Physician Quality Reporting System (PQRS)
PQRS is a quality measures reporting program that uses a combination of incentive payments and payment adjustments to be used by Eligible Professionals (EP).

There are several ways in which EPs may report quality measures; reporting individual measures via claims or registry, reporting measures groups via a qualified registry, or reporting on measures via either EHR direct submission or a qualified EHR data submission vendor.

EPs may report measures either as an individual provider or as part of a group practice. The Group Practice Reporting Option (GPRO) consists of its own set of measures. EPs reporting as an individual provider have the option of choosing to report 9 individual measures across 3 National Quality Strategy domains or reporting 1 measures group for 20 eligible patients (at least 11 of which must be Medicare).

Individual Measures Reporting
If reporting using individual measures an EP must report on at least 9 individual measures via claims or qualified registry for at least 50% of the eligible patients. Individual measures specifications should be consulted to find the reporting method allowed for a particular measure.

Measures Group Reporting
If reporting using a measures group an EP must report at least 1 measures group (to include Parkinson's disease, dementia, sleep apnea) for at least 20 eligible patients (greater than 50% must be Medicare).

GPRO
GPRO was introduced in 2010 as a reporting method for group practices to qualify to earn a PQRS incentive. PQRS defines a group practice as a single Tax Identification Number (TIN) with 2 or more individual EPs (as identified by Individual National Provider Identifier [NPI]) that have reassigned their billing rights to the TIN.

- **2014 PQRS GPRO – 101 / Introduction**

Medicare EHR Incentive Program overview:
The Medicare EHR Incentive Program is currently in its 3rd quarter reporting period for 2014 (began July 1, 2014). Those who began participation in the program in 2011 or 2012 will be reporting on Stage 2 criteria (see below for this criteria). Those who began in 2013 or beyond will report Stage 1 for two years before moving to Stage 2. Since some participants are beginning Stage 2 of meaningful use while others are in Stage 1, it is important to understand which stage you are in and what the requirements for that stage are.

Choose your reporting period based on your participation year:

- Medicare eligible providers (EPs) beyond their first year of meaningful use: Select a three-month reporting period fixed to the quarter of the calendar year (at this point July-September or October-December).
    - **If an eligible professional (EP) does not successfully demonstrate meaningful use of certified EHR technology for a defined 90-day quarter in 2014, his or her Medicare physician fee schedule amount for covered professional services will be subject to a 2-percent penalty in 2016.**

- Medicare EPs in their first year of meaningful use: Select any 90-day reporting period. **To avoid the 2015 payment adjustment, must begin reporting by July 1 and attest by October 1.**
    - Upon successful participation, you will successfully avoid the 2015 penalty and earn up to a $12,000 incentive payment for 2014 (and be eligible for up to $24,000 over the next three years).

Regardless of the stage, all participants must be using 2014 certified EHR technology. This year is the last year to begin reporting and be eligible for incentive payments.

Clinical Quality Measures in the meaningful use program:
Beginning in 2014, reporting of CQMs changes for all providers regardless of whether they are participating in Stage 1 or Stage 2 of meaningful use.

- Eligible professionals must report on 9 of 64 approved CQMs (CMS has made recommendations for core CQMs for both the adult population and the pediatric population)
- All Medicare-eligible providers beyond their first year of meaningful use must electronically report their CQM data to CMS.

Criteria to successfully participate in Stage 2 :
Under Stage 2 of the Medicare EHR Incentive Program, you must:

- Meet 20 total objectives: 17 core objectives and three menu objectives from a list of six
- Report on 9 out of 64 total CQMs
- Select CQMs from at least three of six key health care policy domains:
    - Patient and Family Engagement
    - Patient Safety
    - Care Coordination
    - Population and Public Health
    - Efficient Use of Healthcare Resources
    - Clinical Processes/Effectiveness

For more information on PQRS and the Medicare EHR Incentive Program, visit Aan.com/practice/medicare

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