Quality Measurement: What providers need to know about CMS Quality Programs

CAPT Michael Toedt, MD, FAAFP
Acting Chief Medical Information Officer
Office of Information Technology, Indian Health Service
August 20, 2015

Objectives

- Provide a general overview of both the PQRS and VM programs
- Describe the national goals of the PQRS and VM programs
- Define eligibility and participation requirements for the PQRS program
- Describe how the VM will be phased in and its linkage to PQRS
- Recommend steps to avoid the PQRS negative payment adjustment and the VM negative payment adjustment
- Provide a high-level overview of the future of CMS quality reporting as a result of the Medicare Reform Law and CHIP Reauthorization Act of 2015 (MACRA)

Goals of the PQRS and VM Program

- Both the PQRS and VM programs contribute to all 3 of the National Quality Strategy aims by promoting consistent, evidence-based care.

- The National Quality Strategy aims are:
  - Better care for individuals
  - Better care for populations
  - Lower costs through improvement

MULTIPLE CHOICE

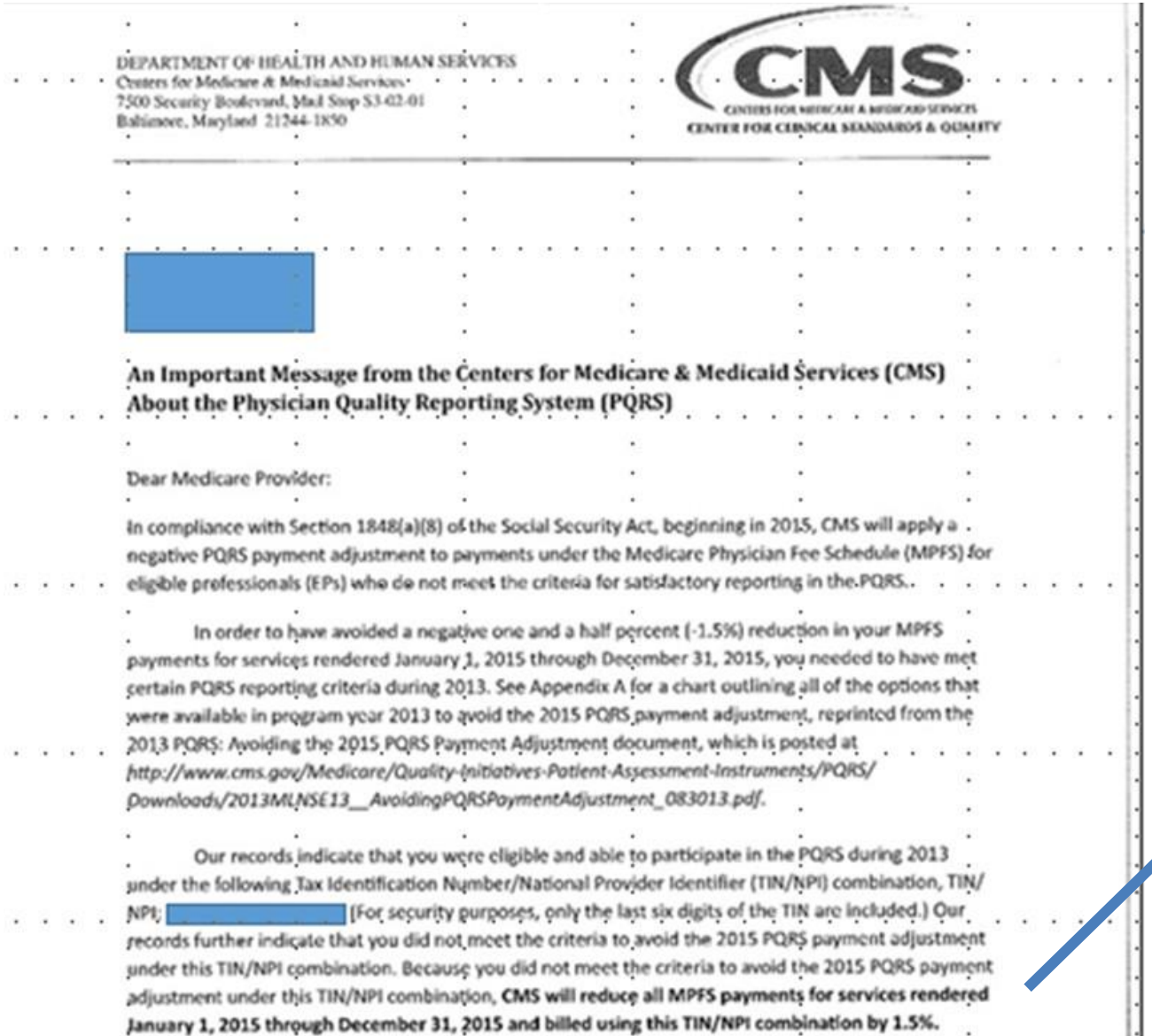
The National Quality Strategy aims are:

