Quality Matters: How to Succeed with PQRS in 2015
Jeanne Chamberlin, MA, FACMPE
Director, MSOC Health

A Short History of PQRS

2007: 3 measures on 80% 2% Bonus
2012: 3 measures on 50% / 80% 0.5% Bonus

2013:
- 3 measures on 50%
- 0.5% Bonus
- 1 measure on 1 patient avoids 1.5% PENALTY

VBM 100+

2014:
- 9 measures on 50%
- 0.5% Bonus
- 3 measures on 50% avoids 2% PENALTY

VBM- 10+

2015:
- NO BONUS
- 9 measures on 50% avoids 2% PENALTY

VBM for All

Participate Or Else.....

2015 Payments Reporting Year Amount
Meaningful Use 2013/2014* -1%
eRX 2013 -1%
PQRS 2013 -1.5%

2016 Payments Reporting Year Amount
Meaningful Use 2014 -2%
PQRS 2014 -2%
VBM if 10+ Providers 2014 -2%

2017 Payments Reporting Year Amount
Meaningful Use 2015 -3%
PQRS 2015 -2%
VBM (+10 Providers) 2015 -2 to -4%

VBM (-/+) 10 Providers 2015 -3.5% -6% -7 to 9%
Introduction to the Value Based Modifier Program

Value Based Modifier (VBM)

- Practice Level (TIN)
- All Sizes & Specialties
- **Penalty** in 2017 if PQRS quality measures are not reported for 2015:
  - 2% if < 10 Providers, 4% if 10+ Providers
  - Via Group Reporting (Register by 6/30/15)
  - Individually by > 50% of eligible providers
  - Applies to MD revenue only in 2017
  - Expands to all revenue in 2018

VBM Concepts

<table>
<thead>
<tr>
<th>Providers</th>
<th>Low Cost</th>
<th>Avg Cost</th>
<th>High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>10+</td>
<td>+ 4%</td>
<td>+ 2%</td>
<td>+ 0%</td>
</tr>
<tr>
<td>Average</td>
<td>+ 3%</td>
<td>+ 0%</td>
<td>- 2%</td>
</tr>
<tr>
<td>Low</td>
<td>+ 0%</td>
<td>- 2%</td>
<td>- 4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Providers</th>
<th>Low Cost</th>
<th>Avg Cost</th>
<th>High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10</td>
<td>+ 2%</td>
<td>+ 1%</td>
<td>+ 0%</td>
</tr>
<tr>
<td>Average</td>
<td>+ 1%</td>
<td>+ 0%</td>
<td>- 1%</td>
</tr>
<tr>
<td>Low</td>
<td>+ 0%</td>
<td>- 1%</td>
<td>- 2%</td>
</tr>
</tbody>
</table>

*Budget Neutral: -4% penalty if PQRS data not reported; these dollars plus those from red boxes must equal increased payments to practices in green boxes.*
VBM in 2015

- Impacts Medicare Revenue in 2017
- +/- applies to all MDs in group in 2017
- 10+ Providers: Fully Implemented
- 1-9 Providers: Upside Only

QRUR Reports – 2013 Data

Requires IACS Login

PQRS Program
The Basics
PQRS: Who Must Participate?
- Physicians, Optometrists, Podiatrists
- Physician Assistants/Nurse Practitioners
- Therapists: PTs, OTs, Speech
- Clinical Psychologists and CSWs
- Dieticians

PAID UNDER MEDICARE PHYSICIAN FEE SCHEDULE
NOT PARTICIPATING IN MEDICARE ACO

PQRS is a Provider-Based Program

TIN/NPI
Same provider/2 practices

Dr. Williams: $100 for a 99213
Dr. Brown: $96 for a 99213

Penalties are 2 Years Ahead

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Penalty Seen In</th>
<th>PQRS Penalty</th>
<th>VBM Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>2015</td>
<td>-1.5%</td>
<td>-2.0%*</td>
</tr>
<tr>
<td>2014</td>
<td>2016</td>
<td>-2.0%</td>
<td>-2.0%*</td>
</tr>
<tr>
<td>2015</td>
<td>2017</td>
<td>-2.0%</td>
<td>-2 to -4%</td>
</tr>
</tbody>
</table>

* Applied to certain practices only, based on size
How to Avoid the 2017 Penalties

- Report Quality Measures
  - 9 measures covering 3 domains on at least 50% of Medicare FFS patients that qualify for that measure
  - All measures in a Measure Group for 20 patients
  - Alternative Reporting: QCDR, GPRO Website
  - VBM: Report as group or >50% of individual providers

- Quality Performance Rate Matters
  - PQRS: Performance Rate > 0% on all measures
  - VBM: Score compared to peers (groups w 10+)

226: Tobacco Screening/Intervention

Measure: % of patients who were screened for tobacco use 1+ times in last 24 months AND who received cessation counseling intervention if identified as a tobacco user

Frequency: Once per reporting period for each patient seen

226: Tobacco Screening/Intervention

Denominator: Patient > Age 18 with CPT code in list (E&M OP visits)

