



Outpatient CMS Quality Measurement Programs

Implications for I/T/U

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Objectives

- Provide a general overview of both 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

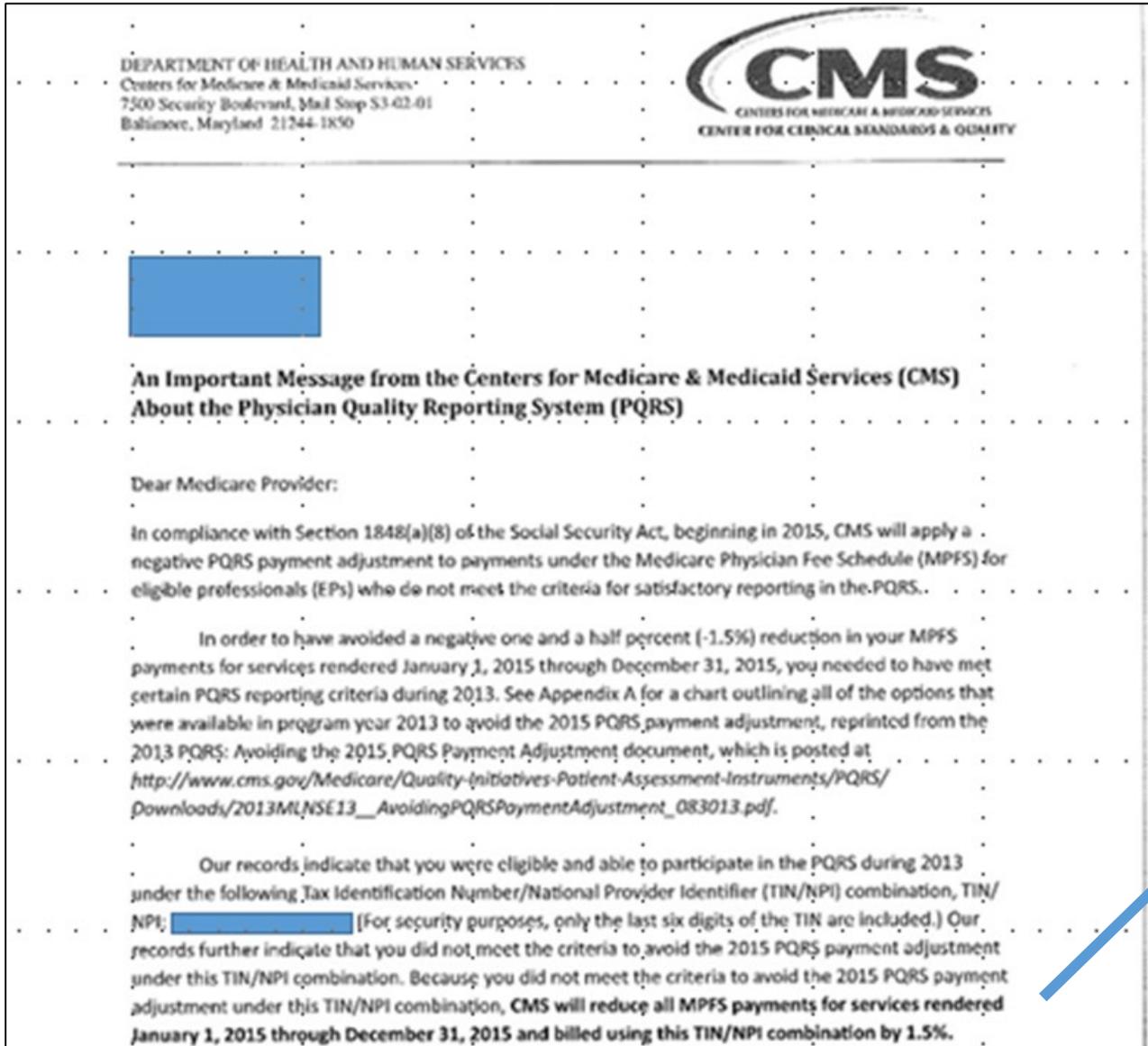
- Both the PQRS and VM programs contribute to all 3 of the National Quality Strategy aims by promoting consistent, evidence-based care.
- The National Quality Strategy aims are:
 - Better care for individuals
 - Better care for populations
 - Lower costs through improvement

