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MICHIGAN STATE MEDICAL SOCIETY

PQRS: The Big Picture

April 12, 2016

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Agenda

- Goals, Trends, and Alignment
- PQRS overview
  - Choosing PRQS reporting option and method
  - Measure selection
  - Avoiding the adjustment
- Physician Value-based Payment Modifier overview
- Merit-based Incentive Payment System
- Impact on Medicare reimbursement

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Medicare Quality Reporting

- Improve quality health care through accountability and public disclosure
- Report quality measures about health care services provided to Medicare beneficiaries
- Impact on eligible professionals
  - Assess quality of care
  - Quantify how often meeting quality metrics
  - Comparison to peers
  - Avoid related financial penalties
  - Opportunities to receive incentives in some cases

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Payment Shift

- HHS goal is to shift payment systems to reward quality and lower costs
- Per U.S. Department of Health and Human Services Secretary Sylvia Maxwell:
  - Tie 30% of traditional/FFS Medicare payments to quality or value via alternative payment models (e.g., ACOs, bundled payments, etc.) by end of 2016 and 50% by end of 2018
  - Tie 85% of all traditional/FFS Medicare payments to quality or value by 2016 and 90% by 2018

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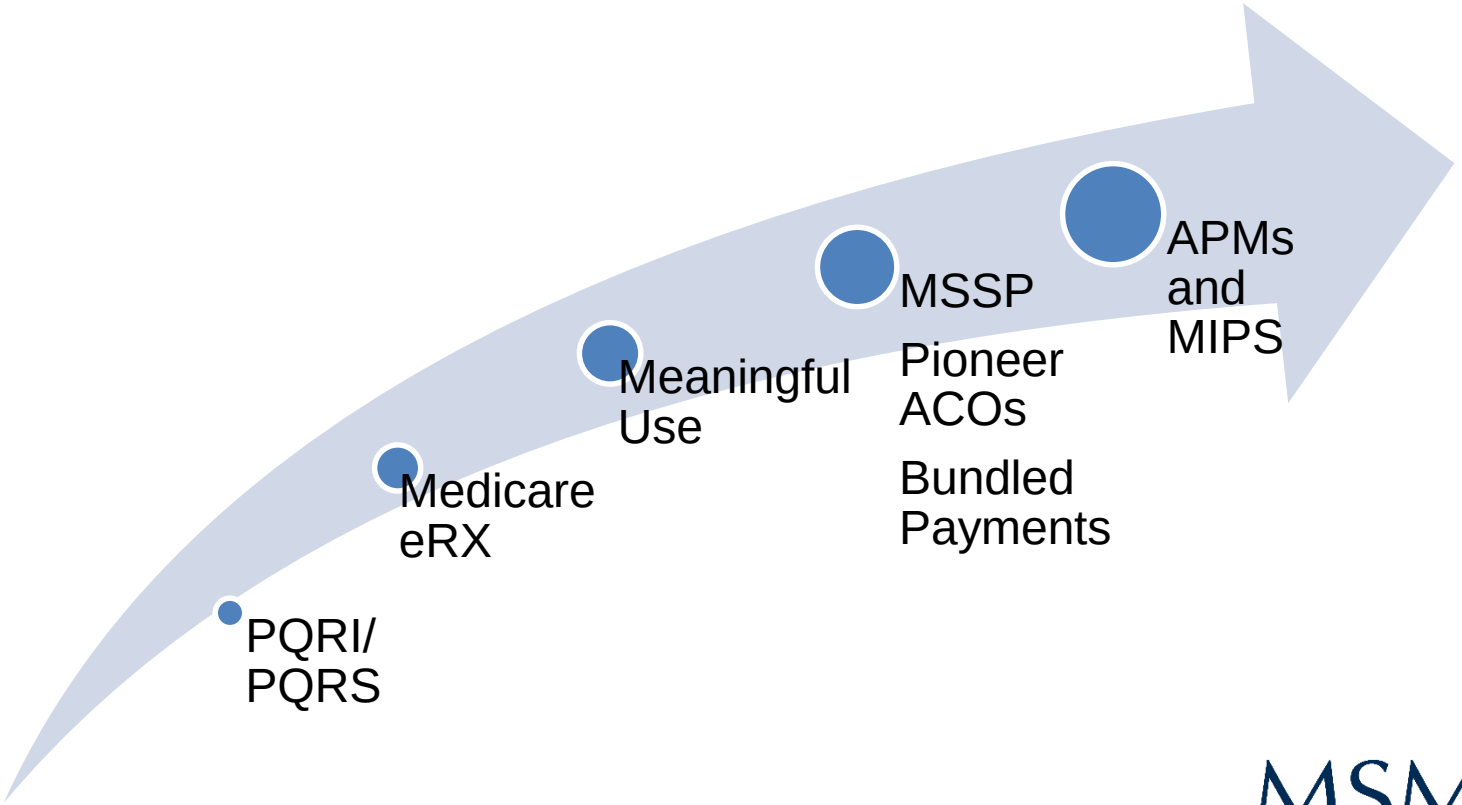
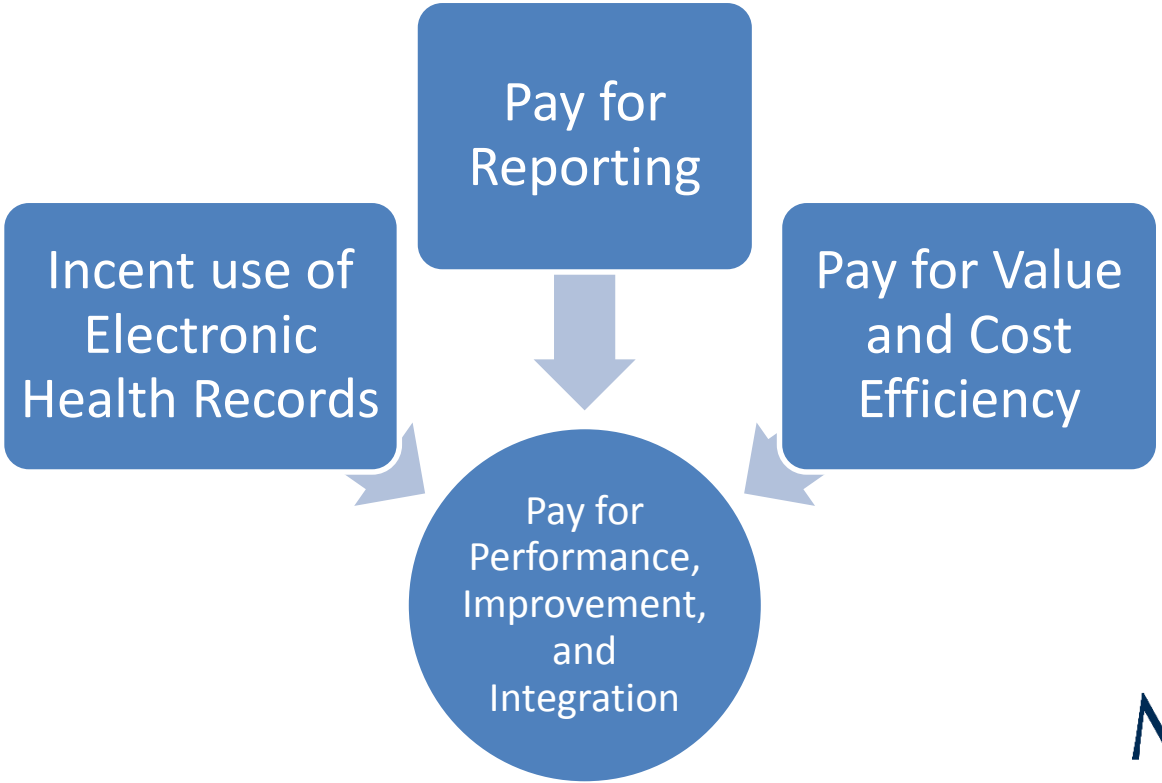
Trends


