MINGLE
ANALYTICS
Transforming Healthcare through Data-Driven Solutions

PQRS
SOLUTIONS
Pay for Performance Solutions

Members of the Practice Physician Network watched our Webinar Recording:
"PQRS 2016 – Why You Should Care"
and
Generated 30 Questions

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Mysteries of PQRS 2016 – REVEALED!

For the Practice Physician Network

June 22, 2016

Register or access recordings
http://mingleanalytics.com/resource-center/?type=videos-webinars

Dr. Dan Mingle, CEO

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Question 1 from PPN

On slide "Avoid the dreaded notice from CMS in the late 2017" talked about a 2% and a 4% payment adjustment. Which is it? or will they be combined?

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Avoid The dreaded Notice from CMS in Late 2017

"You will be subject to a 2.0% downward payment adjustment against all of your Medicare payments for 2018 services due to failure to make a qualifying 2016 PQRS submission"

"You will be subject to a 4.0% downward payment adjustment against all of your Medicare payments for 2018 services due to your Quality Tiering Adjustment for 2016"

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3 Checkpoints

Checkpoints	Judged as	Submit as	Adjustment
PQRS	Practice-Provider	Individual or Group (GPRO)	0 or -2%
VBM	Practice Group	Group or ≥ 50% Individuals	0 or -2% or -4%
Quality Tiering	Practice Group	Group	-2% to +2% on Cost -2% to +2% on Quality

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At Risk 2016

	PQRS Adjustment (-2%)		VBM Adjustment (-2%)	VBM Adjustment (-4%)
Based On	Failure to make a qualifying PQRS Submission		Groups < 10 Providers where ≥ half did not submit PQRS	Groups ≥ 10 Providers where ≥ half did not submit PQRS
	Average	Max	Average	Average
MD/DO	**$2,000**	**$335,000**	**$2,000** / Provider	**$4,000** / Provider
Other Provider	**$650**	**$40,000**	**$650** / Provider	**$1,300** / Provider

Based on CMS 2013 PQRS Experience Report

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Question 2 from PPN

We are not submitting right now so could we lose even more $ than we are right now if we started submitting and then get a low score?

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Question 3 from PPN

Is VBM & Quality Tiering only for groups?

Reporting Year	First Program Year	First Neg QT Year	Who	Size	
2013	2015	2015	Physician Groups	100 or more	
2014	2016	2017	Physician Groups	10 or more	
2015	2017	2018	Physicians	Solo and All Groups	
2016	2018	MIPS	Select Non-Physicians	Solo and All Groups	
2017	2019	2019	All of the above		

Physicians = Doctors of Medicine, Osteopathy, Dental surgery, Dental medicine, Podiatric medicine, Optometry, Chiropracty

Select Non-Physicians = Nurse Practitioner, Physician Assistant, Certified Registered Nurse Anesthetist, Clinical Nurse Specialist

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Question 7 from PPN

Will the company that reports PQRS also report VBM and Quality Tier?

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Question 9 from PPN

Do you need to report to PQRS, VBM & Tier Quality?

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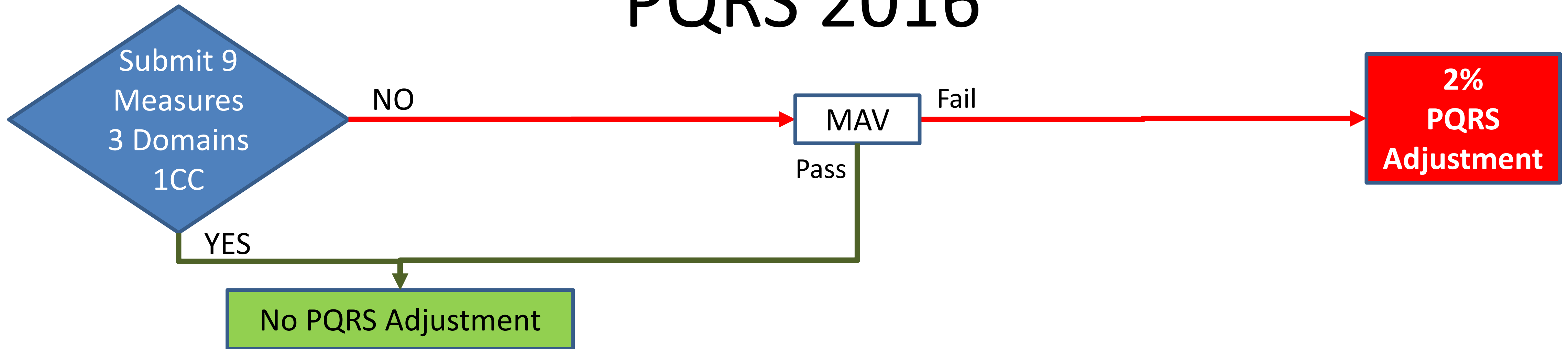
PQRS 2016