Quality Codes:
- 1036F – Not current tobacco-user
- 4004F – Current tobacco user and cessation counseling/intervention provided
  - 4004F-1P – counseling not provided for medical reason
  - 4004F-8P – counseling not provided, no reason given
226: Tobacco Screening/Intervention

MC Patients with office visit during year: 1200
   Over Age 18: 1200
   FFS (not MC Advantage Plans): 1000 = DENOMINATOR

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1036F (Non-Smoker)</td>
<td>500</td>
</tr>
<tr>
<td>4004F (Smoker w/ Counseling)</td>
<td>100</td>
</tr>
<tr>
<td>4004F-1P (Medical Exception): 10</td>
<td></td>
</tr>
<tr>
<td>4004F-8P (Smoker, no counsel): 140</td>
<td></td>
</tr>
<tr>
<td>Total of Above:</td>
<td>750</td>
</tr>
</tbody>
</table>

Reporting Rate: 750/1000 = 75%
Performance Rate: (500+100)/(750-10) = 600/740 = 81%

Reporting Options
For 2015

Group vs Individual Reporting
Group = 2+ Providers in same TIN
- Required for practices with 100+ providers
- Less work for larger/multi-spec practices
- Balance under & over-performing providers

- Register by 6/30/15 (IACS) & Specify Method
- Fewer Reporting Choices
- Reported on Physician Compare
Option 1: Report Through Your EHR
• 2014 CEHRT and 9 CQMs (7/14 Version)
• Report same 9 quality measures for both MU & PQRS for full year on all patients (3 domains)
• One MC patient in one measure
• Group or Individual Provider
• Caution – Possible low performance results
• Caution – EHRs may charge a fee
• Caution – Many vendors lack experience

Option 2: Measure Group
2015 – 22 Measure Groups (-5, +2 compared to 2014)

<table>
<thead>
<tr>
<th>Measure Group</th>
<th>2015 Count</th>
<th>2014 Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prev. Care</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>CAD</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Cataracts</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Diabetes</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Dementia</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Asthma</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>CAABG</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Parkinson’s</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>COPD</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Sleep Apnea</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Acute Otitis Externa</td>
<td>8</td>
<td>-</td>
</tr>
<tr>
<td>Exposure to Ionizing Radiation</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Sinusitis</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Gen Surgery</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Rheumatoid Arthritis</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>IBD</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Total Knee Replacement</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>HIV</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

NEW: Exposure to Ionizing Radiation (6) Chronic Kidney Disease (6) Sinusitis (6) Hepatitis C (8) Gen Surgery (7) Rheumatoid Arthritis (8) IBD (7) Total Knee Replacement (6) HIV (8)

Deleted: Back Pain, Perioperative, CV Prev, Htx, IVD

Report on sample of 20 patients, 11 must be Medicare
Report via Registry Program
Individual Provider Only, No Group Reporting

Option 3: Individual Measures
• 9 Measures from 3 Domains
• New Requirement: 1 of 9 measures must be from “Cross-Cutting” List
• For each measure:
  – Reporting Rate > 50%: Quality indicator is reported on over half of the qualifying Medicare FFS patients
  – Performance Rate > 0%: Meet quality performance on at least 1 of the patients included
• Individual Provider: Claims or Registry
• Group: Registry Only
Summary of PQRS Options

### Individual Reporting

<table>
<thead>
<tr>
<th>Option</th>
<th>EMR</th>
<th>Measure Group</th>
<th>Individual Measures</th>
<th>Requirements</th>
<th>Claims</th>
<th>Registry</th>
<th>Qualified Clinical Data Repository</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Avoidance to Avoid Penalty</strong></td>
<td>9 measures - 3 same ones reported for MU</td>
<td>1 Measure Group (6+ Measures)</td>
<td>9 measures covering 3 domains</td>
<td>At least 9 measures covering 3 domains</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Population</strong></td>
<td>All patients</td>
<td>All in Group 1 from CMS List</td>
<td>1 of 9 from CMS List</td>
<td>1 of 9 from CMS List</td>
<td>1-2 outcomes measured</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Penalty Measures</strong></td>
<td>20 patients with defined DX, 11 must be Medicare FFS</td>
<td>50% of Medicare FFS patients with qualifying service</td>
<td>50% of Medicare FFS patients with qualifying service</td>
<td>50% of eligible patients with qualifying service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reported When</strong></td>
<td>Jan-Feb 2016 for DOIs in 2015</td>
<td>On each claim for qualifying service</td>
<td>Jan-Feb 2016 for DOIs in 2015</td>
<td>Jan-Feb 2016 for DOIs in 2015</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>$250-500/provider</td>
<td>Negligible except workflow changes</td>
<td>$250-500/provider, chart abstraction</td>
<td>Depends on GCCDR</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Group Reporting

