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HEALTHCARE SOLUTIONS

PQRS AND THE VALUE MODIFIER: WHAT DOES IT ALL MEAN FOR YOUR QUALITY REPORTING?

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Today's Presenters

***Crystal Vervaecke**
Senior Consultant

***Christy Erickson MSN, PMP**
Director, Clinical Transformational Services

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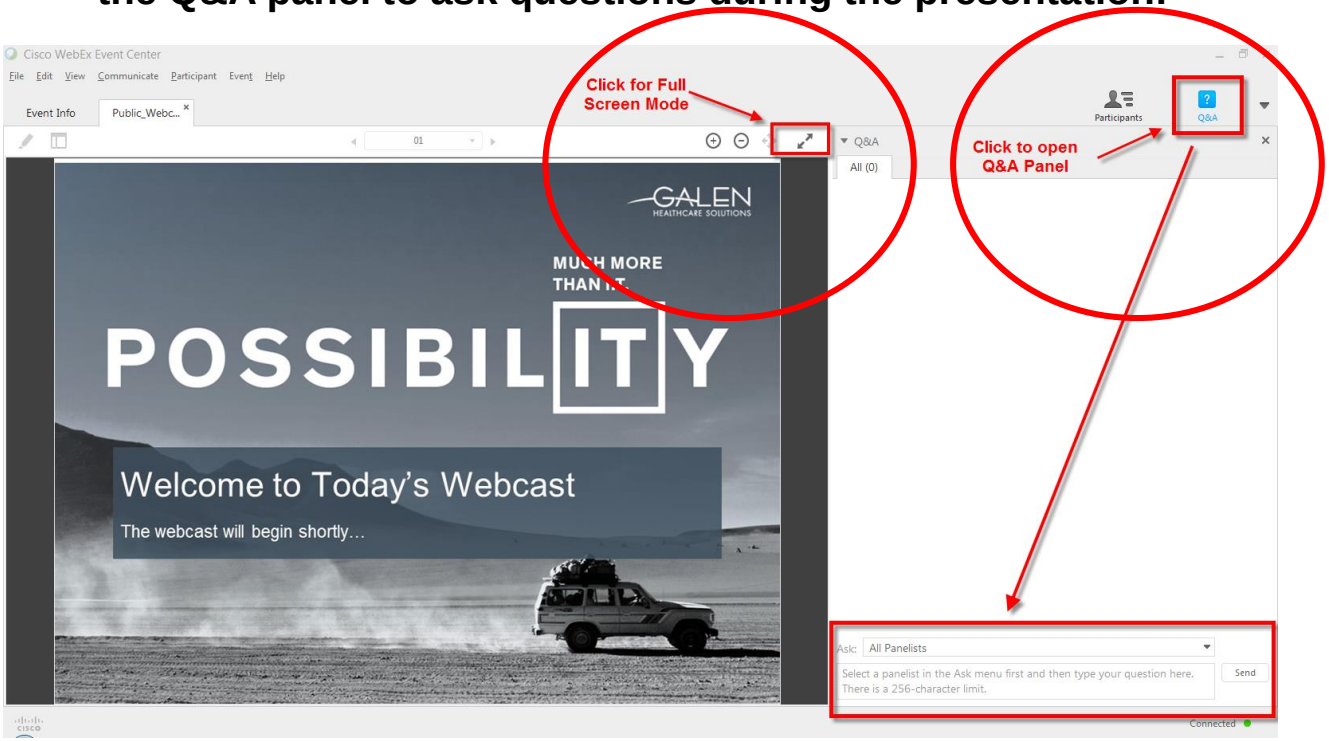

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Today's Agenda

1. High level review of PQRS/VM
2. Analysis of Clinical Quality Measure Selection
3. Impact to Your Organization

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1. High level review of PQRS/VM

PQRS- Physician Quality Reporting System

- Why Report?
  - To avoid a 2018 negative payment adjustment!
  - Help improve health care quality

PQRS- Physician Quality Reporting System

❑ Who Qualifies to Report?

