Ins and Outs of PQRS

October 30, 2015
Agenda

• Goals, Trends, and Alignment
• PQRS overview
  o Choosing PRQS reporting option and method
  o Measure selection
  o Avoiding the adjustment
• Physician Value-based Payment Modifier overview
• Merit-based Incentive Payment System
• Impact on Medicare reimbursement

Stated Goals

• HHS goal is to shift payment systems to reward quality and lower costs
• Per U.S. Department of Health and Human Services Secretary Sylvia Maxwell:
  o Tie 30% of traditional/FFS Medicare payments to quality or value via alternative payment models (e.g., ACOs, bundled payments, etc.) by end of 2016 and 50% by end of 2018
  o Tie 85% of all traditional/FFS Medicare payments to quality or value by 2016 and 90% by 2018
Trends

Alignment

- Initially, multiple programs and requirements
- Shift to report once, get credit for many
  - MU CQMs and PQRS via EHR
- Recognition of ongoing professional quality initiatives
  - Qualified Clinical Data Registries
- Fold existing programs into new initiatives
Alignment

Incent use of Electronic Health Records

Pay for Reporting

Pay for Performance, Improvement, and Integration

Pay for Value and Cost Efficiency

What Happens Now?

• Current programs and payment adjustments in place through end of 2018

• Physicians and other eligible professionals must participate to avoid negative payment adjustments

• Medicare Access and CHIP Reauthorization Act of 2015 (HR 2) builds upon current programs and retains many components

• Be prepared for the Physician Value-Based Payment Modifier = participate in PQRS
PQRS Overview

- PQRS was designed to promote reporting of best practice quality measures
  - Voluntary program
  - Began 8 years ago
  - “Carrot and stick” approach
    - Incentives paid through 2014
    - Negative adjustment of 1.5% in 2015 and 2% in 2016 and beyond
  - 250+ individual measures and 22 measures groups in 2015
  - Multiple reporting methods

### Carrots and Sticks

<table>
<thead>
<tr>
<th>Program Year</th>
<th>Incentive Amount</th>
<th>Payment Adjustment Amount</th>
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</thead>
<tbody>
<tr>
<td>2007</td>
<td>1.5%</td>
<td>None</td>
</tr>
<tr>
<td>2008</td>
<td>1.5%</td>
<td>None</td>
</tr>
<tr>
<td>2009</td>
<td>2.0%</td>
<td>None</td>
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<tr>
<td>2010</td>
<td>2.0%</td>
<td>None</td>
</tr>
<tr>
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<tr>
<td>2014</td>
<td>0.5%</td>
<td>None</td>
</tr>
<tr>
<td>2015</td>
<td>None</td>
<td>1.5% (based on 2013 participation)</td>
</tr>
<tr>
<td>2016 and beyond</td>
<td>None</td>
<td>2.0% (for 2016 based on 2014 participation)</td>
</tr>
</tbody>
</table>
PQRS Overview

• Multiple reporting factors to consider
  o Individually or register for the Group Practice Reporting Option
  o Methods
  o 12 month reporting period (calendar year)
  o Individual measures or measures groups
  o Reporting through another CMS program (e.g., MSSP, CPCI, Pioneer ACO)

• 250+ individual measures and 22 measures groups
• Changes made annually

PQRS Overview

• Eligible professionals (EPs)
  o Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Oral Surgery, Doctor of Dental Medicine, Doctor of Chiropractic
  o 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, Audiologist
  o Physical Therapist, Occupational Therapist, Qualified Speech-Language Therapist
PQRS Consequences

• Downward payment adjustments for non-participation (2-year look-back)
  o 1.5% downward payment adjustment in 2015
  o 2.0% downward payment adjustment in future years

• Lack of participation impacts penalty under the Physician Value-Based Payment Modifier

Considerations

• Potential payment reduction (0.02 x total Medicare Part B PFS allowed charges)
• Staff time
• Other costs (e.g., registry, EHR, consultant, etc.)
• CMS public reporting of participation
PQRS Reporting Options