A. Better care for individuals
B. Better care for populations
C. Lower costs through improvement
D. All of the above

CMS Quality Reporting for EPs

- PQRS- Physician Quality Reporting System (2017 penalties based on 2015 CY performance, -2% MPFS)
- VM- Value Modifier (as above, -2% MPFS)
- MACRA- Medicare and CHIPS Reauthorization Act (signed into law 4/16/15)
- MIPS- Merit-based Incentive Payment System – replaces PQRS/VM/EHR-MU incentives 1/1/19 (based on 2017 CY performance) +/- 4%...
- TPS – Total Performance Score- Quality 30%; Resource Use 30%; Clinical Improvement Activities 15%; MU of EHRs 25%

Fiscal Impact (Medicare Physician Fee Schedule)



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-02-01
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CLINICAL STANDARDS & QUALITY

[redacted]

An Important Message from the Centers for Medicare & Medicaid Services (CMS) About the Physician Quality Reporting System (PQRS)

Dear Medicare Provider:

In compliance with Section 1848(a)(8) of the Social Security Act, beginning in 2015, CMS will apply a negative PQRS payment adjustment to payments under the Medicare Physician Fee Schedule (MPFS) for eligible professionals (EPs) who do not meet the criteria for satisfactory reporting in the PQRS.

In order to have avoided a negative one and a half percent (-1.5%) reduction in your MPFS payments for services rendered January 1, 2015 through December 31, 2015, you needed to have met certain PQRS reporting criteria during 2013. See Appendix A for a chart outlining all of the options that were available in program year 2013 to avoid the 2015 PQRS payment adjustment, reprinted from the 2013 PQRS: Avoiding the 2015 PQRS Payment Adjustment document, which is posted at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013MLNSE13__AvoidingPQRSPaymentAdjustment_083013.pdf*.

Our records indicate that you were eligible and able to participate in the PQRS during 2013 under the following Tax Identification Number/National Provider Identifier (TIN/NPI) combination, TIN/NPI; [redacted] (For security purposes, only the last six digits of the TIN are included.) Our records further indicate that you did not meet the criteria to avoid the 2015 PQRS payment adjustment under this TIN/NPI combination. Because you did not meet the criteria to avoid the 2015 PQRS payment adjustment under this TIN/NPI combination, **CMS will reduce all MPFS payments for services rendered January 1, 2015 through December 31, 2015 and billed using this TIN/NPI combination by 1.5%.**

"CMS will reduce all MPFS payments for services rendered January 1, 2015 through December 31, 2015 and billed with this TIN/NPI combination by 1.5%"

Fiscal Impact (Medicare Physician Fee Schedule)

YEAR	Meaningful Use	PQRS	eRX	Medicare Sequestration	VBM	Total Penalties
2012			-1.0%			-1.0%
2013			-1.5%	-2.0%		-3.5%
2014			-2.0%	-2.0%		-4.0%
2015	-1.0%	-1.5%		-2.0%	-1.0%	-5.5%
2016	-2.0%	-2.0%		-2.0%	-2.0%	-8.0%
2017	-3.0%	-2.0%		-2.0%	-2.0%	-9.0%
2018	Up to -5.0%	-2.0%		-2.0%	-2.0%	-11.0%

What is PQRS?

- Established in 2007, PQRS is a Medicare Part B reporting program that uses a combination of incentive payments and negative payment adjustments to promote reporting of MPFS quality information by EPs or group practices participating in GPRO.
- The 2013 MPFS Final Rule established the requirements for the PQRS incentive payment and for the 2015 PQRS negative payment adjust
- The 2014 MPFS Final Rule established the 2016 PQRS negative payment adjustments.
- The 2015 MPFS Final Rule establishes the 2017 PQRS negative payment adjustments.

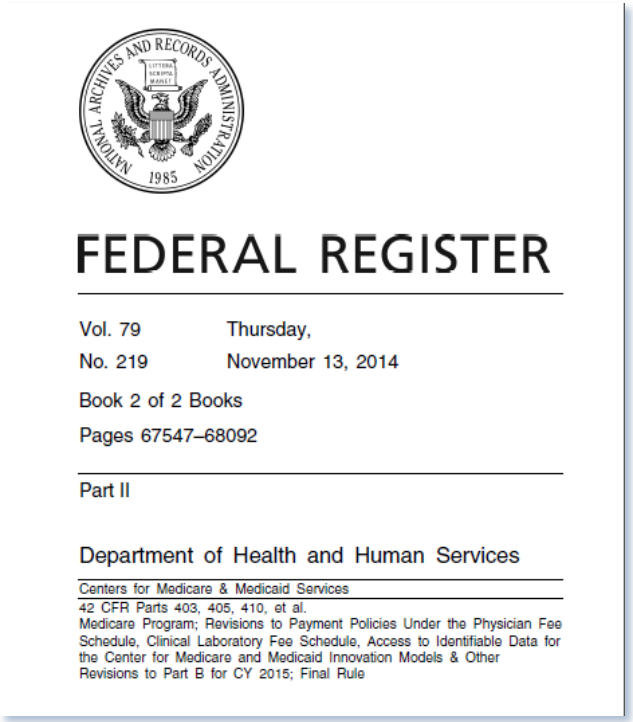
MULTIPLE CHOICE

The 2015 Medicare Physician Fee Schedule (MPFS) Final Rule establishes the 2017 PQRS negative payment adjustments. This means that payment adjustments for the MPFS are based on a performance period which is:

