How to Prepare

Quality Reporting: PQRS and the VBM

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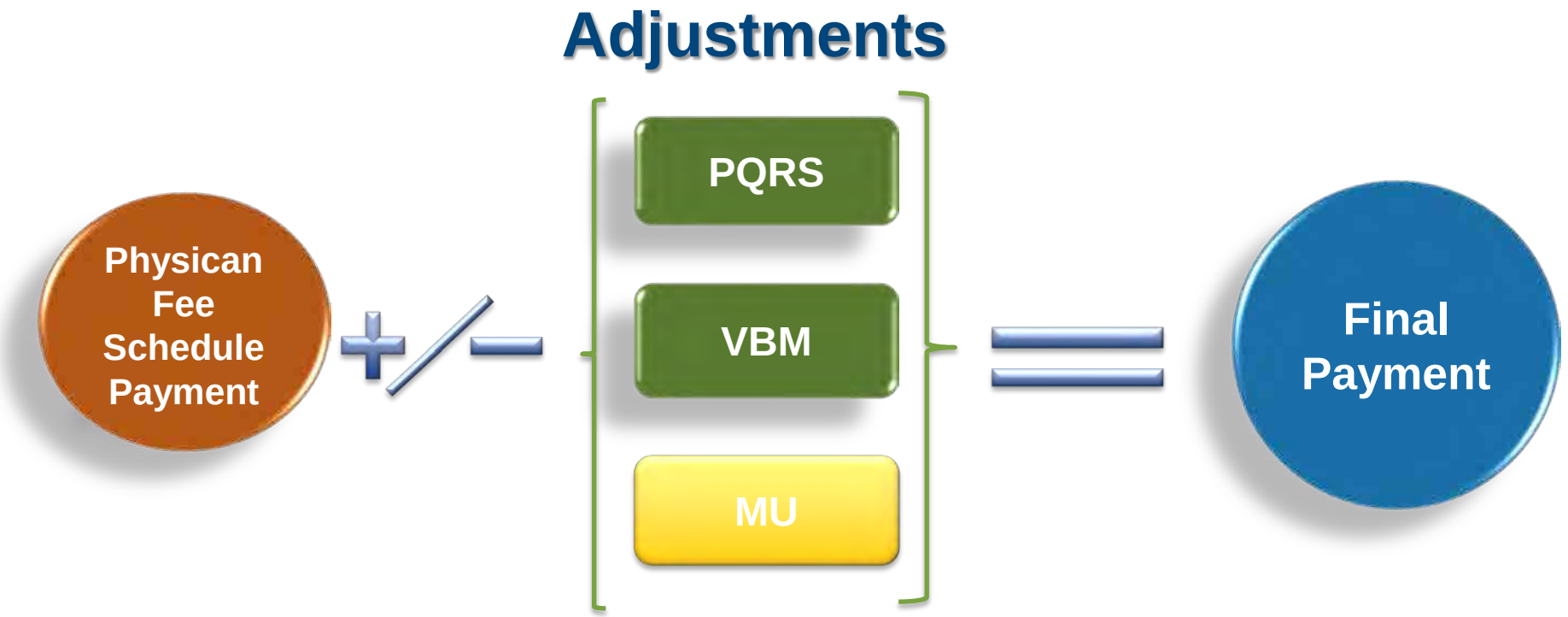
Paying for Value and Quality

The Physician Quality Reporting System (PQRS) and Value- Based Payment Modifier (VBM) programs represent a ***basic shift*** for CMS provider reimbursement ***from fee-for-service payments to "pay-for-performance."*** The programs ***assess*** performance on certain ***quality and cost measures***, *and* ***reimburses for high quality and efficient use of resources***, with the goal of ensuring patients get the ***right care at the right time.***

How Does Medicare Pay Me Now?



What is the Physician Quality Reporting System?

- Medicare Part B
- Quality Reporting Program
- Eligible Professionals (EPs) and Groups
- Data Collection on Quality Measures
- Covered Physician Fee Schedule (PFS) Services

Why is PQRS Reporting Important?

By reporting quality measures, clinicians can:

- Focus and improve the quality of care provided to patients
- Know and understand how they compare to their peers
- Avoid penalties in for not reporting

How is reported data used?