You Pass or Fail in PQRS Individually
Unless you deliberately choose
Group Practice Reporting Option (GPRO)

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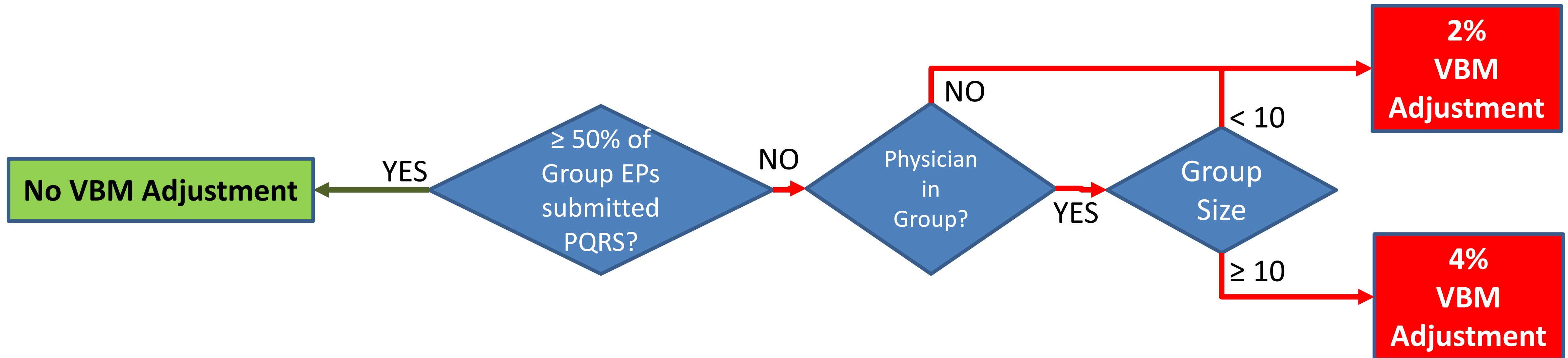
VBM 2016

You Pass or Fail in VBM as a Group



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Then There's Quality Tiering

Submit 9 Measures 3 Domains 1CC

NO → MAV

MAV: Fail → **2% PQRS Adjustment**

MAV: Pass → No PQRS Adjustment

YES → No PQRS Adjustment

No PQRS Adjustment / 2% PQRS Adjustment → ≥ 50% of Group EPs submitted PQRS?

≥ 50% of Group EPs submitted PQRS?: YES → **No VBM Adjustment** → VBM Quality Tiering

≥ 50% of Group EPs submitted PQRS?: NO → Physician in Group?