Physicians

Doctor of:

- Medicine
- Osteopathy
- Podiatric Medicine
- Optometry
- Oral Surgery
- Dental Medicine
- Chiropractic

Practitioners

- PA
- NP
- CNS
- CRNA
- Midwife
- Clinical Social Worker
- Clinical Psychologist
- Registered Dietician
- Audiologists

Therapists

- Physical Therapist
- Occupational Therapists
- Speech-Language Therapists

PQRS- Physician Quality Reporting System

❑ How to Report?

- Individual EP- NPI/TIN
- Group Reporting- 2 or more as single TIN

PQRS- Physician Quality Reporting System

❑ Which reporting mechanism?

Individual EP's	Group Practices
• Medicare Part B claims • Qualified PQRS registry • Direct Electronic Health Record (using Certified EHR technology • CEHRT via data submission vendor • Qualified clinical data registry (QCDR)	• Qualified PQRS registry • Web Interface (for groups >25 only) • Direct EHR using CEHRT • CEHRT via data submission vendor • CAHPS for PQRS via CMS-certified survey vendor (for groups practices >2 to supplement PQRS group practice reporting

PQRS- Physician Quality Reporting System

❑ What do you need to report?

- 9 individual measures across 3 National Quality domains for at least 50% of denominator eligible Medicare Part B FFS patients.
- And 1 cross cutting measure*

❑ Which measures to report?

- What applies to your practice (patient population, provider specialty)

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PQRS- Physician Quality Reporting System

Measure Title	Measure Number			Measure Description	NQS Domain	Measure Developer/Steward			Reporting Method(s)							Use in Other Reporting Program(s)				
	CMS	NQF	PQRS			#1	#2	#3	Claims	CSV	EHR	GPRO Web Interface	Measure Group	Registry	Measure Group(s)	ACO	AQA	Meaningful Use	Meaningful Use	Million Heart
Diabetes: Hemoglobin A1c Poor Control	122v4	0059	001	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period	Effective Clinical Care	National Committee for Quality Assurance	-	-	X	-	X	X	X	X	Diabetic Mellitus Diabetic Retinopathy	X	-	-	X	-
Diabetes: Low Density Lipoprotein (LDL-C) Control (< 100 mg/dL)	163v4	NA	002	Percentage of patients 18-75 years of age with diabetes whose LDL-C was adequately controlled (< 100 mg/dL) during the measurement period	Effective Clinical Care	National Committee for Quality Assurance	-	-	-	-	X	-	-	-	-	-	-	-	X	X
Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	135v4	0081	005	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR on each hospital discharge	Effective Clinical Care	American Medical Association Physician Consortium	American College of Cardiology Foundation	American Heart Association	-	-	X	-	X	X	Heart Failure	-	-	-	X	-
Coronary Artery Disease (CAD): Antiplatelet Therapy	NA	0067	006	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12 month period who were prescribed aspirin or clopidogrel	Effective Clinical Care	American College of Cardiology	American Heart Association	American Medical Association	-	-	-	-	X	X	Coronary Artery Disease	X	-	-	-	-
Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)	145v4	0070	007	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior MI OR a current or prior LVEF < 40% who were prescribed beta-blocker therapy	Effective Clinical Care	American Medical Association Physician Consortium	American College of Cardiology Foundation	American Heart Association	-	-	X	-	X	X	Coronary Artery Disease	-	-	-	X	-
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	144v4	0083	008	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR on each	Effective Clinical Care	American Medical Association Physician Consortium	American College of Cardiology Foundation	American Heart Association	-	-	X	X	X	X	Heart Failure	X	-	-	X	-
Anti-Depressant Medication Management	128v4	0105	009	Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported	Effective Clinical Care	National Committee for Quality Assurance	-	-	-	-	X	-	-	-	-	-	-	-	X	-
Primary Open-Angle Glaucoma	[illegible]	[illegible]	[illegible]	Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who	[illegible]	American Medical	National Committe		[illegible]											

PQRS- Physician Quality Reporting System

IMPACT if you don't do it at all!

Automatically penalty for non-reporters:

- -2% for small groups
- -4% for >10+ size group

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Value-Based Modifier (VM)

This program is an adjustment that builds on top of PQRS.

Starting in 2013, CMS began to phase in a new program known as the Value based Modifier or "VM" for short.

