Changes In Medicare Quality Programs…

and what you should be doing to overcome them

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Central Florida MGMA

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2% Sequestration Extended thru 2025

- Part of August 2011 legislation, Budget Control Act.
- Act requires $1.2 trillion in federal spending cuts over nine years. Unless Congress changes the law, sequestration was supposed to last until 2021.
- Congress has continued to extend the reduction in a variety of bills since 2011 in order to solve fiscal issues.
- Congress acted again! - In November, 2015 a 2 year budget deal was passed that extends sequestration thru 2025.

What happened to guarantee of 0.5% CF Update for 2016?

- MACRA (Medicare Access & CHIP Reauthorization Act) – signed into law 4/16/15.
- Eliminated SGR formula for Dollar Conversion Factor (CF) in determining Medicare allowed amounts.
- Guaranteed CF increase of **0.5%** for years **2016 thru 2019.**
- **0%** update **2020 thru 2025**.

What happened to guarantee of 0.5% CF Update for 2016?

- 2015 – after MACRA passed CF $35.9335.
- 2016 – CF started the year $35.8279.
- 2016 – CF factor lowered further due to emergency update to fee schedule released by CMS 1/8/16.
- New 2016 CF - $35.8043.
- What happened to your guaranteed 0.5% increase for 2016?

What happened to guarantee of 0.5% CF Update for 2016?

- CMS requirements from separate legislation prior to MACRA.
- Misvalued Code Targets & Budget Neutrality.
- High expenditure billing codes reviewed to determine if misvalued (relative values too high or low).
- Any relative value increases must be budget neutral (can't increase Medicare spending)
- In addition, CMS now must reduce spending for misvalued services by achieving annual targets established by law.

What happened to guarantee of 0.5% CF Update for 2016?

- Target for 2016 was 1%.
- CMS missed the target by 0.77%.
- CF mandated reduction due to missed target.
- Calculation for CF as follows:

2015 Medicare conversion factor	**$35.9335**
MACRA Update	+0.5%
RVU budget neutrality adjustment	-0.02%
Misvalued code target adjustment	-0.77%
2016 Medicare conversion factor	$35.8279

What happened to guarantee of 0.5% CF Update for 2016?

- Final CF ended up even lower due to emergency fee schedule update 1/8/16.
- Relative value changes again resulted in the final reduction of CF to $35.0843.
- So you started in 2015 with CF $35.9335 & ended up in 2016 with $35.0843.
- So much for the guaranteed update of 0.5%.
- Trend could continue 2017-2019.

Separate Penalties in PQRS, Value Modifier, & EHR
Remember: 2% sequestration ALSO remains

Year	PQRS	EHR	Value Modifier If applicable
2015 (based on 2013)	1.5%	1.0%	Grp 100+ 1%
2016 (based on 2014)	2.0%	2.0%	Grp 10+ 2%
2017 (based on 2015)	2.0%	3.0%	Grp 10+ 4% 2-9 or Solo 2%
2018 Based on 2016)	2.0%	3 or 4% depending on per cent of EHR Users nationally	Grp 10+ 4% 2-9 or Solo 2%

Separate Penalties Sunset as of 2019 BUT Do Not Go Away

- As part of MACRA, Merit Based Incentive Payment System (MIPS) starts 2019 (probably based on your 2017 data).
- You will have to continue quality reporting & meaningful use.
- Instead of separate penalties, MIPS implements composite scores from which incentives or penalties are determined.

The Merit Based Incentive Payment System MIPS

- Professionals receive composite score based on performance in 4 categories:
    1. Quality (reporting measures)
    2. Resource Use (what you cost the Medicare program aka value modifier)
    3. EHR meaningful use
    4. Clinical practice improvement

NOTE: HHS is required to provide "group concepts" in the MIPS system as well as individual EP.

MIPS Payment Adjustments

- Composite score of 0-100 is applied to the "professional" for the performance year.
- Lowest score possible is applied to the MIPS EP who fails to report on applicable measures and activities.
- MIPS EPs are encouraged to report using EHRs & Qualified Clinical Data Registries (QCDRs)

MIPS Payment Adjustments

- **Performance weights**:
  - Quality – 30%
  - Resource Use 30%
  - EHR Meaningful Use – 25%
  - Clinical Practice Improvement – 15%
- **Performance thresholds** will be established by HHS for each performance year.
- MIPS EP composite score will be compared to the performance threshold.