- Report as an individual or under the group practice reporting option (GPRO)
  - Individual EPs
  - Groups via the GPRO
    - 2 or more EPs
    - Single TIN
    - Reassigned billing rights to the TIN
- Group practice ≠ GPRO

Individual vs. Group Reporting

<table>
<thead>
<tr>
<th>Pros</th>
<th>Individual Reporting</th>
<th>Group Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPs select measures that fit their practice</td>
<td>• Potential to earn incentive and avoid adjustment even if others in the practice don’t • Additional reporting options</td>
<td>• Simpler to track single set of measures • Potential to earn incentive and avoid penalties for all EPs in group even if a few don’t meet the threshold</td>
</tr>
<tr>
<td>Cons</td>
<td>• Difficult to identify and track measures for a variety of EPs</td>
<td>• Selected measures may not be applicable to all EPs in the group</td>
</tr>
</tbody>
</table>

Measure Selection

• Key considerations
  o Clinical conditions commonly treated
  o Types of care frequently delivered (e.g., preventive, chronic, acute)
  o Settings where care is delivered
  o Quality improvement goals
  o Other quality reporting programs in use or being considered

• Review Measures List (individual and/or measures groups)

Measure Selection

Individual Measures
• Select 9 measures
• At least 3 domains
• Report on at least 50% of applicable Medicare Part B FFS patients

Measures Group
• Bundle of individual Measures
• Select 1 Measures Group
• Report on 20 patients (over 50% must be Medicare Part B FFS)
Measure Selection

• Review specifications
• Domains
• Cross cutting measures
• Limitations
  o Measures Groups
    ▪ Registry
    ▪ Individuals
  o GPRO group practices
    ▪ No claims reporting
    ▪ EHR or registry reporting or Web Interface

Measures - Domains

- Patient Safety
- Person & Caregiver-Centered Experience and Outcomes
- Communication and Care Coordination
- Effective Clinical Care
- Community/Population Health
- Efficiency and Cost Reduction
## Measures List Example

| Measure Title | Measure Number | Measure Title | Measure Number | Measure Title | Measure Number | Measure Title | Measure Number | Measure Title | Measure Number |
|---------------|----------------|---------------|----------------|---------------|----------------|---------------|----------------|---------------|---------------|----------------|
| NIA 0048      | E40            | Effective Clinical Care | E40            | Effective Clinical Care | E40            | Effective Clinical Care | E40            | Effective Clinical Care | E40            |
| NIA 0049      | E41            | Effective Clinical Care | E41            | Effective Clinical Care | E41            | Effective Clinical Care | E41            | Effective Clinical Care | E41            |
| NIA 0134      | E43            | Effective Clinical Care | E43            | Effective Clinical Care | E43            | Effective Clinical Care | E43            | Effective Clinical Care | E43            |
| NIA 0236      | E44            | Effective Clinical Care | E44            | Effective Clinical Care | E44            | Effective Clinical Care | E44            | Effective Clinical Care | E44            |
| NIA 0637      | E45            | Effective Clinical Care | E45            | Effective Clinical Care | E45            | Effective Clinical Care | E45            | Effective Clinical Care | E45            |
| NIA 0097      | E46            | Effective Clinical Care | E46            | Effective Clinical Care | E46            | Effective Clinical Care | E46            | Effective Clinical Care | E46            |
|              |                |               |                |                |                |                |                |                |                |

### Additional Notes

- **Osteoporosis Management Following Fracture of Hip, Spine, or Dorsal Radius for Men and Women Aged 55 Years and Older:** Percentage of patients aged 55 years and older with fracture of the hip, spine, or dorsal radius who had a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed and pharmacologic therapy prescribed.

- **Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery:** Percentage of patients aged 16 years and older undergoing isolated CABG surgery who received an IMA graft.