- Used in the EHR Incentive program as part of your demonstration of meaningful use of EHRs
- Used to calculate the quality component of the Value Modifier in the Value based Modifier Program.
- Used on the physician compare website, where information about individual practitioners and group practices
  - Can see and track heir performance as compared to their peers
  - Allows patients to make informed decisions

Step 1: Determining Reporting Eligibility

Medicare Physicians, Practitioners and Therapists are eligible to participate in the PQRS Program. EPs must report for services payable under the Physician Fee Schedule Only

Physicians, including Doctors of:	Practitioners:	Therapists:
• Medicine • Osteopathy • Podiatric Medicine • Optometry • Oral Surgery • Dental Medicine • Chiropractic Medicine	• Physician Assistant • Nurse Practitioner • Advanced 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	• Physical Therapist • Occupational Therapists • Qualified Speech-Language Therapists

Source: Centers for Medicare and Medicaid Services: Physician Quality Reporting System; http://www.cms.gov

Step 2: Individual v. Group Reporting

Individual Eligible Professionals (EPs)

- identified on claims
- individual National Provider Identifier (NPI); and
- Tax Identification Number (TIN).

Group Practices (GPRO)

- Identified by a single TIN
- 2 or more Individual EPs assign billing rights to TIN

Source: Centers for Medicare and Medicaid Services: Physician Quality Reporting System; http://www.cms.gov

Step 3: How Do I Report?

Individual Eligible Professionals (EPs)

Measure Sets

- Individual Quality Measures
- Measure groups

Mechanisms

- Claims Reporting
- PQRS Registry Reporting
- CEHRT (EPS)
- Qualified Clinical Data Registry Reporting

Source: Centers for Medicare and Medicaid Services: Physician Quality Reporting System; http://www.cms.gov

Group Practices (GPRO)

Measure Sets

Mechanisms

- PQRS Registry Reporting
- CEHRT
- GPRO Web Interface (25+ EPs)
- Qualified Clinical Data Registry (QOPI)
- CAHPS for PQRS via CMS-Certified Survey Vendor Webpage (2+ EPs)

Step 4: Which measures should I report?

EPs and GPROs must choose:

- ✓ **At least 9 individual measures**
- ✓ **From 3 NQS Domains; or**

❑ Patient and Caregiver-Centered Experience
❑ Patient Safety
❑ Communication and Care Coordination

❑ Community, Population and Public Health
❑ Efficiency and Cost Reduction Use of Healthcare Resources
❑ Effective Clinical Care

- ✓ **1 measure group**

  not required for GPRO Web Interface

- ✓ **1 <u>cross cutting measure</u>, for face-to-face encounter**

  not required in QCDR reporting

Source: Centers for Medicare and Medicaid Services: Physician Quality Reporting System; http://www.cms.gov

ASCO INSTITUTE FOR QUALITY™

QOPI® and PQRS Reporting

- Individual Eligible Professionals

  AND

- Group Practice Reporting (new**)

QOPI® THE QUALITY ONCOLOGY PRACTICE INITIATIVE

Quality Cancer Care: Pursuing Excellence

ASCO INSTITUTE FOR QUALITY™

Oncology Measures Group

- Standard registry reporting
  - Consists of 7 measures in the oncology measures group
  - Manual abstraction only
  - 20 charts per eligible professional
  - Available to all ASCO membership
  - There is a fee to use QOPI for PQRS reporting

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Qualified Clinical Data Registry

- QCDR – Qualified Clinical Data Registry
  - Consists of 20 measures (from eQOPI measures)
  - Report on 9 measures, including 2 outcome measures
  - 50% of eligible cases per eligible professional
  - Only available thru eQOPI (due to high number of charts required)

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How to get started

- Register in QOPI® System
  - One active ASCO member
  - Designate Primary Contacts
    - (Corresponding Physician (PHC) and QOPI Program Administrator (PRA)
  - Enter information for all providers
  - Enter Information for all office locations
  - Update practice and site characteristics
  - Ensure ALL legal agreements are signed

Step 4: What else should I know about measures?