MIPS Negative Payment Adjustments

- Composite performance score equal to or greater than "0" but not greater than ¼ of the performance threshold will receive a negative payment adjustment.
  - 2019 4% (?based on 2017 data)
  - 2020 5% (?based on 2018 data)
  - 2021 7% (?based on 2019 data)
  - 2022 & subsequent years 9%

MIPS "0"% or Positive Payment Adjustments

- Composite performance score equal to or greater than "0" and greater than ¼ of the performance threshold will receive a "0" per cent or greater positive payment adjustment based on a sliding scale. The law appears to also allow for an "additional" upward adjustment 2019-2024 for "exceptional performance"; but is ill defined.
  - 2019 4%
  - 2020 5%
  - 2021 7%
  - 2022 & subsequent years 9%

Only 1 Way to Avoid MIPS "Qualified Participation" in APM

- Participation in an Advanced Payment Model (APM) (i.e. ACO, PCMH, Bundled Payments).
- APMs ill defined in MACRA legislation. CMS yet to propose or finalize many MACRA rules.
- "Qualified Participation" as currently defined in MACRA requires more & more of your Medicare revenue be attributable to the APM.
- Starts with 25% & increases to 75%.

Advanced Payment Models (APM)

- Eligible professionals participating in Alternative Payment Models (APMs) are still required to:
  - Be meaningful users of certified EHRs
  - Participate in quality and value based performance programs in accordance with the APM entity.

Advanced Payment Models (APM)
Don't Be Fooled by Incentive Payments

- MACRA legislation offers possible incentives.
- **For the period 2019 thru 2023** eligible professionals who are "qualified APM participants" receive a 5% incentive.
- HOWEVER, the incentive **payment is made to the "APM entity"** as a lump sum & **not** to the "APM participant".

2016 PQRS Reporter & Non-Reporter
The Value Modifier Connection for 2018

In 2018 ALL Physicians, PAs, NPs, CNS & CRNAs

Category 1

PQRS Reporters 2016

1. Elected GPRO, successfully reported PQRS OR
2. Did not elect GPRO; but 50% of all EPs in group successfully reported individually.
3. Solo Practitioners successfully reported individually.

Quality Tiering-VM incentive or penalty

ONLY NPP Practices	9 or less EPS	10 or more EPS
0% TO +2%	-2% TO +2 %	-4% TO +4%

Category 2

Non-PQRS Reporters 2016
Groups & Solo Practitioners who did not successfully report PQRS in 2016

If in Category 2, -2% PQRS Penalty AND MAXIMUM VM Penalty based on practice size

Practices with only NPPs	Practices with 9 or less EPs	Practices with 10 or more EPs
2% VM Penalty	2% VM Penalty	4% VM Penalty

Value Modifier Penalty for 2018 Certain EPs are excluded

- **NOTE**: Value Modifier penalties in 2018 will apply ONLY to Physicians, ARNP, PA, CNS, & CRNA.
- Other EPs such as PT, OT will not be affected.
- This is due to the MACRA legislation and CMS starting to transition to the MIPS program.

Meaningful Use (MU) Incentive Payments (if 2015 or later is first year of EHR MU participation, EP DOES NOT qualify for incentives)

Maximum Payment by Start Year of MU	Annual Incentive Paid					
	2011	2012	2013	2014	2015	2016
2011						
$44,000	$18,000	$12,000	$8000	$4000	$2000	
2012						
$44,000		$18,000	$12,000	$8,000	$4,000	$2,000
2013						
$39,000			$15,000	$12,000	$8,000	$4,000
2014						
$24,000				$12,000	$8,000	$4,000

