Avoid a Medicare Payment Penalty

How to Participate in Medicare’s New Quality Payment Program

July 2017
Meet Today’s Presenters

• Jill Rathbun
  – Galileo Consulting Group, Inc.

• Taylor Smith, MD
  – SVS Quality and Performance Measurement Committee

• Patrick Ryan, MD
  – SVS Quality and Performance Measurement Committee
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Agenda

• General Overview - Quality Payment Program
• 2017 Participation Status – How do I know?
  - Steps to Check Your Status
• So I have to Participate, Now What?
• Go At Your Own Pace in 2017 to Avoid the Penalty
• How to Report Quality Measures
  – Via a Registry (VQI)
  – Via an Electronic Health Record
  – Via a Medicare Claims Form
• How to Report Clinical Improvement Activities
• Information on Advancing Care Information
• Questions and Answers
The End of the Annual Cliff in Medicare Physician Payment

ON APRIL 16, 2015, PRESIDENT OBAMA SIGNED INTO LAW, H.R. 2 THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 (MACRA) – A NEW ERA IN MD MEDICARE PAYMENTS BEGINS...
Baseline Medicare Payments

• Repeals the SGR
• Positive Updates for 4.5 Years
  – 0.5 percent for July 2015 – 2019
  – 2017 Conversion factor is $35.8887
• Flat for 2020 through 2025
• For 2026 and beyond...
  – 0.75 percent per year, if participating in APM
  – 0.25 percent for all others
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<td>Meaningful Use of Certified EHR Technology</td>
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<td>PQRS, Value Modifier, EHR Incentives</td>
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<td>MIPS Payment Adjustment (+/-)</td>
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<td><strong>APM</strong></td>
<td>Qualifying APM Participant</td>
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<td>5% Incentive Payment</td>
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<td>Medicare Payment Threshold Excluded from MIPS</td>
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* Qualifying APM conversion factor  
** Non-qualifying APM conversion factor
2017: The Quality Payment Program

- The Quality Payment Program policy will reform Medicare Part B payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care delivery system.
- Clinicians can choose how they want to participate in the Quality Payment Program based on their practice size, specialty, location, or patient population.

Two tracks to choose from, but SVS Members will be in MIPS given lack of APMs:

- **Advanced Alternative Payment Models (APMs)**
  - If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

- **The Merit-based Incentive Payment System (MIPS)**
  - If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.
Who Participates in the Quality Payment Program?

- Medicare Part B clinicians billing more $30,000 a year and providing care for more than 100 Medicare patients a year.
- These clinicians include:
  - Physicians
  - Physician Assistants
  - Nurse Practitioners
  - Clinical Nurse Specialists
  - Certified Registered Nurse Anesthetists
Who is Excluded from the Quality Payment Program?

- **Newly-enrolled Medicare clinicians**
  - Clinicians who enroll in Medicare for the first time during a performance period are exempt from reporting on measures and activities for MIPS until the following performance year.

- **Clinicians below the low-volume threshold**
  - Medicare Part B allowed charges less than or equal to $30,000 **OR** 100 or fewer Medicare Part B patients

- **Clinicians significantly participating in Advanced APMs**
2017 Participation Status

www.qpp.cms.gov
MIPS Participation Status
To check if you need to submit data to MIPS, enter your 10-digit National Provider Identifier (NPI) number.
If you're exempt from MIPS with the first review, you won't need to do anything else for MIPS this year. If you are included in MIPS, you may be exempt with the second review of eligibility determinations at the end of 2017. Learn more about MIPS eligibility.

A National Provider Identifier (NPI) is a unique 10-digit number without spaces or punctuation. An NPI can be assigned to an individual health care provider or an organization.

Participation Status
Included in MIPS
BRAD L JOHNSON must submit data to MIPS by March 2018. This clinician will need to report as an individual or with a group.

What Can I Do Now?

Clinician Details
BRAD L JOHNSON, MD

Provider Type
Doctor of Medicine

Associated TINs
1

Enrolled in Medicare Before January 1, 2017
Yes
Practice Details

UNIVERSITY MEDICAL SERVICE ASSOCIATION INC
4202 EAST FOWLER AVENUE SHS 100 TAMPA, FL 33620-6750

If the clinician reports as an individual
Included in MIPS
This clinician has billed Medicare for more than $30,000 and has provided care for more than 100 patients at this practice

If the clinician reports as a group *
Included in MIPS
This practice has billed Medicare for more than $30,000 and has provided care for more than 100 patients.