- **Medication Reconciliation: Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician, prescribing Practitioner, registered nurse, or clinical pharmacist providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented.**
Reporting Methods

• For Individual EPs
  o Medicare Part B claims
  o Qualified PQRS Registry
  o Qualified EHR or EHR data submission vendor
    ▪ Certified Electronic Health Record Technology (CEHRT)
  o Qualified Clinical Data Registry (QCDR)

• For Groups via the GPRO
  o Qualified PQRS registry (groups of 2+)
  o Qualified CEHRT EHR or EHR data submission vendor (groups of 2+)
  o Web Interface (groups of 25+ only)
  o CG CAHPS CMS-certified survey vendor (groups of 2+)
  o June 30, 2015 deadline to register selected reporting mechanism
Measure Components

• Measure = Numerator / Denominator
  o Denominator defines the eligible population to be measured
  o Numerator represents those patients for whom the quality action was performed
• Indicators of how often a process of care or outcome of care occurs
• Quality data codes are used to report measures

Numerator

• The upper portion of a fraction used to calculate a rate, proportion, or ratio. The numerator must detail the quality clinical action expected that satisfies the condition(s) and is the focus of the measurement for each patient, procedure, or other unit of measurement established by the denominator (that is, patients who received a particular service or providers that completed a specific outcome/process).

Denominator

• The lower portion of a fraction used to calculate a rate, proportion, or ratio. The denominator must describe the population eligible (or episodes of care) to be evaluated by the measure. This should indicate age, condition, setting, and timeframe (when applicable). For example, “Patients aged 18 through 75 years with a diagnosis of diabetes.”
# Measure Components

## Measure Specification Construct (example)

### NUMERATOR

- CPT II 4004F
- CPT II 1096F
- [Clinical action required for performance]

### DENOMINATOR

[Describe eligible cases for which the action was performed: the eligible population defined by denominator specification]

## Reporting Method

<table>
<thead>
<tr>
<th>Reporting Method</th>
<th>Individual</th>
<th>GPRO</th>
<th>Reporting Requirements</th>
<th>Submission</th>
<th>Other Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part B FFS Claims</td>
<td>X</td>
<td></td>
<td>9 measures/3 domains for 50% of applicable patients + if at least 1 face-to-face encounter w/Medicare patient, report required cross-cutting measure</td>
<td>Concurrent w/claims submission</td>
<td>Cannot retroactively correct claims for the purpose of adding the quality measures</td>
</tr>
<tr>
<td>Qualified Registry</td>
<td>X X</td>
<td></td>
<td>9 measures/3 domains for 50% of applicable patients + if at least 1 face-to-face encounter w/Medicare patient, report 1 cross-cutting measure or 1 measures group (20 patients and at least 11 are Medicare Part B patients)</td>
<td>Registry submits data annually</td>
<td>Only method for reporting measures group Only individuals can report measures groups</td>
</tr>
<tr>
<td>Qualified EHR</td>
<td>X X</td>
<td></td>
<td>9 measures/3 domains for 50% of applicable patients</td>
<td>Annual submission</td>
<td>May be able to coordinate w/MU CQM requirements</td>
</tr>
<tr>
<td>GPRO Web-based Interface</td>
<td>X</td>
<td></td>
<td>Report on 21 CMS pre-selected measures for a sample of assigned beneficiaries</td>
<td>Annual submission</td>
<td>Option only available for groups of 25 or more EPs</td>
</tr>
<tr>
<td>Qualified Clinical Data Registry</td>
<td>X</td>
<td></td>
<td>9 measures/3 domains for 50% of applicable patients (two measures must be outcome measures)</td>
<td>QCDR submits data annually</td>
<td>May be preferable, more meaningful option for specialists</td>
</tr>
<tr>
<td>CMS Certified Survey Vendor (CG-CAHPS)</td>
<td>X</td>
<td></td>
<td>12 CAHPS survey modules selected by CMS + at least 6 measures/2 domains (registry &amp; EHR reporting); GPRO groups of 25-99 EPs reporting via WI must report CAHPS + all 21 measures within the GPRO WI Assignment of beneficiaries</td>
<td>Administered and collected by survey vendor</td>
<td>Optional: Groups of 2-99 EPs Required: Groups of 100 or more EPs reporting via the Web-based interface</td>
</tr>
</tbody>
</table>
Getting Started in 2015