Clinical Quality Measures (CQMs) Attestation vs Electronic Submission

- CQM reporting is separate from reporting CORE objectives for EHR Meaningful Use.
- **2015-2017** - Manual attestation or electronic submission is acceptable for CQM reporting.
- **As of 2018 – Mandatory electronic submission.** EPs would only be allowed manual attestation IF EP attests that *"electronic submission is not feasible such as data submission system failure, natural disaster, or certification issue outside the control of the provider."*

Aligning CQMs & PQRS EHR Measures

NOTE: ALL EPs Must be using EHR NOT just Physicians

- **64 PQRS Measures** are the **same 64 Measures** used in reporting for the Medicare EHR Incentive Program Clinical Quality Measures **(CQMs).**
- For PQRS, the EHR Measures must ALWAYS be tracked for reporting for a full year & must be submitted electronically.
- **Specifications are found** at the CMS eCQM Library site:
- https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html Download "eCQMs for EPs Table May 2015" (to be used for 2016).

Aligning CQMs & PQRS EHR Measures

NOTE: ALL EPs Must be using EHR NOT just Physicians

- EHR Vendors are NOT mandated to be certified for ALL 64 Measures.
- They are minimally mandated to be certified for 9 measures in 3 Domains due to meaningful use requirements for CQMs.
- Check with EHR vendor to find out which ones they are certified for, and when they will add more.

Aligning CQMs & PQRS EHR Measures

NOTE: ALL EPs Must be using EHR

NOT just Physicians

- If you are tracking 9 CQMs for EHR Meaningful Use, why not use the same measures for PQRS EHR reporting?
- PQRS EHR measures submitted electronically

  1 of 2 ways:

  - Direct EHR Vendor – YOU electronically submit the measures OR
  - EHR Data Submission Vendor – Your EHR vendor does the electronic submission
- If YOU submit electronic measures you MUST have someone with a profile/login at CMS Enterprise Portal for "PQRS Submitter".

2016 CMS PQRS EHR Reporting Requirement

Reporting Mechanism	Reporting Criteria Individual EPs or GPRO Reporting	Reporting Period
Direct EHR OR EHR Data Submission Vendor (64 PQRS EHR measures- check which ones vendor is certified for)	Report 9 PQRS EHR measures covering at least 3 of the NQS domains. If an eligible professional's EHR does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional must report the measures for which there is patient data. Although all-payer data may be included in the file, an eligible professional must report on at least 1 measure for which there is Medicare patient data. ***	January 1, 2016 thru December 31, 2016 ***NOTE the absence of a per cent threshold to meet

What is a QCDR?

- **QCDR –** Qualified Clinical Data Registry
- New option for PQRS reporting offered by CMS starting 2014 only for individual EP.
- As of 2016 now offered for GPRO.
- Jury is still out – QCDRs in infancy phase for EPs.
- Different from regular registry as QCDR not limited to reporting only CMS PQRS measures.
- Offers Non-PQRS measures more applicable for specialty practices.

What is a QCDR?

- Submits data for quality measures on multiple payers.
- May integrate with EHR-some offer CQM submission for EHR Incentive Program.
- May provide performance information dashboards with comparison to peers & actionable information.
- Now also playing potential role in EHR Incentive Program for Public Health Core Objective for specialized registry.
- Also mentioned in the MACRA legislation related to the Merit Based Incentive Payment System (MIPS).
- MACRA legislation encourages use of EHRs & QCDRs

2016 PQRS QCDR Reporting- Individual EP or GPRO

Qualified Clinical Data Registry (QCDR) – May be PQRS Measures and/or Other Measures Outside the PQRS Measures Set Reporting is for Medicare & Non-Medicare patients	**Report 9 measures under QCDR covering at least 3 NQS domains AND 2 measures MUST be outcome measures.** **If <2 outcome measures available, 1 outcome measure must be reported AND at least 1 of the following types of measure – resource use, patient experience of care, efficiency/appropriate use, or patient safety. AND** **report each measure for at least 50 percent of the EPs applicable patients (Multiple Payers NOT just Medicare) seen during reporting period to which the measure applies.** **If less than 9 measures apply to the EP you DO NOT have the option of reporting less than 9.**	**January 1, 2016 thru December 31, 2016**

Where to Find CMS Approved QCDR Listings

- Web link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Qualified-Clinical-Data-Registry-Reporting.html
- Scroll down to the bottom to "2015 Qualified Clinical Data Registries"
- Click on "2015 Qualified Clinical Data Registries"
- Listing for 2016 not yet posted.