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)

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%



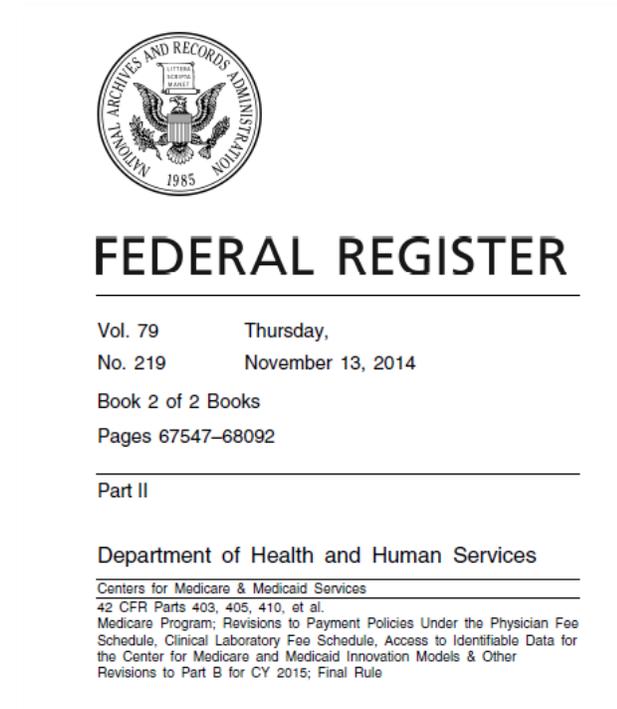
Physician Quality Reporting System (PQRS)

- 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.
- Payment adjustments are applied 2 years following the performance year, and apply only to payments on the Medicare Physician Fee Schedule made to the NPI/TIN combination.
- The 2015 MPFS Final Rule establishes the 2017 PQRS negative payment adjustments.



2015 Medicare Physician Fee Schedule

- Published in Federal Register
11-13-2014
- 464 pages
- Separate from the CMS
Meaningful Use and ONC
Certification Criteria
- WATCH for 2016 MPFS final
rule, est. by 11/1/15.





