

Making Reporting Easy

% at Risk for PQRS and VBM

ReportingMD[®]

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This white paper is intended to bring clarity and understanding to the Physician Quality Reporting System (PQRS) and to explain how Registry reporting offers a simple and practical solution for any size practice...big or small.



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Although few exceptions exist, if you bill Medicare Part B Physician Fee Schedule Services (Medicare PFS), you need to report PQRS or you will be penalized. If you bill Medicare and you choose not to report PQRS in 2015, you will be penalized 2% for PQRS as well as an additional 2% or 4% for the Value-Based Payment Modifier (VBM) program, depending on the number of eligible professionals (EPs) in your practice. Figure 1 below shows the PQRS penalty amounts and the potential VBM payment adjustment amounts for 3 differently sized internal medicine practices. The average amount billed to Medicare by internal medicine EPs in 2013 was \$247,028/EP.¹ You can see how much each practice would be penalized annually based on the size of the practice.

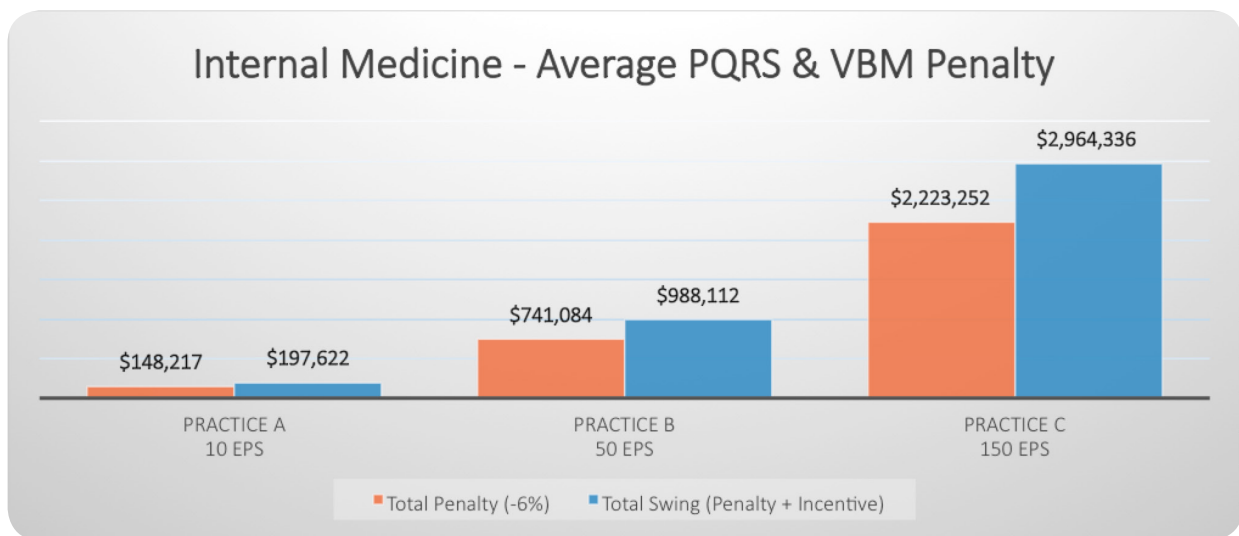


Figure 1: Penalty vs. Total Penalty/Incentive swing for 3 sample internal medicine practices¹

The total swing includes the penalty for not reporting (both PQRS and VBM) as well as the amount potentially attained through the VBM incentive if a practice has excellent quality of care and very low cost of care in comparison to their peers.

Currently, over 55 million Americans are covered by Medicare, which is up 3 million from 2012.² This rapid growth in Medicare beneficiaries combined with the potential dollar sum lost to penalties affirms that the choice to simply ignore PQRS will be costly.

Understanding PQRS is the only path to penalty avoidance, and embracing this challenge can open the door to the potential for earning available bonus money for quality service and affordable care through the Value-Based Payment Modifier (VBM).