- **Patient-Process:** report a minimum of once per reporting period per indivicual EP (NPI)
- **Patient -Intermediate**: Report a minimum of once per reporting period per individual EP (NPI). The most recent quality action is utilized for performance calculation.
- **Patient -Periodic:** Report once per time frame specified in the measure for each individual EP (NPI)during the reporting period.
- **Episode:** Report once for each occurrence of a particular illness/condition by each individual EP (NPI) during a reporting period
- **Procedure**: report each time a procedure is performed by the individual EP (NPI) during a reporting period
- **Visit:** Report each time the patient is seen by the individual EP (NPI) during the reporting period

Source: Centers for Medicare and Medicaid Services; https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016_PQRS_ImplementationGuide.pdf; accessed August 13, 2016.

Step 5: Review Confidential Feedback Report

Beginning in 2015 failure to report results in a negative payment adjustment of -2.0 percent of Medicare of Physician Fee Schedule payments

Individuals can access:

- **NPI-Level Reports available to** who submitted claims as an individual http://www.qualitynet.org/pqrs
- TIN-level report for all individual EPs under a TIN http://www.qualitynet.org/pqrs,

Groups can access :

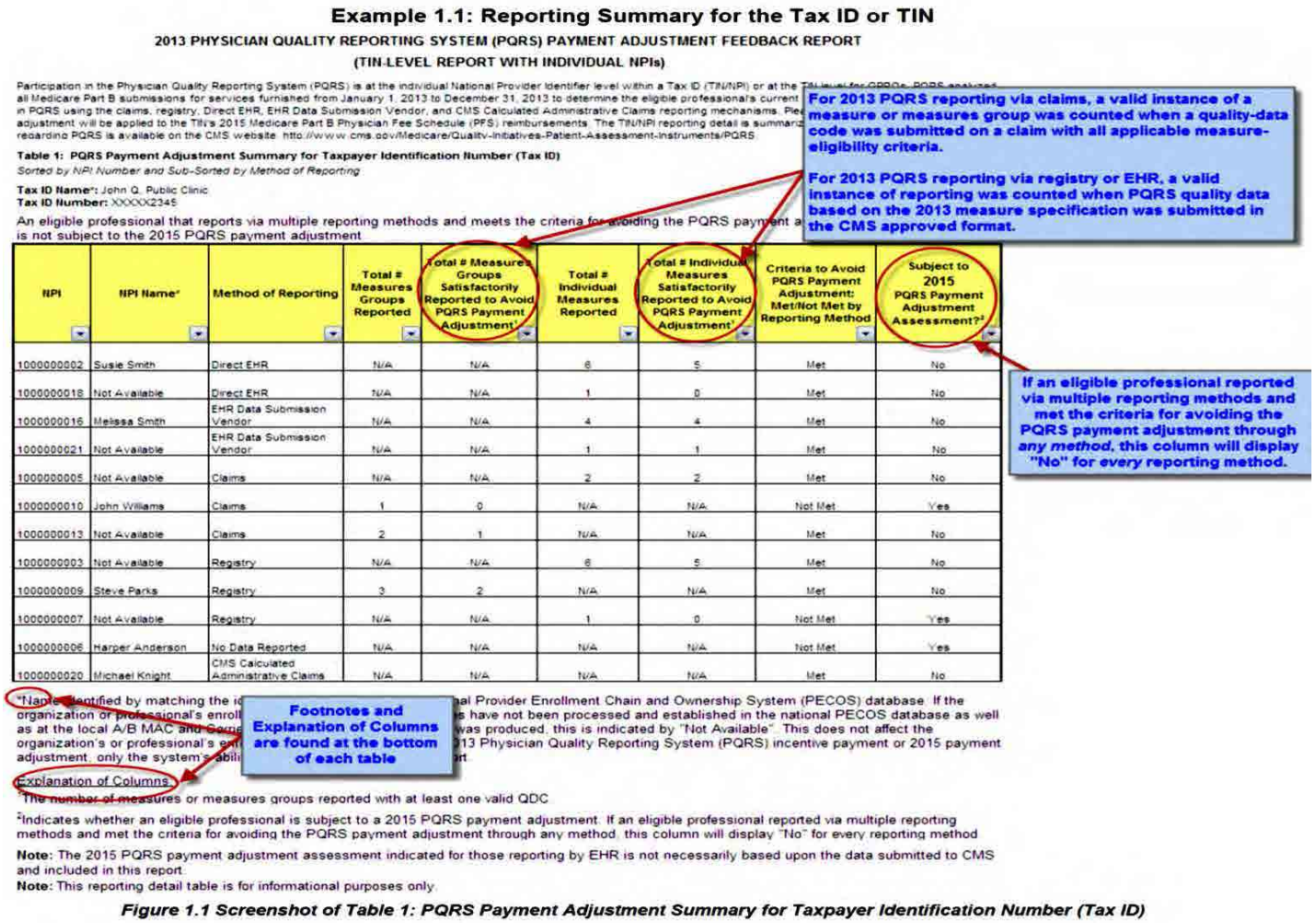
- **TIN-Level Reports for individuals within the same** practice or for group practices http://www.qualitynet.org/pqrs,