• Select reporting option
  o If GPRO, register through the online PV-PQRS Registration System at https://portal.cms.gov by June 30, 2015 (instructions can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html)

• Select reporting method

• Select measures
  o For claims, registry, and EHR reporting method
    ▪ At least 9 individual measures covering at least 3 of 6 domains
    ▪ 1 measures group (only individuals reporting via registry)

Getting Started in 2015

• Review applicable documents (Specifications Manual and Implementation Guide)
• Select a qualified registry if reporting a measures group
• Report on at least 50% of your Medicare Part B FFS patients if individual measures
• Report 20 patients if measures group (at least 11 must be Medicare Part B FFS)
• No need to sign-up or pre-register with CMS
Example 1

Appendix D: Satisfactory Reporting via Claims Scenario

Satisfactorily Reporting Scenario
Measure #6: Coronary Artery Disease (CAD): Antiplatelet Therapy

Mr. Jones, age 65, presents for office visit (99213) with Dr. Thomas

Mr. Jones has diagnosis of CAD ($14.00)

Scenario 1
Dr. Thomas prescribes aspirin or clopidogrel
4086F

Scenario 2
Dr. Thomas does not prescribe aspirin or clopidogrel for Medical Patient or Systemic Erosions
4086F with 1P
4086F with 2P
4086F with 3P

Scenario 3
Dr. Thomas does not prescribe aspirin or clopidogrel and does not specify the reason
4086F with 8P

Example 1 (continued)

Appendix D: CMS-1500 Claim PQRS Example

Example of an individual NPI reporting on a single CMS-1500 claim.
Example 2

- PQRS Measure #130 – Documentation of Current Medications in the Medical Record
  - Denominator = All visits for patients ≥18 years of age
  - Numerator = Patients ≥18 years of age for which the EP attests to documenting, updating, or reviewing patient’s current medications
  - Numerator Quality-Data Coding Options for Satisfactory Reporting
    - G8427 = Current medications documented
    - G8430 = Current Medications not documented, patient not eligible
    - G8428 = Current medications w/name, dosage, frequency, or route not documented, reason not given
  - Frequency = reported each visit during the 12-month reporting period

Example 3

- PQRS Measure #47 – Advance Care Plan
  - Percentage of patients ≥65 who have an advance care plan or surrogate decision maker documented or documented that plan discussed but patient did not wish or was unable to name a surrogate or provide an advance care plan
  - No diagnosis required
  - E&M 99221, 99222, 99223 (+ others) define denominator eligible patients
Example 3 (continued)

• Reporting Options
  o 1123F – Documented
  o 1124F – Documented as discussed – patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
  o 1123F-8P – Advance care planning not documented, reason not otherwise specified

• Documented in the medical record that during the visit an advance care plan was discussed. Patient does not have an advanced directive or living will. Her daughter will be the surrogate decision maker

MAV

• Measures Applicability Validation (MAV) process
  o Recognition that not all specialists can report on 9 measures or across 3 domains
  o Successful PQRS participation if EP passes MAV test
  o 2-step validation process
    ▪ Any other reportable measures
    ▪ Minimum threshold test
Avoiding the 2017 Adjustment

Individual EPs and Groups selecting GPRO:

• Satisfactory report 2015 PQRS measures via selected reporting method

Tips

• Be sure to use the 2015 PQRS Quality Measure specifications
• Review the 2015 PQRS Implementation Guide to better understand the program and how to report and to make sure you’re reporting on all required codes
• Print off the coding specifications for those measures or measures groups
• Pay attention to timeframe and reporting frequency
Tips

• Recognize that some measures are driven by the surgical procedure; others by the diagnosis or office visit
• Make sure your billing software and/or clearinghouse can capture the PQRS codes and report the measures to the carrier/AB MAC
• Make sure each claim includes the appropriate quality data codes (numerator), diagnoses (if applicable), encounter codes (denominator), charges (note: QDC has charge of $0.01)