Physician in Group?: NO → **2% VBM Adjustment**

Physician in Group?: YES → Group Size

Group Size: < 10 → **2% VBM Adjustment**

Group Size: ≥ 10 → **4% VBM Adjustment**

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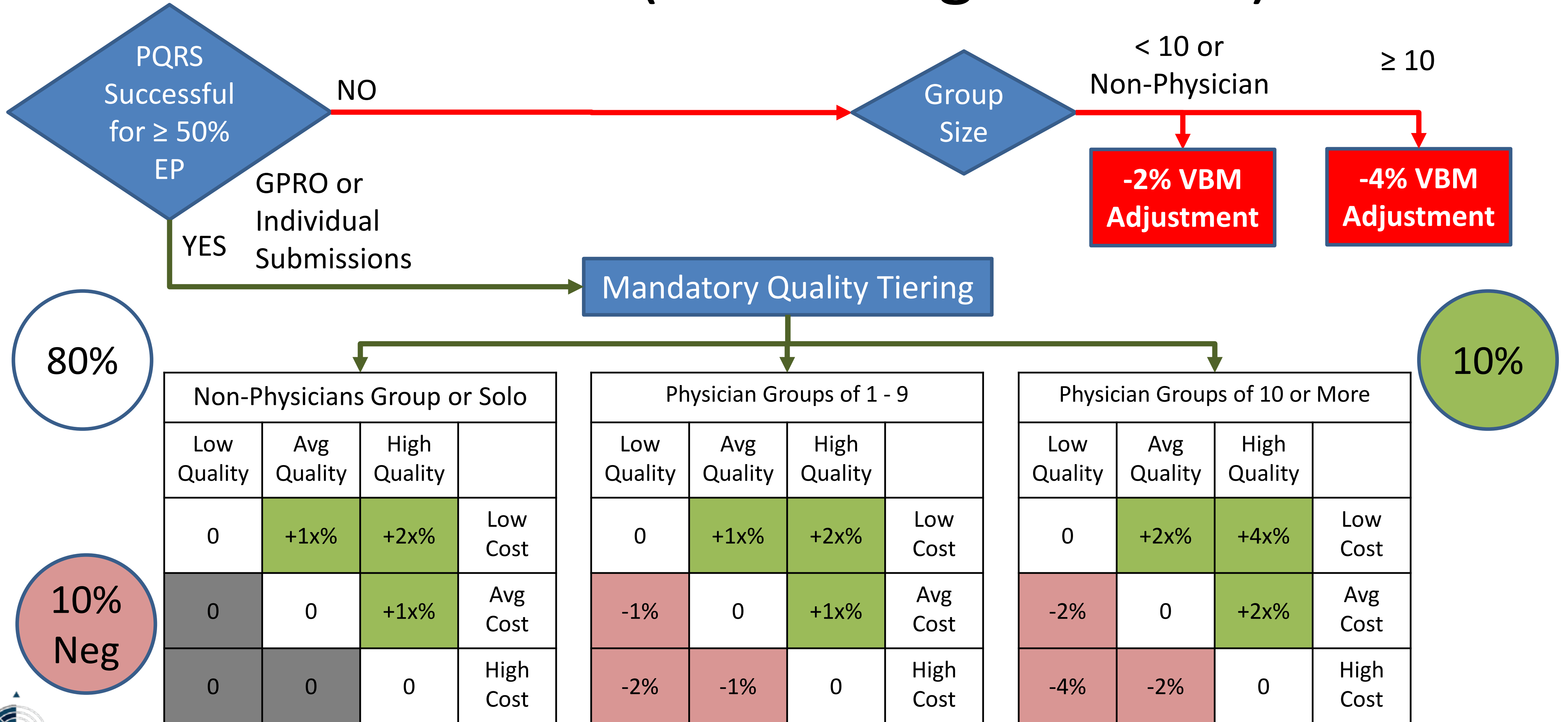
VBM 2016 (2018 Program Year)



Non-Physicians Group or Solo			
Low Quality	Avg Quality	High Quality	
0	+1x%	+2x%	Low Cost
0	0	+1x%	Avg Cost
0	0	0	High Cost

Physician Groups of 1 - 9			
Low Quality	Avg Quality	High Quality	
0	+1x%	+2x%	Low Cost
-1%	0	+1x%	Avg Cost
-2%	-1%	0	High Cost

Physician Groups of 10 or More			
Low Quality	Avg Quality	High Quality	
0	+2x%	+4x%	Low Cost
-2%	0	+2x%	Avg Cost
-4%	-2%	0	High Cost

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Question 10 from PPN

Is it too late to start reporting PQRS?
How do you sign up for it?
Can we submit using only claims & registry?
What if not using EHR/EMR?
Is there a cost for submission or a cost associated with submitting?

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Question 24 from PPN

How do solo practices register for PQRS? We do claims based reporting. CMS website says solo practices do not have to register. We get conflicting answers from provider services.

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http://mingleanalytics.com/

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Figure 6: PQRS Incentive Eligibility Rate by Mechanism or Alternative Program (2014)

Mechanism or Alternative Program	Incentive Eligibility Rate
Claims	40%
Registry Individual Measures	59%
Registry Measures Groups	93%
EHR	57%
QCDR	43%
GPRO Web Interface	98%
GPRO Registry	85%
GPRO EHR	42%
Pioneer ACO	63%
SSP ACO	99%
CPC	95%

CMS 2014 PQRS Experience Report

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Question 30 from PPN

Which reporting option would you recommend?