Source: Centers for Medicare and Medicaid Services: Physician Quality Reporting System; http://www.cms.gov

Step 5: Review Confidential Feedback Report

Reports will contain a Reporting Summary by Tax ID or TIN and include:

- Total number of measures satisfactorily reported on- individual and group
- Indication whether EP/Group subject to payment adjustment



Example 1.1: Reporting Summary for the Tax ID or TIN

2013 PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) PAYMENT ADJUSTMENT FEEDBACK REPORT

(TIN-LEVEL REPORT WITH INDIVIDUAL NPIs)

Participation in the Physician Quality Reporting System (PQRS) is at the individual National Provider Identifier level within a Tax ID (TIN/NPI) or at the TIN level for GPROs. PQRS analyses all Medicare Part B submissions for services furnished from January 1, 2013 to December 31, 2013 to determine the eligible professional's current in PQRS using the claims, registry, Direct EHR, EHR Data Submission Vendor, and CMS Calculated Administrative Claims reporting mechanisms. Ple adjustment will be applied to the TIN's 2015 Medicare Part B Physician Fee Schedule (PFS) reimbursements. The TIN/NPI reporting detail is summariz regarding PQRS is available on the CMS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS

Table 1: PQRS Payment Adjustment Summary for Taxpayer Identification Number (Tax ID)

Sorted by NPI Number and Sub-Sorted by Method of Reporting

Tax ID Name*: John Q. Public Clinic
Tax ID Number: XXXXX2345

An eligible professional that reports via multiple reporting methods and meets the criteria for avoiding the PQRS payment a is not subject to the 2015 PQRS payment adjustment

NPI	NPI Name*	Method of Reporting	Total # Measures Groups Reported	Total # Measures Groups Satisfactorily Reported to Avoid PQRS Payment Adjustment[1]	Total # Individual Measures Reported	Total # Individual Measures Satisfactorily Reported to Avoid PQRS Payment Adjustment[1]	Criteria to Avoid PQRS Payment Adjustment: Met/Not Met by Reporting Method	Subject to 2015 PQRS Payment Adjustment Assessment?[2]
1000000002	Susie Smith	Direct EHR	N/A	N/A	6	5	Met	No
1000000018	Not Available	Direct EHR	N/A	N/A	1	0	Met	No
1000000016	Melissa Smith	EHR Data Submission Vendor	N/A	N/A	4	4	Met	No
1000000021	Not Available	EHR Data Submission Vendor	N/A	N/A	1	1	Met	No
1000000005	Not Available	Claims	N/A	N/A	2	2	Met	No
1000000010	John Williams	Claims	1	0	N/A	N/A	Not Met	Yes
1000000013	Not Available	Claims	2	1	N/A	N/A	Met	No
1000000003	Not Available	Registry	N/A	N/A	6	5	Met	No
1000000009	Steve Parks	Registry	3	2	N/A	N/A	Met	No
1000000007	Not Available	Registry	N/A	N/A	1	0	Not Met	Yes
1000000006	Harper Anderson	No Data Reported	N/A	N/A	N/A	N/A	Not Met	Yes
1000000020	Michael Knight	CMS Calculated Administrative Claims	N/A	N/A	N/A	N/A	Met	No

*Name identified by matching the i al Provider Enrollment Chain and Ownership System (PECOS) database. If the organization or professional's enroll s have not been processed and established in the national PECOS database as well as at the local A/B MAC and Carrie was produced, this is indicated by "Not Available". This does not affect the organization's or professional's en 013 Physician Quality Reporting System (PQRS) incentive payment or 2015 payment adjustment, only the system's abili rt.

