



# 2018 Physician Quality Reporting System (PQRS) Payment Adjustment Resource Document

September 2017

## Background

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The Physician Quality Reporting System (PQRS) is a voluntary quality reporting program that improves quality health care through accountability and public disclosure. PQRS encourages individual eligible professionals (EPs) and PQRS group practices to report quality measures in order to avoid a downward payment adjustment. By reporting quality measures, clinicians can assess the quality of care they provide to their patients and quantify how often they are meeting a particular quality metric.

The program applies a downward payment adjustment to practices with EPs identified on claims by their individual National Provider Identifier (NPI) and Tax Identification Number (TIN), or group practices participating via the group practice reporting option (GPRO), referred to as PQRS group practices, who do not satisfactorily report data on quality measures for covered Medicare Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). Those who report satisfactorily for the 2016 program year will avoid the 2018 PQRS downward payment adjustment.

**Note:** *2016 was the last program year for the PQRS quality reporting program. PQRS transitioned to the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program. The final data submission timeframe for reporting 2016 PQRS quality data to avoid the 2018 PQRS downward payment adjustment was January through March 2017. The first MIPS performance period is January through December 2017. For more information, please visit the [Quality Payment Program website](#).*

## Purpose

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PQRS is part of CMS's effort to transform the health care delivery system by linking Medicare payments to the quality of care delivered to Medicare beneficiaries. To do this, individual EPs and PQRS group practices are required to participate in reporting quality metrics.

Individual EPs and PQRS group practices who provided professional services paid under or based on the Medicare PFS from January 1, 2016 through December 31, 2016, are analyzed for the 2018 PQRS downward payment adjustment. This is in compliance with Section 1848(a)(8) of the Social Security Act. In 2015, CMS began to apply the downward payment adjustment to payments under the Medicare PFS for individual EPs and group practices who do not meet the criteria for satisfactory reporting in PQRS.

In order to have avoided a downward two percent (-2.0%) reduction in your Medicare PFS payments for services rendered January 1, 2018 through December 31, 2018, you must have met certain PQRS reporting criteria during 2016.

This document provides helpful resources for EPs who were able to participate in PQRS during 2016 but did not meet the criteria to avoid the 2018 PQRS downward payment adjustment (based on professional services rendered in 2016) under a TIN/NPI combination.

## Quality Measures

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Quality measures are indicators of the quality of care provided by physicians and other health care providers. They are tools that help us measure or quantify health care processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include: effective, safe, efficient, patient-centered, equitable, and timely care. Quality measures consist of a numerator and a denominator that permit the calculation of the percentage of a defined patient population that receive a particular process of care or achieve a particular outcome.

Measures are classified according to the 6 National Quality Strategy (NQS) domains based on the NQS priorities. The NQS domains include: Communication and Care Coordination, Community/Population Health, Effective Clinical Care, Efficiency and Cost Reduction, Patient Safety, and Person and Caregiver-Centered Experience and Outcomes. For reporting in \*2016, PQRS reporting mechanisms typically required an individual EP or PQRS group practice to report 9 or more measures covering at least 3 NQS domains. Individual EPs and PQRS group practices with billable face-to-face encounters must also have reported at least one cross-cutting measure (which reflects population health, such as blood pressure screening or influenza vaccination) in order to avoid the 2018 PQRS downward payment adjustment.

**\* Note:** In 42 CFR 414.90 (effective January 1, 2017), CMS proposes to reduce the number of measures needed to satisfactorily report to avoid the 2018 downward payment adjustment. The proposal would change the current 2016 PQRS program policy in the Medicare Physician Fee Schedule that requires reporting of 9 measures across 3 National Quality Strategy domains to only require reporting of 6 measures. If fewer than 6 measures apply, then eligible professionals would be required to report on each measure that is applicable. “Applicable” is defined as which measures are relevant to an EP’s services or care rendered. In order to ease the program requirements that physicians have found confusing in regards to the transition to the Merit-based Incentive Payment System (MIPS), the 2016 requirements will be aligned with the Quality Payment Program. For MIPS, EPs only need to report 6 quality measures for the quality performance category, except those reporting via the Web Interface with no requirement to ensure that the measures span across 3 NQS domains.