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Question 29 from PPN

For a group of 25+ providers, what are the benefits of registering as a GPRO? Any risks or items to be aware of?

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Question 15 from PPN

Based on slide "Figure 6: PQRS Incentive Eligibility Rate by Mechanism (2014)" What benefit would mingle analytics offer to a solo practitioner that they could not do themselves in submitting to CMS?

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Figure 6: PQRS Incentive Eligibility Rate by Mechanism or Alternative Program (2014)

We fill the white space. The effectiveness of our submissions "hugs" the 100% line.

Incentive Eligibility Rate

Mechanism	Rate
Claims	40%
Registry Individual Measures	59%
Registry Measures Groups	93%
EHR	57%
QCDR	43%
GPRO Web Interface	98%
GPRO Registry	85%
GPRO EHR	42%
Pioneer ACO	63%
SSP ACO	99%
CPC	95%

2016 (EHR) · 2016 (QCDR) · 2016 (GPRO Web Interface) · 2016 (GPRO EHR) · 2016 (Pioneer ACO)

We are adding these mechanisms in 2016

First mechanisms offered after claims. Great backup to GPRO Registry. Highly Effective in our hands

Still the Best Mechanism Cost-Effective and Reliable

This is queued for expansion. Complex rules suggest value of strategic partnerships

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Question 16 from PPN

On slide "2016 Supported Method-Measures", it talks about 5 different measures - can you do just one or have to do them all? Also, said to beware of inverse measures - Please explain further. Please give an example of a stratified measure.

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2016 Supported Method-Measures

	2014	2015	2016
Claims Measures	110	72	79
EHR (CQM) Measures	64	62	63
Registry Measures	201	175	198
Web Interface Measures	22	17	18
Measures Groups	24	22	25

Beware: Inverse Measures, Stratified Measures, Annual re-assignment of methods and domains

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Inverse Example

Measure #1 Diabetes: Hemoglobin A1c Poor Control

NUMERATOR:

- Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%

NUMERATOR NOTE:

- *A lower calculated performance rate for this measure indicates better clinical care or control.*

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Stratified Example

(All the work of 3 measures with credit for 1)

Measure #53: Asthma: Pharmacologic Therapy for Persistent Asthma - Ambulatory Care Setting

This measure will be calculated with 3 performance rates:

- 1) Patients prescribed inhaled corticosteroids (ICS) as their long-term control medication
- 2) Patients prescribed other alternative long-term control medications (non-ICS)
- 3) Total patients prescribed long-term control medication

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Question 17 from PPN

What are the eligible instances that are acceptable for cross-cutting measures when you have a least one face to face?

When you say at least one face to face, are you meaning for the patient or are you reporting on every visit?

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Providers Are Patient Facing or Not (Face to Face)

- If you are Face to Face, you have to submit 1 cross-cutting measure
- Typical non-face to face providers: Radiology, Pathology, Anesthesiology
- You are not required to submit a cross-cutting measure with fewer than 15 eligible instances

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Cross-Cutting Measures 2016

#	Topic	Mthd
1	Hemoglobin A1c control	C,R,E
46	Medication Reconciliation	C,R
47	Care Plan	C,R
110	Influenza	C,R,E
111	Pneumovax	C,R,E
112	Breast Cancer Screening	C,R,E
128	BMI and Plan	C,R,E
130	Current Medications	C,R,E
131	Pain Assessment and Plan	C,R
134	Screen for Depression and Plan	C,R,E
154	Falls: Risk Assessment	C,R
155	Falls: Plan of Care	C,R

#	Topic	Mthd
182	Functional Outcome Assessment and Plan	C,R
226	Tobacco Use and Plan	C,R,E
236	Controlling High Blood Pressure	C,R,E
240	Childhood Immunization Status	E
317	Screen for HTN and Plan	C,R,E
318	Screen for Fall Risk	E
321	CAHPS for PQRS Survey	S
374	Receipt of Specialist Report	E
400	Hepatitis C Screening	R
402	Tobacco Use and Plan in Adolescents	R,MG
431	Unhealthy Alcohol Use: Screening & Brief Counseling	R

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Question 20 from PPN

Is the cross cutting measure 1 of the 9 measures or is it in ADDITION to the 9?