PQRI/
PQRS
Medicare
eRX
Meaningful
Use
MSSP
Pioneer
ACOs
Bundled
Payments
APMs
and
MIPS

Alignment



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PQRS Overview

- PQRS was designed to promote reporting of best practice quality measures
  - Began 8 years ago
  - “Carrot and stick” approach
    - Incentives paid through 2014
    - Negative adjustment of 1.5% in 2015 and 2% in 2016 and beyond
  - 281 measures in 2016
- Annual updates

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PQRS Overview

- Multiple reporting factors to consider
  - Individually or register for the Group Practice Reporting Option
  - Methods (claims, registry, EHR, Web Interface, QCDR)
  - 12 month reporting period (calendar year)
  - Individual measures, measures groups, and cross-cutting measures
  - Reporting through another CMS program (e.g., MSSP, CPCI, Pioneer ACO)

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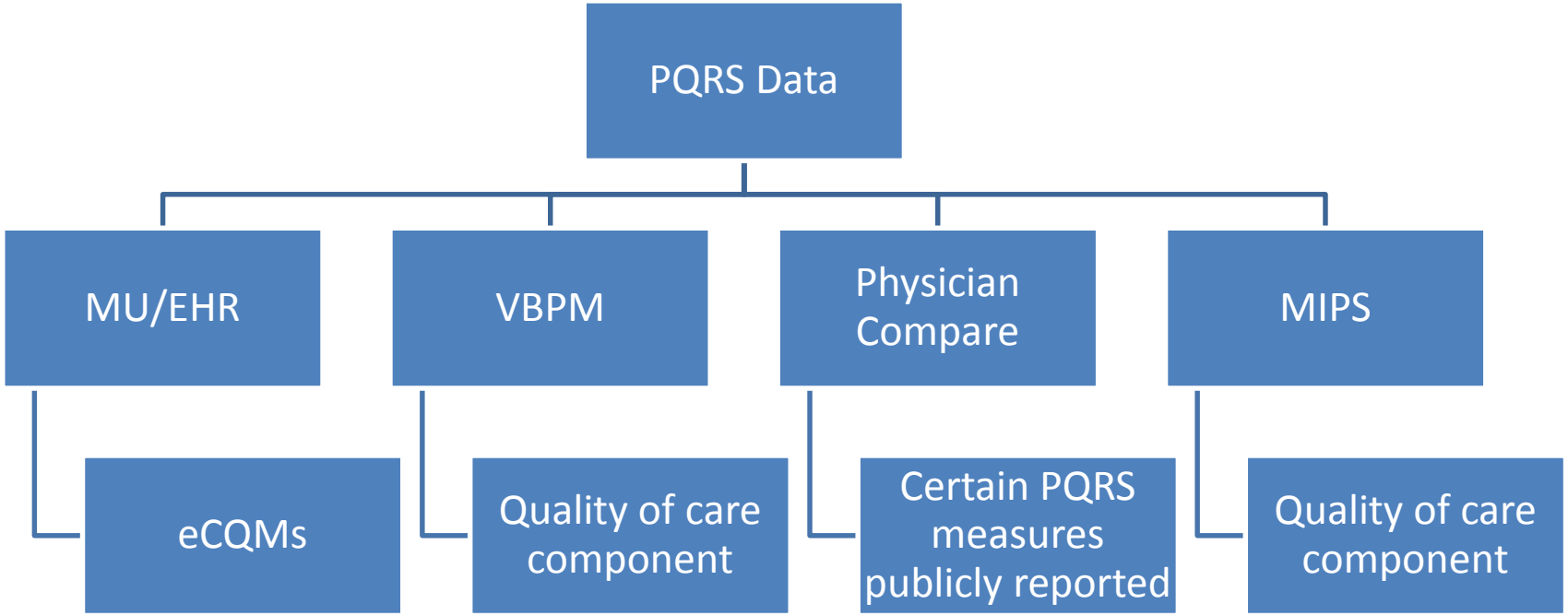
PQRS Big Picture



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Considerations

- Downward payment adjustment (0.02 x total Medicare Part B PFS allowed charges)
- Additional automatic penalty of 2%-4% under the Value-based Payment Modifier
- Disadvantage under the future Merit-based Incentive Payment System (MIPS)
- Staff time
- Other costs (e.g., registry, EHR, consultant, etc.)
- CMS public reporting of participation

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PQRS Roadmap

- Determine eligibility
  - Eligible professionals (EPs)
    - Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Oral Surgery, Doctor of Dental Medicine, Doctor of Chiropractic
    - Physician Assistant, Nurse Practitioner*, Clinical Nurse Specialist*, Certified Registered Nurse Anesthetist* (and Anesthesiologist Assistant), Certified Nurse Midwife*, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Nutrition Professional, Audiologist
    - Physical Therapist, Occupational Therapist, Qualified Speech-Language Therapist

*Includes Advanced Practice Registered Nurse

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PQRS Roadmap

- Decide how your EPs will report
  - As individuals
  - Via the group practice reporting option (GPRO)
    - 2 or more EPs
    - Single TIN
    - Reassigned billing rights to the TIN
  - Through participation in another CMS Program
- Group practice ≠ GPRO
- GPRO registration open from 4/1/16 – 6/30/16