PQRS reporters could also satisfy the clinical quality measure (CQM) component of the Medicare EHR Incentive Program, and avoid the automatic downward payment adjustment and qualify for adjustments based on performance under the Value-Based Payment Modifier (Value Modifier) in 2018. PQRS offered several reporting mechanisms for reporting measures to avoid the 2018 downward payment adjustment. Please see the “2016 PQRS Implementation Guide” on the [2016 PQRS webpage](#) for Decision Trees designed to help participants select among the multiple reporting mechanisms available in PQRS. Individual EPs and PQRS group practices were encouraged to consider which reporting mechanism best fit their practice and to choose measures within the same mechanism of reporting.

For the 2016 reporting period, the majority of EPs successfully reported to PQRs and avoided the downward payment adjustment. CMS expects that successful trend to continue, under the new Quality Payment Program. The new Quality Payment Program replaces PQRs and the Value Modifier program, as well as the separate payment adjustments under the Medicare EHR Incentive Program, with a streamlined program that has reduced quality reporting requirements and a flexible design that allows eligible clinicians to pick their pace of participation in the first year. To learn more about the new Quality Payment Program and how to prepare for success, please visit [qpp.cms.gov](http://qpp.cms.gov).

## PQRs Feedback Reports & QRURs

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The 2016 PQRs feedback report provides the final determination of whether an individual EP or PQRs group practice met the 2016 PQRs criteria for avoiding the 2018 PQRs downward payment adjustment at the time the reports were generated. **Note:** Individual EPs and PQRs group practices will also receive a payment adjustment letter notifying them that they are subject to the 2018 PQRs payment adjustment.

Individual EPs and group practices can access their 2016 PQRs feedback reports from the [CMS Enterprise Portal](#), with a CMS Enterprise Identity Management (EIDM) login. See the [CMS EIDM User Guide](#) and/or the [PQRs-specific user guide](#) on the [Physician and Other Health Care Professionals Quality Reporting Portal](#) for more information.

2016 PQRs feedback reports are hosted on the [CMS Enterprise Portal](#). See the "2016 PQRs Feedback Report User Guide" and "Quick Reference Guide for Accessing 2016 PQRs Feedback Reports" on the [PQRs Analysis and Payment webpage](#), as well as the "Quick Access Guide for the 2016 PQRs Feedback Reports".

Detailed performance information for group practices and EPs that submitted quality data to PQRs will be available in the 2016 Annual Quality and Resource Use Reports (QRURs), which can be accessed on the [CMS Enterprise Portal](#) using an EIDM account with the correct role. See the [How to Obtain a QRUR webpage](#) for instructions on how to set up an EIDM account and access your TIN's 2016 Annual QRUR.

Both reports can be accessed on the [CMS Enterprise Portal](#) using the same EIDM account.

The 2016 PQRs feedback reports and the 2016 Annual QRURs will be available in September 2017, and CMS will announce their availability through web and listserv channels. Sign up and look for the announcements through the [PQRs Listserv](#).

## Informal Review

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If you participated in 2016 PQRs and believe that the 2018 PQRs downward payment adjustment is being applied in error, you can submit an informal review request. Request an informal review of your 2016 PQRs results during the informal review period which will begin in September 2017 with release of the PQRs feedback reports, and will last for 60 days.

Informal review is the process in which CMS will investigate whether an EP or PQRs group practice met the criteria for satisfactorily reporting under PQRs. All requests must be submitted via the Quality Reporting [Communication Support Page](#).