Special Status At This Practice
View descriptions of each special status For this clinician at this practice
Non-Patient Facing No
Hospital Based No
Small Practice No
Rural No
Health Professional Shortage Area (HPSA) No
For this practice
Non-Patient Facing No
Hospital Based No
Small Practice No
Rural No
Health Professional Shortage Area (HPSA) Yes
SO I HAVE TO PARTICIPATE, NOW WHAT?
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)
Components of MIPS

Quality
Replaces PQRS

Improvement Activities
New Category

Advancing Care Information
Replaces Meaningful Use

Cost
Replaces Value Based Modifier

MIPS Composite Performance Score (CPS)

Weights of MIPS Score Components in Final Rule

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2018</th>
<th>2019+</th>
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<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
<td>50%</td>
<td>30%</td>
</tr>
<tr>
<td>Cost</td>
<td>15%</td>
<td>15%</td>
<td>30%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
<td>15%</td>
<td>15%</td>
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</table>

Society for Vascular Surgery
m2S
Society for Vascular Medicine
MIPS Reporting

- Eligible Clinician Identifier
  - Must elect the same MIPS identifier for all categories
  - Reporting as an “Individual,” - combination of TIN/NPI
  - Reporting as a “Group,” – Group’s billing TIN as identifier
    - Group = 2 or more Eligible Clinicians (EC) that have assigned billing rights to the same TIN
    - No “virtual groups,” till 2018 reporting year
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MIPS Proposed Timeline for 2019 Payment

Why I should care NOW

PERFORMANCE YEAR → SUBMIT DATA → FEEDBACK AVAILABLE → PAYMENT ADJUSTMENT

JANUARY 1 – DECEMBER 31, 2017  MARCH 31, 2018  JANUARY 1, 2019

What you do today, will impact your payment in 2019!
GO AT YOUR OWN PACE IN 2017
Transition Year—Pick Your Pace

Merit Incentive Payment System (MIPS) Reporting

Test Pace
- Submit **some** data after January 1, 2017
- Neutral or small payment adjustment

Partial Year
- Report for 90-day period after January 1, 2017
- Small positive payment adjustment

Full Year
- Fully participate starting January 1, 2017
- Modest positive payment adjustment

Not participating in the Quality Payment Program for the transition year will result in a negative 4% payment adjustment.
Choosing to Test for 2017

• If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity), you can avoid a downward adjustment
  – 1 Quality Measure for 90 days; or
  – 1 Clinical Improvement Activity for 90 days; or
  – 5 Required Advancing Clinical Care Information Measures
Partial Participation for 2017

• If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.
• That means if you’re not ready on January 1, you can choose to start anytime between January 1 and October 2, 2017. Whenever you choose to start, you'll need to send in performance data by March 31, 2018.
• More elements means more possibility of positive payment adjustment
Full Participation for 2017

• If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment. The best way to earn the largest positive adjustment is to participate fully in the program by submitting information in all the MIPS performance categories.

Key Takeaway:
• Positive adjustments are based on the performance data on the performance information submitted, not the amount of information or length of time submitted.
## MIPS Reporting Submission Options

<table>
<thead>
<tr>
<th>MIPS Category</th>
<th>Available Reporting Mechanisms</th>
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<tbody>
<tr>
<td>Quality of Care</td>
<td>Qualified Clinical Data Registry (QCDR)</td>
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<td>Qualified Registry</td>
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<td>Electronic Health Record</td>
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<td>Claims Data</td>
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<td></td>
<td>GPRO (For groups, only)</td>
</tr>
<tr>
<td>Resource Use (Not in 2017)</td>
<td>Claims Data</td>
</tr>
<tr>
<td>Advancing Care Information (MU)</td>
<td>Attestations</td>
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<tr>
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<td>QCDR</td>
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<td>EHR</td>
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<td>Clinical Improvement Activities</td>
<td>Attestation</td>
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<td>QCDR</td>
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<td>Qualified Registry</td>
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<td>EHR</td>
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</table>
MIPS Performance Category: Quality

Category Requirements

• Replaces PQRS and Quality Portion of the Value Modifier
• 60% of final score
• Select 6 of about 300 quality measures (minimum of 90 days); 1 must be:
  – Outcome measure OR
  – High-priority measure – defined as outcome measure, appropriate use measure, patient experience, patient safety, or care coordination
• May also select specialty-specific set of measures
• Readmission measure for group submissions that have ≥ 16 clinicians and a sufficient number of cases (no requirement to submit)
• Different requirements for groups reporting CMS Web Interface or those in MIPS-APMs
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VQI – One Stop for MIPS