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Individual vs. Group Reporting

	Individual Reporting	Group Reporting
Pros	•EPs select measures that fit their practice •Potential to earn incentive and avoid adjustment even if others in the practice don't •Additional reporting options	•Simpler to track single set of measures •Potential to earn incentive and avoid penalties for all EPs in group even if a few don't meet the threshold
Cons	•Difficult to identify and track measures for a variety of EPs	•Selected measures may not be applicable to all EPs in the group

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PQRS Roadmap

- Choose your reporting method

For Individual EPs

- Medicare Part B claims
- Qualified PQRS Registry
- Qualified Certified Electronic Health Record Technology (CEHRT) EHR or EHR data submission vendor
- Qualified Clinical Data Registry (QCDR)

For Groups via the GPRO

- Qualified PQRS registry (groups of 2+)
- Qualified CEHRT EHR or EHR data submission vendor (groups of 2+)
- Web Interface (groups of 25+ only)
- CG CAHPS CMS-certified survey vendor (groups of 2+) (required for groups of 100+)
- Qualified Clinical Data Registry (groups of 2+)

Reporting Method	Individual	GPRO	Reporting Requirements	Submission	Other Comments
Medicare Part B FFS Claims	X		9 measures/3 domains for 50% of applicable patients + if at least 1face-to-face encounter w/Medicare patient, report required cross-cutting measure	Concurrent w/claims submission	Cannot retroactively correct claims for the purpose of adding the quality measures
Qualified Registry	X	X	9 measures/3 domains for 50% of applicable patients + if at least 1face-to-face encounter w/Medicare patient ,report 1 cross-cutting measure or 1 measures group (20 patients and at least 11 are Medicare Part B patients); GPRO groups of 100+ must administer the CAHPS for PQRS survey	Registry submits data annually	Only method for reporting measures group **Only individuals can report measures groups**
Qualified EHR	X	X	9 measures/3 domains for 50% of applicable patients	Annual submission	May be able to coordinate w/MU CQM requirements
GPRO Web-based Interface		X	Report on 18 CMS pre-selected measures for a sample of assigned beneficiaries (248)	Annual submission	Option only available for groups of 25 or more EPs
Qualified Clinical Data Registry	X	X	9 measures/3 domains for 50% of applicable patients (2 measures must be outcome measures; if there aren't 2 measures, then 1 measure + 1 measure type); includes both PQRS and non-PQRS measures	QCDR submits data annually	May be preferable, more meaningful option for specialists
CMS Certified Survey Vendor (CG-CAHPS)		X	12 CAHPS survey modules selected by CMS + at least 6 measures/2 domains (registry, EHR reporting, & QCDR); GPRO groups of 25-99 EPs reporting via WI must report CAHPS + all 18 measures within the GPRO WI; CMS draws a sample of Medicare beneficiaries assigned to a practice – min sample size based on # of EPs	Administered and collected by survey vendor	**Optional:** Groups of 2-99 EPs **Required:** Groups of 100 or more EPs reporting via the Web-based interface

PQRS Roadmap

- Select your measures
  - Clinical conditions commonly treated
  - Types of care frequently delivered (e.g., preventive, chronic, acute)
  - Settings where care is delivered
  - Quality improvement goals
  - CMS suggested Specialty Measure Sets
  - Other quality reporting programs in use or being considered
- Review Measures List or the 2016 PQRS Single Source Code Master

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Measure Selection

Individual Measures

- Select 9 measures
- At least 3 domains
- Report on at least 50% of applicable Medicare Part B FFS patients
- 1 cross-cutting measure if at least 1 Medicare face-to-face encounter

Measures Group (for individual reporters only)

- Bundle of individual Measures
- Select 1 Measures Group
- Report on 20 patients (over 50% must be Medicare Part B FFS)
- Report via registry only

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Measure Selection

- Review specifications
- Domains
- Cross cutting measures (23 measures in 2016)
- Limitations
  - Measures Groups
    - Registry
    - Individuals
  - GPRO group practices
    - No claims reporting

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Measures - Domains

Patient Safety	Person & Caregiver-Centered Experience and Outcomes	Communication and Care Coordination
Effective Clinical Care	Community/Population Health	Efficiency and Cost Reduction

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Measures List Example

Measure Title	Measure Number CMS	NQF	PQPS	Measure Description	NQS Domain	Measure Type	Measure Developer/Stewar #1	#2	#3	Reporting Meth Claim	CS
Perioperative Anti-platelet Therapy for Patients Undergoing Carotid Endarterectomy	N/A	0465	423	Percentage of patients undergoing carotid endarterectomy (CEA) who are taking an anti-platelet agent (aspirin or clopidogrel or equivalent such as aggrenox/tiglacor, etc.) within 48 hours prior to surgery and are prescribed this medication at hospital discharge following surgery	Effective Clinical Care	Process	Society for Vascular Surgeons	-	-	X	-
Perioperative Temperature Management	N/A	2681	424	Percentage of patients, regardless of age, who undergo surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer for whom at least one body temperature greater than or equal to 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) was	Patient Safety	Process	American Society of Anesthesiologists	-	-	-	-
Photodocumentation of Cecal Intubation	N/A	N/A	425	The rate of screening and surveillance colonoscopies for which photodocumentation of landmarks of cecal intubation is performed to establish a complete examination	Effective Clinical Care	Process	American College of Gastroenterology	American Gastroenterological Association	American Society for Gastrointestinal	X	-
Post-Anesthetic Transfer of Care Measure: Procedure Room to a Post Anesthesia Care Unit (PACU):	N/A	N/A	426	Percentage of patients, regardless of age, who are under the care of an anesthesia practitioner and are admitted to a PACU in which a post-anesthetic formal transfer of care protocol or checklist which includes the key transfer of care elements is utilized	Communication and Care Coordination	Process	American Society of Anesthesiologists	-	-	-	-
Post-Anesthetic Transfer of Care: Use of Checklist or Protocol for Direct Transfer of Care from Procedure Room to Intensive Care Unit (ICU)	N/A	N/A	427	Percentage of patients, regardless of age, who undergo a procedure under anesthesia and are admitted to an Intensive Care Unit (ICU) directly from the anesthetizing location, who have a documented use of a checklist or protocol for the transfer of care from the responsible	Communication and Care Coordination	Process	American Society of Anesthesiologists	-	-	-	-
Pelvic Organ Prolapse: Preoperative Assessment of Occult Stress Urinary Incontinence	N/A	N/A	428	Percentage of patients undergoing appropriate preoperative evaluation for the indication of stress urinary incontinence per ACOG/AUGS/AUA guidelines	Effective Clinical Care	Process	American Urogynecologic Society	-	-	-	-
Pelvic Organ Prolapse: Preoperative Screening for Uterine Malignancy	N/A	N/A	429	Percentage of patients who are screened for uterine malignancy prior to surgery for pelvic organ prolapse.	Patient Safety	Process	American Urogynecologic Society	-	-	X	-
Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy	N/A	N/A	430	Percentage of patients, aged 18 years and older, who undergo a procedure under an inhalational general anesthetic, AND who have three or more risk factors for post-operative nausea and vomiting (PONV), who receive	Patient Safety	Process	American Society of Anesthesiologists	-	-	-	-