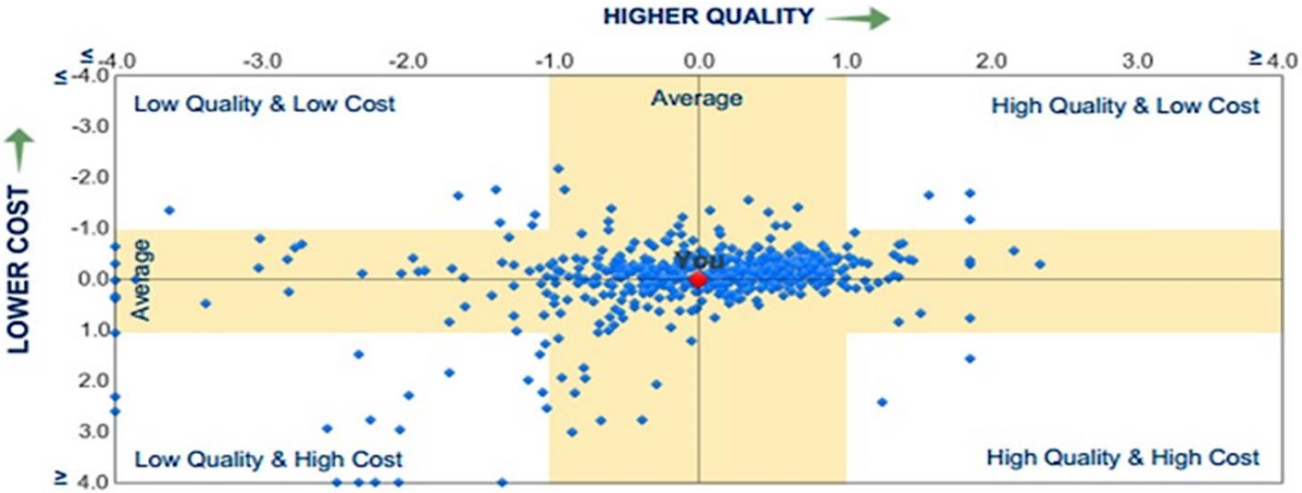
Each year, practices are provided with a Quality and Resource Use Report (QRUR), whereby CMS uses a practice's data reported from the PQRS program in conjunction with the data found on patient's Medicare claims to score on two metrics:

1. Cost (low/medium/high)
2. Quality (low/medium/high)

Under this program, all of the PQRS scores are entered into a system that uses an algorithm to add each provider (TIN) or group to a scatterplot. This scatterplot is then overlaid onto 3x3 matrix of a grid that shows low/medium/high cost and low/medium/high quality grid. This determines their VM fee modifier.

Sample QRUR

Your Performance: Average Quality, Average Cost



QRUR- Quality and Resource Use Reports

- ***WAIT? What is this?***
- ***How to get one:*** https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html
- ***Set up an EIDM account***

How the Value-Based Modifier works

Based on 2016 performance, if a group of 10+ provider shows a high cost/low quality of care, it'll be hit with a 4% penalty. Of course, on the flip side, there's also the opportunity to get a 4% fee schedule bump by providing patients with high quality/low cost care.

Groups with 10+ Providers

Cost \ Quality	Low	Avg	High
Low	**0%**	+2.0%	+4.0%
Avg	-2.0%	**0%**	+2.0%
High	-4.0%	-2.0%	**0%**

Groups with <10 Providers or individual Providers

Cost \ Quality	Low	Avg	High
Low	**0%**	+1.0%	+2.0%
Avg	**0%**	**0%**	+1.0%
High	**0%**	**0%**	**0%**

Based on 2016 performance, if a group of less than 10 providers or individual providers shows a high cost/low quality of care, it'll be hit with a 0% penalty. Of course, there's also the opportunity to get a 2% fee schedule bump by providing patients with high quality/low cost care.