PQRI to QRS: From Bonus to Penalty

PQRS started out as an initiative called ‘PQRI – Physician Quality Reporting Initiative’ in 2007 and was a quality reporting program that paid out bonuses to physicians that chose to report. The program started out utilizing claims as the only method to submit data, however in 2008, registries were added on as an alternative reporting mechanism. **Figure 3** below shows a time line of all notable milestones in the PQRS program history.

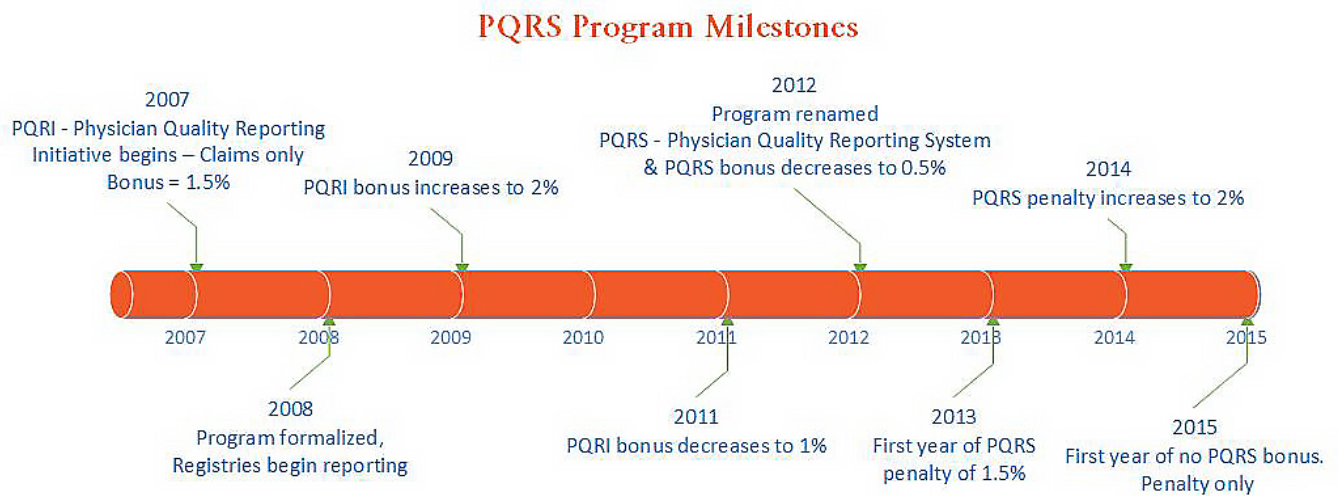


Figure 3: PQRS Program Milestones timeline³

As the PQRS program has evolved, the incentive and penalty amounts have also changed. **Figure 4** below shows the life cycle of the PQRS incentives and penalties. At one point, CMS was paying out a 2% bonus to EPs who reported PQRS, regardless of measure performance.