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Question 18 from PPN

On cross-cutting measure #374, what is "Receipt of a specialist report"?

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Excerpt from the Specifications Manual

eMeasure Title	**Closing the Referral Loop: Receipt of Specialist Report**		
eMeasure Identifier (Measure Authoring Tool)	50	**eMeasure Version number**	4.0.000
NQF Number	Not Applicable	**GUID**	f58fc0d6-edf5-416a-8d29-79afbfd24dea
Measurement Period	January 1, 20XX through December 31, 20XX		
Measure Steward	Centers for Medicare & Medicaid Services (CMS)		
Measure Developer	National Committee for Quality Assurance		
Endorsed By	None		
Description	**Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.**		

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Question 4 from PPN

What is maintenance of certification?

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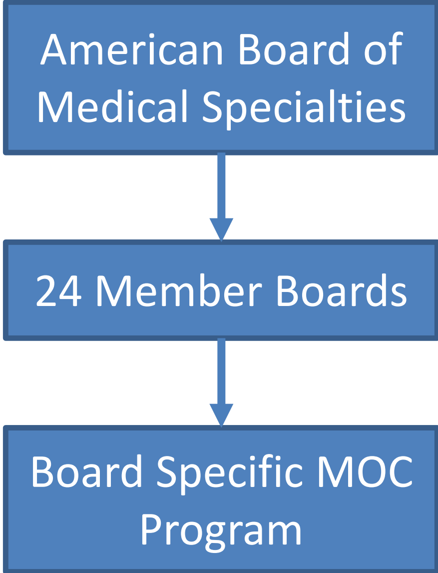
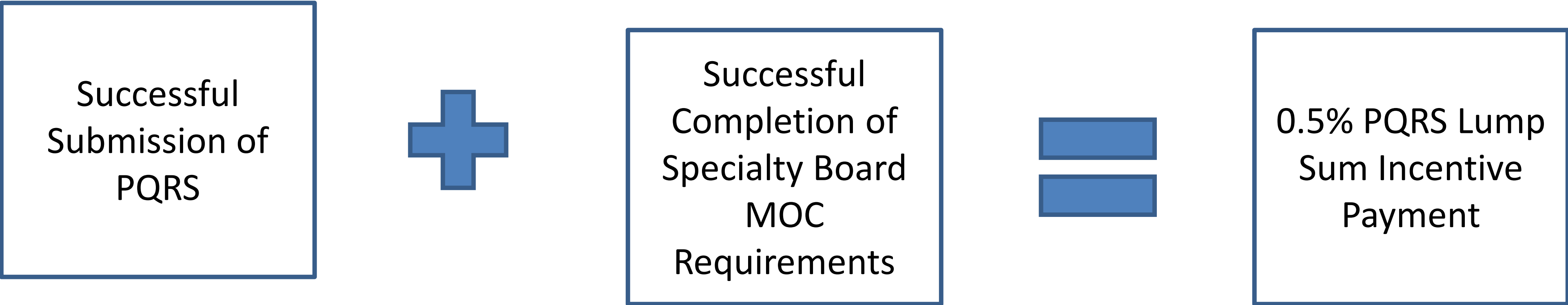
Maintenance of Certification (MOC)





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Question 6 from PPN

What is the difference between measure groups vs GPRO?

How do you sign up for a measure group?

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GPRO and Measures Groups

Measures Group

- A sampling technique
- 20 patient sample
- that share a set of eligibility criteria
- Graded on each of 6 or more measures
- Submitted by an individual provider
- Using a Qualified Registry

GPRO

- Group Practice Reporting Option
- Any practice
- Of 2 or more providers
- That assign their billing to a single Tax ID Number (TIN)
- And submit as if a single individual
- Must declare yourselves as a GPRO by June 30
- Through the PQRS Portal