*** **Non-reporters:** 2% penalty for small groups, 4% automatic penalty to 10+ size groups

This JUST In……Value-Based Modifier

Monday-3/7/16

- 13,813 physician groups with 10 or more EP's were subject to VM based on 2014 statistics
- 40% of TIN's – downward payment adjustment of -2%
- 60% fell into the quality-tiering and met criteria
  - 128 groups receiving an upward adjustment of +15.92% or +31.84%
  - 59 groups will receive downward adjustment of -1% or -2%
  - Majority will remain neutral (no positive or negative adjustment

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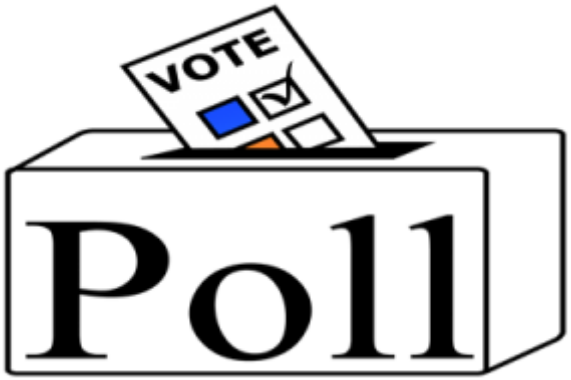
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-VM-Overview-PDF-Memo.pdf



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Checklist #1

- ✓ **Reporting on PQRS- 2016?**
- ✓ **QRUR data available and reviewed?**
- ✓ **Understand role of value modifier?**
- ✓ **Are you currently getting penalties/incentives based on PQRS/VM on 2016 FFS claims?**

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2. Analysis of Clinical Quality Measure Selection

Analysis of Clinical Quality Measures

Before we start we need to understand the following:

- How are you reporting individual or group?
- What is your mechanism to report?
- What specialties and types of eligible providers do you have?
- What does your patient population look like?
- What are you reporting on for MU, ACO, or other initiatives?
- What are your current EP's statistics?
- Have you reviewed the CMS specialty based recommendations?

Initial Steps for Analysis

- Run a FULL CQM for ALL provider report
- Evaluate each individual EP report
- Compare to CMS specialty
- Compare to current known workflows

Sample analysis review

	Provider	NQF	Name	Description	Domain	Num	Den	IPP	Excl	Excp	Score
1	Provider, A	0018 (V3)	Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period	Clinical Processes/Effectiveness	460	678	699	1	0	68%
2	Provider, A	0022 a (V3)	Use Of High Risk Meds In Elderly	"Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. (A) Percentage of patients who were ordered at least one high-risk medication.	Patient Safety	377	914	914	0	0	41%
3	Provider, A	0022 b (V3)	Use High Risk Elderly Med Greater than 2 Counts	"Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. (B) Percentage of patients who were ordered at least two different high-risk medications."	Patient Safety	88	914	914	0	0	10%
4	Provider, A	0028 (V3)	Preventive Care and Screening Tobacco Use Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Population and Public Health	559	653	653	0	0	86%
5	Provider, A	0034 (V3)	Colorectal Cancer Screening	Percentage of patients 50 - 75 years of age who had appropriate screening for colorectal cancer	Clinical Processes/Effectiveness	800	843	953	110	0	95%
6	Provider, A	0052 (V4)	Use of Imaging Studies for Low Back Pain	Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	Efficient Use of Healthcare Resources	2	2	6	4	0	100%
7	Provider, A	0062 (V3)	Diabetes Urine Protein Screening	The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period	Clinical Processes/Effectiveness	169	276	276	0	0	61%

Post Analysis Review

- Provide stats on each provider
- Provide recommendations on each provider
- Consider configuring to different measures without training
- Consider configuring to different measures with training
- Consider how VM plays into this game
- How often are PQRS monitored?

Checklist #2

- ✓ Complete Provider/Organization analysis of current selections
- ✓ Recommend changes, if applicable
  - New reporting metrics
  - New reporting methods and
  - New reporting mechanism
- ✓ Define monitoring timeline based on findings

3. Impact to Your Organization

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Overlapping payment adjustments threaten physician practice viability

