming endeavor.

Consider the following specialty-related steps:

1. See if any of the measures groups applies to your specialty. For example, family practice or internal medicine providers can choose to report the Diabetes measures group or the Preventive Care measures group. Cardiologists may choose to report the CAD measures group.
2. If no measures group applies to your specialty, you can choose the Preventive Care measures group.
3. If you prefer to select individual measures, you can still include some that relate closely to your specialty, following a Specialty Measure Set as a guideline. A collaboration between CMS and various specialty societies, a Specialty Measure Set lists suggested measures associated with a particular clinical area. Check the CMS website for specific details on each of the 12 Specialty Measure sets.

The ideal set of benchmarking capabilities:

- Ability to compare your practice and providers' performance to benchmark data
- Flexibility to modify your workflow to improve performance on metrics
- Tools to track improvement over time
- Ability to select alternate reporting measures, if performance cannot be improved

Without this kind of transparency and nimbleness, meeting quality requirements may be difficult; if issues arise, success may be unattainable.

5. Implement an effective patient engagement strategy.

To deliver care per quality guidelines, you need to get patients in the door and manage their care as effectively as possible. Patient engagement is critical to accomplish this, and can significantly contribute to improving efficiency, reducing cost, supporting patient safety, and streamlining care coordination and population health management. Hundreds of PQRS measures assess performance across these domains.

The foundation to successful patient engagement is having the right health information technology and services in place and working efficiently. At the center of those services is an effective patient portal.

A patient portal enhances patient-provider communication, but it also plays a direct role in achieving particular program measures. The Secure Electronic Messaging measure that's currently part of Meaningful Use Stage 2 is a perfect example.

Patient portals also reduce administrative tasks for practice staff, as patients take an active part in registration, appointment scheduling, and making payments online, all at their convenience. And patient portals that include secure messaging exchange with providers can reduce labor costs because of reduced telephone volume and mailing costs.[4]

Evidence also demonstrates that patients more actively involved in their health care have better health outcomes and lower per capita costs, compared to less engaged patients.[5]

Thriving with Cloud-Based Services

With the future of health care now coming into focus, one thing is clear: Succeeding with PQRS and other value-based programs is virtually impossible without an intelligent EHR workflow. The EHR is a revenue driver in this new world with reimbursement tied to clinical outcomes more than ever – and increasing in the years to come.

But the right EHR must be supported by the right partner. One that helps medical practices tackle the complexity of PQRS and stay focused on patients. For more than 64,000 providers, this is where the cloud-based services of athenahealth come in.

Traditional health IT vendors sell software and leave providers to do the best they can. athenahealth acts as a partner to deliver results through a proven combination of software, knowledge and services.

- **Software –** Our cloud-based software is continuously updated, giving you actionable insight at the point of care. Clinical measures are surfaced where they're easiest to satisfy and least obtrusive – and addressed outside of the exam room as much as possible.
- **Knowledge –** The athenahealth Clinical Intelligence team stays on top of program measures, and continuously updates our Quality Management Engine™, which automatically embeds PQRS and other measures into the most optimal point of the workflow. Providers stay up-to-date on clinical measures and reporting requirements, while staying focused on patients.
- **Services –** Clients get coaching, education and expert advice for navigating PQRS. Our teams help select measures that practices are most likely to succeed with, and adjust the selection if performance is lagging. For clients using our EHR to report their data to PQRS, we submit the data on their behalf. We help manage performance—and ensure clients' success.

The athenahealth PQRS Guarantee

With our cloud-based platform, complete visibility into provider performance, and proven partnership model, athenahealth is uniquely positioned to help practices thrive through PQRS. And we guarantee it.

We are the only EHR vendor in the industry to guarantee that our clients will avoid any penalties related to PQRS reporting or quality scores. If we don't deliver, you don't pay the penalty – we do.

Why? Because we align our financial incentives directly with yours. When you do well, we do well. And our track record proves that we continually help providers thrive through change: In 2014, athenahealth led the industry in Meaningful Use with a 98.2% Stage 2 attestation rate. Additionally, we guarantee practices a successful ICD-10 transition.*

athenaOne®

The ease, convenience and power of a single, integrated suite of cloud-based services keeps health care providers up-to-date each day and focused on patient care. athenaOne includes:

athenaCollector®

Cloud-based medical billing and practice management services that help boost revenue while significantly reducing your administrative work. Rated Best in KLAS for practice management**, 2012-2014, with 94% of all claims paid upon first submission.

athenaClinicals®

Our unique, cloud-based EHR service, named "most usable" by KLAS**. Delivers greater clinical control and insights, with a streamlined workflow designed to optimize revenue opportunities.

athenaCommunicator®

Live and automated communication services that drive patient engagement and alleviate your staff's phone call burden. Automated messaging, live operator services, an award-winning patient portal and population health outreach campaigns all help maintain schedule density and empower patients.