A. 1 year prior to the payment year
B. 2 years prior to the payment year
C. 3 years prior to the payment year
D. 4 years prior to the payment year

2015 Medicare Physician Fee Schedule

- Published in Federal Register 11-13-2014
- 464 pages
- Separate from the CMS Meaningful Use and ONC Certification Criteria



FEDERAL REGISTER

Vol. 79 Thursday,
No. 219 November 13, 2014
Book 2 of 2 Books
Pages 67547–68092

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 403, 405, 410, et al.
Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Final Rule

What is the Value Modifier?

- A new payment modifier under the MPFS mandated by the Affordable Care Act
- VM Assesses both quality of care furnished and the cost of that care under the MPFS
- Performance on quality and cost measures is provided to physicians through annual physician feedback reports, also know as QRURs.

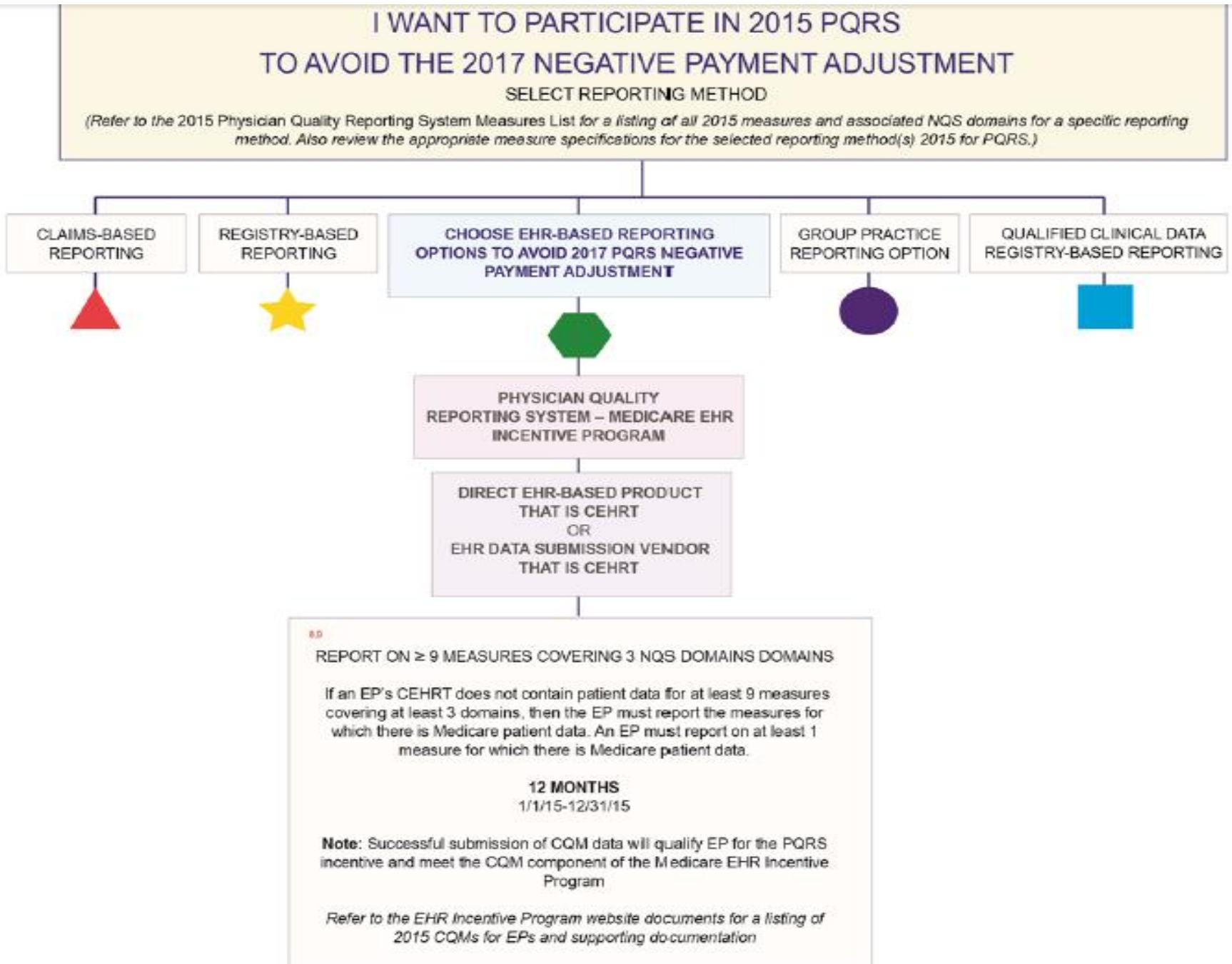
PQRS Eligibility

Medicare Physicians	Practitioners	Therapists
Doctor of Medicine	Physician Assistant	Physical Therapist
Doctor of Osteopathy	Nurse Practitioner	Occupational Therapist
Doctor of Podiatric Medicine	Clinical Nurse Specialist	Qualified Speech-Language Therapist
Doctor of Optometry	Certified RN Anesthetist	
Doctor of Oral Surgery	Certified Nurse Midwife	
Doctor of Dental Medicine	Clinical Social Worker	
Doctor of Chiropractic	Registered Dietitians	
	Nutritional Professional	
	Audiologist	

