

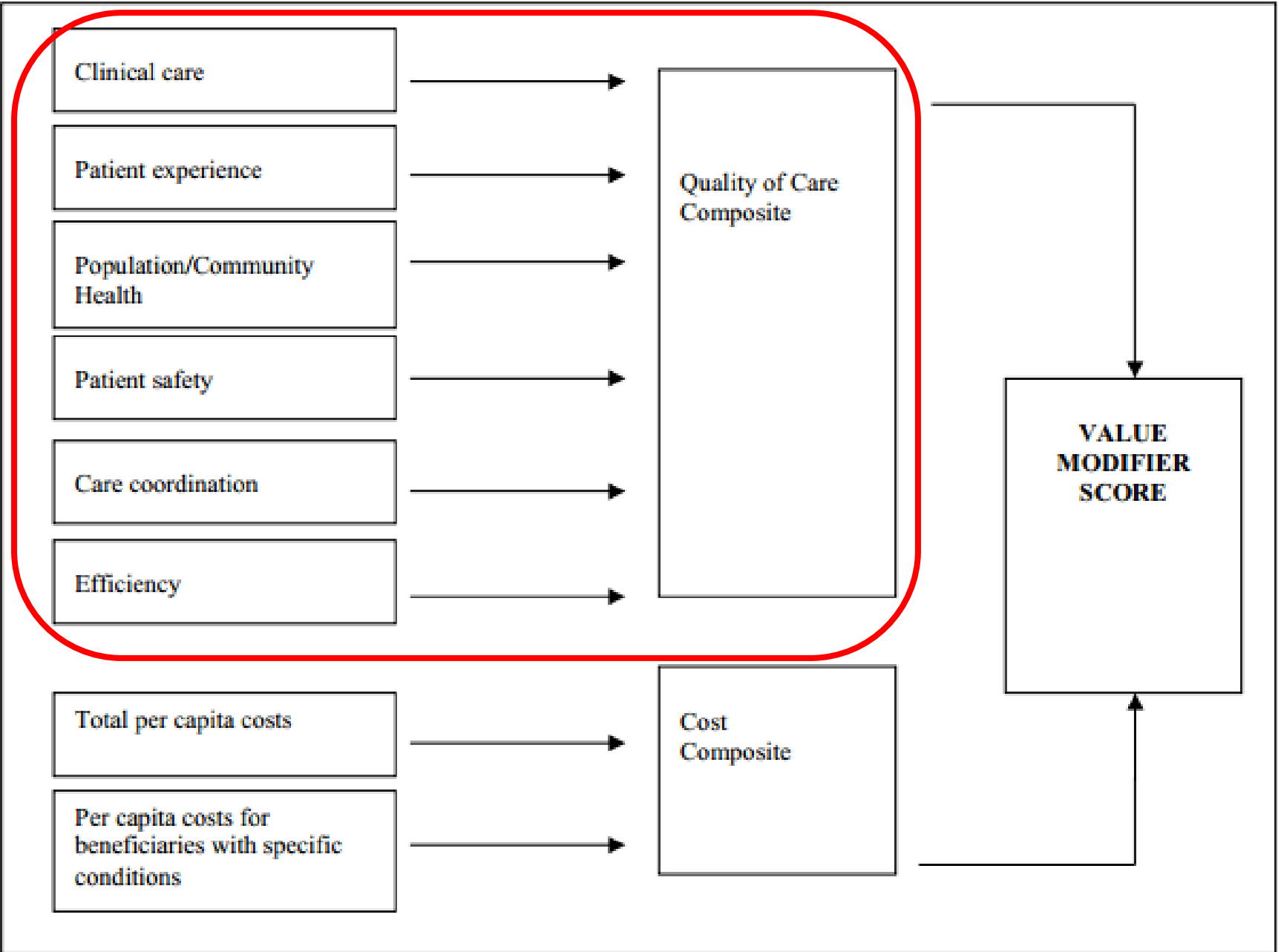


Advanced  
Management  
Strategies

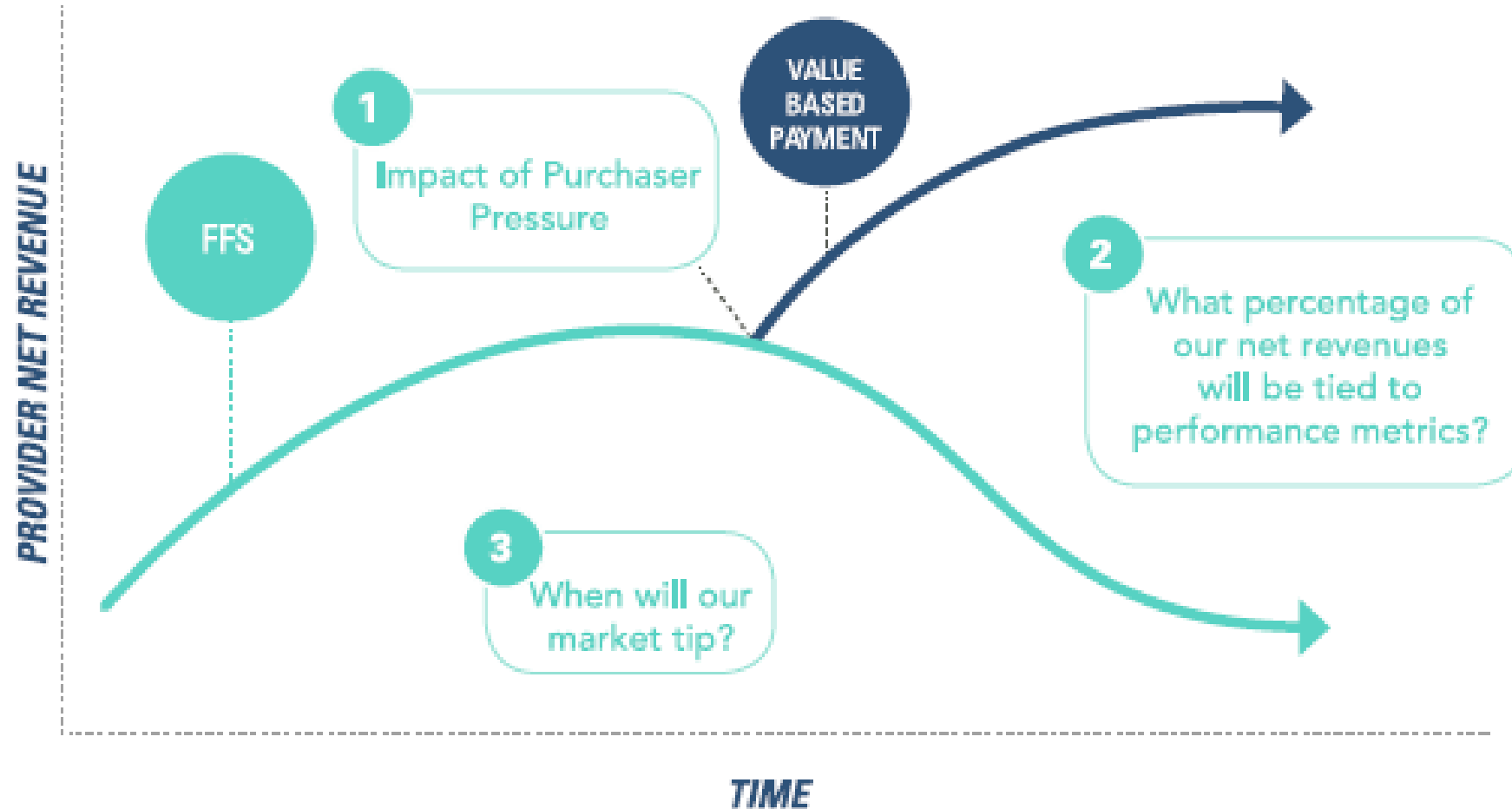
**Figure 2: Relationship between Quality of Care and Cost Composites and the Value Modifier**

Focus:

Reporting  
Quality  
Measures



# Understanding The Tipping Point at Altitude



# Legislated Payment Adjustment Schemes

Program	Report Year	\$ Adjustment Year	Group Size	Max Penalty (ignoring PQRS)	Cost	Quality	EHR MU	Practice Improvement
VBP	2014	2016	0-99	0 - +2%	50%	50%	-	-
VBP	2015	2017	1-9	± 2% (Drs. Only)	50%	50%	-	-
VBP	2015	2017	10+	± 4% (Drs. Only)	50%	50%	-	-
VBP	2016	2018	1+ all EPs	±4%	50%	50%	-	-
MIPS	2017	2019	1+	±4%	30%	30%	25%	15%
MIPS	2018	2020	1+	±5%	30%	30%	25%	15%
MIPS	2019	2021	1+	±7%	30%	30%	25%	15%

# Definitions

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- **PQRS** – Physician Quality Reporting System: a CMS quality reporting program
- **VM** - Value-based Payment Modifier: A budget-neutral CMS program that provides for differential payment under the Medicare PFS based upon the quality of care compared to the cost of care furnished to Fee-for-Service (FFS) Medicare beneficiaries during a performance period.
- **EPs** – Eligible Professionals (MDs, DOs, NPs, PA-Cs)
- **Registry** – An organization (e.g. The Geriatric Practice Management LTC Registry) approved by CMS to report quality measure data to CMS, on behalf of individual eligible professionals (EPs) and group practices (via GPRO) for their Medicare Part B FFS patients. Data is sent to CMS by the organization per XML specifications on selected measures or measures groups. (XML is a computer language that is both human-readable and machine-readable).
- **QCDR** - