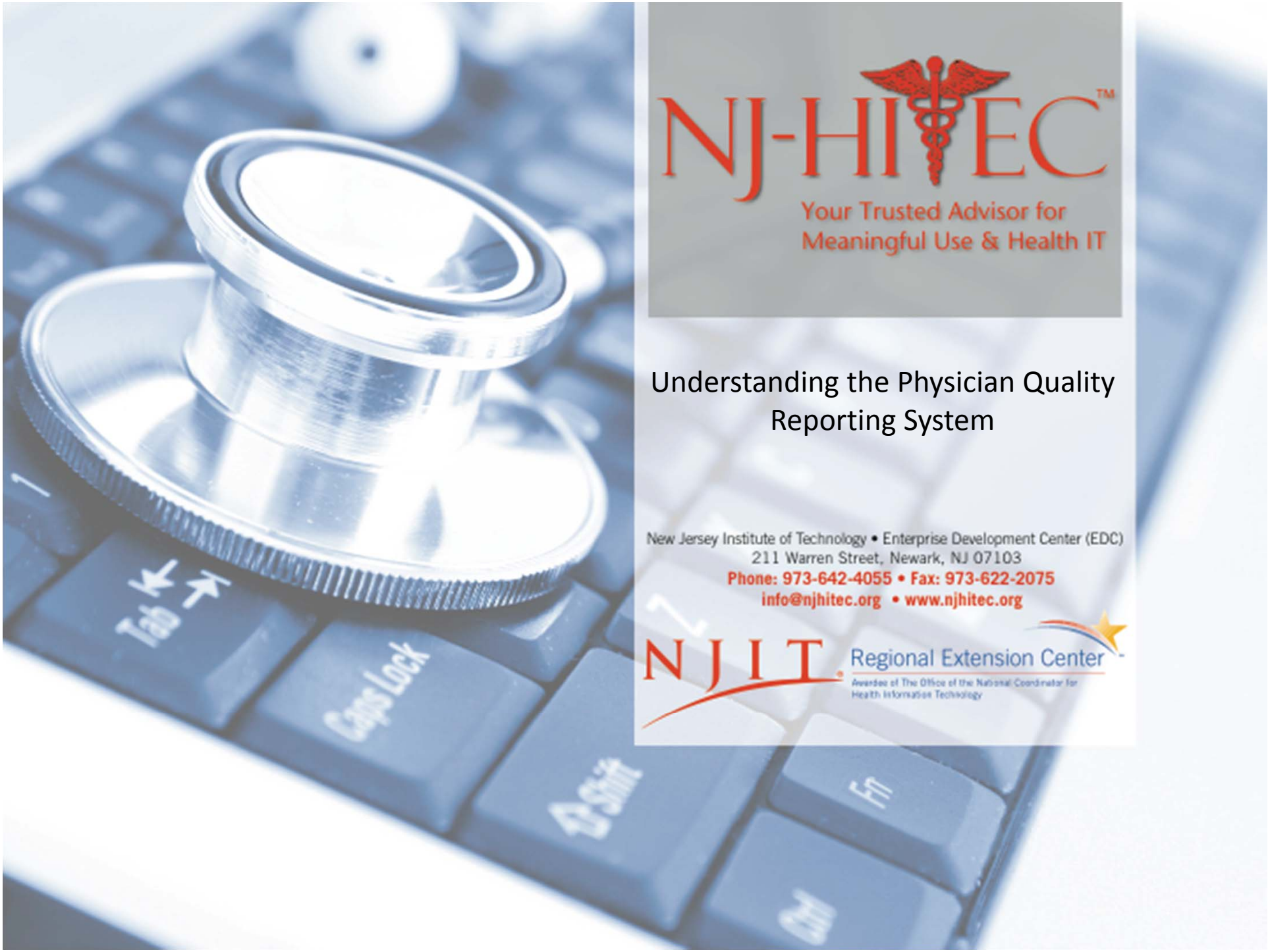


Understanding the Physician Quality Reporting System

New Jersey Institute of Technology • Enterprise Development Center (EDC)
211 Warren Street, Newark, NJ 07103
Phone: 973-642-4055 • Fax: 973-622-2075
info@njhitec.org • www.njhitec.org

NJIT Regional Extension Center
Awardee of The Office of the National Coordinator for Health Information Technology

Objectives

- ✓ Provide a history and overview of the Physician Quality Reporting System (PQRS)
- ✓ Review eligibility, incentives, and payment adjustments for 2014 PY
- ✓ Discuss and compare methods of reporting to CMS
- ✓ Explore reporting options for Eligible Professionals and Group Practices and benefits/considerations for each
- ✓ Review alignment of PQRS and other CMS programs

Physician Quality Reporting System (PQRS)

Overview

- The Physician Quality Reporting System (PQRS) is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals.
- The program provides an incentive payment to practices with eligible professionals (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN]), or group practices participating in the group practice reporting option (GPRO) who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to **Medicare Part B Fee-for-Service (FFS) beneficiaries** (including Railroad Retirement Board and Medicare Secondary Payer).
- Beginning in 2015, the program also applies a payment adjustment to eligible professionals who do not satisfactorily report data on quality measures for covered professional services during the 2013 PQRS program year.

History

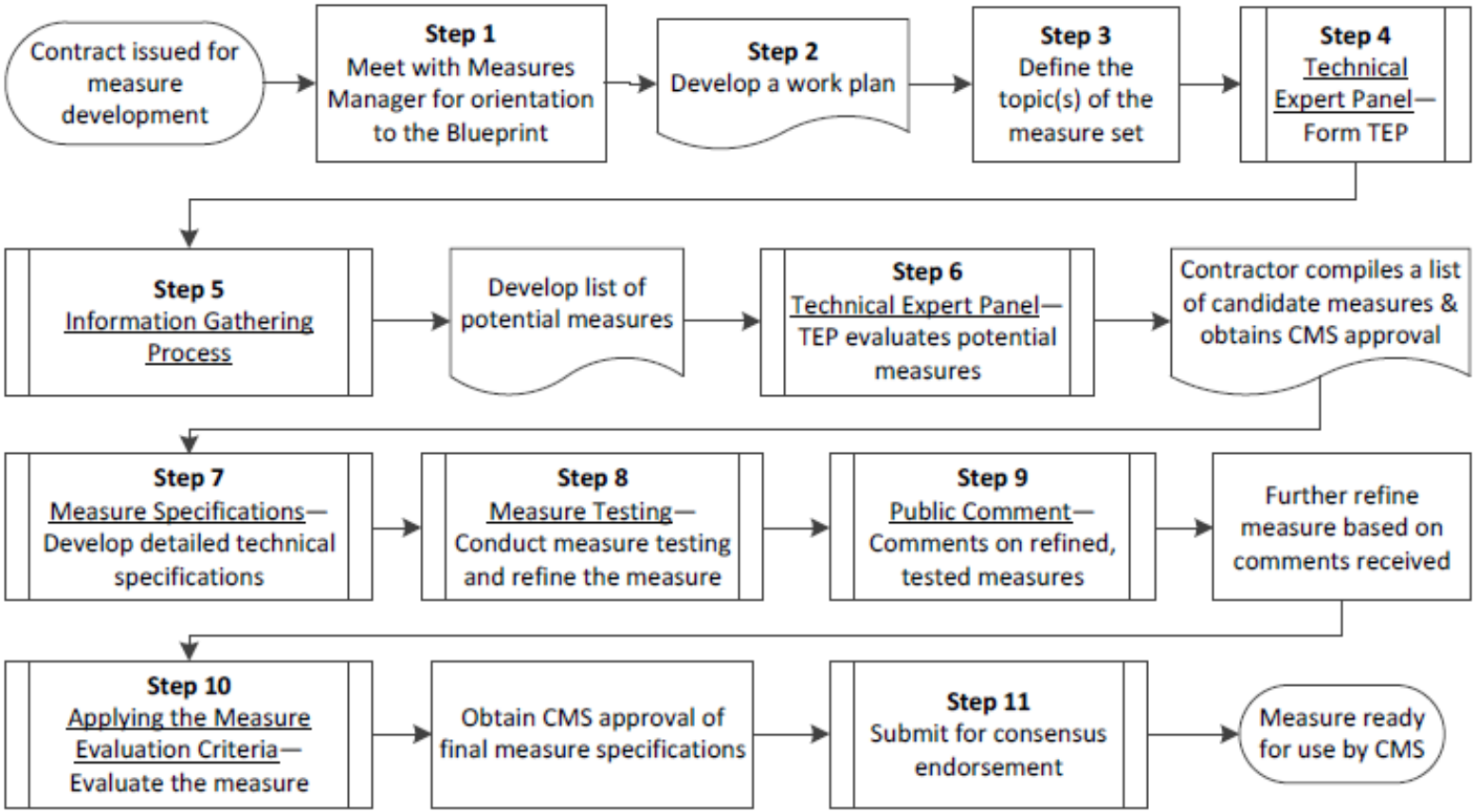
- Originally established by CMS as the Physician Quality Reporting Initiative (PQRI) in 2007 under the Tax Relief and Healthcare Act (TRCHA) of 2006
- Intent is to encourage professionals to adopt evidence-based and outcome-driven healthcare delivery practices.
- Part of an overall effort by CMS and Congress to transform health care into a value-based purchasing (VBP) system

Measure Development

- Standardized approach for development and maintenance of quality measures used in CMS quality initiatives and programs
- Currently >25 Measure Developers, most notably:
  - American Medical Association (AMA)-convened Physician Consortium for Performance Improvement® (PCPI™)
  - National Committee for Quality Assurance (NCQA)

Measure Development

Figure 1 Flow of Measure Development Processes



Key Updates for 2014

- Providers can no longer report at least 1 measure for at least 1 patient to avoid PQRS payment adjustments
- Addition of Qualified Clinical Data Registry reporting mechanism
- Alignment with EHR Incentive Program Clinical Quality Measures (CQMs)
- Measures Groups **only** reportable via Registry (Claims-based method retired for measures groups in 2014)
- Implementation of the Value Modifier for groups of 10+ EPs

Incentive Eligibility and Payment Adjustments

List of Eligible Professionals

Medicare physicians
Doctor of Medicine
Doctor of Osteopathy
Doctor of Podiatric Medicine
Doctor of Optometry
Doctor of Oral Surgery
Doctor of Dental Medicine
Doctor of Chiropractic

Therapists
Physical Therapist
Occupational Therapist
Qualified Speech-Language Therapist

Practitioners
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
Audiologists

**Includes Advanced Practice Registered Nurse (APRN)*

List of Eligible Professionals

	PQRS		Value Modifier		EHR Incentive Program		
	Eligible for Incentive	Subject to Payment Adjustment	Included in Definition of "Group" (1)	Subject to VM (2)	Eligible for Medicare Incentive(3)	Eligible for Medicaid Incentive (4,5)	Subject to Medicare Payment Adjustment (7,8)
Medicare Physicians							
Doctor of Medicine	X	X	X	X	X	X	X
Doctor of Osteopathy	X	X	X	X	X	X	X
Doctor of Podiatric Medicine	X	X	X	X	X		X
Doctor of Optometry	X	X	X	X	X		X
Doctor of Oral Surgery	X	X	X	X	X	X	X
Doctor of Dental Medicine	X	X	X	X	X	X	X
Doctor of Chiropractic	X	X	X	X	X		X
Practitioners							
Physician Assistant	X	X	X			X (6)	
Nurse Practitioner	X	X	X			X	
Clinical Nurse Specialist	X	X	X				
Certified Registered Nurse Anesthetist (10)	X	X	X				
Certified Nurse Midwife	X	X	X			X	
Clinical Social Worker	X	X	X				
Clinical Psychologist	X	X	X				
Registered Dietician	X	X	X				
Nutrition Professional	X	X	X				
Audiologists	X	X	X				
Therapists							
Physical Therapist	X	X	X				
Occupational Therapist	X	X	X				
Qualified Speech-Language Therapist	X	X	X				

Timeline of Incentives and Payment Adjustments

Reporting Year	PQRS Incentives/ Payment Adjustments
2012	0.5%
2013	0.5%
2014	**0.5%**
2015	-1.5% (based on 2013 reporting)
2016	**-2.0% (based on 2014 reporting)**

Note: Payment Adjustments are based on the combination of Individual NPI and Billing Tax ID for individual EPs and are based on Billing Tax ID for Group Practices

Incentives and Payment Adjustments Calculations

- Incentive = ***0.5%*** of total Medicare Part B allowable charges for 2014
- Payment Adjustment = ***-2%*** of Medicare Part B reimbursement in 2016

Example: An average Internal Medicine EP may have $200,000 in allowable charges in a year

- Incentive Payment = ($200,000)*(0.005) = $1,000
- Payment Adjustment = ($200,000)*(0.02) = $4,000

Incentives and Payment Adjustments Calculations

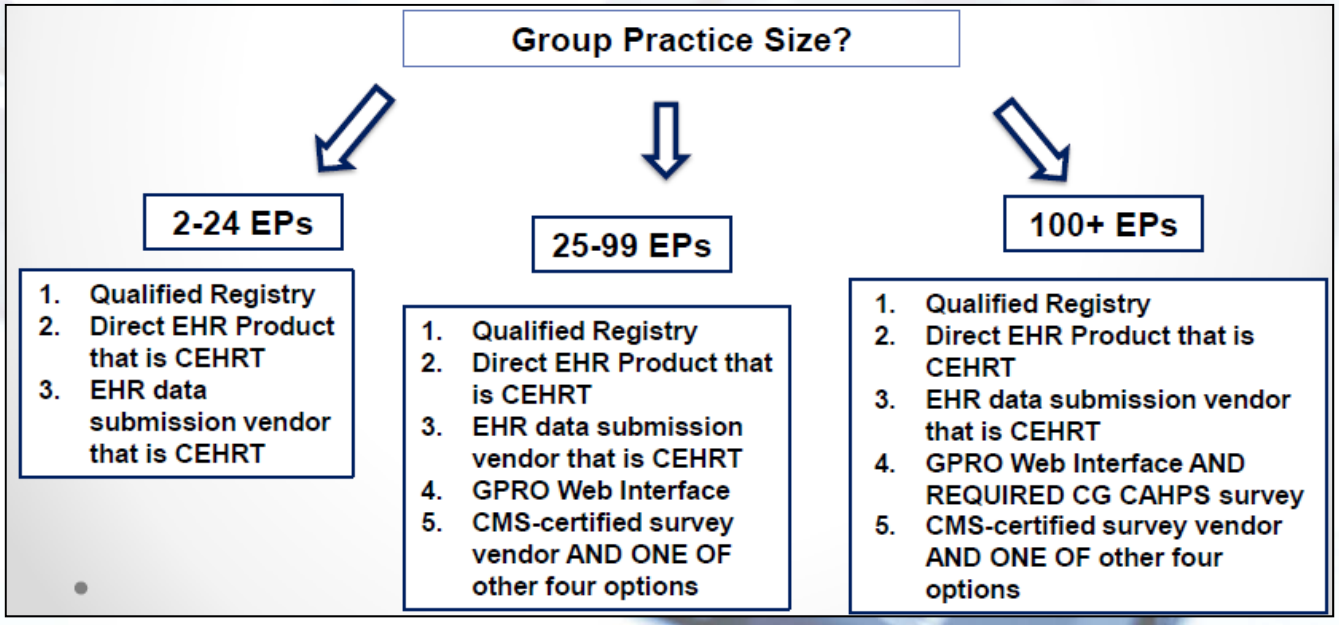
- Incentive payments are aggregated for all NPIs within the TIN and distributed to the TIN in a lump-sum payment.
- GPRO incentive payments are distributed to the associated TIN in a lump-sum payment.
- Method for calculating incentives is published by CMS each year
- EPs or Group Practices can access:
  - Interim Feedback Dashboards
  - PQRS Feedback Reports
  - PQRS Incentive Payment User Guides

Reporting Methods

Reporting Methods for PQRS

- Individuals can report using 5 methods:
  - Claims
  - Qualified Registry Vendor
  - Direct EHR product that is CEHRT
  - EHR data submission vendor that is CEHRT
  - Qualified Clinical Data Registry

- Options for reporting under the Group Practice Reporting Option (GPRO) depends on the size of the group



Reporting Method Comparison

	Claims	Registry	EHR Direct/Data Submission Vendor
Individual Measures	✓	✓	✓
Measures Groups		✓	
Group Practice Reporting Option		✓	✓
Submission Period	Submitted to CMS on claims throughout the calendar reporting year	Submitted to CMS during the 2 months following the reporting year	Submitted to CMS during the 2 months following the reporting year

Vendor Qualification

- CMS lists the 2014 Qualified Registry Vendors and Qualified Clinical Data Registries.
- EHR Data Submission Vendors and EHR Direct Vendors must be ONC-certified to report on Clinical Quality Measures

Reporting Requirements

Reporting Requirements for Individual Measures

- Report 9 measures across 3 National Quality Strategy Domains
  - Report on at least 50% of eligible Medicare Part B FFS patients for the measure
    - Traditional Medicare and Railroad Medicare
    - Eligibility may be based on Diagnosis (ICD-9), Procedure Codes (CPT), Age, and Gender, and other clinical criteria]
  - Reporting period January 1, 2014- December 31, 2014
  - Each measure must have 0% performance rate [*does not apply to EHR-based reporting methods*]

1. Patient and Family Engagement
2. Patient Safety
3. Care Coordination
4. Population/Public Health
5. Efficient Use of Healthcare Resources
6. Clinical Process/Effectiveness

Measures Applicability Validation Process

- Measures Applicability Validation (MAV) Process is an ***automatic*** analysis that CMS does when a provider reports via claims or Registry and reports LESS THAN 9 measures or LESS THAN 3 domains but reports at least 1-8 measures.

- Used to determine if EP should receive an incentive payment and avoid penalties.

- CMS determines whether a provider could have or should have reported on additional measures by comparing the measures the EP has reported to the clinically-related cluster the measure is in.

Measures Applicability Validation (example)

- **Cluster 10: Oncology Pain Care**
  - #143: Oncology: Medical and Radiation – Pain Intensity Quantified
  - #144: Oncology: Medical and Radiation – Plan of Care for Pain
- **Cluster #18: Pathology Breast Cancer**
  - #99: Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
  - #251: Immunohistochemical (IHC) Evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) for Breast Cancer Patients
- **Non-cluster Measures:**
  - #71: Breast Cancer: Hormonal Therapy for Stage IC - IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
  - #72: Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients
  - #100: Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
  - #110: Preventive Care and Screening: Influenza Immunization
  - #111: Pneumonia Vaccination Status for Older Adults
  - #112: Breast Cancer Screening
  - #113: Colorectal Cancer Screening
  - #194: Oncology: Cancer Stage Documented

Reporting Requirements for Measures Groups

- Select only 1 measures group, a grouping of clinically related measures.
- Identify 20 patients who fit the measures group's patient criteria.
- Majority of patient sample must be Medicare FFS patients.
- Record the performance each *applicable* measure for all 20 patients.
- Report data to Qualified Registry during submission period in early 2015Each measure must have 0% performance rate.

Oncology Measures Group

2014 PQRS

Oncology Measures Group

#71: Breast Cancer: Hormonal Therapy for Stage IC - IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
#72: Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients
#110: Preventive Care and Screening: Influenza Immunization
#130: Documentation of Current Medications in the Medical Record
#143: Oncology: Medical and Radiation – Pain Intensity Quantified
#144: Oncology: Medical and Radiation – Plan of Care for Pain
#194: Oncology: Cancer Stage Documented
#226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Oncology Measures Group

Patient Sample Criteria

- Aged 18 years or older
- One of the following diagnosis codes indicating cancer: (See Oncology Measures Group Specifications)
- Accompanied by one of the following patient encounter codes: 77427, 77431, 77432, 77435, 77470

-OR-

One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
-AND-
One of the following patient encounter code: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96446, 96450, 96521, 96522, 96523, 96542, 96549

- Visit date between January 1 - December 31, 2014
- The majority of the patient sample must be Medicare Part B FFS (fee for service) patients.

Alignment with other CMS Programs

Alignment with Other CMS Programs

- **PQRS and MU: EHR Incentive Pilot**
  - Beginning in 2012, EPs could report Meaningful Use CQMs to CMS with an EHR Data Submission Vendor or EHR Direct Vendor
  - EPs must indicate within the EHR Incentive Program Registration and Attestation System their intent to fulfill the meaningful use objective of reporting CQMs through participation in the Pilot.
  - Required to report CQMs on full calendar year CQMs based on a full calendar

- **ACO Reporting:**
  - ACO program data completely reported will automatically satisfy PQRS Incentive program requirements.
  - Physician Quality Reporting eligible taxpayer identification numbers (TINs) within ACOs will be eligible to receive the Physician Quality Reporting incentive payments for each calendar year in which they fully and completely report the ACO GPRO measures

- **CPCi: PQRS Waiver**
  - Eligible Professionals who successfully meet all of the CPC EHR CQM reporting requirements can satisfy PQRS reporting and be eligible to receive the PQRS incentive payment and not be subject to the PQRS payment adjustment with respect to the applicable year

Value Based Payment Modifier

- VM assesses both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule
  - Combination of Cost measures and Quality measures (from PQRS reporting)
  - Like PQRS, 2014 reporting will affect 2016 reimbursement
  - Group Practices 10+ are incentivized to report using one of the GPRO options

- If a group does not seek to report quality measures as a group, CMS will calculate a group quality score if at least 50 percent of the eligible professionals within the group report measures individually.

Quality/cost	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Medium quality	+1.0x*	+0.0%	-1.0%
Low quality	+0.0%	-1.0%	-2.0%

* 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.

Value Modifier Incentives/Penalties

	PQRS		Value Modifier			
			10-99 EPs		100+ EPs	
	Incentive	Adjustment	Reporting PQRS	NOT Reporting PQRS	Reporting PQRS	NOT Reporting PQRS
Physicians	**0.5% of MPFS**	**-2.0% of MPFS**	**+2.0 (x), +1.0(x), or neutral**	**-2.0% of MPFS**	**+2.0 (x), +1.0(x), neutral -2.0 (x), or -1.0(x)**	**-2.0% of MPFS**
Practitioners	**0.5% of MPFS**	**-2.0% of MPFS**	EPs included in the definition of "group" to determine group size for application of the value modifier in 2016 (10 or more EPs); VM only applied to reimbursement of physicians in the group			
Therapists	**0.5% of MPFS**	**-2.0% of MPFS**				

National Quality Strategy

Better Care: Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.

Healthy People/Healthy Communities: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care.

Affordable Care: Reduce the cost of quality health care for individuals, families, employers, and government.

CMS Helpdesk

Contact the QualityNet Helpdesk with any questions related to:

- General CMS PQRS and eRx Incentive Program information
- Portal password issues
- Feedback report availability and access
- PQRS-IACS registration questions
- PQRS-IACS login issues

Monday – Friday; 7:00 AM–7:00 PM CST
Phone: 1-866-288-8912 TTY: 1-877-715-6222 Email: Qnetsupport@sdps.org

Questions?