Explanation of Columns:

[1]The number of measures or measures groups reported with at least one valid QDC

[2]Indicates whether an eligible professional is subject to a 2015 PQRS payment adjustment. If an eligible professional reported via multiple reporting methods and met the criteria for avoiding the PQRS payment adjustment through any method, this column will display "No" for every reporting method

Note: The 2015 PQRS payment adjustment assessment indicated for those reporting by EHR is not necessarily based upon the data submitted to CMS and included in this report.

Note: This reporting detail table is for informational purposes only.

For 2013 PQRS reporting via claims, a valid instance of a measure or measures group was counted when a quality-data code was submitted on a claim with all applicable measure-eligibility criteria.

For 2013 PQRS reporting via registry or EHR, a valid instance of reporting was counted when PQRS quality data based on the 2013 measure specification was submitted in the CMS approved format.

If an eligible professional reported via multiple reporting methods and met the criteria for avoiding the PQRS payment adjustment through *any method*, this column will display "No" for *every* reporting method.

Footnotes and Explanation of Columns are found at the bottom of each table

Figure 1.1 Screenshot of Table 1: PQRS Payment Adjustment Summary for Taxpayer Identification Number (Tax ID)

Source: Centers for Medicare and Medicaid Services; https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_PQRSPaymentAdjustment_FeedbackReport_UserGuide_03-11-2014.pdf; accessed August 13, 2016.

Choosing the Right Measures for Your Practice

In considering which measures to select for reporting, consider:

- Your patients
  - specific disease, condition, progression
- Your Practice
  - Whether you report as an individual or in a group and the care setting
  - Any quality improvement goals your organization has set
  - Whether you are participating in other quality reporting programs

Select those measures that apply to services most frequently provided to Medicare patients by the EP or Group within your Practice

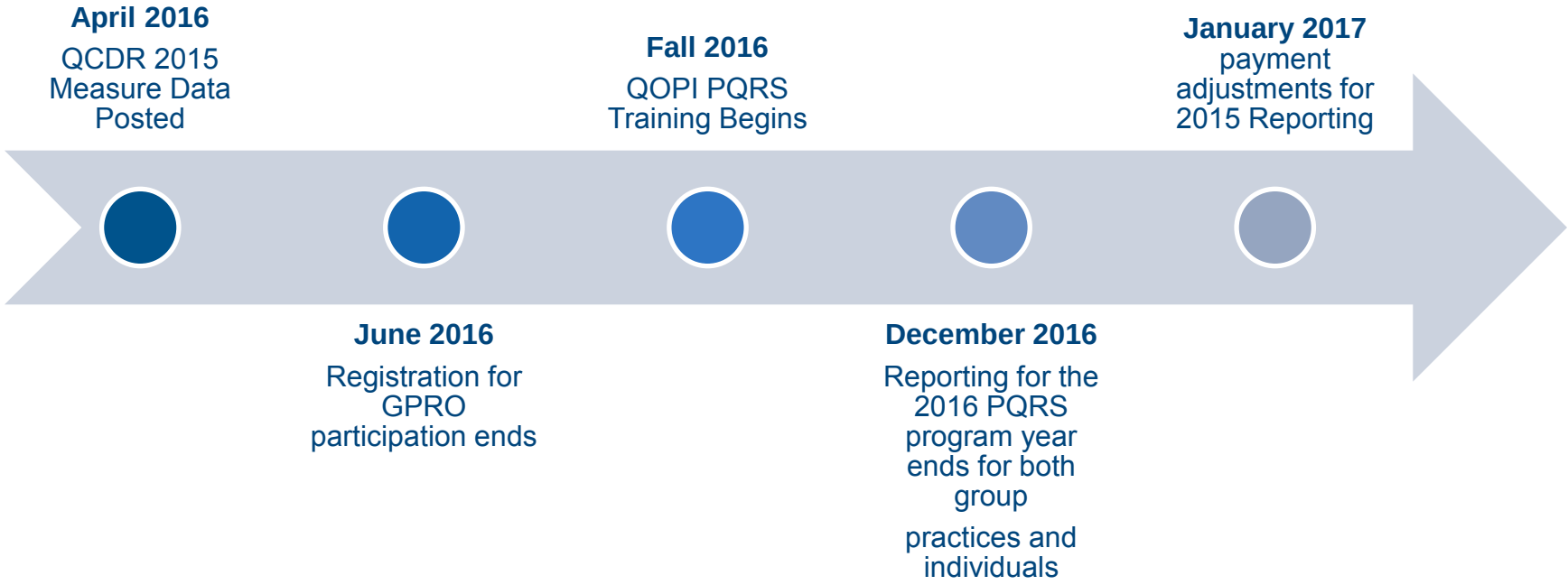
2016 Oncology/Hematology Preferred Specialty Measure Set