Measure Components

- Measure = Numerator／Denominator
  - Denominator defines the eligible population to be measured
  - Numerator represents those patients for whom the quality action was performed
- Indicators of how often a process of care or outcome of care occurs
- Quality data codes are used to report measures

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Getting Started in 2015

- Select reporting option
  - If GPRO, register through the online PV-PQRS Registration System at https://portal.cms.gov by June 30, 2015 (instructions can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html)
- Select reporting method
- Select measures
  - For claims, registry, and EHR reporting method
    - At least 9 individual measures covering at least 3 of 6 domains
    - 1 measures group (only individuals reporting via registry)

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Example 1

Appendix D: Satisfactory Reporting via Claims Scenario

Satisfactorily Reporting Scenario
Measure #6: Coronary Artery Disease (CAD): Antiplatelet Therapy

Mr. Jones, age 65, presents for office visit (**99213**) with Dr. Thomas

Mr. Jones, has diagnosis of CAD (414.00)

Scenario 1

Dr. Thomas prescribes aspirin or clopidogrel

4086F

Scenario 2

Dr. Thomas does not prescribe aspirin or clopidogrel for Medical, Patient or System Reasons

4086F with 1P
4086F with 2P
4086F with 3P

Scenario 3

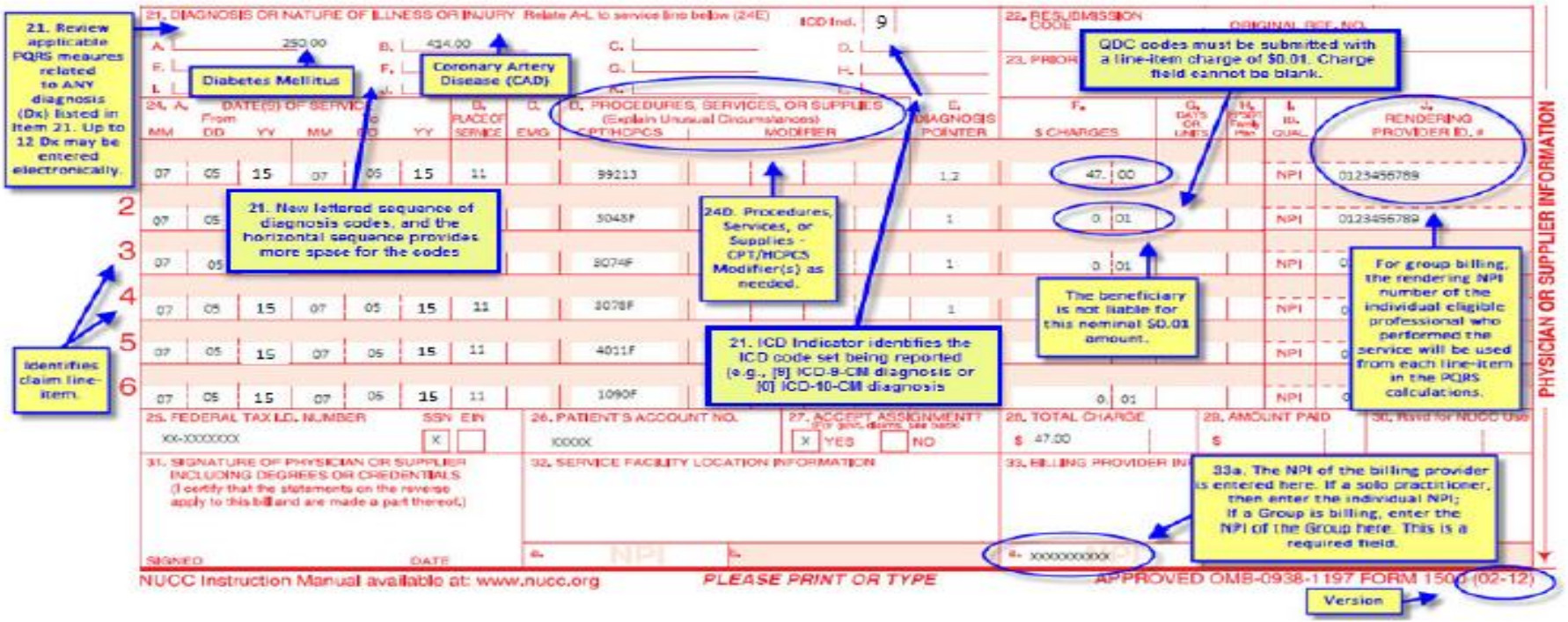
Dr. Thomas does not prescribe aspirin or clopidogrel and does not specify the reason

4086F with 8P

Example 1 (continued)

Appendix D: CMS-1500 Claim PQRS Example

Example of an individual NPI reporting on a single CMS-1500 claim.
See http://www.cms.gov/manuals/downloads/clm104c26.pdf for more information and complete billing requirements.