Once the informal review request is received, CMS will investigate the merits of the request and issue a decision. CMS attempts to complete the informal review process prior to the start of the payment adjustment period. Most of the informal reviews completed prior to the adjustment period are reflected on the payment adjustment file distributed to the Medicare Administrative Contractors (MACs). In the event that informal reviews are still being conducted after the payment adjustments are applied, updated files are distributed periodically to provide the necessary updates. In this situation, a reversal is applied and all previously adjusted claims are reprocessed at the correct rate. However, there is no exact timeframe as to when this will occur.

More information and instructions for requesting an informal review are included in this document, and are also available on the [PQRS Analysis and Payment webpage](#).

### **Step 1: Identify WHO will submit the request**

- Individual EPs or designated support staff will need to submit a request for an informal review for each individual rendering NPI for each TIN under which the requestor submitted 2016 PQRS data. The informal review is at the TIN/NPI level; therefore, a separate request should be submitted for each TIN/NPI combination for which an individual is requesting an informal review. The correct TIN/NPI combination listed on the payment adjustment letter that the EP received must be used.
  - If you are part of a group practice that registered to participate in PQRS GPRO for 2016, the group practice's point of contact will need to request an informal review for the TIN under which the group practice submitted 2016 PQRS data. An individual NPI cannot submit an informal review request for the group.
  - If you are part of a practice that participated in the Comprehensive Primary Care (CPC) initiative in 2016, the CPC practice site point-of-contact will need to request an informal review for the entire CPC practice site by entering the CPC Practice Site ID in the appropriate Communication Support Page field. This informal review request will apply to all EPs who were actively participating in CPC through 12/31/2016 and were listed on the CPC staffing roster. For questions regarding the EPs actively participating in the initiative during that time, please contact CPC Support ([cpcsupport@telligen.org](mailto:cpcsupport@telligen.org) or 1-800-381-4724).
- Certified EHR vendors, Qualified Clinical Data Registries, and Qualified Registries can request an informal review on behalf of their client(s). One request will need to be submitted for every provider for which they would like CMS to conduct an informal review. The decision will be sent to the applicable provider and not to the vendor.

### **Step 2: Understand WHERE to submit**

- To submit the request, go to the [Communication Support Page](#).

The Communication Support Page will be available from the start of the IR period in September 2017 and, will remain available for 60 days. CMS will announce its availability through MLN Connects Provider eNews and the PQRS listserv.

### **Step 3: Know HOW and take action to submit**

- Complete the mandatory fields in the online form, including the appropriate justification, for the request to be deemed valid. If the form is not completed in full, the informal review request will not be analyzed. CMS or the QualityNet Help Desk may contact the requestor for additional information if necessary.

## Other Medicare Physician Quality Programs that Will Apply Adjustments in 2018

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In compliance with Section 1848(a)(8) of the Social Security Act, in 2015 CMS began to apply the downward payment adjustment to payments under the Medicare PFS for individual EPs and group practices who do not meet the criteria for satisfactory reporting in PQRS.

Please note: EPs and group practices may be subject to an additional and separate payment adjustments from one or both of the programs listed below. Please contact the respective program's help desk for assistance.