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Measure Groups 2016

1. Diabetes Measures Group
2. Chronic Kidney Disease (CKD) Measures Group
3. Preventive Care Measures Group
4. Coronary Artery Bypass Graft (CABG) Measures Group
5. Rheumatoid Arthritis (RA) Measures Group
6. Hepatitis C Measures Group
7. Heart Failure (HF) Measures Group
8. Coronary Artery Disease (CAD) Measures Group
9. HIV/AIDS Measures Group
10. Asthma Measures Group
11. Chronic Obstructive Pulmonary Disease (COPD) Measures Group
12. Inflammatory Bowel Disease (IBD) Measures Group
13. Sleep Apnea Measures Group
14. Dementia Measures Group
15. Parkinson's Disease Measures Group
16. Cataracts Measures Group
17. Oncology Measures Group
18. Total Knee Replacement (TKR) Measures Group
19. General Surgery Measures Group
20. Optimizing Patient Exposure to Ionizing Radiation (OPEIR) Measures Group
21. Sinusitis Measures Group
22. Acute Otitis Externa (AOE) Measures Group
23. Cardiovascular Prevention Measures Group
24. Diabetic Retinopathy Measures Group
25. Multiple Chronic Conditions Measures Group

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Question 14 from PPN

What is the difference between Registry Individual Measures & Registry Measures Groups?

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2016 Physician Quality Reporting System (PQRS) Measure Specification and Measure Flow Guide for Claims and Registry Reporting of Individual Measures

Utilized by Individual Eligible Professionals for Claims and Registry Reporting and Clinical Practices Participating in Group Practice Reporting Option (GPRO) for Registry Reporting

11/17/15

1 Version 1.0

Measure #414: Evaluation or Interview for Risk of Opioid Misuse – National Quality Strategy Domain: Effective Clinical Care

2016 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, SOAAP-R) or patient interview documented at least once during Opioid Therapy in the medical record

INSTRUCTIONS:
This measure is to be reported **once per reporting period** for all patients being prescribed opioids for duration longer than six weeks during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
CPT codes, a quality-data code, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients 18 and older prescribed opiates for longer than six weeks duration

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
AND
Patients prescribed opiates for longer than six weeks: G9583

NUMERATOR:
Patients evaluated for risk of misuse of opiates by using a brief validated instrument (e.g., Opioid Risk Tool, SOAAP-R) or patient interview at least once during opioid therapy

Numerator Options:

Performance Met: Patient evaluated for risk of misuse of opiates by using a brief validated instrument (e.g., Opioid Risk Tool, SOAAP-R) or patient interviewed at least once during opioid therapy **(G9584)**

OR

Performance Not Met: Patient not evaluated for risk of misuse of opiates by using a brief validated instrument (e.g., Opioid Risk Tool, SOAAP-R) or patient not interviewed at least once during opioid therapy **(G9585)**

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2016 Physician Quality Reporting System (PQRS)

Measures Groups Specifications Manual

Utilized by Individual Eligible Professionals
Registry ONLY Reporting

This manual contains specific guidance for reporting 2016 Physician Quality Reporting System (PQRS) Measures Groups. Measures Groups are a subset of four or more PQRS measures that have a particular clinical condition or focus in common. Only those measures groups defined in this document can be utilized when reporting the measures group options. All other individual measures that are included in PQRS but not defined in this manual as included in a measures group cannot be grouped together to define a measures group.

Version 9.1 12/18/2015 Page **1** of **471**
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DIABETES MEASURES GROUP OVERVIEW

2016 PQRS OPTIONS FOR MEASURES GROUPS:

2016 PQRS MEASURES IN DIABETES MEASURES GROUP:

#1 Diabetes: Hemoglobin A1c Poor Control
#110 Preventive Care and Screening: Influenza Immunization
#117 Diabetes: Eye Exam
#119 Diabetes: Medical Attention for Nephropathy
#126 Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation
#226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Question 13 from PPN

How do CMS determine quality & cost measures?

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1: You choose 9 Quality Measures or one Measures Group or the Web Interface Submission Mechanism

	2014	2015	2016
Claims Measures	110	72	79
EHR (CQM) Measures	64	62	63
Registry Measures	201	175	198
Web Interface Measures	22	17	18
Measures Groups	24	22	25

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2: Medicare Calculates 3 Quality Measures from Claims

1. All Cause 30-day readmissions
2. Potentially Avoidable Acute Care Admissions
    a. Bacterial Pneumonia
    b. Urinary Tract Infection
    c. Dehydration
3. Potentially Avoidable Chronic Disease Admissions
    a. COPD
    b. Heart Failure
    c. Diabetes
        1) Uncontrolled
        2) Short Term Complications
        3) Long Term Complications
        4) Lower Extremity Amputations