Tips

• Use a tracking list or edit on billing software to track each patient and what needs to be reported during the reporting period
• Use CMS-1500 claim form version 02-12 for paper-based submission (version 08-05 will not be accepted after 3/31/15)
• Regularly review the Remittance Advice notices from the Carrier/AB MAC
  o N620 code – if $0.00 billed on QDC line item
  o CO 246 N620 code – if $0.01 billed
Tips

• Make sure all claims submitted in time to reach the national Medicare claims system data warehouse by February 26, 2016
• Provide the correct TIN/NPI combination with registry reporting
  o For individual EPs – TIN and individual NPI to which Medicare Part B charges are billed
  o For group reporting – TIN to which Medicare Part B charges are billed

Common Errors

• No QDC on eligible claim
• Individual rendering NPI not on claim
• QDC on claim, but no encounter codes
• Reporting a QDC on a claim with an office visit code when the measure required a surgical procedure code
• Diagnosis is incorrect on claim for measure reported
• Reporting one QDC when the claim requires two QDCs
• Demographic data doesn’t match-up
Common Errors

- Reporting a QDC on a claim for a service that was not covered by Medicare (or claim was denied by carrier)
- Submitting incorrect exclusion modifiers for measures that didn’t have exclusion modifiers or not submitting exclusion modifiers
- Not reporting on the required number of patients that fit in the denominator

Physician VBPM

- Federal initiative that begins to move Medicare Part B from fee-for-service (FFS) towards fee-for-value (FFV)
- Section 3007 of the Patient Protection and Affordable Care Act
- Differential payment based on the quality of care furnished compared to cost of care furnished
- An adjustment made on a per claim basis to Medicare payments for items and services under the Medicare Physician Fee Schedule (PFS)
Physician VBPM

• Eligible Professionals (EPs)
  o Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Oral Surgery, Doctor of Dental Medicine, and Doctor of Chiropractic
  o 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
  o Physical Therapist, Occupational Therapist, Qualified Speech-Language Therapist

Implementation

Year 1 Phase-in

• Physicians in groups with 100 or more EPs
• First Performance Year = CY 2013
• First Payment Adjustment Year = CY 2015
**Implementation**

**Year 2 Phase-in**
- Physicians in groups with 10–99 EPs
- First Performance Year = CY 2014
- First Payment Adjustment Year = CY 2016

**Year 3 Phase-in**
- Physicians in groups with 2-9 EPs, solo practitioners, and MSSP, Pioneer ACO, and CPC Initiative participants
- First Performance Year = CY 2015
- First Payment Adjustment Year = CY 2017
Implementation

Year 4 Phase-in

- Non-Physician EPs
- First Performance Year = CY 2016
- First Payment Adjustment Year = CY 2018

Alignment

- Aligned with and based on participation in the Physician Quality Reporting System (PQRS)
- CMS objectives:
  - Improve the quality of care for Medicare beneficiaries
  - Provide a common base that does not increase physician reporting burden
  - Emphasize the importance of reporting quality
2015 Physician VBPM

Groups of physicians with \(\geq 100\) EPs

- **PQRS Reporters**
  - If elect quality tiering calculation, upward, no, or downward adjustment based on quality tiering
  - If quality tiering calculation not elected, 0.0% (no adjustment)

- **Non-PQRS Reporters**
  - -1.0% (downward adjustment)

2016 Physician VBPM

Groups of physicians with \(\geq 10\) EPs

- **PQRS Reporters** – 2 types
  1. Group reporters via PQRS GPRO
  2. Individual reporters in a group – at least 50% of EPs in group successfully participate

- **Groups of physicians w/10-99 EPs**
  - Upward or no adjustment based on quality tiering

- **Groups of physicians w/100+ EPs**
  - Upward, no, or downward adjustment based on quality tiering

- **Non-PQRS Reporters**
  - -2.0% (automatic downward adjustment)
2017 Physician VBPM