Year	Deficit reduction sequester	E-Prescribing	Health Information Technology/ Meaningful Use	Physician Quality Reporting System, including Maintenance of Certification (MOC) Program	Value-Based Modifier (Budget neutral increases and descreases in payments based on cost/ quality data measures from 2 years earlier)	Total Possible Payment Cuts including Sequester
2014	**(-2%)**	**(-2%)**	**$4-12K**	**.5% if no MOC; 1.0% if MOC**		**(-4%)**
2015	(-2%)		**$2-8K (-1% to 2%)**	**(-1.5%)**	**(-1%)** Applied to groups of 100 or more/2013 data**	**(-5.5% to 6.5%)**
2016	**(-2%)**		**$2-4K (-2%)**	**(-2%)**	**(-2%)** Groups of 10 or more/2014 data**	**(-8%)**
2017	**(-2%)**		**(-3%)**	**(-2%)**	**(-4%)** all physicians/2015 data*"*	**(-11%)**
2018	**(-2%)**		**(-4%)**	**(-2%)**	**(?)** all physicians/2016 data**	**(-12%) or more**
2019	**(-2%)**		**(-5%)**	**(-2%)**	**(?)** all physicians/2017 data**	**(-13%) or more**

* red text indicates penalties, green text indicates bonuses

** 2017 marks the third year that the VBM will be applied; the magnitude of the adjustments that will be made in the future years is determined through annual rulemaking. Since the adjustments have doubles eah year since the VBM was first implemented, the potential for increasingly severe cuts in 2018 and beyond is significant. Some physicians will qualify for payment bonuses of an amount not yet known.

What else is going on in your organization?

- Mergers/Acquisitions
- Consideration of other value based programs such as:
  - ACO
  - PCMH/PCSP

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Checklist #3

- ✓ Financial Report
- ✓ Decide if changes are needed, if so monitor frequently any NEW changes

References

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How_To_Get_Started.html

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016_PQRS_IndivMeasures_Guide_11_17_2015.pdf

https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeedbackprogram/valuebasedpaymentmodifier.html#2016QualityBenchmarks

transformation@galenhealthcare.com

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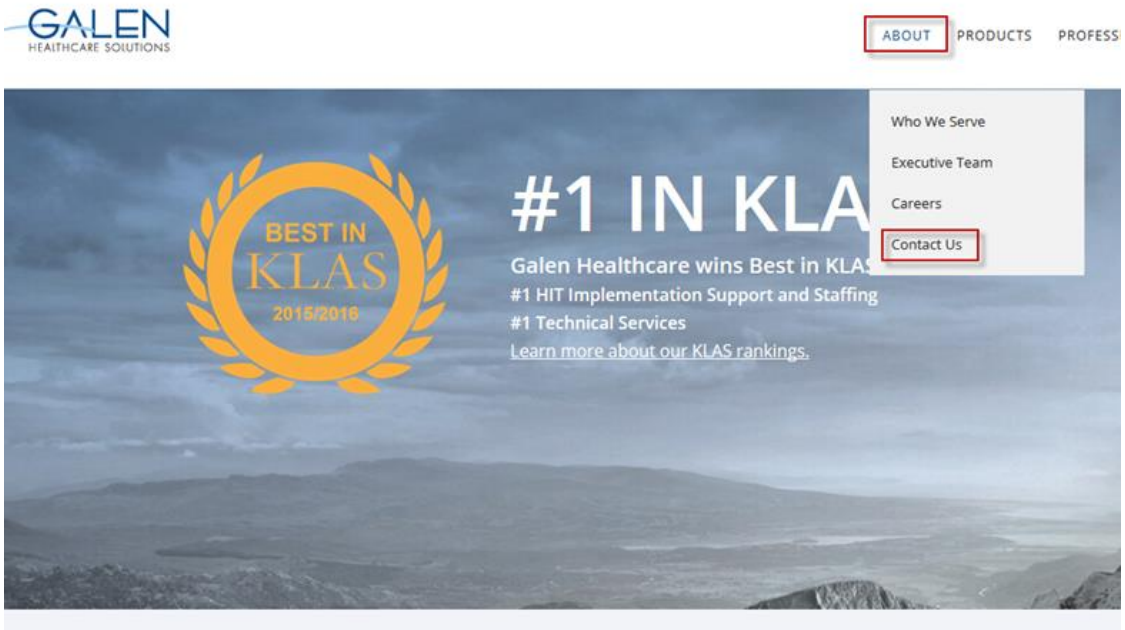

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