### Value-Based Payment Modifier (Value Modifier):

- In 2018, the Value Modifier will apply upward, downward, or neutral adjustments to payments made under the Medicare PFS to all physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs) in groups with 2 or more eligible professionals (EPs) and those who are solo practitioners. Groups and solo practitioners are identified by their Medicare-enrolled TIN.
- Physicians, PAs, NPs, CNSs, and CRNAs in groups and those who are solo practitioners can avoid the automatic -1.0% or -2.0% Value Modifier downward payment adjustment as **proposed in the 2018 Medicare Physician Fee Schedule Proposed Rule** (depending on the composition and size of the TIN) in 2018 by (1) participating in the PQRS group practice reporting option (GPRO) in 2016 and avoiding the 2018 PQRS downward payment adjustment, or (2) ensuring that at least 50% of the EPs in the group avoid the 2018 PQRS downward payment adjustment, or (3) as a solo practitioner that avoids the 2018 PQRS downward payment adjustment by participating in the PQRS as an individual.
- CY 2016 is the performance period for the Value Modifier that will be applied in 2018. Adjustment amounts will vary with the size and composition of the TIN.
- Quality-tiering is the methodology that is used to evaluate a TIN's performance on quality and cost measures for the Value Modifier, and is mandatory for TINs subject to the Value Modifier in 2018. Under quality-tiering, TINs are eligible for upward or neutral adjustments under the 2018 Value Modifier based on their quality and cost performance **in 2016 as proposed in the 2018 Medicare Physician Fee Schedule Proposed Rule**.
- To determine whether your TIN will be subject to an upward, neutral, or downward adjustment (as **proposed in the 2018 Medicare Physician Fee Schedule Proposed Rule**) under the Value Modifier in 2018, access your TIN's 2016 Annual Quality and Resource Use Report (QRUR) on the CMS Enterprise Portal at <https://portal.cms.gov>. To access a QRUR, an EIDM account with the correct role is required. See the [How to Obtain a QRUR Page](#) for instructions on how to set up an EIDM account and access your TIN's QRUR.
- If your TIN is subject to the Value Modifier in 2018 and you disagree with the Value Modifier calculation indicated in your TIN's 2016 Annual QRUR, then an authorized representative of your TIN can submit a request for an Informal Review through the CMS Enterprise Portal. Please refer to the [2016 QRUR and 2018 Value Modifier](#) website for more information about the 2016 Annual QRURs, 2018 Value Modifier, and how to submit an informal review request.

Visit the [CMS Value-Based Payment Modifier](#) website for more information.

## Electronic Health Record (EHR) Incentive Program:

- As required by section 1848(a)(7) of the Social Security Act, EPs who are not meaningful EHR users for an applicable EHR reporting period will be subject to a downward payment adjustment for covered professional services furnished in CY 2018.
- EPs that are subject to the EHR Incentive Program Medicare payment adjustment for CY 2018 will receive separate notification from CMS via a United States Postal Service (USPS) letter in December 2017. Instructions on how to apply for a reconsideration will be in this letter.
- The payment adjustment is a -3% reduction to covered professional services billed under Medicare PFS in CY 2018.

Visit the EHR Incentive Program [Payment Adjustments and Hardship Exceptions webpage](#) for more information.

## The Future of Quality Reporting

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The [Quality Payment Program](#) combines and replaces three separate Medicare related programs with a single system where Medicare clinicians have the opportunity to be paid more for doing what they do best – making their patients safer and healthier. The vast majority of measures in the program are clinician-initiated, ensuring that we are rewarding what matters most to clinicians and their patients.

CMS developed Strategic Objectives for the Quality Payment Program to guide future rulemaking in order to design, implement and evolve a Quality Payment Program that aims to improve health outcomes, promote smarter spending, minimize burden of participation, and provide fairness and transparency in operations.

The Strategic Objectives include the following:

1. Improve beneficiary outcomes and engage patients through patient-centered Advanced Alternative Payment Model (APM) and Merit-based Incentive Payment System (MIPS) policies.
2. Enhance clinician experience through flexible and transparent program design and interactions with easy-to-use program tools.
3. Increase the availability and adoption of robust Advanced APMs.
4. Promote program understanding and maximize participation through customized communication, education, outreach, and support that meet the needs of the diversity of physician practices and patients, especially the unique needs of small practices.
5. Improve data and information sharing to provide accurate, timely, and actionable feedback to clinicians and other stakeholders.
6. Promote IT systems capabilities that meet the needs of users, and are seamless, efficient, and valuable on the front and back-end.
7. Ensure operational excellence in program implementation and ongoing development.

CMS relies heavily on quality measurement and public reporting to facilitate the delivery of high-quality care. We will continue working with the medical community and other stakeholders to build upon successful physician quality reporting programs as we implement the new Quality Payment Program. We will strive to reach a future-state where quality measurement and public reporting are optimized to help achieve the CMS strategic objectives for the Quality Payment Program and, therefore, contribute to improved health care quality across the nation, including better care, smarter spending, and healthier people.