<table>
<thead>
<tr>
<th>Option</th>
<th>EMR</th>
<th>Measure Group</th>
<th>Individual Measures</th>
<th>Requirements</th>
<th>Claims</th>
<th>Registry</th>
<th>Qualified Clinical Data Repository</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Avoidance to Avoid Penalty</strong></td>
<td>9 measures - 3 same ones reported for MU</td>
<td>1 Measure Group (6+ Measures)</td>
<td>9 measures covering 3 domains</td>
<td>Option 1: 6 measures</td>
<td>Option 2: 6 measures</td>
<td>Option 3: all measures</td>
<td></td>
</tr>
<tr>
<td><strong>Patient Population</strong></td>
<td>All patients, at least one must be Medicare</td>
<td>50% of Medicare FFS patients with qualifying service</td>
<td>PAIR: All patients assigned by CMS (up to 24S)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reported When</strong></td>
<td>Jan-Feb 2016 for DOIs in 2015</td>
<td>On each claim for qualifying service</td>
<td>Jan-Feb 2016 for DOIs in 2015</td>
<td>Jan-Feb 2016 for DOIs in 2015</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>Depends on EMR</td>
<td>Chart abstraction and data entry</td>
<td>Depends on Selections and Vendor selected</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Suggestions for Neurosurgery
www.cms.gov/pqrs

Page Down/Click on Links

List of Measures

Detailed Specifications

Measure Specification Document

Open/Save largest file - 600+ Pages
  Each measure has 2-4 pages of detail

CMS.gov

04/03/2015
### Considerations

- How big is the qualifying population?
- How easy to identify a qualifying patient?
- How easy to capture quality detail?
- Coordinate with Quality Improvement Goals
- Other Quality Reporting programs
  - Patient Centered Specialty Practice Recognition
  - Commercial payer programs
- How will you monitor throughout year?
Claims-Based Reporting

- Submit quality codes on same claim as qualifying service
- Must submit a code on at least 50% of Medicare Part B patients eligible for that measure seen any time during 2015
- Not recommended
  - Fewer measures available
  - Easy to make mistakes
  - Very difficult to monitor success

Claims-based Reporting Tips

- START NOW!
  - Add Quality Codes to paper encounter forms
  - Edits in PM System to kick-out if no quality code
  - Manually review all charges before claim release
  - Collect for all payers, not just Medicare
  - Choose simple measures
  - Check beyond primary diagnosis code

Registry Reporting

- Select Registry from approved list (Fee)
- Collect data for full calendar year on selected measures
- If reporting as a Group, register with CMS by June 30, 2015
- Report data to registry Jan-Feb 2016
  - Most require patient-level data
  - Some accept aggregate data
- Registry must report data to CMS by 3/31/16
Capturing Data with an EHR

- EHR Template
  - Alert when denominator criteria entered
  - Default most typical responses
  - EHR report of template fields
- Use CQMs available in EHR
  - If report can be generated at payer level
  - If report can be exported to excel to get patient-level data

Capturing Data Outside the EHR

- Time of Service Data Capture
  - PQRS paper forms; enter to spreadsheet
  - Add to encounter form; enter & report from PM
- Generate list of qualified patients from PM
  - Always Measures: Set numerator equal to denominator less error %
  - Find One Patient: Identify single patient that meets quality criteria and default others to not meeting (OK for small practices in 2015, not for 2016)

What If Fewer than 9 Measures Fit Your Practice?
**MAV Process**

- Report 1-8 Measures
  - Reporting Rate > 50% on each measure reported
  - Performance Rate >0% on each measure
  - 1 cross-cutting measure reported

- **What Clinical Clusters are Represented?**
  - CMS analyzes claims to ID other measures in same cluster that could have been reported
  - If reporting on claims, excluded if < 15 in denominator (no minimum for registry reporting)

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**Example: Report 130, 24, 40 - Registry**

- All 3 in Osteoporosis Cluster (Registry)
- 110 and 226 also in cluster
- Medicare claims data: many patients meet denominator for 110 and 226

**Penalty**
-2% PQRS + -2 to -4% VBM

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**Example: Report 21, 22, 23 - Claims**

- All 3 in Perioperative Clinical Cluster (Claims)
- No other measures in cluster
- No cross-cutting measure reported
- Not eligible for MAV process

**Penalty**
-2% PQRS + -2 to -4% VBM
Example: Report 130, 226, 385-Registry

- 130 & 226 are cross-cutting measures
- 385 is in no clinical cluster
- 130/226 do not trigger cluster

Passes MAV – No Penalty

Keys to MAV

- Review available measures and denominator criteria; select all that are appropriate to your practice
- Use the right 2015 Clinical Cluster definition (www.cms.gov/pqrs, Analysis & Payment)
- Validate # of qualifying Medicare FFS patients for any other measure in the same cluster (0 for registry, 15 for claims)
- Report 1 cross-cutting measure

Summary
The Game Has Changed

PQRS = Pay for Reporting

VBM = Pay for Performance

You Can't Do It Alone......

Resources


VBM: www.cms.gov/physicianfeedbackprogram
      888-734-6433 option 3

MU: www.cms.gov/ehrincentiveprograms
    888-734-6433 option 1

Medicare Quality Programs Resource List
www.msochealth.com
QUESTIONS?

Jeanne Chamberlin, FACMPE
Practice Management Consultant
j.chamberlin@msochealth.com
919-442-2422