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3: Medicare Calculates 6 Cost Measures from Claims

1. Per Capita for All Attributed Beneficiaries (Cost per Patient per Year)
2. Medicare Spending per Beneficiary (Cost per patient per hospitalization)
3. Per Capita for All Attributed Diabetic Patients (Cost per Diabetic Patient per Year)
4. Per Capita for All Attributed COPD Patients (Cost per COPD Patient per Year)
5. Per Capita for All Attributed Heart Failure Patients (Cost per Heart Failure Patient per Year)
6. Per Capita for All Attributed CAD Patients (Cost per CAD Patient per Year)

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Question 8 from PPN

On the slide "Reporting Basics" - 9 measures, 3 domains... what do you do if you are an orthopedic specialist and you can't meet all of that?

What do they mean by "eligible" Medicare patients?

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Reporting Basics

- 9 Measures
- 3 Domains
- ≥ 50 % of Eligible Medicare Patients
- Any Measure with 0% Performance will not be Counted
- Submit 1 Cross-Cutting Measure
  - If there is at least 1 face-to-face visit
  - AND 15 Eligible instances for any Cross-Cutting Measure

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Not Enough Measures?

- Claims and Registry Reporting
  - Measure Applicability Validation (MAV)
- EHR Reporting:
  - Submit what you've got
- Web Interface
  - Submit what you've got
- Qualified Clinical Data Registry
  - No excuses

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PQRS 2016 (2018 Program Year)

and the Measure Applicability Validation Test (MAV)

Submit 9 Measures 3 Domains 1CC

NO

YES

≥1 Measure Submitted

≥50% Reporting Rate

Non-Zero Performance

YES

NO

≥1 CC Meas Submitted

<15 Elig Instances for all Cross Cutting Measures

No Face to Face Visits

No Adjustment

No other Applicable measures

MAV

CMS test for other applicable measures

Other applicable Measures not submitted

-2% PQRS Adjustment

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Don’t be Intimidated by Medicare

“CMS fully expects individual eligible professionals to report a full complement of 9 measures covering 3 domains”

(CMS 1/14/2016)

CMS Qualifies that with:

“only use the MAV processes when reporting 9 measures covering 3 domains is

Simply not Appropriate or Possible*”*

(CMS 1/14/2016)

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Measure #40 (NQF 0048): Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older

Denominator Criteria (Eligible Instances):

Patients aged ≥ 50 years on date of encounter

AND

Diagnosis for hip, spine, or distal radial fracture (ICD-10-CM)

AND

> Patient encounter during the reporting period (CPT or HCPCS) - 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, G0402
>
> **OR**
>
> Patient encounter during the reporting period (CPT): 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248

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Question 19 from PPN

What is MAV?
How do you do that?
What does it mean to have >50% reporting rate
& Non-Zero performance?

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Question 21 from PPN

Tobacco use measure – if a modifier 8P is added (No Tobacco Counseling Done) does the measure count towards the 50% we need?

8P = Performance NOT MET
Hurts your Performance Rate
Helps your Reporting Rate

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Question 11 from PPN

How many attributed patients do need for cost measures? He was speaking of specialist and them possibly not having enough patients attributed to the MD?

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Cost is Considered Average when < 20 Attributed Patients

2-Stage Patient Attribution Process	
If there is a Primary Care Provider	Assign to the Primary Care Provider with the highest $ value of Primary Care CPT Codes
No Primary Care Provider	Assign to the Specialist with the highest $ Value of Primary Care CPT Codes

- 99201 through 99215 for office E/M services
- 99304 through 99340 for nursing facility E/M services
- 99341 through 99350 for Home Care E/M services

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Primary Care CPT Codes

- 99201 through 99215 for office E/M services
- 99304 through 99340 for nursing facility E/M services
- 99341 through 99350 for Home Care E/M services

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Question 22 from PPN

Does PQRS apply to Medicaid also?

NO

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Question 23 from PPN

Do Pediatric facilities/Pediatricians need to report?

NO

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Questions 25 - 28

- EHR Specific Reporting Scenario
  - For Post Op Appointments
  - File a billable E&M code (99211) in addition to the appropriate Post Op Global Code
  - Enables reporting for Biopsy, medication reconciliation, post op complications, etc
  - Write off the charge
  - It is awkward – Any alternatives

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Question 5 from PPN

What does a specialist solo practice need to do to avoid the 9% Negative Adjustment in the 2022 MIPS program?