Find out more at 866.817.5738 or athenahealth.com.

Supplemental/Appendix Information

A. List of Eligible Providers

The following professionals are eligible to participate in PQRS:

1. 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
2. Practitioners
   - Physician Assistant
   - Nurse Practitioner*
   - Clinical Nurse Specialist*
   - Certified Registered Nurse
   - Anesthetist* (and Anesthesiologist Assistant)
   - Certified Nurse Midwife*
   - Clinical Social Worker
   - Clinical Psychologist
   - Registered Dietician
   - Nutrition Professional
   - Audiologists

   **Includes Advanced Practice Registered Nurse (APRN)*
3. Therapists
   - Physical Therapist
   - Occupational Therapist
   - Qualified Speech-Language Therapist

Some professionals may be eligible to participate per their specialty, but due to billing method may not be able to participate:

- Professionals who do not bill Medicare at an individual National Provider Identifier (NPI) level, where the rendering provider's individual NPI is entered on CMS-1500 type paper or electronic claims billing, associated with specific line-item services.

Services payable under fee schedules or methodologies other than the PFS are not included in PQRS.

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

B. The Six NQS Domains

1. Patient Safety
2. Person and Caregiver-Centered Experience and Outcomes
3. Communication and Care Coordination
4. Effective Clinical Care
5. Community/ Population Health
6. Efficiency and Cost Reduction

Source: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_PQRS_ImplementationGuide.pdf

C. PQRS Measures

2015 PQRS Measures List

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_2015_Measure-List_111014.zip

2015 Cross-Cutting Measures List

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_PQRS_CrosscuttingMeasures_12172014.pdf

D. 2015 Measures Groups

Twenty-two measures groups have been established for 2015 PQRS. 2015 PQRS measures groups include a minimum of 6 individual measures.

1. Diabetes
2. Chronic Kidney Disease (CKD)
3. Preventive Care
4. Coronary Artery Bypass Graft (CABG)
5. Rheumatoid Arthritis (RA)
6. Hepatitis C
7. Heart Failure (HF)
8. Coronary Artery Disease (CAD)
9. HIV/AIDS
10. Asthma
11. Chronic Obstructive Pulmonary Disease (COPD)
12. Inflammatory Bowel Disease (IBD)
13. Sleep Apnea
14. Dementia
15. Parkinson's Disease
16. Cataracts
17. Oncology
18. Total Knee Replacement (TKR)
19. General Surgery
20. Optimizing Patient Exposure to Ionizing Radiation (OPEIR)
21. Sinusitis
22. Acute Otitis Externa (AOE)

E. Specialty Measure Sets

1. Potential Cardiology Preferred Measure Set
2. Potential Emergency Medicine Preferred Measure Set
3. Potential Gastroenterology Preferred Measure Set
4. Potential General Practice/Family Preferred Measure Set
5. Potential Internal Medicine Preferred Measure Set
6. Potential Multiple Chronic Conditions Preferred Measure Set
7. Potential Obstetrics/Gynecology Preferred Measure Set
8. Potential Oncology/Hematology Preferred Measure Set
9. Potential Ophthalmology Preferred Measure Set
10. Potential Pathology Preferred Measure Set
11. Potential Radiology Preferred Measure Set
12. Potential Surgery Preferred Measure Set

F. CMS Quality Benchmark Data

Performance Year 2014 Prior Year Benchmark [PDF, 452KB]

Endnotes

1. U.S. Department of Health & Human Services, "Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value," January 26, 2015. http://www.hhs.gov/news/press/2015pres/01/20150126a.html

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Disclaimers

*PQRS Guarantee: To be eligible for this Guarantee with respect to the 2015 reporting period, you and all of your eligible providers must go live on athenaOne by June 30, 2015. Guarantee eligibility is limited to certain specialties for practices of 10 or more eligible providers, per CMS' definition. For multi-specialty groups of 10 or more eligible providers, 80% of providers must be in a specialty covered by the Guarantee. Under this Guarantee, athenahealth will cover the combined PQRS and VM reductions to reimbursement, except for VM reductions resulting from reporting high cost. This promotion may be modified or canceled any time at athenahealth's sole and absolute discretion. Additional terms, conditions, and limitations apply.

ICD-10 Guarantee: For any practice that enters into an initial agreement for the provision of athenaOne services and goes live on those services by June 30, 2015, we guarantee that athenahealth will be ICD-10 compliant or we will waive our service fees until the compliance standards are met. This promotion may be modified or canceled any time at athenahealth's sole discretion. Additional terms, conditions, and limitations apply.

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