CMS PQRS Analysis & Feedback Reports for 2014

- Miserable Failure with no meaningful disclosure or transparency.
- No detail to Feedback reports – only "insufficient measures".
- Claims reporting-some EPs reporting less than 9 measures received 0.5% incentive.
- EHR submissions failed – CMS changed format without notifying EHR vendors.
- Registries – isolated? Instances due to registry failure? or CMS failure?

CMS PQRS Analysis & Feedback Reports for 2014

- Failed analysis resulting in unjustified 2% PQRS penalty for 2016 for EPs - ? How many.
- Depending on group size also resulted in unjustified additional penalty for value modifier of up to 4%.
- CMS waived PQRS penalty for certain EPs/Groups who submitted PQRS using EHR. Did not address Value Modifier penalties.
- EPs & Groups had to file needless informal appeals for both PQRS & Value Modifier.

CMS Analysis for Value Modifier for 2014 as Performance Year

- 2014 Quality Resource Use Reports (QRUR) inaccurate
- **CMS email 11/16/15**: *CMS identified issues that impacted the 2014 Annual …(QRURs) released on September 8, 2015. There were issues with data submitted via electronic health record (EHR) and Qualified Clinical Data Registry (QCDR), as well as a technical issue with the claims used to calculate claims-based measures. CMS has successfully corrected these issues and produced revised 2014 Annual QRURs, which are now available via the CMS Enterprise Portal. For a small percentage of groups, this correction resulted in a change to their Value-Based Payment Modifier (Value Modifier) calculation, and these groups will receive a separate notification.*

What Should You Do Moving Forward for 2015 Reports?

- Insure profiles/logins at the CMS Enterprise Portal are set up and working throughout the year.

  https://portal.cms.gov/wps/portal/unauthportal/home/
- You MUST reset passwords every 60 days.
- 2015 PQRS Feedback & QRUR for Value Modifier reports will be available "early September 2016".
- Access them immediately!
- File appeals early. Appeals period lasts only 60 days after reports released (unless CMS extends)
- Insure vendors used are your advocates!

Sign up for CMS listservs

- Sign up for weekly CMS eNews, MLN Connects Provider eNews:
- https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/index.html?redirect=/FFSProvPartProg/
- Upon entering your email you will have a menu to sign up for other email listservs. Sign up for: EHR, PQRS, CMS News Releases

The Recent National Hysteria Over New EHR Public Health Objective

- During the last few weeks if you received communications indicating "you must register with a specialized registry no later than 2/29/16 or you will not be able to attest to meaningful use for 2016", the statement was highly inaccurate & resulted in needless fear for medical practices.
- Why?
- Statement taken out of context – alluded to only 1 aspect of the CMS rule & avoided any reference to valid exclusions.
- The player missing in the discussion?...CMS!
- Promoted by Non-CMS entities.

Public Health Reporting Objective for Meaningful Use-3 Measures for EPs

- **Measure 1**

Immunization Registry Reporting: The EP is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).

- **Measure 2**

Syndromic Surveillance Reporting: The EP is in active engagement with a public health agency to submit syndromic surveillance data from a non-urgent care ambulatory setting.

- **Measure 3**

Specialized Data Registry Reporting: The EP is in active engagement to submit data to a specialized data registry. **NOTE:** CMS interchangeably is using the words "Clinical Data Registry"

Public Health Reporting Objective
3 Measure Options

- 2016 Objective Requirement for EPs

  Report 2 of 3 Measures.

  – If the EP meets multiple exclusions, and remaining measures available is less than 2, then report 1.

  – If no measures remain available, EP can meet objective by claiming exclusions for all measures.

  PLEASE insure you have documentation to support exclusions.

Public Health Objective

- Required for ALL EPs for 2015 thru 2017.
- Language for the objective was changed by CMS from "ongoing submission" requirement to "active engagement".
- "Active engagement" means EP is in process of moving toward sending "production" data to PH or Specialized Registry.
- Establishes 3 "active engagement" options for compliance with measures.

