Current Status Of Legislation on Quality Bench Marks

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Reason For Quality Measures

• Progressive increase in healthcare costs under the fee-for-service model
• Doctors are compensated more by performing more procedures
• Proposed shift from “quantity” to “quality”
• Assumed → less cost and better outcomes

Medicare Quality Reporting

• 2006 Tax Relief and Healthcare Act, Section 101 created:
  Physician Quality Reporting Initiative
  “PQRI”
• Renamed in the CY 2011 MPFS rule:
  Physician Quality Reporting System
  “PQRS”
PQRS Measures To Choose

- 66 Measures in 2007
- 119 Measures in 2008
- 153 Measures in 2009
- 179 Measures in 2010
- 194 Measures in 2011
- 284 Measures in 2014
  - 37 individual quality measures were added
  - 45 individual quality measures were retired

Initial PQRI Reporting

- Claims-based reporting
- CPT Category II codes or temporary G-codes
- Must be reported with the primary procedure on CMS1500 claims or electronic 837-P claims
- Quality codes must be reported on the same claims as the payment codes
  - If you forgot to include, you cannot resubmit
  - Program closes in February of the following year

Initial PQRI Requirements

- Provider chooses 3 appropriate measures
- Each measure must be reported for at least 80% of the cases in which it was reportable
- Not graded on outcomes, just reporting
  - Positive score for reporting “I didn’t give abx”
- Analysis is at the “provider” level
- Requires consistent use of individual National Provider Identifier (NPI) on claims

“The Antibiotic Measures”

Order it before OR

Choose cephalosporin

Stop it after OR
Incentive Payments

- 2007  1.5% bonus
- 2008  1.5% bonus
- 2009  2.0% bonus
- 2010  2.0% bonus
- 2011  1.0% bonus
- 2012  0.5% bonus
- 2013  0.5% bonus
- 2014  0.5% bonus

From 2015 onwards, there are NO further incentive payments.

Incentive payments for each year are issued separately as a lump sum in the following year.

All payments from 2013 on are subject to the 2% sequestration policy.

2014 PQRS Changes

- Successful reporting involves:
  - at least 9 measures (instead of 3 in prior years)
  - Covering at least 3 National Quality Strategy domains
  - Each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies

2014 PQRS Changes

- If a provider successfully reports LESS than 9 (1-8) measures covering LESS than 3 National Quality Strategy domains:

  **2014 PQRS Measure-Applicability Validation (MAV) Process**

- Details unpublished by CMS at this time

Future Payment Adjustments

- 2013 PQRS data used for 2015 payments
  - 0% versus 1.5% penalty

- 2014 PQRS data used for 2016 payments
  - 0% versus 2.0% penalty

- Future years - similar with 2 year windows
2014 PQRS Changes

• If at least 9 measures are successfully submitted, the 2016 2% penalty is avoided and the 2014 0.5% bonus will be given

• If at least 3 measures are successfully submitted, the 2016 2% penalty is avoided but the 2014 0.5% bonus is NOT rendered

Ways To Submit Your Data

• Using Medicare Part B Claims
• Group Practice Reporting Option (GPRO)

• Qualified electronic health record (EHR)
• Qualified Clinical Data Registry (QCDR)

Vascular Quality Initiative®

VQI and The Vascular Surgeon

• Approved for 2014 data submission
• Identified 9 measures across 3 domains
• Reassess your data periodically to ensure that you meet the requirements
• For an additional $349 fee per provider, VQI will submit the data for you to CMS

278 Centers, 45 States + Ontario
as of 2/1/2014
Pre-2014 Implementation Overhead

- Overall relatively low
- “Buy in” from physicians to document needed
- Majority
  - Monitoring the data in the medical record
  - Validating the data for charge entry
- Minority
  - Charge entry personnel submitting the claims

Post-2014 Implementation Overhead

- Overall significantly higher
- Registry option “mandatory” for submission of data so VQI or some equivalent needed
- Staff and physician time to update
- Validation by CPT code billing at the end of the year
- And then add ICD-10 compliance

Current Legislation

SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION ACT OF 2014

- H.R. 4015/S. 2000
- SGR would be repealed immediately
- 5 years of ↑0.5% and 5 years at 0% updates
- A Merit-based Incentive Payment System (MIPS) will consolidate PQRS, Value-Based Modifier and EHR Meaningful Use

Current Legislation On MIPS

Assess Performance in 4 Categories

- Quality
- Resource use (risk-adjusted)
- EHR Meaningful Use
- Clinical practice improvement

Begin in 2018 with score of 0-100
Current Legislation On MIPS

- Physician-developed clinical care guidelines to reduce inappropriate care and spending
- Prospectively set performance thresholds in collaboration with medical societies
- Funding pool would be increased and no longer be budget neutral ("bar" to surpass)
- Details are few at this point

Current Legislation On MIPS Proposed Scoring

- Positive updates
  - 4% in 2018 and grow up to 9% in 2021
  - Additional incentive if in 25th percentile above threshold (e.g., over 70 if threshold=60)
- Negative updates
  - If MIPS score is between zero and ¼ of the threshold (e.g., between 0 &15 if threshold=60)
  - Capped at 4% in 2018 up to 9% in 2021

Conclusion

- PQRS requirements have increased in 2014
- Registry reporting is becoming the standard
- Penalties are increasing for non-compliance
- The VQI is the most logical option for the vascular surgeon at this point
- The SVS must oversee the development and implementation of appropriate quality measures in years to come