PQRS Reporting

- Individual EP Reporting
  - Under PQRS, covered professional services are those paid under or based on the MPFS. To the extent that EPs are providing services that get paid under or based on the MPFS, those services are subject to negative payment adjustments.

- Group Practice Reporting
  - For the 2015 program, a group practice is defined as a single TIN with 2 or more individual EPs (as identified by individual NPIs) who have reassigned their billing rights to the TIN.


I WANT TO PARTICIPATE IN 2015 PQRS
TO AVOID THE 2017 NEGATIVE PAYMENT ADJUSTMENT
SELECT REPORTING METHOD
(Refer to the 2015 Physician Quality Reporting System Measures List for a listing of all 2015 measures and associated NQS domains for a specific reporting method. Also review the appropriate measure specifications for the selected reporting method(s) 2015 for PQRS.)
CLAIMS-BASED REPORTING
REGISTRY-BASED REPORTING
CHOOSE EHR-BASED REPORTING OPTIONS TO AVOID 2017 PQRS NEGATIVE PAYMENT ADJUSTMENT
GROUP PRACTICE REPORTING OPTION
QUALIFIED CLINICAL DATA REGISTRY-BASED REPORTING
PHYSICIAN QUALITY REPORTING SYSTEM – MEDICARE EHR INCENTIVE PROGRAM
DIRECT EHR-BASED PRODUCT THAT IS CEHRT
OR
EHR DATA SUBMISSION VENDOR THAT IS CEHRT
REPORT ON ≥ 9 MEASURES COVERING 3 NQS DOMAINS DOMAINS
If an EP's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the EP must report the measures for which there is Medicare patient data. An EP must report on at least 1 measure for which there is Medicare patient data.
12 MONTHS
1/1/15-12/31/15
Note: Successful submission of CQM data will qualify EP for the PQRS incentive and meet the CQM component of the Medicare EHR Incentive Program
Refer to the EHR Incentive Program website documents for a listing of 2015 CQMs for EPs and supporting documentation

PQRS reporting in 2016 (for PY2015) in order to avoid payment reduction in 2017

- OIT on schedule to have CQM engine completed this year that will allow for electronic submission of *some* CQMs for both MU2 reporting and PQRS reporting.

- Outstanding issues: 2014 updates to measures still under development / deployment /field use; some EPs will need to choose CQMs that must be reported by other methods

VALUE BASED PAYMENT MODIFIER (VM)