• Quality
  – Submit Quality Measures through VQI QCDR
    • Submit 1 measure for Pick your Pace – avoid a negative payment
    • Submit 90 days of data for Pick your Pace – earn small positive adjustment
    • Submit 6 measures including 1 outcome for moderate positive adjustment
  – Program provides measure web-based feedback reports
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Medicare Claims-based Reporting


- Search for a quality measure(s) that you can submit via Medicare claims
Filter your search terms by vascular surgery, high priority measures, and reportable by claims. The following three measures should be found:

<table>
<thead>
<tr>
<th>MEASURE NAME</th>
<th>MEASURE DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Plan</td>
<td>Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (&lt;140/90mmHg) during the measurement period.</td>
</tr>
<tr>
<td>Documentation of Current Medications in the Medical Record</td>
<td>Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency, and route of administration.</td>
</tr>
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</table>
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Filter your search terms by vascular and reportable by claims. In addition to the three measures on Slide 29, the following six measures should be found:

<table>
<thead>
<tr>
<th>MEASURE NAME</th>
<th>MEASURE DESCRIPTION</th>
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<tbody>
<tr>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet</td>
<td>Percentage of patients 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antiplatelet during the measurement period.</td>
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<tr>
<td>Perioperative Anti-Platelet Therapy for Patients Undergoing Carotid Endarterectomy</td>
<td>Percentage of patients undergoing carotid endarterectomy (CEA) who are taking an anti-platelet agent within 48 hours prior to surgery and are prescribed this medication at hospital discharge following surgery.</td>
</tr>
<tr>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan</td>
<td>Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter. NormalParameters: Age 18 years and older BMI =&gt; 18.5 and &lt; 25 kg/m2.</td>
</tr>
<tr>
<td>Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented</td>
<td>Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.</td>
</tr>
<tr>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.</td>
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<tr>
<td>Rate of Surgical Conversion from Lower Extremity Endovascular Revascularization Procedure</td>
<td>Inpatients assigned to endovascular treatment for obstructive arterial disease, the percent of patients who undergo unplanned major amputation or surgical bypass within 48 hours of the index procedure.</td>
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Next Steps

• Select the measure to report from the QPP website.

• Go to the “Quality Measure Specifications,” zip file on the resources/tools page.

• By number, find the sheet for the measure you want to report and see the dominator and numerator specifications describing on who to report on their claims and then what to report on the claim.
Measure #423 (NQF 0465): Perioperative Anti-platelet Therapy for Patients Undergoing Carotid Endarterectomy - National Quality Strategy Domain: Effective Clinical Care

DESCRIPTION: Percentage of patients undergoing carotid endarterectomy (CEA) who are taking an anti-platelet agent within 48 hours prior to surgery and are prescribed this medication at hospital discharge following surgery INSTRUCTIONS: This measure is to be reported each time carotid endarterectomy is performed during the performance period. This measure may be reported by eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.
DENOMINATOR: Patients over age 18 undergoing carotid endarterectomy Denominator Criteria (Eligible Cases): Patients aged ≥ 18 years on date of encounter AND Patient procedure during the performance period (CPT): 35301

NUMERATOR: Patients undergoing carotid endarterectomy who received anti-platelet agents within 48 hours prior to the initiation of surgery AND are prescribed this medication at hospital discharge following surgery OR

Numerator Instructions: There must be documentation in the patient’s medical record of an order (written order, verbal order, or standing order/protocol) for anti-platelet agents OR documentation that anti-platelet agents was given within 48 hours prior to surgery AND patient has prescription for this medication hospital discharge following surgery.

Numerator Quality-Data Coding Options:
- Documentation of Order for anti-platelet agents (written order, verbal order, or standing order/protocol) Performance Met: G9609:
- Documentation of an order for anti-platelet agents Order for anti-platelet agents not ordered for Medical Reasons Denominator Exception: G9610: Documentation of medical reason(s) in the patient’s record for not ordering anti-platelet agents
  OR
- Order for anti-platelet agents not ordered, Reasons Not Given Performance Not Met: G9611: Order for anti-platelet agents was not documented in the patient’s record, reason not given
MIPS Performance Category: Improvement Activities

- Assesses participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access
- Clinicians choose from about 90+ activities under 9 subcategories:
  1. Expanded Practice Access
  2. Population Management
  3. Care Coordination
  4. Beneficiary Engagement
  5. Patient Safety and Practice Assessment
  6. Participation in an APM
  7. Achieving Health Equity
  8. Integrating Behavioral and Mental Health
  9. Emergency Preparedness and Response
Submitting Improvement Activities

- Eligible clinicians may submit their improvement activities by attestation via the CMS Quality Payment Program website, a qualified clinical data registry, a qualified registry, or, when possible, from their electronic health record system. Groups of 25 or more may choose to use the CMS Web Interface. Eligible clinicians and groups only need to attest via the Quality Payment Program website that they completed the improvement activities they selected or should work with their vendor to determine the best way to submit their activities via a qualified clinical data registry (QCDR), a qualified registry, or their electronic health record system.

