Physician Quality Reporting System (PQRS) Reporting with MeHI’s Registry and Services

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Today’s presenters:

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Agenda

- Who We Are
- PQRS Context
- Your Practice and PQRS
- PQRS Eligibility
- Reporting Methods
- Reporting Considerations
- MeHI’s Qualified Registry
- Future of PQRS and Quality Reporting
- Next Steps
- Questions
A division of the Massachusetts Technology Collaborative, a public economic development agency, MeHI is:

- The state's entity for health care innovation, technology and competitiveness
- Helping accelerate the adoption of eHealth technologies
  - Supporting the safety, quality and efficiency of health care in MA
  - Advancing the dissemination of HealthIT throughout MA, including deployment of electronic health records (EHR) systems in all health care provider settings networked through a statewide health information exchange (HIE)
Your trusted Health IT advisor

- **Chapter 305** created MeHI, which is overseen by the Health Information Technology Council
- **Chapter 224** further delineates MeHI’s role in advancing HealthIT and supporting organizations in reaching Meaningful Use of EHR technology
- **MassHealth** contracted with MeHI to administer key components of the Medicaid EHR Incentive Payment Program

We’re here to help!

- MeHI assists the provider community in navigating the increasingly complex landscape of HealthIT and government regulations
- Our staff has gained considerable insight into the HealthIT needs of providers and the most effective methods of delivering assistance
Who We Are

Support healthcare providers in achieving Meaningful Use of EHR technology

- Meaningful Use Gap Analysis
- Registration and Attestation support
- Secure document storage and audit preparation

Support providers with Physician Quality Reporting System (PQRS) reporting

- Qualified registry for submitting PQRS measures

Collaborate with external partners to offer

- Patient engagement resources
- Privacy and security tools
- Other HealthIT resources

Engage in thought leadership

- Educational outreach, informational webinars and training courses
- Subject matter expertise on topics of interest to provider organizations
The Purpose of PQRS

- In an effort to improve the quality and lower the cost of health care, the Centers for Medicare and Medicaid Services (CMS) is moving toward performance-based reimbursement and away from the fee-for-service (FFS) payment model.
- PQRS is one of several initiatives designed to accomplish that goal.
- PQRS is a reporting program that uses a combination of incentive payments and negative payment adjustments to promote reporting of quality information by eligible professionals (EPs).
How does PQRS work?

- Eligible Professionals (EPs) report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B FFS beneficiaries
- EPs must report on **each** unique NPI/TIN combination
- Providers participating with a Medicare Accountable Care Organization (ACO) are eligible for the 2014 PQRS incentive and avoid the 2016 PQRS payment adjustment based on the ACO’s reporting for 2014
I work for 2 different organizations, so I have 2 different NPI/TINs I bill under. Which one do I use for reporting?

Eligible Professionals must report for each NPI/TIN combination they used to bill Medicare during the 2014 calendar year in order to avoid the 2016 PQRS payment adjustment.
PQRS Incentives and Payment Adjustments

- **2014 program year incentive: 0.5%**
  - Incentive payments for 2014 are issued separately as a single consolidated payment in 2015

- **2014 program year payment penalty: -2.0%**
  - Payment adjustments for reporting year 2014 apply to Medicare reimbursements in 2016

- **2014 reporting year is the last year** to earn an incentive

- **Payment penalties will continue**
  - Failure to report PQRS in 2015 will result in a payment adjustment in 2017, and so on

- These penalties are in addition to MU penalties and Value-Based Modifier penalties
Your Practice and PQRS

- Why should I participate in PQRS?
  - Earn an incentive for 2014 reporting
  - Avoid penalties

- Value-Based Modifier (VM)
  - Currently applies to group practices with 10+ EPs practicing under a single Tax ID
  - Going forward, will apply to all practices, including single providers
  - Can result in additional penalties of up to -2%

- Example: Group of 10+ practice bills $2,000,000 to Medicare
  - If successful in PQRS reporting, incentive = $10,000
  - If NOT successful in PQRS reporting
    - PQRS Penalty: -$40,000 AND
    - Value-Based Modifier Penalty: -$40,000
  - Total Penalty for not reporting = $80,000
## Your Practice and PQRS