Example 2

- PQRS Measure #130 – Documentation of Current Medications in the Medical Record
  - Denominator = All visits for patients ≥18 years of age
  - Numerator = Patients ≥18 years of age for which the EP attests to documenting, updating, or reviewing patient's current medications
  - Numerator Quality-Data Coding Options for Satisfactory Reporting
    - G8427 = Current medications documented
    - G8430 = Current Medications not documented, patient not eligible
    - G8428 = Current medications w/name, dosage, frequency, or route not documented, reason not given
  - Frequency = reported each visit during the 12-month reporting period

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Example 3

- PQRS Measure #47 – Advance Care Plan
- Percentage of patients ≥65 who have an advance care plan or surrogate decision maker documented or documented that plan discussed but patient did not wish or was unable to name a surrogate or provide an advance care plan
- No diagnosis required
- E&M 99221, 99222, 99223 (+ others) define denominator eligible patients

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Example 3 (continued)

- Reporting Options
  - 1123F – Documented
  - 1124F – Documented as discussed – patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
  - 1123F-8P – Advance care planning not documented, reason not otherwise specified
- Documented in the medical record that during the visit an advance care plan was discussed. Patient does not have an advanced directive or living will. Her daughter will be the surrogate decision maker

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MAV

- Measures Applicability Validation (MAV) process
  - Recognition that not all specialists can report on 9 measures or across 3 domains
  - Successful PQRS participation if EP passes MAV test
  - 2-step validation process
    - Any other reportable measures
    - Minimum threshold test

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Avoiding the 2018 Adjustment

Individual EPs and Groups selecting GPRO:

- Satisfactory report 2016 PQRS measures via selected reporting method

What Happens Now?

- Current programs and payment adjustments in place through end of 2018
- Physicians and other eligible professionals must participate to avoid negative payment adjustments
- Medicare Access and CHIP Reauthorization Act of 2015 (HR 2) builds upon current programs and retains many components
- Be prepared for the Physician Value-Based Payment Modifier = participate in PQRS

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Physician VBPM

- Federal initiative that begins to move Medicare Part B from fee-for-service (FFS) towards fee-for-value (FFV)
- Section 3007 of the Patient Protection and Affordable Care Act
- Differential payment based on the quality of care furnished compared to cost of care furnished
- An adjustment made on a per claim basis to Medicare payments for items and services under the Medicare Physician Fee Schedule (PFS)

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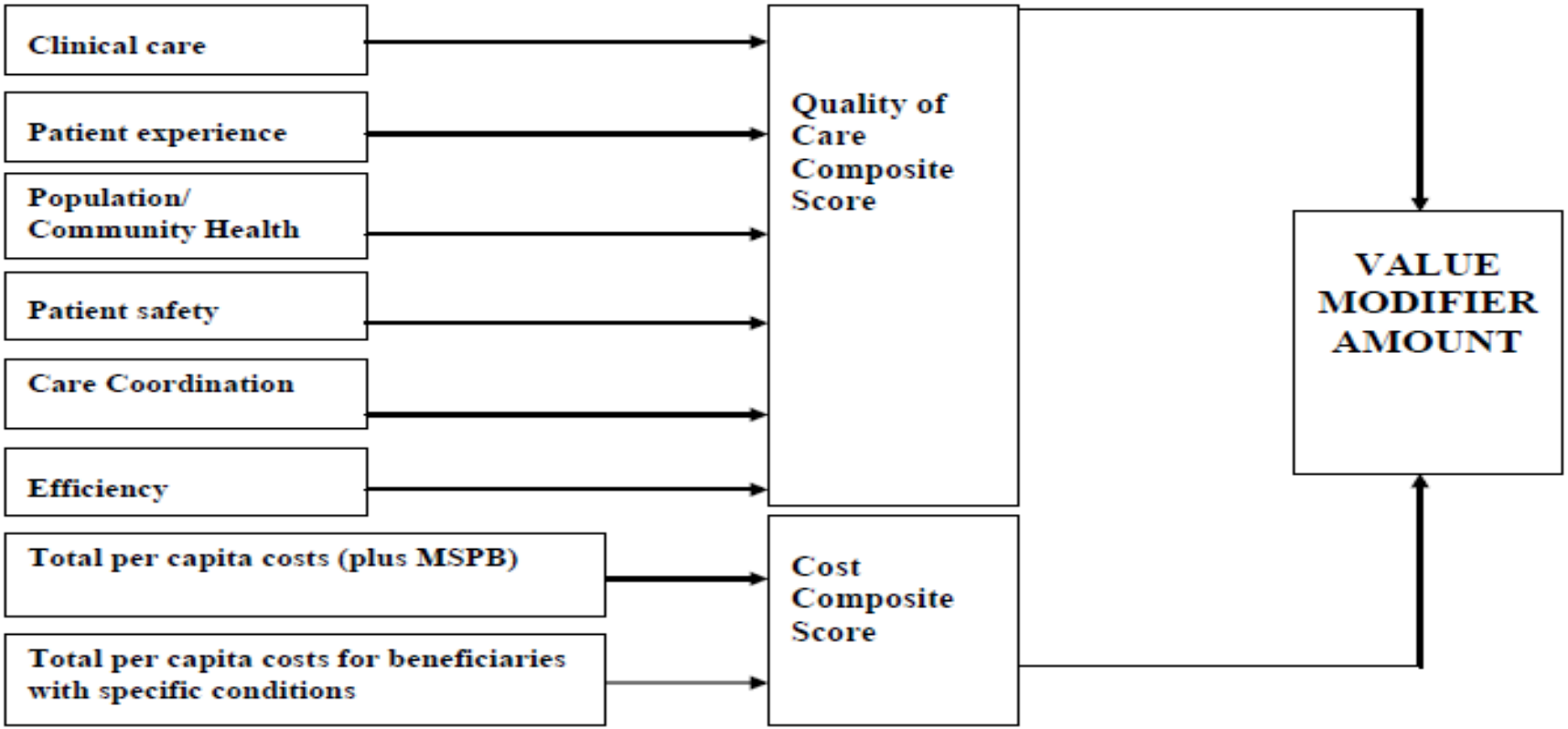
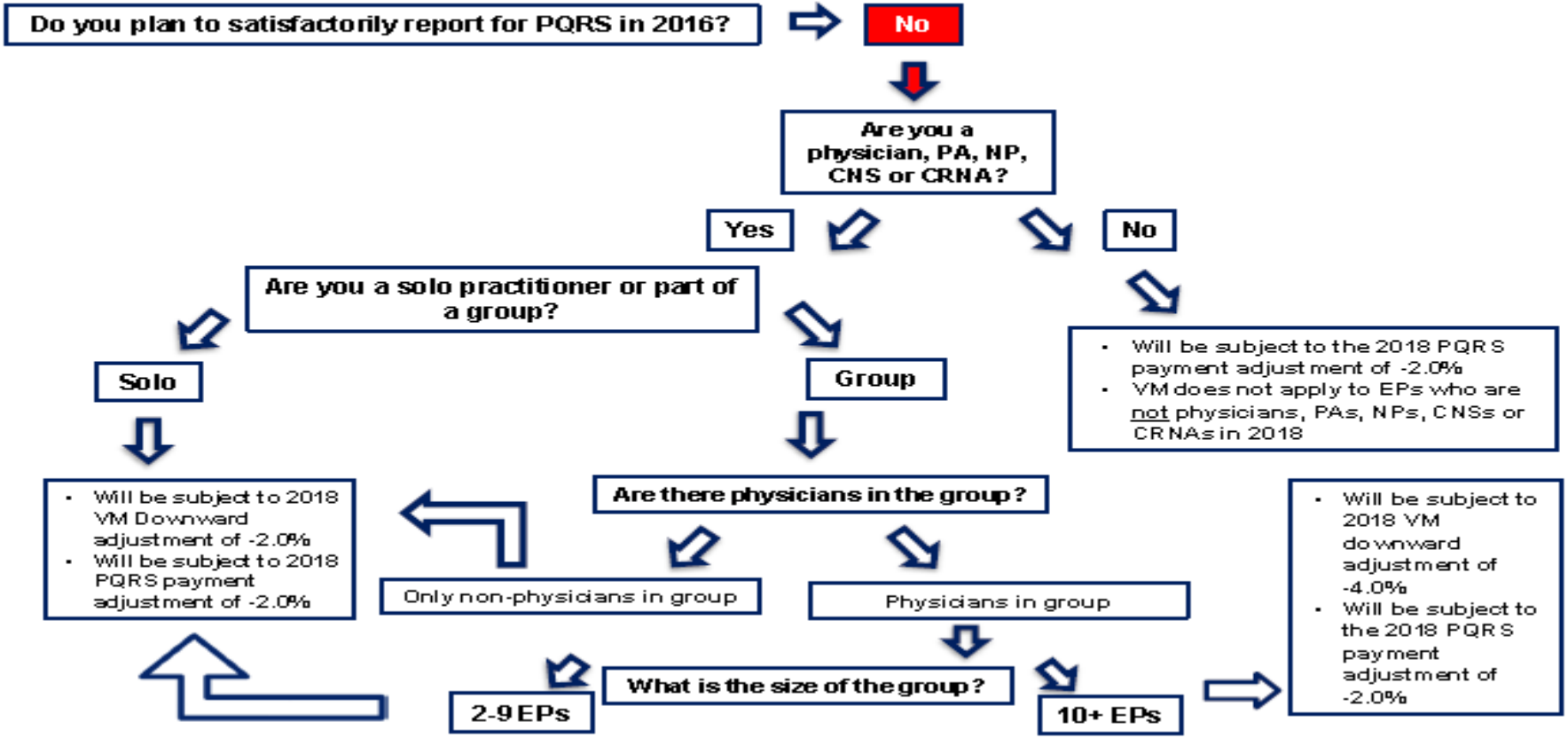
Quality Tiering Methodology