PQRS#	NQF#	Reporting Method	National Quality Strategy Domain	Measure Title: Description
67	0377	Registry	Effective Clinical Care	Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow: Percentage of patients aged 18 years and older with a diagnosis of myelodysplastic syndrome (MDS) or an acute leukemia who had baseline cytogenetic testing performed on bone marrow
68	0378	Registry	Effective Clinical Care	Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy: Percentage of patients aged 18 years and older with a diagnosis of myelodysplastic syndrome (MDS) who are receiving erythropoietin therapy with documentation of iron stores within 60 days prior to initiating erythropoietin therapy
69	0380	Registry	Effective Clinical Care	Hematology: Multiple Myeloma: Treatment with Bisphosphonates: Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonate therapy within the 12-month reporting period
70	0379	Registry	Effective Clinical Care	Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry: Percentage of patients aged 18 years and older seen within a 12 month reporting period with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period who had baseline flow cytometry studies performed and documented in the chart
71	0387	Claims, Registry, EHR, Measures Groups	Effective Clinical Care	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer: Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period
72	0385	Claims, Registry, EHR, Measures Groups	Effective Clinical Care	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients: Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period
143	0384	Registry, EHR, Measures Groups	Person and Caregiver- Centered Experience and Outcomes	Oncology: Medical and Radiation – Pain Intensity Quantified: Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified
144	0383	Registry, Measures Groups	Person and Caregiver- Centered Experience and Outcomes	Oncology: Medical and Radiation – Plan of Care for Pain: Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain

2016 ASCO QOPI Measure Set

QOPI #	Reporting Method	Measure Title	NQS Domain
71 (NQF 0387)	QOPI	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	Effective Clinical Care (Process)
72 (NQF 0385)	QOPI	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients	Effective Clinical Care (Process)
110 (NQF 0041)	QOPI	Preventive Care and Screening: Influenza Immunization	Community/Population Health (Process)
130 (NQF 0419)	QOPI	Documentation of Current Medications in the Medical Record	Patient Safety (Process)
143 (NQF 0384)	QOPI	Oncology: Medical and radiation - Pain Intensified Quantified	Person and Caregiver-Centered Experience and Outcomes (Process)
144 (NQF 0383)	QOPI	Oncology: Medical and Radiation - Plan of care for Pain	Person and Caregiver-Centered Experience and Outcomes (Process)
226 (NQF 0028)	QOPI	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Community/Population Health (Process)

PQRS Timeline



What is the Value Based Modifier?

- Medicare Part B MPFS
- Upward or downward payment adjustments
- Individual physician or group of physicians
- Compares the quality of care; and
- Cost of care
- For performance period
- Claim based for Part B items and services

Value Based Payment Modifier

(VBM)

Why is the VBM Important?

- Offers an opportunity for CMS to reward quality performance and lower costs

- View their published quality metrics alongside that of their peers on the Physician Compare website

Step 1: Determining Reporting Eligibility

- **All provider groups and solo practices**
- **At least 1 EP**
- **Include both physicians and non-physicians**

- 2015: TINs with 100+ EPs
- 2016: Tins with 10+ EPs
- **2017: All solo practitioners and groups with 2 or more EPs**

Step 3: How Do I Report?

EPs and Group Practices

Cost:

Part B

Claims Data

Quality:

PQRS Reporting

Step 4: Measuring Cost and Quality

Calculation of Composite Scores

Quality

- PQRS Quality measures in 6 NQS domains; plus
- Three outcome measures from FFS Medicare claims

Cost	Quality

- overall composite score is calculated,
- equally-weighted mean of the TIN's domain performance scores,
- for at least one domain included in the composite
- mean domain score standardized to generate mean domain scores of zero
- standard deviation of 1

Source: Centers for Medicare and Medicaid Services; https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html#What is the Value-Based Payment Modifier (Value Modifier); accessed August, 2016.

Step 5: How are Adjustments Applied?

- Positive Adjustment:

❑adjustments based on whether EPs and groups rated as "high, average, or low" on quality and cost dimensions compared to peers nationally.