Public Health (PH) "Active Engagement" Options

- ***Option 1—Completed Registration to Submit Data***:
- The EP registered to submit data with the PH agency (immunization, syndromic) or Specialty Registry within 60 days after start of EHR reporting period or prior to the reporting period; and
- Is awaiting invitation to begin testing & validation with PH Agency/Specialized Registry.
- Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.

Public Health (PH) "Active Engagement" Options

- ***Option 2—Testing and Validation***
- The EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PH Agency/Specialized Registry within 30 days; failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.

Public Health (PH) "Active Engagement" Options

- ***Option 3—Production***
- The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PH Agency/Specialized Registry.

Exclusions to Public Health Reporting Measures

Measures	Exclusions
1. Immunization Registry	EP does not administer immunizations; OR No registry capable of receiving data or declared readiness to receive data in the jurisdiction.
2. Syndromic Surveillance	EP is not in a category of providers from which ambulatory syndromic data is collected; OR No PHA capable of receiving data or has declared readiness to receive data in the jurisdiction.
3. Specialized Registry Reporting	EP does not treat/diagnose disease/ conditions for which data is collected in jurisdiction; OR No registry capable of receiving data or declared readiness to receive data in jurisdiction.

CMS Releases FAQs for Public Health Objective 2/25/16

- Very important FAQs to tamp down the hysteria created.
- FAQ#s: 14393, 14397, 14401, 13657
  14117 (only for hospitals), 13653
- Accessing full FAQs: https://questions.cms.gov/
- On left click on bullet FAQ#
- Enter FAQ# in search area
- Be sure to sign up for EHR listserv so you do not miss these important emails.

FAQ #14393

- **FAQ #14393 (New): Can a provider register their intent after the first 60 days of the reporting period in order to meet the measures if a registry becomes available after that date?**
- If a registry declares readiness at any point in the calendar year after the initial 60 days, a provider may still register their intent to report with that registry to meet the measure under Active Engagement Option 1. However, a provider who could report to that registry may still exclude for that calendar year if they had already planned to exclude based on the registry not being ready to allow for registrations of intent within the first 60 days of the reporting period.

FAQ #13657

- **FAQ #13657 (Updated): What steps does a provider have to take to determine if there is a specialized registry available for them, or if they should instead claim an exclusion?**
  The eligible professional (EP) is not required to make an exhaustive search of all potential registries. Instead, they must do a few steps to meet due diligence in determining if there is a registry available for them, or if they meet the exclusion criteria.1 – An EP should check with their State* to determine if there is an available specialized registry maintained by a public health agency.
- 2 – An EP should check with any specialty society with which they are affiliated to determine if the society maintains a specialized registry and for which they have made a public declaration of readiness to receive data for meaningful use no later than the first day of the provider's EHR reporting period.
- If the EP determines no registries are available, they may exclude from the measure.

FAQ #14401

- **FAQ #14401 (New): For 2016, what alternate exclusions are available for the public health reporting objective? Is there an alternate exclusion available to accommodate the changes to how the measures are counted?**
- We do not intend to inadvertently penalize providers for changes to their systems or reporting made necessary by the provisions of the 2015 EHR Incentive Programs Final Rule. This includes alternate exclusions for providers for certain measures in 2016, which might require the acquisition of additional technologies they did not previously have or did not previously intend to include in their activities for meaningful use. *(continued next slide)*

FAQ #14401 (continued)

- We will allow providers to claim an alternate exclusion for the Public Health Reporting measure(s) which might require the acquisition of additional technologies providers did not previously have or did not previously intend to include in their activities for meaningful use. We will allow Alternate Exclusions for the Public Health Reporting Objective in 2016 as follows:

- EPs scheduled to be in Stage 1 and Stage 2: Must attest to at least 2 measures from the Public Health Reporting Objective Measures 1-3
    - May claim an Alternate Exclusion for Measure 2 and Measure 3 (Syndromic Surveillance and Specialized Registry Reporting).
    - An Alternate Exclusion may only be claimed for up to two measures, then the provider must either attest to or meet the exclusion requirements for the remaining measure described in 495.22 (e)(10)(i)(C).