**Physician solo practitioners and physician groups with 2+ EPs**

**PQRS Reporters – 2 types**
1. Group reporters via PQRS GPRO
2. Individual reporters in a group – at least 50% of EPs in group successfully participate

**Groups of physicians w/2-9 EPs and solo practitioners**
- Upward or neutral adjustment based on quality-tiering (+0.0% to +2.0x of MPFS)

**Groups of physicians w/10+ EPs**
- Upward, neutral, or downward adjustment based on quality-tiering (-4.0% to +4.0x of MPFS)

**Non-PQRS Reporters**
- Automatic downward adjustment:
  - -2.0% for groups w/2-9 EPs and solo practitioners
  - -4.0% for groups w/10+ EPs

**Quality Tiering**

- Methodology used to reward or penalize a group based on cost and quality
- Evaluates groups of EPs against national average benchmarks based on cost and quality
- Determines whether a group of EPs receives a positive, negative, or neutral payment adjustment based on a two-year performance look-back
- Includes a quality composite score and a cost composite score
Quality Tiering Methodology

- Clinical care
- Patient experience
- Population/Community Health
- Patient safety
- Care Coordination
- Efficiency

Calculation of VBPM

- Uses PQRS quality data and Medicare cost data to determine overall value score
- Quality benchmarks set for each performance year based on prior year’s performance data of all solo practitioners and groups nationwide
- Greatest reward to high-performing, lower cost EPs
- Greatest negative adjustment to low-performing, higher cost EPs
Calculation of VBPM

• Quality of Care Composite
  o PQRS + 3 outcomes measures
    ▪ All-cause hospital readmissions
    ▪ Composite of preventable hospitalizations for acute conditions:
      □ Bacterial pneumonia
      □ Urinary tract infection
      □ Dehydration
    ▪ Composite of preventable hospitalizations for chronic conditions:
      □ Chronic obstructive pulmonary disease
      □ Heart failure
      □ Diabetes
  o Optional – CAHPS measures

Calculation of VBPM

• Cost Composite
  o Total per capita costs (Parts A & B)
  o Total per capita costs for beneficiaries with four chronic conditions:
    ▪ COPD
    ▪ Heart Failure
    ▪ Coronary Artery Disease
    ▪ Diabetes
  o Medicare Spending Per Beneficiary (3 days before and 30 days after an inpatient hospitalization)

• Payment-standardized and risk-adjusted and adjusted for specialty mix of EPs in the group
Calculation of VBPM

• For MSSP in 2017
  o Cost composite: Average
  o Quality composite: Based on ACO’s quality data

• For Pioneer ACOs and CPC Initiative participants
  o At least 1 EP in Pioneer ACO or CPC Initiative
  o Cost Composite: Average
  o Quality Composite: Average

<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>

*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.
2017 VM for Groups w/10+ EPs

<table>
<thead>
<tr>
<th>Cost/Qulity</th>
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<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<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>+4.0x*</td>
</tr>
<tr>
<td>High Cost</td>
<td>-4.0%</td>
<td>-2.0%</td>
<td>+0.0%</td>
</tr>
</tbody>
</table>

*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.

Quality and Resource Use Reports

- Provide comparative performance information for attributed Medicare FFS beneficiaries
- Goal is to provide meaningful and actionable information to physicians and medical groups
- Disseminated by CMS
- Provided for each Medicare-enrolled TIN
- Display quality and cost composite scores that will be used to calculate VBPM
Quality and Resource Use Reports

Action Required in 2015

• Participate successfully in PQRS
  o Option 1: Participate as a group practice via the Group Practice Reporting Option (GPRO)
    ▪ Physician groups with 2 or more EPs
    ▪ Register for GPRO by 6/30/15 – NOTE: DEADLINE PASSED
      ❑ Online PV-PQRS Registration System at https://portal.cms.gov
      ❑ Instructions at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html
  o Option 2: Participate as an individual
    ▪ Solo practitioners and groups with 2 or more EPs
    ▪ Make sure at least 50% of the EPs in the group successfully report under PQRS
Action Required in 2015