<table>
<thead>
<tr>
<th>PQRS</th>
<th>Value Modifier</th>
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<tr>
<td></td>
<td>10-99 EPs</td>
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<td>Reporting PQRS</td>
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<tr>
<td>Physicians</td>
<td>0.5% of MPFS</td>
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<tr>
<td>Practitioner</td>
<td>0.5% of MPFS</td>
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<tr>
<td>Therapists</td>
<td>0.5% of MPFS</td>
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</tbody>
</table>

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
What is the payment adjustment specifically for the Value-Based Modifier?

The Value-Based Modifier payment adjustments are based on quality tiering. Quality tiering is the analysis used to determine the type of adjustment (upward, downward or neutral) and the range of adjustment based on performance on quality and cost measures. Quality tiering will determine if a group practice’s performance is statistically better than, the same as, or worse than the national mean. The exact amount of the adjustment cannot be determined until the data is analyzed and quality tiering is complete. For more information on the Value-Based Modifier, please visit: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html)
Your Practice and PQRS

Steps for your practice

1. Determine eligibility
2. Choose a reporting method
3. Choose measures
4. Collect and organize data
5. Submit data
PQRS Eligibility

- PQRS is relevant to you if you furnish services to Medicare Part B FFS beneficiaries and are considered an Eligible Professional:

<table>
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<tr>
<th></th>
<th>PQRS</th>
<th>Value Modifier</th>
<th>EHR Incentive Program</th>
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Massachusetts eHealth Institute
Knowledge Check

- **Is there a minimum number of Medicare patients I need to see to qualify for PQRS?**

  Eligible Professionals who had at least 1 eligible Medicare Part B FFS patient encounter during 2014 qualify for a PQRS incentive payment, and will be subject to a -2% payment adjustment in 2016 for failure to report.
Individual eligible professionals (EPs)

Individual EPs still have time to participate in 2014 PQRS through the following reporting methods:

- Qualified registry
- Qualified Clinical Data Registry (QCDR)
- Direct EHR using Certified EHR Technology (CEHRT)
- CEHRT via Data Submission Vendor

Individual EPs may also participate via claims-based reporting; however, it is too late to use this method for Program Year 2014.

Deadlines for PQRS data submission:
- Direct EHR or CEHRT via Data Submission Vendor – Feb 28, 2015
- MeHI’s Qualified Registry – March 19, 2015
- QCDR – March 31, 2015
Group Practice Reporting Option (G-PRO)

- A group is defined as 2 or more individual EPs who have reassigned their billing rights to the group TIN

- Groups can report PQRS data using the following methods:
  - Qualified registry
  - Direct EHR using CEHRT
  - CEHRT via Data Submission Vendor
  - Web interface (groups of 25+ only)
  - Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) via CMS-certified survey vendor (groups of 25+ only)

- Deadline to register as a group for PQRS Program Year 2014 was October 3, 2014
  - Deadline for Program Year 2015 is June 30, 2015
  - Registration must be through the CMS Physician Value-Physician Quality Reporting System (PV-PQRS) Registration System
Reporting Considerations

Individual Measures and Measures Groups

- Individual Measures
  - Report on at least 50 percent of eligible encounters
  - All measures must have a >0% performance rate
  - 3 measures = eligible to avoid 2016 payment adjustment (-2%)
  - 9 measures across 3 NQS domains = eligible for 2014 incentive (+0.5) AND avoid 2016 payment adjustment (-2%)
  - If reporting using G-PRO, must report Individual Measures

- Measures Groups
  - EP chooses 1 measures group of related measures
  - Report on all applicable measures for 20 eligible patients (majority must be traditional Medicare Part B beneficiaries)
  - All measures must have a >0% performance rate
Knowledge Check

- I have a low Medicare volume, so I don’t have 20 patients (or 11 Medicare patients) for any Measures Group. Can I report on less than 20 patients and at least avoid the payment adjustment?