FAQ #13653

- **FAQ #13653 (Updated): What can count as a specialized registry?**
- A submission to a specialized registry may count if the receiving entity meets the following requirements: The receiving entity must declare that they are ready to accept data as a specialized registry and be using the data to improve population health outcomes. Until such time as a centralized repository is available to search for registries, most public health agencies and clinical data registries are declaring readiness via a public online posting. Registries should make this information publically available for potential registrants.

- The receiving entity must also be able to receive electronic data generated from CEHRT. The electronic file can be sent to the receiving entity through any appropriately secure mechanism including, but not limited to, a secure upload function on a web portal, sFTP, or Direct. Manual data entry into a web portal would not qualify for submission to a specialized registry.

(continued next slide)

FAQ #13653 (Continued)

- The receiving entity should have a registration of intent process, a process to take the provider through test and validation and a process to move into production. The receiving entity should be able to provide appropriate documentation for the sending provider or their current status in Active Engagement.
- For qualified clinical data registries, reporting to a QCDR may count for the public health specialized registry measure as long as the submission to the registry is **not** only for the purposes of meeting CQM requirements for PQRS or the EHR Incentive Programs. In other words, the submission may count if the registry is also using the data for a public health purpose. Many QCDRs use the data for a public health purpose beyond CQM reporting to CMS. A submission to such a registry would meet the requirement for the measure if the submission data is derived from CEHRT and transmitted electronically.

Great CMS Resource for MU Core Objective Detail & Explanations

- CMS 2016 EP specification sheets for EPs
- Web link: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/
- Click on the left: 2016 Program Requirements
- Under Objectives and Measures click on "View the 2016 Specification Sheets for Eligible Professionals"

EHR Hardship Filing Deadline Extended

- CMS EHR email 2/26/16 – deadline to submit hardship exception extended from 3/15/16 to 7/1/16.
- Filing is to avoid 2017 payment adjustment based on 2015 Meaningful Use.
- https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html

Medicare Provider Enrollment Revalidation – Cycle 2

- It's Back!!
- All providers (until the end of time!) must revalidate periodically:
  - DME every 3 years
  - All other providers every 5 years.
- Cycle 1 ended with final notices 3/23/15.
- Now time for Cycle 2 starting "March, 2016".
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html

Medicare Provider Enrollment Revalidation – Cycle 2

- Dates have been established by which provider revalidations must be done.
- Due dates are the last day of the month.
- These dates should “generally” remain the same in subsequent revalidation cycles.
- Due dates are posted to new CMS lookup tool.
- Available 3/1/16. Any due date listed represents a current revalidation request.
- “TBD” = to be determined.

Medicare Provider Enrollment Revalidation – Cycle 2

- Due dates are supposed to be posted up to 6 months before actual date.
- Revalidation submitted greater than 6 months in advance of due date will not be accepted!
- Revalidations submitted when lookup tool indicates TBD will not be accepted.
- Includes crosswalk to reassignments.
- Medicare contractors will still send letters, emails as in past.

Medicare Provider Enrollment Revalidation-The BAD News!

- Non-response to revalidation results in deactivation of Medicare PTAN.
- Once reactivated, PTAN will be same; BUT no payments will be made during the deactivation; AND
- Reactivation date is based on DATE contractor receives the new application; AND
- NO retroactive billing for services during the time enrollment was deactivated!!!!