- Negative Adjustment:

Example: For 2015 Performance Year:

❑-4% for provider groups with at least 10 eligible professionals

❑-2% for groups and solo practitioners with less than 10 EPs

❑*This automatic penalty is in addition to the -2% assessed by the PQRS program*

Source: Centers for Medicare and Medicaid Services; https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html#What is the Value-Based Payment Modifier (Value Modifier); accessed August, 2016.

Step 6: How do I track results?

- Centers for Medicare & Medicaid Services (CMS) releases two types of Quality and Resource Use Feedback Reports (QRUR)
  - Mid-Year QRUR
    - Informational progress report that previews how group practices will score
  - Annual QRUR
    - full quality and cost metrics;
    - indication of incentive or penalty, and if so how much
- Authorized individuals must use their Enterprise Identity Management (EIDM) account to log into the CMS Enterprise Portal to access reports

Source: Centers for Medicare and Medicaid Services; https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html#What is the Value-Based Payment Modifier (Value Modifier); accessed August, 2016.

VBM Timeline

September/October

Prior Calendar Year QRUR available

November

Final MPFS available with VMB Rules

January

VBM Performance Year Begins

April 2016 QCDR Measure Data Posted

June Registration for GPRO participation ends

December

Reporting for PQRS program year ends for both group practices and individuals

January payment adjustments for 2015 Reporting

Reviewing your QRUR

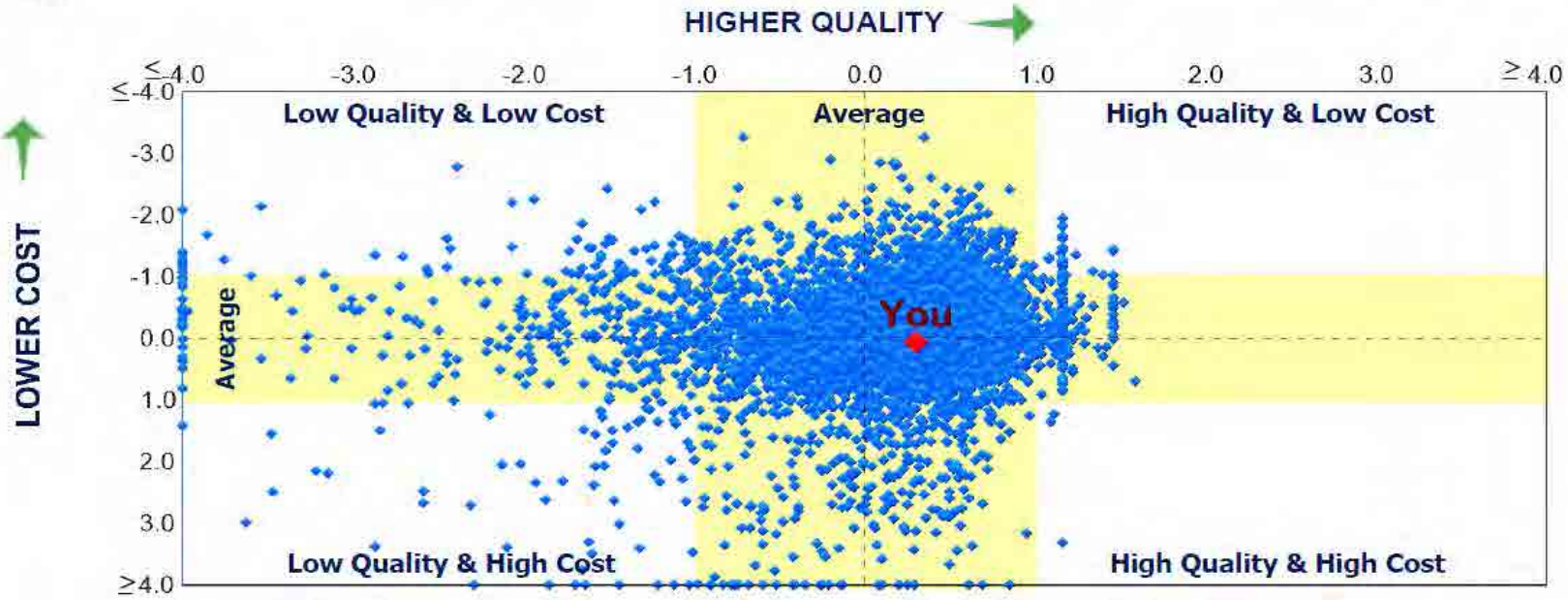
Quality and Resource Use Reports (QRUR)

- Shows how you performed on quality and cost
  - QRUR is provided for each TIN (tax i.d. number)
- Annual QRUR available in the fall after the reporting period (fall 2017 for calendar year 2016)
- One person from your TIN must register to obtain your QRUR
  - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html

What does your QRUR show?