How Does 2016 PQRS Participation Affect the VM in 2018?



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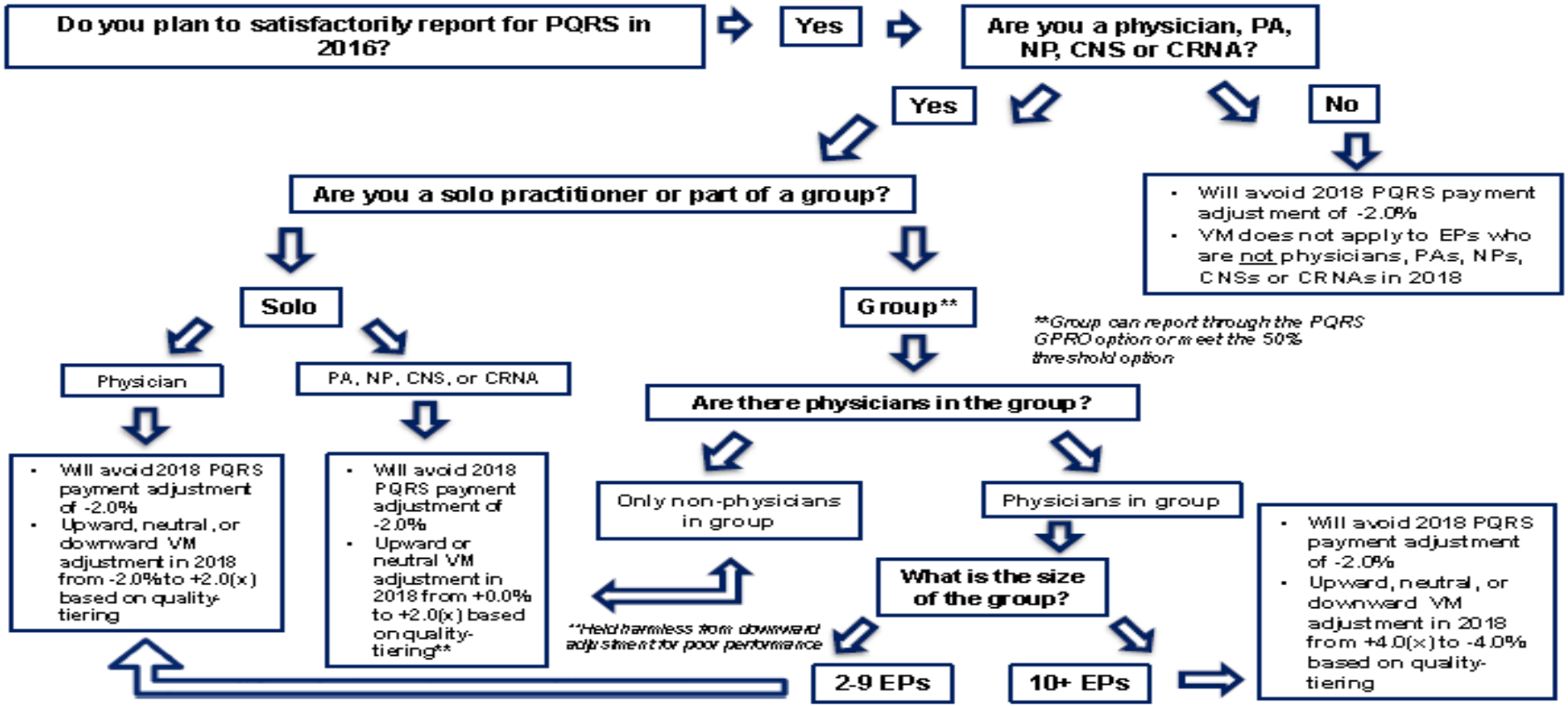
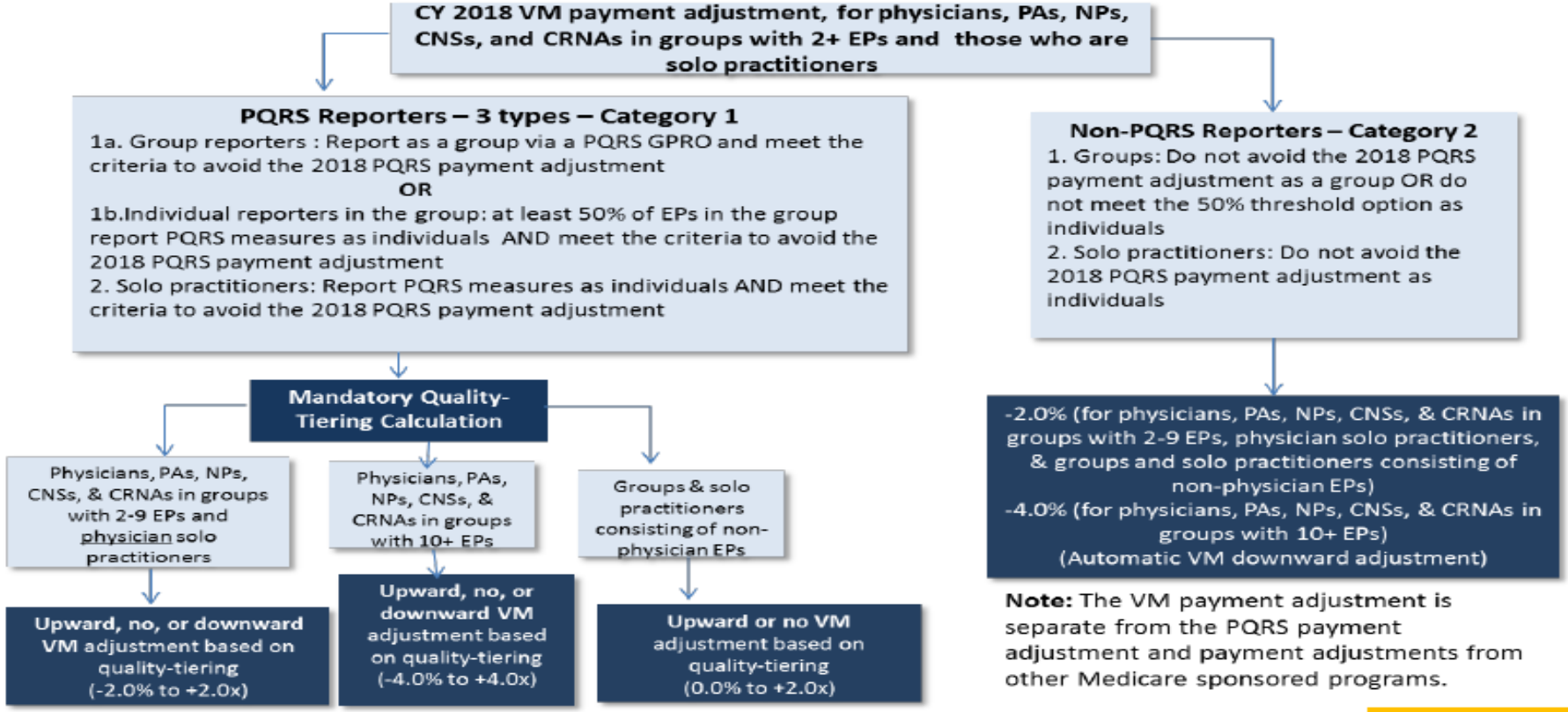