• Review Quality and Resource Use Reports (QRURs)
  o Download at https://portal.cms.gov
  o See directions on how to obtain your QRUR at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html

• Request informal review if disagree with findings within 60 calendar days after the release of the QRURs

• QRURs with 2014 data have been released

HR 2

• Medicare Access and CHIP Reauthorization Act of 2015
• Repeal of SGR
• Replace with payment updates of 0.5% through 2019
• Reward participation in alternative payment models (APMs) with a 5.0% bonus in years 2019 to 2024
• Annual updates beginning in 2026 of 0.75% for physicians in APMs and 0.25% for all others
• Pay-for-Performance incentive for high quality, low cost performers
• $20 million/year from 2016 to 2020 appropriated to provide technical support to smaller practices to health them participate in these new payment models
MIPS

- Merit-based Incentive Payment System (MIPS)
  - Combines and streamlines the current three quality incentive payment programs (PQRS, MU, VBPM)
  - Replaces multiple downward payment adjustments with one payment adjustment structure

- Composite score of 0-100 for physicians and other EPs based on performance in four categories
  - Quality
  - Resource Use
  - Meaningful Use
  - Clinical Practice Improvement Activities

MIPS

- Eligible Professionals (EPs)
  - Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Oral Surgery, Doctor of Dental Medicine, and Doctor of Chiropractic
  - Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist

- Some exceptions
  - Participating in APMs
  - Low volume

- All can be winners
MIPS

- Quality
  - PQRS, VBPM, and MU quality measures will be used
  - New measures may be proposed
  - Qualified clinical data registries (QCDR) still recognized
  - Final measures list to be published annually
  - Funding appropriated to develop additional quality measures

- Resource Use
  - Includes measures in current VBPM
  - Enhanced methodology to be developed with public input and health professional engagement
  - EPs report their role in treating the patient and type of treatment
  - Potential use of relationship codes
  - Risk adjustment methodology
MIPS

• Meaningful Use (MU)
  o Utilize current MU requirements
  o Allow report once to get credit for both MIPS quality category and MU CQMs

MIPS

• Clinical Practice Improvement Activities

• Physicians and other EPs will be assessed on their effort to engage in clinical practice improvement activities including at least
  o Expanded practice access
  o Population management
  o Care coordination
  o Beneficiary engagement
  o Patient safety and practice assessment
  o Participation in an APM

• Credit for improvement

• Recognized activities developed in collaboration with physicians and other health care professionals

• Reward for designation as PCMH or comparable specialty practice

• Must be attainable for small practices
MIPS

MIPS Performance Categories and Weights (Resource Use Ramps Up Over 3 Years)

<table>
<thead>
<tr>
<th>Performance Categories*</th>
<th>Year 1 (2019)</th>
<th>Year 2 (2020)</th>
<th>2021-forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>50%</td>
<td>45%</td>
<td>30%</td>
</tr>
<tr>
<td>Resource Use</td>
<td>10%</td>
<td>15%</td>
<td>30%</td>
</tr>
<tr>
<td>Clinical Practice Improvement Activities</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Meaningful Use of EHR*</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Maximum MIPS Reduction</td>
<td>4%</td>
<td>5%</td>
<td>7% (2021)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>9% (2022-forward)</td>
</tr>
</tbody>
</table>

* Meaningful use weight can decrease to 15% and be redistributed if EHR adoption reaches 75%. If Secretary determines an EP does not have enough measures, then CMS may change weight distribution.