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	



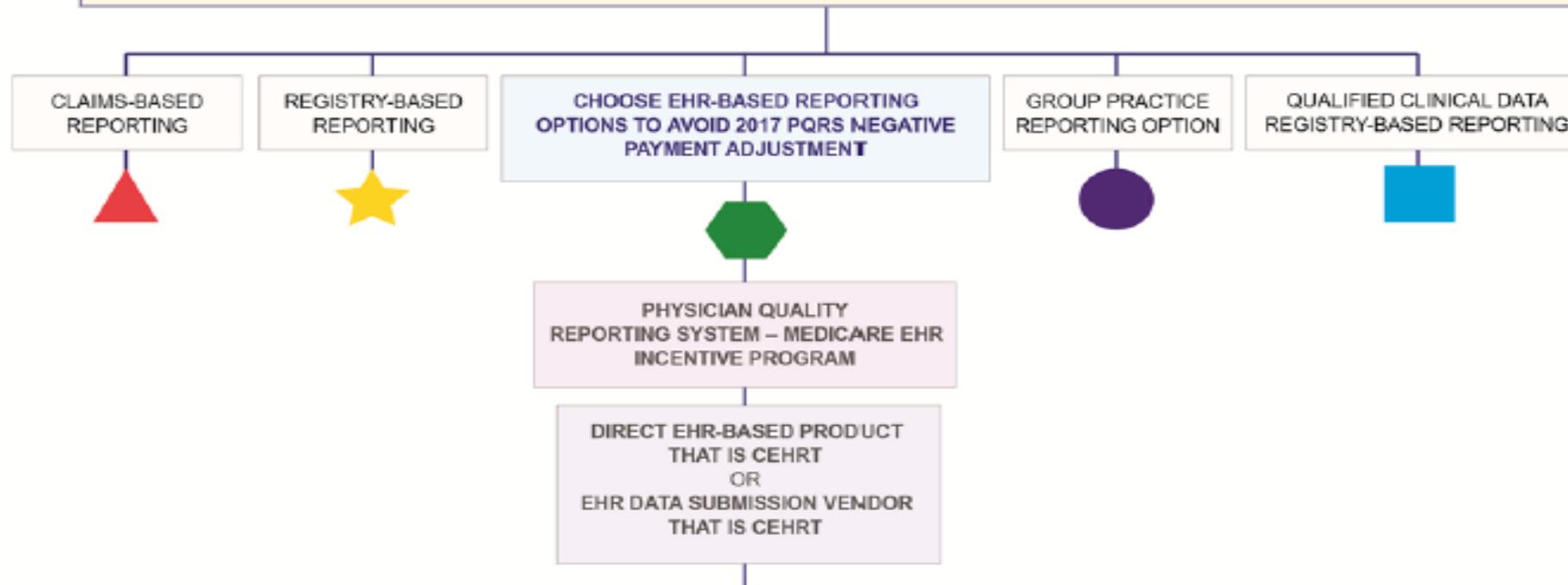
PQRS Reporting

- 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.)



8.9

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

RPMS Practice Management Application Suite:

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



Value Modifier (VM)

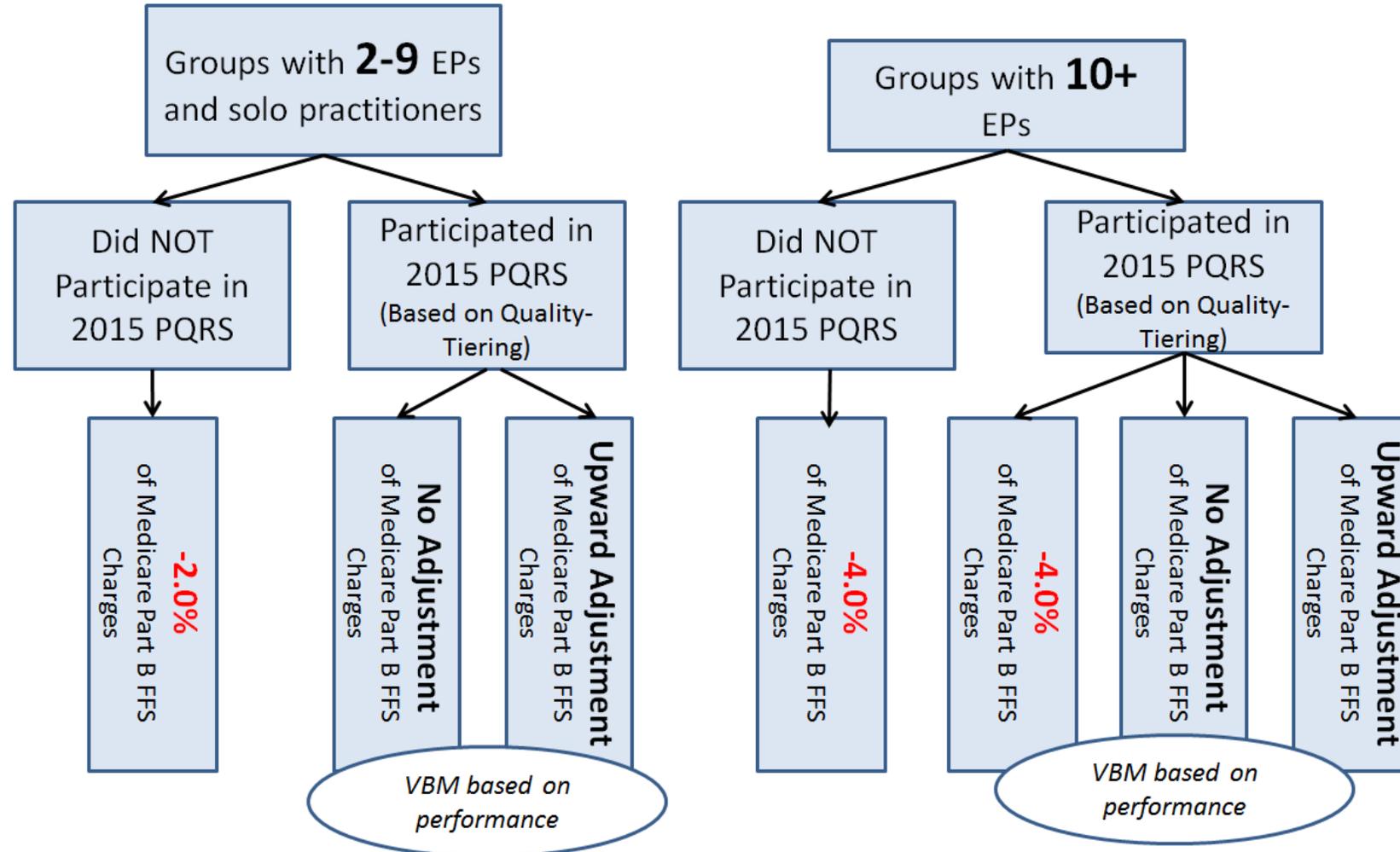
- A new payment modifier under the Medicare Physician Fee Schedule (MPFS) mandated by the Affordable Care Act
- VM Assesses both quality of care furnished and the cost of that care under the MPFS
- Performance on quality and cost measures is provided to physicians through annual physician feedback reports,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