The Value Modifier

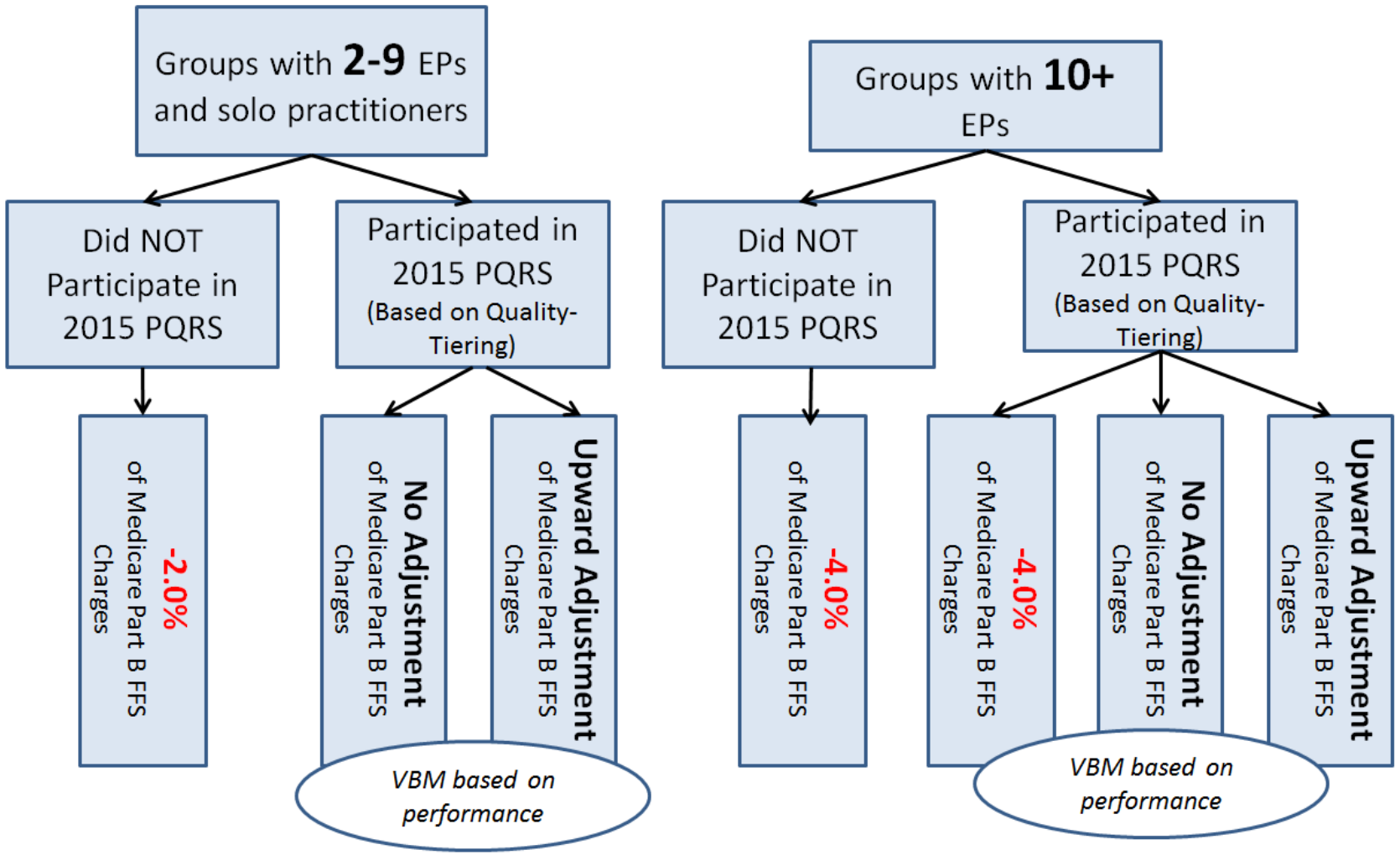
- All physicians participating in the MPFS in 2015 and beyond will be subject to the value modifier in 2017 and 2018.

- The VM will not apply to:
  - Medicare physicians who are not paid under the MPFS including
  - Rural health clinics
  - Federally qualified health centers
  - Critical access hospitals (for physicians electing method II billing)

- PQRS and Value Modifier will be replaced by Merit-based Incentive Payment System (MIPS) in 2019 and beyond (2017 performance year)

Value Modifier Payment Adjustments for Eligible Professionals in 2017

(Based on 2015 quality and cost data)