MIPS

• MIPS Payment Adjustment
  o Composite scores compared to a performance threshold
  o Performance threshold = the mean or median of the composite performance scores for all MIPS EPs during a period prior to the performance year
    ▪ Below threshold = negative adjustment
    ▪ At threshold = no adjustment
    ▪ Above threshold = positive adjustment
APM Path

- Participation in alternative payment models (APMs) is encouraged
- Qualifying APM participants eligible for bonus payments from 2019-2024 on their FFS payments
- APMs are to be tested that are relevant to specialties, small practices, and those that are aligned with private and state-based payer initiatives
- Creation of Technical Advisory Committee to consider physician-focused APMs
- No MIPS risk for qualifying and partially qualifying

Cumulative Medicare Payment Adjustments

<table>
<thead>
<tr>
<th>Year</th>
<th>eRx</th>
<th>PQRS</th>
<th>EHR</th>
<th>VBPM</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>1.0%</td>
<td></td>
<td></td>
<td></td>
<td>1.0%</td>
</tr>
<tr>
<td>2013</td>
<td>1.5%</td>
<td></td>
<td></td>
<td></td>
<td>1.5%</td>
</tr>
<tr>
<td>2014</td>
<td>2.0%</td>
<td></td>
<td></td>
<td></td>
<td>2.0%</td>
</tr>
<tr>
<td>2015</td>
<td>1.0%</td>
<td>1.5%</td>
<td>1.0%</td>
<td>Up to 1.0%</td>
<td>Up to 4.5%</td>
</tr>
<tr>
<td>2016</td>
<td>2.0%</td>
<td>2.0%</td>
<td></td>
<td>Up to 2.0% (for groups w/10+ EPs)</td>
<td>Up to 6.0%</td>
</tr>
<tr>
<td>2017</td>
<td>2.0%</td>
<td>3.0%</td>
<td>2.0% (for groups w/2-9 EPs and solo practitioners)</td>
<td>4.0% (for groups w/10+ EPs)</td>
<td>Up to 7.0% (for groups w/2-9 EPs and solo practitioners) Up to 9.0% (for groups w/10+ EPs)</td>
</tr>
<tr>
<td>2018</td>
<td>2.0%</td>
<td>3.0% or 4%</td>
<td>TBD</td>
<td></td>
<td>Likely 9.0%-10.0% minimaly</td>
</tr>
</tbody>
</table>
# MIPS and APM Impact

<table>
<thead>
<tr>
<th>Year</th>
<th>Baseline</th>
<th>MIPS Incentive Adjustment</th>
<th>MIPS Incentive Adjustment w/ exceptional performance adjustment</th>
<th>APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>0.5%</td>
<td>+/- 4.0%</td>
<td>14.0%</td>
<td>FFS Bonus: +5.0%</td>
</tr>
<tr>
<td>2020</td>
<td>0.0%</td>
<td>+/- 5.0%</td>
<td>15.0%</td>
<td>FFS Bonus: +5.0%</td>
</tr>
<tr>
<td>2021</td>
<td>0.0%</td>
<td>+/- 7.0%</td>
<td>17.0%</td>
<td>FFS Bonus: +5.0%</td>
</tr>
<tr>
<td>2022-2024</td>
<td>0.0%</td>
<td>+/- 9.0%</td>
<td>19.0%</td>
<td>FFS Bonus: +5.0%</td>
</tr>
<tr>
<td>2025</td>
<td>0.0%</td>
<td>+/- 9.0%</td>
<td>NA</td>
<td>0.0%</td>
</tr>
<tr>
<td>2026 and subsequent years</td>
<td>0.25% (for non-APM physicians only)</td>
<td>+/- 9.0%</td>
<td>NA</td>
<td>0.75%</td>
</tr>
</tbody>
</table>

# PQRS & VBPM Resources

- CMS PQRS Web Site (main page with links to other resources) - [http://cms.hhs.gov/PQRS](http://cms.hhs.gov/PQRS)
- CMS Value-based Payment Modifier – [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)
- QRURs - [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html)
- FAQs – [https://questions.cms.gov](https://questions.cms.gov)
PQRS & VBPM Resources

• QualityNet Help Desk
  o 1-866-288-8912 (TTY 1-877-715-6222)
  o qnetsupport@hcqis.org

• National Provider Calls

• FFS Provider Listserv
  o https://list.nih.gov/cgi-bin/wa.exe?A0=PHYSICIANS-L

Thank You!

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Physicians’ trusted source for education, advocacy and support since 1866.