Your TIN's Performance: Average Quality, Average Cost

The scatter plot below displays your TIN's quality and cost performance ("You" diamond), relative to that of your peers.



What does your QRUR show?

High-Risk Bonus Adjustment: Not Eligible

The average beneficiary risk for your TIN is at the 77th percentile of beneficiaries nationwide.

Medicare determined your TIN's eligibility for an additional upward adjustment for serving high-risk beneficiaries based on whether your TIN met (✓) or did not meet (✖) the following criteria in 2014:

✓ Your TIN's average beneficiary's risk is at or above the 75th percentile of beneficiaries nationwide.

✖ Your TIN had strong quality and cost performance.

✓ Your TIN met the criteria to avoid the PQRS payment adjustment as a group, or at least 50 percent of your TIN's eligible professionals met the criteria to avoid the PQRS payment adjustment as individuals in 2016.

What does your QRUR show?

Your TIN's Value Modifier: Neutral Adjustment

The highlighted payment adjustment will be applied to payments under the Medicare Physician Fee Schedule for physicians billing under in your TIN in 2016.

	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0 x AF	+2.0 x AF
Average Cost	-1.0%	**0.0%**	+1.0 x AF
High Cost	-2.0%	-1.0%	0.0%

How will PQRS Change?
Quality Performance Category

Proposed Requirement

- ✓ **6 measures**
- ✓ **1 cross-cutting measure, 1 outcome measure, or another high priority measure if outcome is unavailable**
- ✓ **Selection from individual measures or a specialty measure set**
- ✓ **Population measures automatically calculated**

Current Requirement

- ✓ **Key Changes from Current Program (PQRS):**
  - **9 measures**
  - **No domain requirement**
  - **Emphasize outcome measures**

How will VBM Change?
Resource Use Category

Proposed Requirement

- ✓ **Will only include cost component of VBM**
- ✓ **Assessment on all resource use measures available**
- ✓ **Assessment as applicable to the clinician**
- ✓ **Calculation based on claims**
- ✓ **New Episodes of Care**
- ✓ **New Patient Relationship cCodes**
- ✓ **New Patient Condition Codes**

Current Requirement

- ✓ **Changes from Current Program (Value Modifier):**
  - **40+ new episode specific measures to address specialty concerns**

ASCO's Three-Pronged Strategy

VOLUNTEER TASKFORCE

- Multi-committee task force leading key areas, including:
- Focus on QOPI & performance measures
- *Alternative payment model strategy (PCOP)*
- Practice tools

EDUCATION AND RESOURCES

- Readiness assessment
- Webinars
- Workshops
- *ASCO Oncology Practice Conference: The Business of Cancer Care* launching in March 2, 2017

INFLUENCING POLICYMAKERS

- Filing Extensive Comments
- Meetings with CMS and Policymakers
- Congressional education, outreach and testimony

Education & Resources

MACRA: Learn the basics, get ready for a post-SGR world	• Webinar slides and recording available at www.asco.org/macra
MACRA Town Hall at Best of ASCO	• Chicago, June 24-25, 2016 • Washington, July 15-16, 2016 • San Diego, August 12-13, 2016
New webinar series **"Are You Ready for MACRA? "** **REGISTER HERE**	• How to prepare for MACRA, July 19, 2016 • Quality Reporting: PQRS and the VBM, August 16, 2016 • Meaningful Use and Clinical Practice Improvement Activities, August 30, 2016 • Alternative Payment Models and New Care Delivery Systems, TBD

Education & Resources

Practice transformation tools for MACRA	• Available Q3 2016
MACRA Workshop	• *Are you ready for MACRA? Tools and resources to help you prepare* • September 23, 2016 at ASCO HQ
Webinar December 2016	• *The MACRA Final Rule: What's next?*

Questions?

Additional questions after the webinar can be sent to: macra@asco.org

Visit www.asco.org/macra for more information