For 2014, EPs reporting a Measures Group must report all applicable measures for 20 eligible patients (11+ Medicare FFS patients) in order to avoid the 2016 PQRS payment adjustment. If an EP does not have enough patients to achieve this with a certain measures group, the EP can choose another measures group that can be reported for 20 patients (11+ Medicare FFS patients). Otherwise the EP will need to report individual measures using all 2014 Medicare patients.
Measures-Applicability Validation (MAV)

- If an EP reports less than 9 measures, or nine or more measures covering less than 3 domains, the MAV process will be applied.

MAV determines if an EP is eligible for an incentive despite reporting less than 9 measures, or nine or more measures covering less than 3 domains.

To receive an incentive in the above circumstances, the EP or group must either:

1. satisfactorily report all applicable measures within a clinical cluster (clinically related measures)
2. satisfactorily report on measures not included within a clinical cluster AND pass the clinical relation/domain test based on the measures within the clinical cluster.
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
- Other quality reporting programs in use or being considered
MeHI offers a CMS Qualified Registry for PQRS submission

- Easiest, most efficient way to report
- Registry is the **ONLY** way to report with a Measures Group for 20 patients – all other reporting methods are limited to Individual Measures
- Subject matter experts to assist you along the way
  - Interpretation of Medicare eligibility and reporting requirements
  - Measures selection guidance by specialty
  - Support for performing data collection, data entry, and submission
  - Data Collection Sheets for Measures Group reporting
  - Customized support for reporting Individual Measures
- MeHI can help you strategize and prepare for future reporting years to avoid future penalties
The Future of PQRS and Quality Reporting

- **PQRS** will continue
  - Requirements may become more stringent
  - Measures will be better aligned across programs
  - Reporting will likely move toward practice level vs individual
  - The measure load will likely increase

- Going forward, **all EPs** will be subject to the **Value-Based Modifier** program which will assess incentives and penalties based on the quality of measures reported
  - Both cost and quality data included in calculating payments
  - Quality tiering is the analysis used to determine the type and amount of the adjustment (upward, downward or neutral)
The Future of PQRS and Quality Reporting

- Significant quality benchmarks will come into play
- The dollar amount of incentives and penalties will continue increasing
- Reimbursement will be tied to quality performance
- Data will become available to the public and performance of practices and providers will be shared

Public Reporting Timeline

- 2013 PQRS, GPRO, eRx & EHR Incentive Program Participation
- 2012 PQRS, GPRO, eRx, & EHR Incentive Program Participation
- Information on ABMS board certification
- 2013 PQRS, GPRO, & EHR Incentive Program Participation
- 2013 PQRS Maintenance of Certification Incentive
- 2012 PQRS GPRO & ACO measures (early 2014)
- 2013 PQRS GPRO & ACO measures (late 2014)
- GPRO Composite Measures (DM & CAD) (late 2014)
- 2013 CG-CAHPS data for ACOs (late 2014)
- Successful reporting of the 2013 Cardiovascular Prevention measures group in support of Million Hearts Initiative

- 2014 PQRS, GPRO, EHR, Incentive Program Participation
- 2014 Maintenance of Certification Incentive
- 2014 PQRS GPRO & ACO measures
- 2014 CG-CAHPS data for GPROs, ACOs, and other groups
- 2014 Individual PQRS Quality Measures
- Measures from the 2014 Cardiovascular Prevention measures group in support of Million Hearts Initiative
- Specialty Society Measures (beyond 2010)

Next Steps

- To get started with MeHI’s PQRS Registry and Services
  - Contact us at 1-855-MASS-EHR or massehr@masstech.org
  - Visit our website to learn more and complete our PQRS interest form at mehi.masstech.org/services/pqrs-services

- Deadline to submit PQRS data using MeHI’s Qualified Registry is March 19, 2015
Questions?
Contact Us

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## Pricing for MeHI’s Qualified Registry

<table>
<thead>
<tr>
<th>Type of Service</th>
<th># Providers</th>
<th>Price per Provider</th>
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