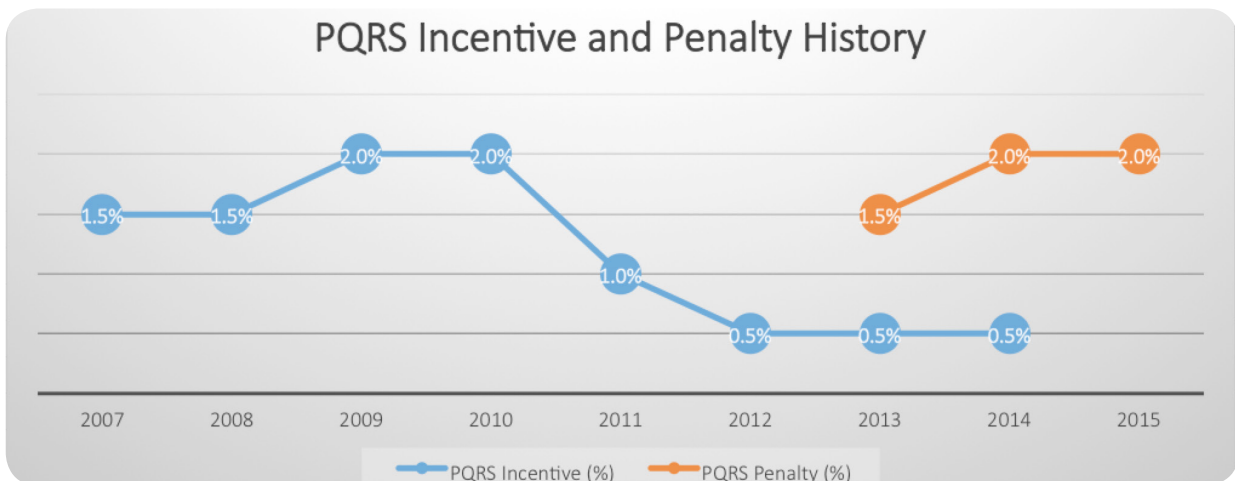


Figure 4: PQRS Incentive and Penalty History³



PQRS Reporting Mechanism:

There are multiple options for pay-for-performance reporting mechanisms including claims and registry reporting among others more recently introduced. Claims and registry reporting are the oldest methods for reporting PQRS. The choice for a reporting mechanism should be centered on which has the best success rate with the least amount of burden on the healthcare providers.

The main difference between reporting PQRS via claims versus registry is the success rate. Providers choosing the claims method have seen success rates as low as 52% in 2007.⁴ With ever-increasing penalties for not reporting, the impact is substantial if only half of the providers are successful in their reporting. ReportingMD has never caused a provider to be penalized in the organization's history as a registry. **Figure 5** below shows the difference in the satisfactorily reporting success between ReportingMD and the claims method of reporting.

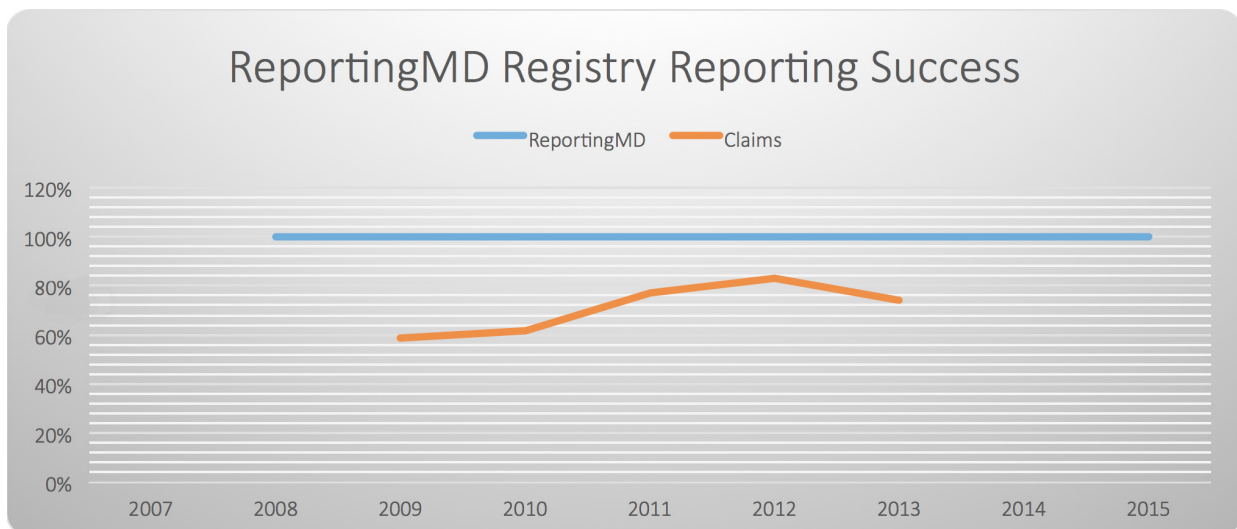


Figure 5: Graphical representation of ReportingMD's submission success rate in comparison to claims reporting⁴⁻⁹

In addition to the PQRS penalty, CMS has been slowly implementing the Value-Based Payment Modifier (VBM), which is intended to turn PQRS from a pay-for-reporting program into a pay-for-performance program. In short, the VBM provides for differential payment to a physician or group of physicians based upon the quality of care provided compared to the cost of care during a performance period. A composite score is generated for both and is then compared to other practices, which results in a standardized cost and quality score. These standardized scores determine how the practice will be financially impacted whether positively, negatively or left neutral. For more information on the VBM, please read ReportingMD's *'White Paper Value-Based Payment Modifier'*.