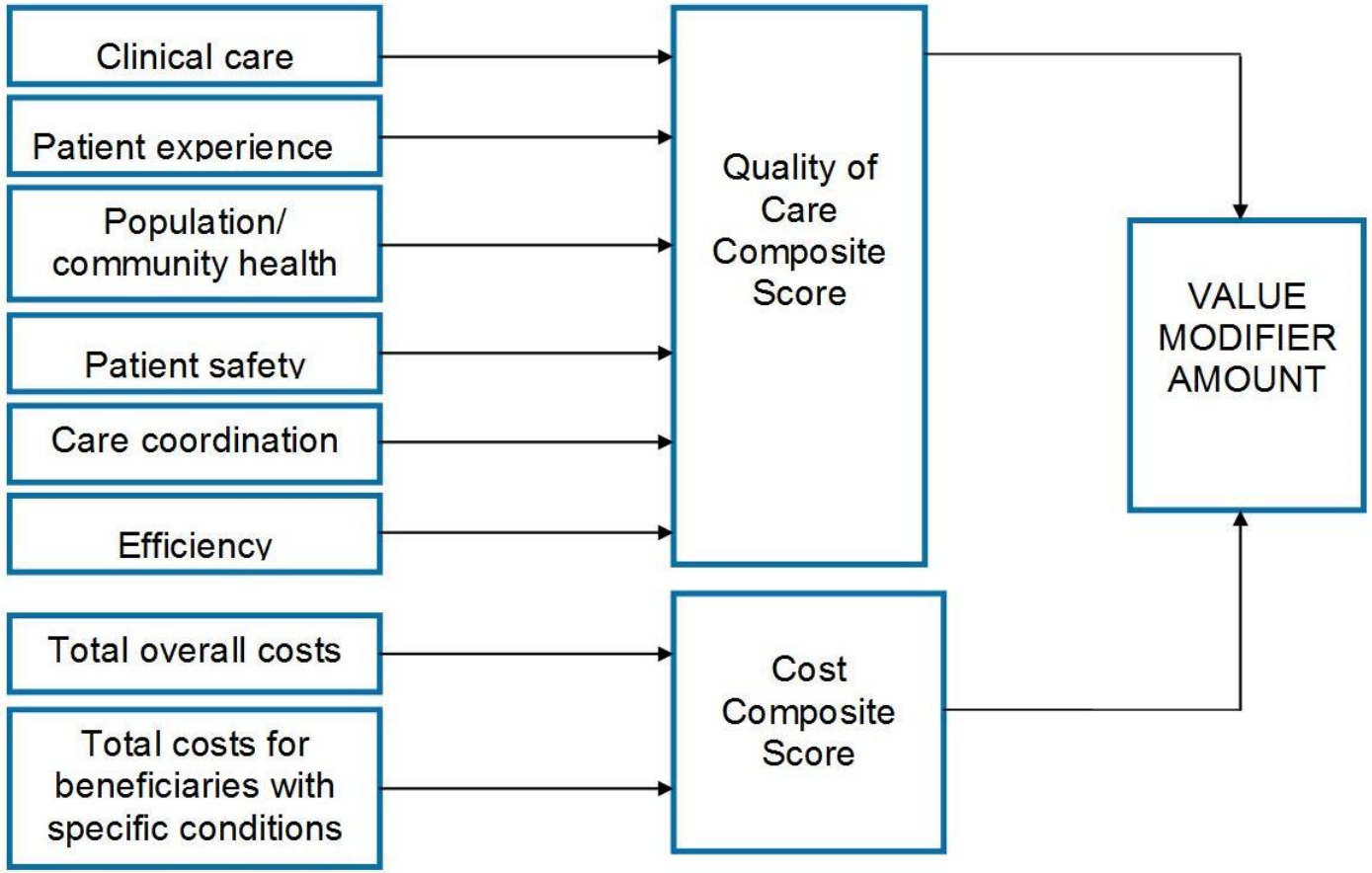


What Cost Measures Will be Used for Quality Tiering?

- Total per capita costs measure (Parts A and B)
- Total per capita costs for beneficiaries with 4 chronic conditions:
  - Chronic obstructive pulmonary disease
  - Heart failure
  - Coronary artery disease
  - Diabetes
- All cost measures are payment-standardized and risk-adjusted

Quality Tiering Methodology

Use domains to combine each quality measure into a quality composite and each cost measure into a cost composite.



Quality Tiering Methodology
CY 2017 VM Payment Adjustment
Groups of 2-9 and Solo Practitioners

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%

**In order to maintain budget neutrality, CMS will first aggregate the downward payment adjustments in the above table with the -4% adjustments for groups of physicians subject to the VBM. Using the total downward payment adjustment amount, CMS will then solve for the upward payment adjustment payment factor (x).*

Quality Tiering Methodology
CY 2017 VM Payment Adjustment
Groups of 10 or more Eligible Professionals

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%

**In order to maintain budget neutrality, CMS will first aggregate the downward payment adjustments in the above table with the -4% adjustments for groups of physicians subject to the VBM. Using the total downward payment adjustment amount, CMS will then solve for the upward payment adjustment payment factor (x).*

MULTIPLE CHOICE

The Medicare and CHIPS Reauthorization Act of 2015 (MACRA) defined that the following CMS Quality Programs will be rolled up into a single Merit-based Incentive Payment System (MIPS):

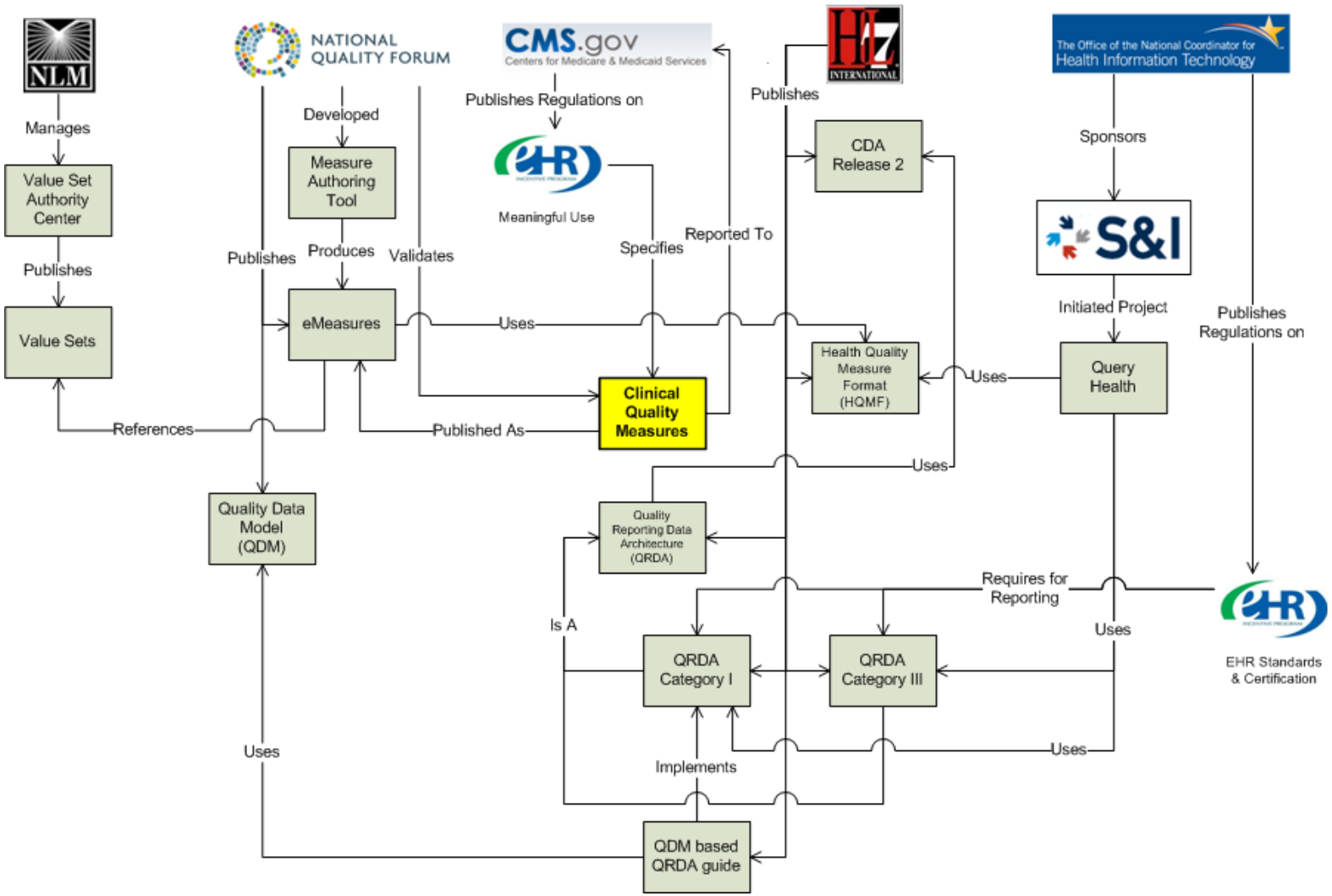
A. Physician Quality Reporting System (PQRS)
B. Value Based Modifier Payment (VBPM) or Value Modifier (VM)
C. EHR Incentive Program
D. All of the above