- Eligible clinicians are encouraged to retain documentation for 6 years as required by the CMS document retention policy.
Reporting Criteria

• You must attest by indicating “Yes” to each activity that meets the 90-day requirement (activities that you performed for at least 90 consecutive days during the current performance period).

• You may report activities using a qualified registry, via certified EHR Technology), qualified clinical data registry (QCDR), the CMS Web Interface (for groups of 25 or more), or via attestation. These intermediaries will need to certify that you performed the activities as indicated.

• You can choose to attest to the set of activities that are most meaningful to your practice since there are no subcategory reporting requirements. That is, you don’t have to select activities in each subcategory or select activities from a certain number of subcategories.

• If you choose to participate in MIPS via a QCDR, you must select and achieve each improvement activity separately. You will not receive credit for multiple activities just by selecting one activity that includes participation in a QCDR.
MIPS Performance Category: Advancing Care Information

• Promotes patient engagement and the electronic exchange of information using certified EHR technology
• Ends and replaces the Medicare EHR Incentive Program (also known as Medicare Meaningful Use)
• Greater flexibility in choosing measures
• In 2017, there are 2 measure sets for reporting based on EHR edition:
  – Advancing Care Information Objectives and Measures
  – 2017 Advancing Care Information Transition Objectives and Measures
MIPS Performance Category: Advancing Care Information

- Clinicians must use certified EHR technology to report
- For those using EHR Technology Certified to the 2015 Edition:
  - Option 1: Advancing Care Information Objectives and Measures
  - Option 2: Combination of Two Measure Sets
- For those using EHR Technology Certified to the 2014 Edition:
  - Option 1: 2017 Advancing Care Information Transition Objectives and Measures
  - Option 2: Combination of the Two Measure Sets
### 2017 Advancing Care Information

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<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
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<tbody>
<tr>
<td>Protect Patient Health Information</td>
<td>Security Risk Analysis</td>
</tr>
<tr>
<td>Electronic Prescribing</td>
<td>e-Prescribing</td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>Provide Patient Access</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Send a Summary of Care</td>
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<tr>
<td>Health Information Exchange</td>
<td>Request/Accept a Summary of Care</td>
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**Transition Objectives and Measures:**

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<th>Objective</th>
<th>Measure</th>
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<td>Electronic Prescribing</td>
<td>e-Prescribing</td>
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<tr>
<td>Patient Electronic Access</td>
<td>Provide Patient Access</td>
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<tr>
<td>Health Information Exchange</td>
<td>Health Information Exchange</td>
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MIPS Testing
• Report some data at any point in CY 2017 to demonstrate capability
• 1 quality measure, or 1 improvement activity, or 4/5 required ACI measures
• No minimum reporting period
• No negative adjustment in 2019

Partial MIPS reporting
• Submit partial MIPS data for at least 90 consecutive days
• 1+ quality measure, or 1+ improvement activities, or 4/5 required ACI measures
• No negative adjustment in 2019
• Potential for some positive adjustment (<4%) in 2019

Full MIPS reporting
• Meet all reporting requirements for at least 90 consecutive days
• No negative adjustment in 2019
• Maximum opportunity for positive 2019 adjustment (<4%)
• Exceptional performers eligible for additional positive adjustment (up to 10%)

Advanced APM participation
• No MIPS reporting requirements (APMs have their own reporting requirements)
• Eligible for 5% advanced APM participation incentive in 2019

The only physicians who will experience negative payment adjustments (-4%) in 2019 are those who report no data in 2017
Getting Started...

- Determine you eligibility status
- Gauge your readiness and choose “how” you want to start
- Choose if you will be reporting as an individual or group
- Decide if you will work with a third party intermediary
- Review the program timeline for dates
- Choose a data submission option
- Reach agreement with Bonus Payments and Reporting Periods
- Assess your Feedback
- Ready, set, go!
Need to sign up for VQI

Email VQI@m2s.com

To learn more about VQI
vqi.org