Pay-For-Performance Data Publication

Pay-for-performance program reporting success resulting in potential penalties and/or incentives isn't the only threat to providers and practices. Releasing provider and practice program performance data to the public also threatens their bottom line. In 2013, CMS began posting the information collected from the PQRS program online on the Physician Compare website (https://www.medicare.gov/physician_compare/search.html) for just a few specialties. Using this website, a patient can search for providers in their area depending on specialty, Medicare participation, Medical School education and more. Patients can also see which providers have participated in which pay-for-performance programs. For example, a person living in New York could research Ophthalmologists practicing within 10 miles of a relative living in Florida. Eventually, patients will be able to search this website for providers based on how well they performed on their reported measures. By supplying provider quality of care information, the Physician Compare website delivers patients the tools they need to make informed decisions about their healthcare needs. The end-to-end goal of this publication is to inform patients while also pressuring providers to improve their quality of care.

CMS and patients aren't alone in their interest in pay-for-performance program data metrics. Private insurance payers are also interested in provider and practice cost of care and quality of care and they are beginning to use this information to alter their reimbursement policies. In some cases, private payers are beginning to implement their own pay-for-performance models to create additional quality metrics on providers for additional reimbursement modifications.

PQRS Requirements: How and what do I report?

To report satisfactorily for the PQRS, the requirements differ depending on the reporting mechanism (Registry, Claims, Web Interface etc.), size of a practice (i.e. how many eligible professionals bill under the practice) and if the practice chooses to report their providers individually or as a group using the Group Practice Reporting Option (GPRO). The below summarizes how to report when using a Registry for PQRS as the reporting mechanism.

Reporting providers individually:

When reporting individually for PQRS, to report satisfactorily the eligible professional (EP) must report one of two ways:

1. EPs can report on a measures group (MG), which is a predefined grouping of measures. There are more than 20 different MGs from which to choose. To report satisfactorily on a MG, each EP must report on 20 unique patients, of which at least 11 of the 20 must be Medicare Part B primary patients. All 20 patients must be eligible for the given MG based on the denominator criteria for that MG. The denominator criteria is typically made up of age, CPT codes and diagnosis codes. In addition, for the numerator at least



1 patient has to have met the criteria for each measure in the measures group.

- a. For example, in measure 1 of the Diabetes MG, at least 1 of the 20 patients in the denominator must have an A1c of less than 9.0%.
2. EPs can also choose to report on **individual measures (IMs)**. An EP must report on 9 IMs that cross 3 National Quality Strategy (NQS) domains. If the provider had at least 1 face-to-face encounter then at least 1 of the 9 measures must also be a cross-cutting measure. To satisfactorily report on IMs, EPs must report on at least 50% of the Medicare Part B and Medicare Railroad patient events eligible for each of the 9 measures based on each measure's denominator criteria for the reporting period. In addition, at least 1 of the patients must have met the numerator criteria for each measure.
- a. For example on measure 130, Documentation of Current Medications, the EP must report on at least 50% of the Medicare Part B and Medicare Railroad patient visits that are eligible for that measure based on the denominator criteria. For the numerator, for at least one of the patients, the EP must attest to documenting in the medical record they obtained, updated, or reviewed the patient's current medications.

Note: if a provider reports on fewer than 9 measures or 9 measures that cross fewer than 3 NQS domains, they will be subject to the Measure Applicability Validation (MAV) process. This is a 2 fold check that CMS uses to determine if the provider reported satisfactorily for PQRS.

If, for example, an EP reports on only 8 measures that cross 3 NQS domains, CMS will run the MAV on that provider. If CMS determines that there were only 8 measures available for that EP to report on then the EP will not be subject to the PQRS penalty. If however, CMS determines that there were 9 measures the EP could have reported on but did not, then the EP would be subject to the PQRS penalty.

Note: When reporting eligible professionals (EPs) individually (either using measures groups or individual measures) at least 50% of the EPs in the group must meet satisfactory reporting criteria, otherwise the practice will be subject to the automatic value-based downward payment adjustment (-2.0% or -4.0% depending on group size).