Value Modifier (VM)

- 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)



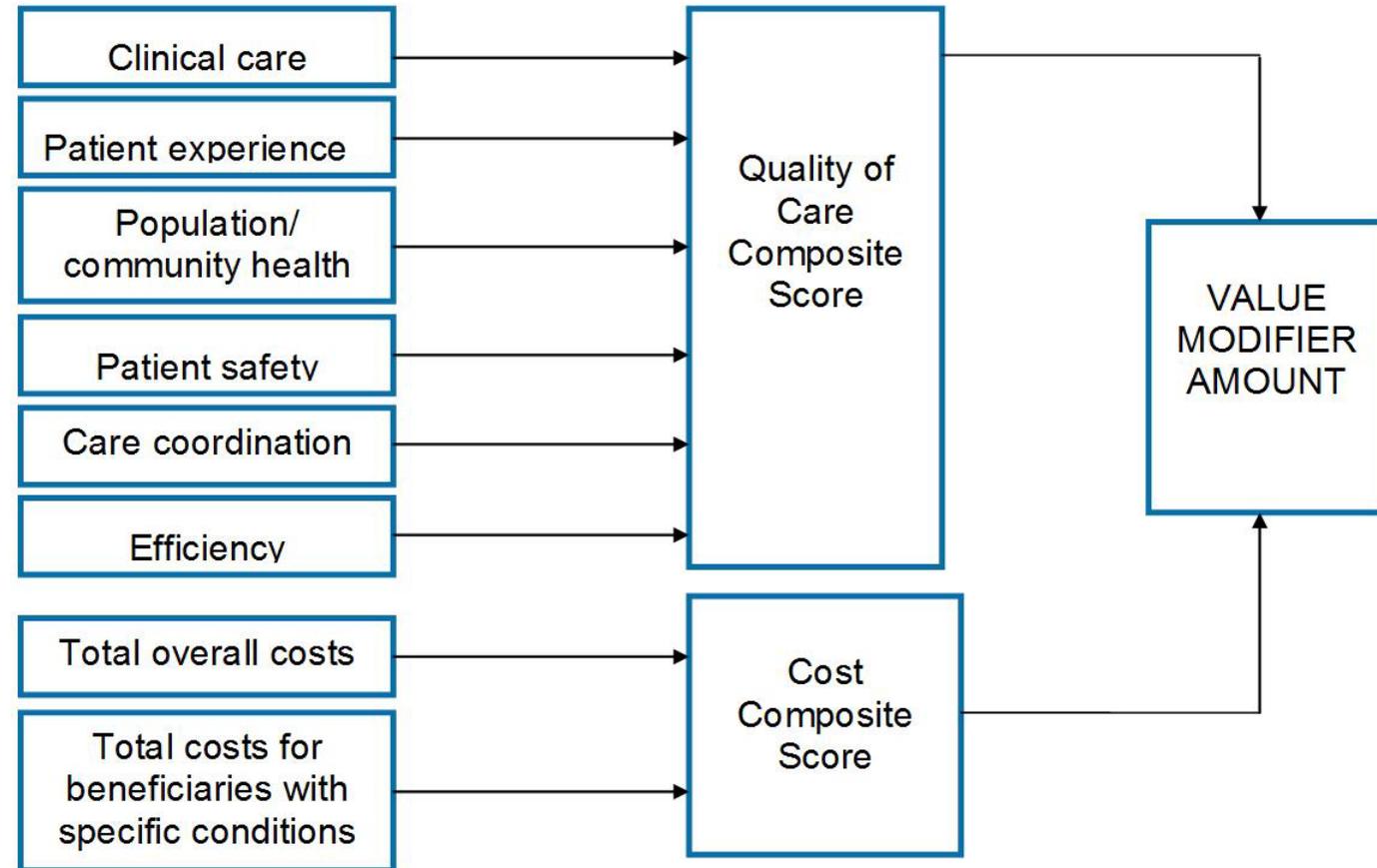


What Cost Measures Will be Used for Quality Tiering?

- 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).*

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Medicare-Medicaid
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Physician Quality Reporting System

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[Group Practice Reporting Option](#)

[GPRO Web Interface](#)

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How To Get Started

[2015 Beginner Reporter Toolkit](#)

New to quality reporting or need a refresher? This beginner-level toolkit contains two documents to help individual EPs and PQRS group practices navigate their way through the various PQRS decision points and the impact of quality reporting. These two resources are meant to complement one another:

- Learn how to report with the "Quality Reporting Roadmap."
- Learn how your data is utilized with the "Take a Moment & Participate Flowchart."

Step-by-Step Instruction in Getting Started with the Physician Quality Reporting System (PQRS)

Note: For eligible professionals participating in other Medicare quality programs (electronic reporting using an EHR, Value-based Modifier, and Accountable Care Organizations), please see [How to Report Once for 2015 Medicare Quality Reporting Programs](#).

STEP 1: Determine your eligibility

Find out whether you are eligible to participate in 2015 PQRS to avoid the 2017 negative payment adjustment. View our [2015 PQRS List of Eligible Professionals](#) to determine your eligibility.

STEP 2: Determine whether you want to participate in PQRS as an individual eligible professional (EP) or as part of a group practice



PQRS Trainings

- IHS ORAP conducted PQRS trainings May 28, June 2, June 4, 2015 and slides remain available: <http://ihs.adobeconnect.com/pqrs>
- ORAP will conduct additional trainings about PQRS in November/December.
- For the most up-to-date information from CMS, please go to www.cms.gov/PQRS



Ahead: MACRA and MIPS

- 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%
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- Possible participation in Alternative Payment Models (APMs)



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



Questions



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Supplemental Materials



Clinical Quality Measures (CQM)

- MU, PQRS, and VM all use CQMs
- CQMs are used in more than 20 different programs.
- 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 | • Population and Public Health |
| • Care Coordination | • Patient Safety |
| • Patient and Family Engagement | • Efficient Use of Healthcare Resources |



FOR MU EP Measures (eCQMs) (must report on 9 covering 3 NQS domains) — Subset of Adult 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 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
CMS 122	Diabetes: Hemoglobin A1c Poor Control	Effective Clinical Care
CMS 131	Diabetes: Eye Exam	Effective Clinical Care
CMS 134	Diabetes: Medical Attention for Nephropathy	Effective Clinical Care
CMS 123	Diabetes: Foot Exam	Effective Clinical Care
CMS 148	Hemoglobin A1C Test for Pediatric Patients	Effective Clinical Care
CMS 163	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 EIDM (formerly 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



Alternative Payment Models (APM)

- A CMMI model (Center for Medicare & Medicaid Innovation (“the Innovation Center”))
- Medicare Shared Savings Program and Accountable Care Organizations
- A CMS demonstration under section 1866C of the SSA; or required by Federal law
- And... any *Eligible alternative payment entity*:
 - Participates in an APM that requires participants to use certified EHR technology and provides for payment for covered professional services based on quality measures “comparable to” measures under the performance category described in the MIPS program established above, and
 - Bears financial risk for monetary losses under the APM that are in excess of a nominal amount
 - Is a medical home expanded under section 1115(c) of the SSA.