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

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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)

“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)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Meaningful Use</th>
<th>PQRS</th>
<th>eRX</th>
<th>Medicare Sequestration</th>
<th>VBM</th>
<th>Total Penalties</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td></td>
<td></td>
<td>-1.0%</td>
<td></td>
<td></td>
<td>-1.0%</td>
</tr>
<tr>
<td>2013</td>
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<td>-3.5%</td>
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<td>2014</td>
<td></td>
<td></td>
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<td>-2.0%</td>
<td></td>
<td>-4.0%</td>
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<td>2015</td>
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<td>-1.5%</td>
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<td></td>
<td>-1.0%</td>
<td>-5.5%</td>
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<tr>
<td>2016</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
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<td>-8.0%</td>
</tr>
<tr>
<td>2017</td>
<td>-3.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-9.0%</td>
</tr>
<tr>
<td>2018</td>
<td>Up to -5.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-11.0%</td>
</tr>
</tbody>
</table>
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.
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
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.
<table>
<thead>
<tr>
<th>Medicare Physicians</th>
<th>Practitioners</th>
<th>Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor of Medicine</td>
<td>Physician Assistant</td>
<td>Physical Therapist</td>
</tr>
<tr>
<td>Doctor of Osteopathy</td>
<td>Nurse Practitioner</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Doctor of Podiatric Medicine</td>
<td>Clinical Nurse Specialist</td>
<td>Qualified Speech-Language Therapist</td>
</tr>
<tr>
<td>Doctor of Optometry</td>
<td>Certified RN Anesthetist</td>
<td></td>
</tr>
<tr>
<td>Doctor of Oral Surgery</td>
<td>Certified Nurse Midwife</td>
<td></td>
</tr>
<tr>
<td>Doctor of Dental Medicine</td>
<td>Clinical Social Worker</td>
<td></td>
</tr>
<tr>
<td>Doctor of Chiropractic</td>
<td>Registered Dietitians</td>
<td>Nutritional Professional</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Audiologist</td>
</tr>
</tbody>
</table>
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 NQIS 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 NQIS 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)

Groups with 2-9 EPs and solo practitioners

- Did NOT Participate in 2015 PQRS
  - Upward Adjustment of Medicare Part B FFS Charges: -2.0%
  - VBM based on performance

- Participated in 2015 PQRS (Based on Quality-Tiering)
  - No Adjustment of Medicare Part B FFS Charges

Groups with 10+ EPs

- Did NOT Participate in 2015 PQRS (Based on Quality-Tiering)
  - Upward Adjustment of Medicare Part B FFS Charges: +4.0%
  - VBM based on performance

- Participated in 2015 PQRS
  - No Adjustment of Medicare Part B FFS Charges
  - Upward Adjustment of Medicare Part B FFS Charges: +4.0%
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.

- Clinical care
- Patient experience
- Population/community health
- Patient safety
- Care coordination
- Efficiency
- Total overall costs
- Total costs for beneficiaries with specific conditions

Quality of Care Composite Score

Cost Composite Score

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

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>0.0%</td>
<td>+1.0x*</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>Average Cost</td>
<td>0.0%</td>
<td>0.0%</td>
<td>+1.0x*</td>
</tr>
<tr>
<td>High Cost</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

*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

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
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<tr>
<td>Low Cost</td>
<td>0.0%</td>
<td>+2.0x*</td>
<td>+4.0x*</td>
</tr>
<tr>
<td>Average Cost</td>
<td>-2.0%</td>
<td>0.0%</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>High Cost</td>
<td>-4.0%</td>
<td>-2.0%</td>
<td>0.0%</td>
</tr>
</tbody>
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*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).*
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
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
Physician Quality Reporting System

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.

FOR MU EP Measures (eCQMs) (must report on 9 covering 3 NQS domains) —
Subset of Adult Core Recommended Measures

<table>
<thead>
<tr>
<th>Measure Code</th>
<th>Measure Description</th>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS 2</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
<td>Population/Public Health</td>
</tr>
<tr>
<td>CMS 50</td>
<td>Closing the referral loop: receipt of specialist report</td>
<td>Care Coordination</td>
</tr>
<tr>
<td>CMS 68</td>
<td>Documentation of Current Medications in the Medical Record</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>CMS 69</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan</td>
<td>Population/Public Health</td>
</tr>
<tr>
<td>CMS 90</td>
<td>Functional status assessment for complex chronic conditions</td>
<td>Patient and Family Engagement</td>
</tr>
<tr>
<td>CMS 138</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>Population/Public Health</td>
</tr>
<tr>
<td>CMS 156</td>
<td>Use of High-Risk Medications in the Elderly</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>CMS 165</td>
<td>Controlling High Blood Pressure</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>CMS 166</td>
<td>Use of Imaging Studies for Low Back Pain</td>
<td>Efficient Use of Healthcare Resources</td>
</tr>
</tbody>
</table>
FOR MU EP Measures (eCQMs) (must report on 9 covering 3 NQS domains)

- **Subset of Peds Core Recommended Measures**

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure Description</th>
<th>Domain</th>
</tr>
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<tbody>
<tr>
<td>CMS 2</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
<td>Population/Public Health</td>
</tr>
<tr>
<td>CMS 75</td>
<td>Children who have dental decay or cavities</td>
<td>Clinical Process/ Effectiveness</td>
</tr>
<tr>
<td>CMS 117</td>
<td>Childhood Immunization Status</td>
<td>Population/Public Health</td>
</tr>
<tr>
<td>CMS 126</td>
<td>Use of Appropriate Medications for Asthma</td>
<td>Clinical Process/ Effectiveness</td>
</tr>
<tr>
<td>CMS 136</td>
<td>ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication</td>
<td>Clinical Process/ Effectiveness</td>
</tr>
<tr>
<td>CMS 146</td>
<td>Appropriate Testing for Children with Pharyngitis</td>
<td>Efficient Use of Healthcare Resources</td>
</tr>
<tr>
<td>CMS 153</td>
<td>Chlamydia Screening for Women</td>
<td>Population/Public Health</td>
</tr>
<tr>
<td>CMS 154</td>
<td>Appropriate Treatment for Children with Upper Respiratory Infection (URI)</td>
<td>Efficient Use of Healthcare Resources</td>
</tr>
<tr>
<td>CMS 155</td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</td>
<td>Population/Public Health</td>
</tr>
</tbody>
</table>
Additional eCQMs under development by OIT for SDPI program

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