Reporting as a group using the Group Practice Reporting Option (GPRO):

When reporting as a GPRO through a qualified registry, the practice must have registered to report as a GPRO with CMS during the registration period. When reporting as a GPRO,



the practice reports their PQRS data at the Tax Identification (TIN) level instead of at the individual provider level.

A GPRO practice must report on individual measures (IMs). A GPRO can NOT report on a measures group. A GPRO practice must report on 9 IMs that cross 3 National Quality Strategy (NQS) domains. If the practice had at least 1 face-to-face encounter then at least 1 of the 9 measures must also be a cross-cutting measure. To satisfactorily report on IMs, the GPRO practice must report on at least 50% of the Medicare Part B and Medicare Railroad patient events eligible for each of the 9 measures based on each measure's denominator criteria for the given reporting period. In addition, at least 1 of the patients must have met the numerator criteria for each measure.

- a. One example is measure 226, Tobacco Screening and Cessation, which is a once per patient per reporting period measure. For this measure, you only have to report on each patient once per reporting period. Even if a patient was seen 7 times by 3 different providers at the practice, you would still only report on that patient once. This is a major difference between reporting as a GPRO and reporting providers individually.

Note: If a GPRO practice reports on fewer than 9 measures or on 9 measures that cross fewer than 3 NQS domains, they will be subject to the Measure Applicability Validation (MAV) process (See MAV definition above).

How ReportingMD can help:

Choosing a registry is the right decision if you want certainty in reporting successfully and a vehicle to improve patient outcomes and advance disease management. ReportingMD has a proven track record and offers practices of all sizes a reporting engine that tracks (daily, weekly, monthly), reports, and submits data for all pay-for-performance programs while also optimizing patient outcomes management.

Whatever the practice makeup, ReportingMD has an easy and efficient solution to support providers as they move toward advanced payment models and navigate complex reporting programs.

ReportingMD has two main product lines: **Total Outcomes Management (TOM)** and the **Medical Informatics Calculator (MIC)**.



TOM - Total Outcomes Management

TOM allows provides to manage patient outcomes on a daily basis to achieve superior performance scores. **TOM** takes the hassle out of PQRS reporting no matter the organization's level of data management maturity. **TOM** aggregates your measures for easy and trouble-free reporting then translates files for QRDA1, QRDA3, HL7, and XML submission to CMS and other entities. **TOM** is the perfect solution for practices with single or disparate systems who want a hands-free approach to managing their PQRS measures toward better clinical performance and care.

TOM can take data from disparate systems (EHR, PMS, etc.) to calculate performance scores without any additional effort. Extracting data identifies the numerator quality actions in data fields or lab results, **TOM** will aggregate the patient events and then automatically populate the numerator quality indicator for each event. Utilize **TOM** to define cohorts and optimize performance within the application. The data will be aggregated appropriately per measure and the numerator information will be included without any manual entry.

If the practice has a paper medical record, **TOM** will use billing data to define the measure cohort based on patient billing experience. Practices can simply enter the clinical indicator directly into **TOM** to drive performance optimization. Using billing data in this way eliminates the hassle of finding measure specific cohorts **TOM** does that work for you.

Practices that utilize Quality Data Codes (QDCs) on their claims can use **TOM** to manage performance daily or weekly.

Once a practice goes live in **TOM**, users can log into **TOM** via a secure web-based portal to monitor and manage their data. Reporting capabilities extend from network or practice level down to provider level all the way down to single patient and visit level data. Thus, care can be viewed and managed across the entire patient continuum.

MIC - Medical Informatics Calculator

For practices that want to report on PQRS measures group or smaller practices or GPRO practices that want to report on individual measures, **MIC** is a straightforward tool that ReportingMD emails directly to the practice to complete. No matter what system you use for billing or clinical, you can use our **MIC** tool. The **MIC** tool is a data entry tool that is Microsoft Excel based and requires Microsoft Excel 2007 or greater. The **MIC** tool is self-validating so it forces the person entering the information to pick from a list



of options that apply specifically to the given measures group. This means no errors and thus no penalties.