## Resources

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### Webpages/Documentation

- [PQRS website](#)
  - “2016 PQRS Feedback Report User Guide,” located on the [PQRS Analysis and Payment webpage](#), assists users with understanding their reports.
  - “Quick Reference Guide for Accessing 2016 PQRS Feedback Reports,” located on the [PQRS Analysis and Payment webpage](#), provides steps to retrieving the reports. A condensed version is also available, called “Quick Access Guide for the 2016 PQRS Feedback Reports”.
  - “2016 PQRS List of Eligible Professionals,” located on the [2016 Physician Quality Reporting System webpage](#), explains who was eligible and able, as well as eligible and unable, to participate in 2016 PQRS.
  - Appendix B: Decision Tree - Avoiding the 2018 PQRS Negative Payment Adjustment – within the “2016 PQRS Implementation Guide,” located on the [2016 Physician Quality Reporting System webpage](#) – contains information on all of the mechanisms that were available in program year 2016 to avoid the 2018 PQRS downward payment adjustment.
  - See the [2016 Physician Quality Reporting System webpage](#) for more information on:
    - Reporting requirements
    - Reporting mechanisms
      - Registry
      - Electronic reporting using an EHR
      - Qualified Clinical Data Registry (QCDR)
      - GPRO Web Interface
      - Claims
      - CMS-Certified Survey Vendor
  - “2016 PQRS: 2018 Payment Adjustment - Informal Review Made Simple,” located on the [PQRS Analysis and Payment webpage](#), explains the process for submitting an informal review request.
  - “Understanding 2018 Medicare Quality Program Payment Adjustments,” located on the [PQRS Payment Adjustment Information webpage](#), provides a general overview of the 2018 payment adjustments for CMS Medicare quality reporting, including PQRS, Medicare EHR Incentive Program, and Value Modifier.

- “How to Report Once for 2016 Medicare Quality Reporting Programs,” located on the [PQRS Payment Adjustment Information webpage](#), offers guidance on aligned reporting mechanisms for both individual EPs and PQRS group practices reporting across PQRS, EHR Incentive Program, Value Modifier, and Accountable Care Organizations in order to avoid the 2018 downward payment adjustment. Please note: this document only includes aligned options and does not contain all PQRS reporting mechanisms.
- [Physician Compare website](#)
- [EHR Incentive Program website](#)
- [Value-Based Payment Modifier website](#)
  - [2016 QRUR and 2018 Value Modifier](#) Web Page

### Listservs

- Subscribe to the [PQRS Listserv](#)
- Register for [MLN Connects Provider eNews](#) announcements

### Help Desks

- Questions about the PQRS, content or data contained in the PQRS feedback reports, or EIDM can be directed to:  
**[QualityNet Help Desk](#)**  
Monday–Friday; 7:00 a.m.–7:00 p.m. Central Time  
Phone: 1-866-288-8912  
TTY: 1-877-715-6222  
Email: [Qnetsupport@hcqis.org](mailto:Qnetsupport@hcqis.org)
- Questions about the QRURs, access issues related to the PQRS feedback reports or QRURs, or Value Modifier payment adjustments can be directed to:  
**Physician Value (PV) Help Desk**  
Monday – Friday; 7:00 a.m.–7:00 p.m. Central Time  
Phone: 1-888-734-6433 (option 3)  
Email: [pvhelpdesk@cms.hhs.gov](mailto:pvhelpdesk@cms.hhs.gov)
- CPC practice sites with questions on 2015 PQRS informal reviews can contact:  
**Comprehensive Primary Care (CPC) Initiative Support Desk**  
Phone: 1-800-381-4724  
Email: [cpcsupport@telligen.org](mailto:cpcsupport@telligen.org)
- [Review Contractor Directory-Interactive Map](#) offers information on how to contact the appropriate provider contact center.