What is an eCQM?

Electronically specified clinical quality measures (eCQMs) are standardized performance measures derived solely from EHRs. Current CMS policy focuses eCQMs on six domains:

- Clinical Processes/ Effectiveness
- Care Coordination
- Patient and Family Engagement
- Population and Public Health
- Patient Safety
- Efficient Use of Healthcare Resources

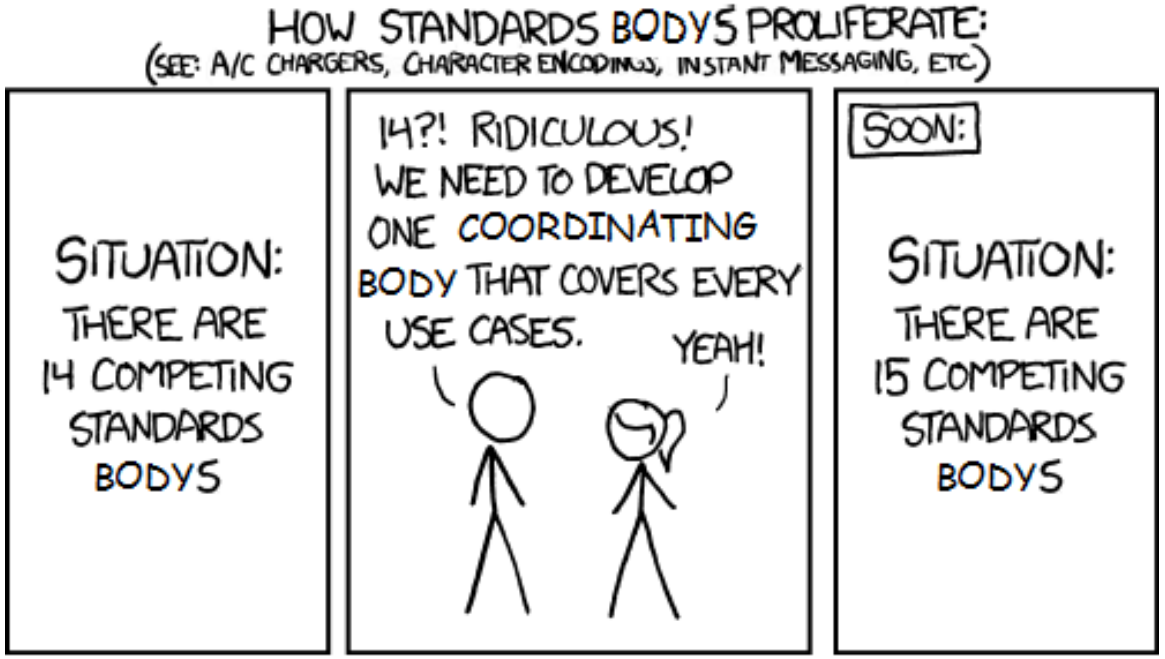
Clinical Quality Measures



Meaningful Use, PQRS, and VM all use CQMs

Clinical Quality Measures

- CQMs are used in more than 20 different programs
- Current CMS policy focuses eCQMs on six domains



Measures Codes

Measures codes contain information about Physician Quality Reporting System (PQRS) quality measures, including detailed specifications and related release notes for the individual PQRS quality measures and measures groups and other measures-related documentation needed by individual eligible professionals for reporting the PQRS measures through claims or qualified registry-based reporting.