- *Physicians First, Inc.* documents are designed to provide reliable and authoritative information, and every reasonable effort has been made to insure the accuracy of information. The company assumes no legal responsibility for the use or misuse of the contents of this document

2016

64 EHR (CQM)/PQRS Measures

EHR CQM#	PQRS#	Description	NQS Domain
CMS122	1	Diabetes A1C	Clinical Care
CMS148	365	Hgb A1C-Pediatric	Clinical Care
CMS163	2	Diabetes – LDL	Clinical Care
CMS135	5	Heart Failure – LVSD	Clinical Care
CMS145	7	CAD-Beta Blocker	Clinical Care
CMS144	8	HF-Beta Blocker	Clinical Care
CMS128	9	Antidepressant Med	Clinical Care
CMS143	12	Glaucoma-Optic Nerve	Clinical Care
CMS167	18	Diabetic Retinopathy	Clinical Care
CMS142	19	Diabetic Retinopathy	Clinical Care
CMS154	65	Children-URI	Efficiency-Cost Reduction
CMS146	66	Children-Testing Pharyngitis	Efficiency-Cost Reduction
CMS140	71	Breast Ca-Hormone	Clinical Care
CMS141	72	Colon Ca-Chemo	Clinical Care
CMS129	102	Prostate Ca-Bone Scan	Efficiency-Cost Reduction
CMS161	107	Depressive Disorder	Clinical Care
CMS147	110	Influenza Vaccine	Community/Pop Health
CMS127	111	Pneumonia Vaccine	Clinical Care
CMS125	112	Breast Ca Screening	Clinical Care
CMS130	113	Colorectal Ca Screening	Clinical Care
CMS131	117	Diabetes Eye Exam	Clinical Care
CMS134	119	Diabetes-Urine Screen Nephropathy	Clinical Care
CMS69	128	BMI	Community/Pop Health
CMS68	130	Current Meds	Patient Safety
CMS2	134	Depression Screening	Community/Pop Health
CMS157	143	Oncology-Med Radiation	Person/Caregiver
CMS52	160	HIV/AIDS	Clinical Care
CMS123	163	Diabetes Foot Exam	Clinical Care
CMS133	191	Cataracts after Surgery	Clinical Care
CMS132	192	Cataracts-Complications	Patient Safety
CMS164	204	IVD-Use of ASA-Other	Clinical Care
CMS138	226	Tobacco Screen-Cessation	Community/Pop Health
CMS165	236	Controlling High BP	Clinical Care
CMS156	238	Use High Risk Meds Elderly	Patient Safety
CMS155	239	Weight Assess-Children	Community/Pop Health

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EHR

CQM#	PQRS#	Description	NQS Domain
CMS117	240	Childhood Immunization	Community/Pop Health
CMS182	241	IVD-Lipid Profile-LDL Control	Clinical Care
CMS 149	281	Dementia	Clinical Care
CMS137	305	Alcohol-Drug Dependence	Clinical Care
CMS124	309	Cervical Ca Screen age 21-64	Clinical Care
CMS153	310	Chlamydia Screen age 21-64	Community/Pop Health
CMS126	311	Use of Meds Asthma-age 5-64	Clinical Care
CMS166	312	Imaging Low Back-age 18-50	Efficiency-Cost Reduction
CMS61	316	Screen Cholesterol-age 20-79	Clinical Care
CMS64	316	Risk Stratified Cholesterol-age 20-79	
CMS22	317	Screen & Follow up-BP	Community/Pop Health
CMS139	318	Falls-Screening	Patient Safety
CMS136	366	ADHD-Children age 6-12	Clinical Care
CMS169	367	Bipolar-Depression	Clinical Care
CMS62	368	HIV/AIDS	Clinical Care
CMS158	369	Pregnant Women HB3AG	Clinical Care
CMS159	370	Depression Remission	Clinical Care
CMS160	371	Depression-Utilize PHQ-9	Clinical Care
CMS82	372	Maternal Depression	Community/Pop Health
CMS65	373	HT-Improve BP age 18-85	Clinical Care
CMS50	374	Closing Referral Loop	Communication/Care Coord
CMS66	375	Functional Status Assess-Knee Replace	Person/Caregiver
CMS56	376	Functional Status Assess-Hip Replace	Person/Caregiver
CMS90	377	Functional Status Assess Complex Cond	Person/Caregiver
CMS75	378	Children-Dental Decay age 0-20	Clinical Care
CMS74	379	Primary Caries Prevention age 0-20	Clinical Care
CMS179	380	ADE Prevention-Warfarin Time	Patient Safety
CMS77	381	HIV/AIDS	Clinical Care
CMS177	382	Child-Adolescent Depression-Suicide	Patient Safety