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Introducing Medicare’s New

Quality Payment Program

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Quality Payment Program(QPP)

Merit-Based Incentive Payment System (MIPS)

- Eligible Clinicians
- Virtual Groups

Alternate Payment Mechanisms (APM)

- APM Type
- APM Entity
- Advanced APM
- Qualified Providers (QP)
- Partial QP
- Split TIN

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FIGURE A: Illustrative Example of MIPS Adjustment Factors Based on Composite Performance Scores (CPS)

Performance Threshold = 60

Adjustment Factor + Additional Adjustment Factor

Adjustment Factor

Adjustment Factors

10%
8%
6%
4%
2%
0%
-2%
-4%
-6%

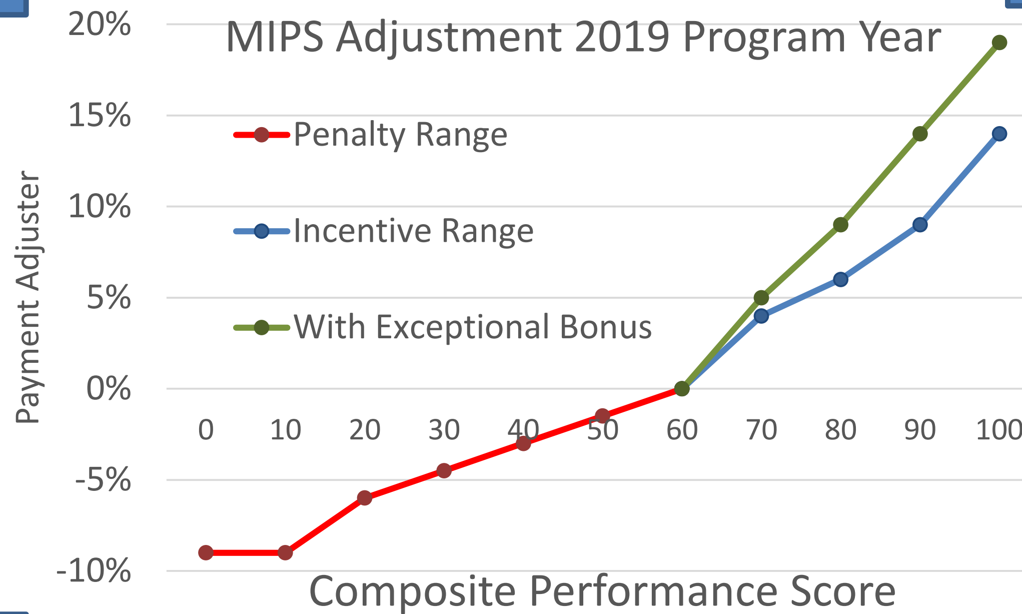
0 10 20 30 40 50 60 70 80 90 100

Composite Performance Score

The QPP Composite Performance Score

30 Quality
Points

30 Cost
Points



25 Advancing Care Information Points (ACI)

PY 2022
± 9%

15 Clinical Practice Improvement Activity Points (CPIA)

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Question 12 from PPN

Is MIPS pass/fail?
How do you sign up for it?
Can we submit using only claims & registry?
What is registry submission?
What if not using EHR/EMR?

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It's coming in

2017

The Merit-Based Incentive Payment System

MIPS

Join us June 14 for a review of the MIPS/MACRA Proposed Rule

The Final Rule will be released November 2016

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Questions and Discussion

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2016 Q1			2016 Q2			2016 Q3			2016 Q4			2017 Q1			2017 Q2		
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun

Providers: Provide Care | Document Care | Accumulate Data

Full Year Data Set

Monitor Extractions, Data Exchange, and Performance. Remediate Problems

2015 Submissions

2016 Submissions

GPRO 2016 Self Nomination Due

Submission Portal Opens

2015 Feedback Reports and QRUR Available

Submission Portal Opens

EHR & QCDR QRDA Due

EHR & QCDR QRDA Due

GPRO Web Interface Due

GPRO Web Interface Due

Registry & QCDR XML Due

2017 Penalty Notices

Registry & QCDR XML Due

MIPS Begins

PQRS Ends