The PQRS measure documents for the current program year may be different from the PQRS measure documents for a prior year. Eligible professionals are responsible for ensuring that they are using the PQRS measure documents for the correct program year. The 2015 PQRS CMS-1500 claim is an example of how an individual National Provider Identifier (NPI) reporting on a single CMS-1500 claim for 2015 PQRS should look. The following document that contains the 2015 PQRS CMS-1500 claim information is the 2015 Physician Quality Reporting System (PQRS) Implementation Guide.

Selecting Measures for 2015 PQRS

At a minimum, the following factors should be considered when selecting measures for reporting:

- Clinical conditions usually treated
- Types of care typically provided – e.g., preventive, chronic, acute
- Settings where care is usually delivered – e.g., office, emergency department (ED), surgical suite
- Quality improvement goals for 2015

2015 Cross-Cutting Measures Requirement

- 254 possible PQRS measures, 19 cross-cutting measures
- **2015 Cross-Cutting Measures Requirement**
- In order for eligible professionals (EPs) to satisfactorily report Physician Quality Reporting System (PQRS) measures, a new reporting criterion has been added for the claims and registry reporting of individual measures. Eligible professionals or group practices are required to report one (1) cross-cutting measure if they have at least one (1) Medicare patient with a face-to-face encounter.
- http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html

9 CQMS OVER 3 NQSD

FOR MU EP Measures (eCQMs) (must report on 9 covering 3 NQS domains) –

Subset of Adult Core Recommended Measures

CMS 2 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Population/Public Health
CMS 50 Closing the referral loop: receipt of specialist report	Care Coordination
CMS 68 Documentation of Current Medications in the Medical Record	Patient Safety
CMS 69 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Population/Public Health
CMS 90 Functional status assessment for complex chronic conditions	Patient and Family Engagement
CMS 138 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Population/Public Health
CMS 156 Use of High-Risk Medications in the Elderly	Patient Safety
CMS 165 Controlling High Blood Pressure	Clinical Process/Effectiveness
CMS 166 Use of Imaging Studies for Low Back Pain	Efficient Use of Healthcare Resources

FOR MU EP Measures (eCQMs) (must report on 9 covering 3 NQS domains)

- **Subset of Peds Core Recommended Measures**

9 CQMS OVER 3 NQSD

CMS 2 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Population/Public Health
CMS 75 Children who have dental decay or cavities	Clinical Process/ Effectiveness
CMS 117 Childhood Immunization Status	Population/Public Health
CMS 126 Use of Appropriate Medications for Asthma	Clinical Process/ Effectiveness
CMS 136 ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	Clinical Process/ Effectiveness
CMS 146 Appropriate Testing for Children with Pharyngitis	Efficient Use of Healthcare Resources
CMS 153 Chlamydia Screening for Women	Population/Public Health
CMS 154 Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Efficient Use of Healthcare Resources
CMS 155 Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Population/Public Health

Additional eCQMs under development by OIT for SDPI program

CMS ID	Measure Title	NQS Domain
122v3	Diabetes: Hemoglobin A1c Poor Control	Effective Clinical Care
131v3	Diabetes: Eye Exam	Effective Clinical Care
134v3	Diabetes: Medical Attention for Nephropathy	Effective Clinical Care
123v3	Diabetes: Foot Exam	Effective Clinical Care
148v3	Hemoglobin A1C Test for Pediatric Patients	Effective Clinical Care
163v3	Diabetes: Low Density Lipoprotein LDL Management	Effective Clinical Care

Steps for PQRS Reporting by EHR

- Step 1 – Determine/identify eligible providers
- Step 2 – Determine which measures apply to EP's practice
  - Select from IHS-developed measures if EHR reporting with RPMS
  - (Must use method other than EHR reporting if can't use any IHS eCQMs)
- Step 3 - Must use ONC-certified EHR product (RPMS is certified)
- Step 4 – Document all patient care and visit-related information in EHR system
- Step 5 – Register for an IACS account through the CMS Reporting Portal
- Step 6- Create required reporting files
- Step 7- Participate in testing to ensure submission
- Step 8 – Submit Files

PQRS Trainings

- IHS ORAP conducted PQRS trainings May 28, June 2, June 4, 2015 and slides remain available: http://ihs.adobeconnect.com/pqrs

- For the most up-to-date information from CMS, please go to www.cms.gov/PQRS

In Conclusion…

- PQRS and VM are federally mandated, interdependent programs that affect revenue through 2018
- MIPS replaces PQRS, VM, and MU in 2019
- OIT is working to make eCQM e-reporting possible for 2015 through RPMS
- Quality Reporting must be a team approach
  - Business Office, Clinicians, Quality Reporting Staff, IT