Final Policies for the 2018 VM



Note: The VM payment adjustment is separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs.

Acronyms

Calculation of VBPM

- Uses PQRS quality data and Medicare cost data to determine overall value score
- Quality benchmarks set for each performance year based on prior year's performance data of all solo practitioners and groups nationwide
- Greatest reward to high-performing, lower cost EPs
- Greatest negative adjustment to low-performing, higher cost EPs

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Calculation of VBPM

- Quality of Care Composite
  - PQRS + 3 outcomes measures
    - All-cause hospital readmissions
    - Composite of preventable hospitalizations for acute conditions:
      - Bacterial pneumonia
      - Urinary tract infection
      - Dehydration
    - Composite of preventable hospitalizations for chronic conditions :
      - Chronic obstructive pulmonary disease
      - Heart failure
      - Diabetes
  - Optional – CAHPS measures

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Calculation of VBPM

- Cost Composite
  - Total per capita costs (Parts A & B)
  - Total per capita costs for beneficiaries with four chronic conditions:
    - COPD
    - Heart Failure
    - Coronary Artery Disease
    - Diabetes
  - Medicare Spending Per Beneficiary (3 days before and 30 days after an inpatient hospitalization)
- Payment-standardized and risk-adjusted and adjusted for specialty mix of EPs in the group

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Calculation of VBPM

- For MSSP in 2018
  - Cost composite: Average
  - Quality composite: Based on ACO's quality data + the ACO all-cause hospital readmissions measure as calculated under the MSSP
- For Pioneer ACOs and CPC Initiative participants in 2018
  - Waived for groups and solo practitioners, as identified by their TIN, if at least 1 EP who bill for PFS items and services under the TIN during the 2016 participated in the Pioneer ACO or CPCI or other similar Innovation Center models

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2018 VM for PAs, NPs, CNSs, & CRNAs who are Solo Practitioners or in Groups of Non-Physicians

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0x*	+2.0x*
Average Cost	+0.0%	+0.0%	+1.0x*
High Cost	+0.0%	+0.0%	+0.0%

*Eligible for an additional +1.0x if reporting clinical data for quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores.

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2018 VM for Groups w/2-9 EPs & Solo Practitioners

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0x*	+2.0x*
Average Cost	-1.0%	+0.0%	+1.0x*
High Cost	-2.0%	-1.0%	+0.0%

*Eligible for an additional +1.0x if reporting clinical data for quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores.

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2018 VM for Groups w/10+ EPs

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+2.0x*	+4.0x*
Average Cost	-2.0%	+0.0%	+2.0x*
High Cost	-4.0%	-2.0%	+0.0%

*Eligible for an additional +1.0x if reporting clinical data for quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores.