For example, the Diabetes measures group has age, CPT codes and a long list of diagnosis codes that establish the denominator eligible patients. In the MIC tool, you enter each patient ID then you pick from a drop-down list of codes that are specific to the Diabetes measures group. This is just one example of how MIC is an error-free and uncomplicated reporting solution.

Why choose ReportingMD®?

The key to program compliance is managing your performance daily or throughout the year by leveraging data from the EHR to build measures that help practices avoid the VBM penalty meanwhile creating the opportunity for VBPM incentive.

As the pay-for-performance programs change and evolve, it's imperative that you have a source available to answer any question or concern that arises. Our industry-known expert staff will accompany whichever product line you decide on. ReportingMD's qualified staff has experience dating back to the program beginning and that expertise will be at your disposal throughout the life of your contract. Your practice will be assigned your own account manager to manage everything from implementation to reporting to submission but you will also have access to the wealth of knowledge throughout the organization. ReportingMD's goal is to support clients throughout the year to achieve the best possible outcomes management with the least amount of impact on the provider.

In addition to the main product lines, ReportingMD offers a wide range of consulting services for whatever medical intelligence problem you're looking to solve. From custom reports to program interpretation to data translation and submission services, ReportingMD has the expertise to support you toward a solution.

No matter how big or small the practice, registry reporting is a simple solution that will facilitate pay-for-performance program success by advancing a practice to superior patient outcomes management, which will consequently result in increased revenue. The tools and expertise offered by ReportingMD will lead a practice to better quality of care and lower cost of care. Whether that practice earns Medicare incentives through the VBM due to high quality and low cost or the practice realizes added revenue from the public release of high-quality PQRS scores, it's clear that a registry like ReportingMD is a valuable resource and vehicle to reach that end. ReportingMD will launch a practice to pay-for-performance program excellence; improved population care management, as well as increased revenue.



Company background:

ReportingMD® provides high quality **Medical Intelligence™ (MI)** products, health information consulting, and custom solutions. We are a qualified registry by the Center for Medicare and Medicaid Services (CMS) for Physician Quality Reporting Systems (PQRS) and e-prescribe since 2008 and a data submission vendor (DSV) for PQRS and Meaningful Use. We help our clients meet the technical challenges of reporting through customizable applications through health information technology engineering, MI analytics, cloud computing and web-based solutions.

Footnotes:

- 1 Center for Medicare and Medicaid Services. *Physician Quality Reporting System – Analysis and Payment*. N.p., 21 July 2015. Web. 05 Aug. 2015. <<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html>>.
- 2 *On its 50th anniversary, more than 55 million Americans covered by Medicare*. Center for Medicare Services, 28 July 2015. Web. <<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-07-28.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending>>
- 3 Medicare Fee-For-Service Provider Utilization & Payment Data: Medicare Physician and Other Supplier Aggregate table, CY2013,2013. Web. <http://download.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Downloads/Medicare_Physician_and_Other_Supplier_NPI_Aggregate_CY2013.zip>
- 4 USA. Department of Health and Human Services. Center for Medicare and Medicaid Services. *Physician Quality Reporting Initiative – 2007 Reporting Experience*. N.p., 3 Dec. 2008.
- 5 USA. Department of Health and Human Services. Center for Medicare and Medicaid Services. *Physician Quality Reporting Initiative – Appendix A. 2009 Reporting Experience and Methods*. N.p.
- 6 USA. Department of Health and Human Services. Center for Medicare and Medicaid Services. *2010 Reporting Experience – Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program*. N.p., 22 Feb. 2012.
- 7 USA. Department of Health and Human Services. Center for Medicare and Medicaid Services. *2011 Reporting Experience – Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program*. N.p., 9 April 2013.
- 8 USA. Department of Health and Human Services. Center for Medicare and Medicaid Services. *2012 Reporting Experience – Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program*. N.p., 14 March 2014.
- 9 USA. Department of Health and Human Services. Center for Medicare and Medicaid Services. *2013 Reporting Experience – Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program*. N.p., 8 April 2015.