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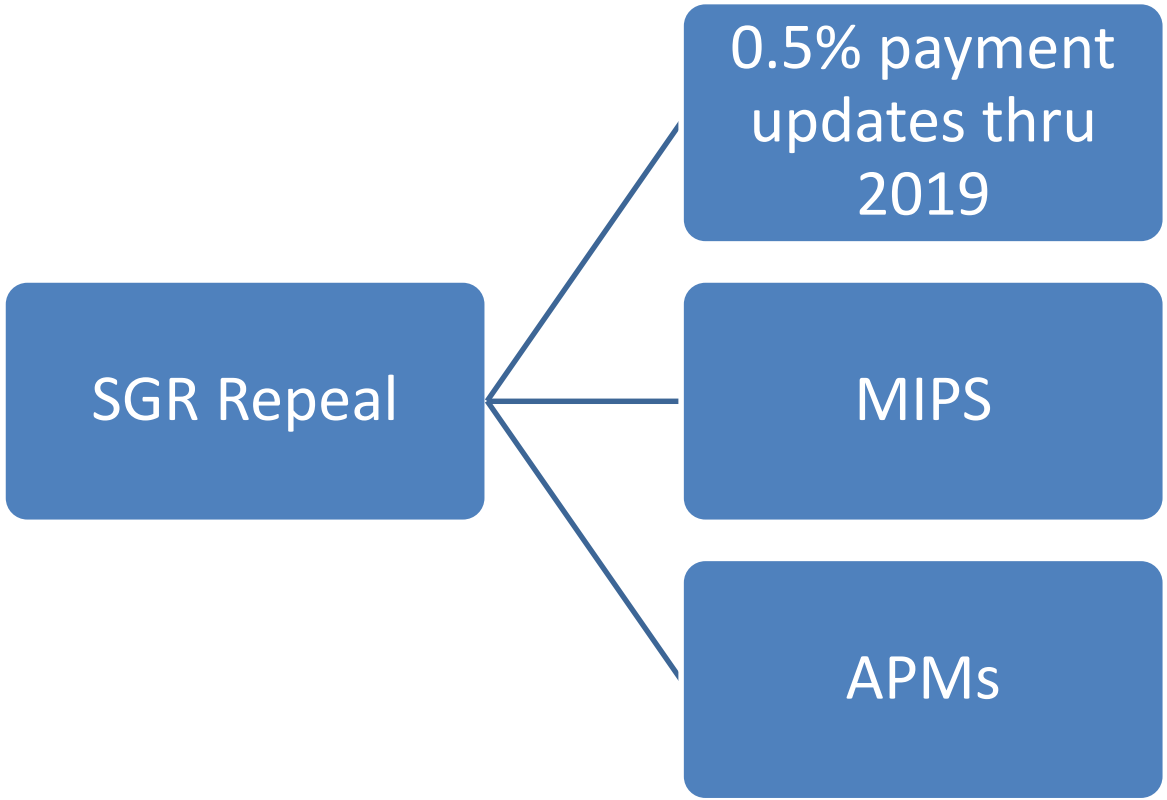

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MIPS Performance Categories and Weights (Resource Use Ramps Up Over 3 Years)

Performance Categories*	Year 1 (2019)	Year 2 (2020)	2021-forward
Quality	50%	45%	30%
Resource Use	10%	15%	30%
Clinical Practice Improvement Activities	15%	15%	15%
Meaningful Use of EHR*	25%	25%	25%
Maximum MIPS Reduction	4%	5%	7% (2021) 9%(2022-forward)

* Meaningful use weight can decrease to 15% and be redistributed if EHR adoption reaches 75%. If Secretary determines an EP does not have enough measures, then CMS may change weight distribution

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Cumulative Medicare Payment Adjustments

Year	eRx	PQRS	EHR	VBPM	Total
2012	1.0%				1.0%
2013	1.5%				1.5%
2014	2.0%				2.0%
2015	1.0%	1.5%	1.0%	Up to 1.0%	Up to 4.5%
2016		2.0%	2.0%	Up to 2.0% (for groups w/10+ EPs)	Up to 6.0%
2017		2.0%	3.0%	2.0% (for groups w/2-9 EPs and solo practitioners) 4.0% (for groups w/10+ EPs)	Up to 7.0% (for groups w/2-9 EPs and solo practitioners) Up to 9.0% (for groups w/10+ EPs)
2018		2.0%	3.0%	2.0% (for groups w/2-9 EPs and solo practitioners) 4.0% (for groups w/10+ EPs)	Up to 7.0% (for groups w/2-9 EPs and solo practitioners) Up to 9.0% (for groups w/10+ EPs)

MIPS and APM Impact

Year	Baseline	MIPS Incentive Adjustment	MIPS Incentive Adjustment w/exceptional performance adjustment	APM
2019	0.5%	+/- 4.0%	14.0%	FFS Bonus: +5.0%
2020	0.0%	+/- 5.0%	15.0%	FFS Bonus: +5.0%
2021	0.0%	+/- 7.0%	17.0%	FFS Bonus: +5.0%
2022-2024	0.0%	+/- 9.0%	19.0%	FFS Bonus: +5.0%
2025	0.0%	+/- 9.0%	NA	0.0%
2026 and subsequent years	0.25% (for non-APM physicians only)	+/- 9.0%	NA	0.75%

Action Recommended

- Review Feedback Reports
- Review Quality and Resource Use Reports (QRURs)
  - Download at https://portal.cms.gov
  - See directions on how to obtain your QRUR at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html#2014-annual-qrur
- Request informal review if disagree with findings within 60 calendar days after the release of the QRURs
- QRURs with 2014 data have been released
- QRURs with 2015 data likely to be released late summer of 2016

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Action Recommended

- Participate successfully in PQRS
  - Option 1: Participate as a group practice via the Group Practice Reporting Option (GPRO)
  - Option 2: Participate as an individual
  - Option 3: Participate as part of the MSSP
- Work on improving administrative processes and performance measurements under PQRS and VBPM

PQRS & VBPM Resources

- CMS PQRS Web Site (main page with links to other resources) - http://cms.hhs.gov/PQRS
- PQRS Measures Codes - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html
- CMS Value-based Payment Modifier – http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html
- QRURs - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html
- FAQs – https://questions.cms.gov

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PQRS & VBPM Resources

- QualityNet Help Desk
  - 1-866-288-8912 (TTY 1-877-715-6222)
  - qnetsupport@hcqis.org
- National Provider Calls
  - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/CMSSponsoredCalls.html
- FFS Provider Listserv
  - https://list.nih.gov/cgi-bin/wa.exe?A0=PHYSICIANS-L

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Thank You!

Stacey Hettiger
Director, Medical and Regulatory Policy
Michigan State Medical Society
(517) 336-5766
shettiger@msms.org

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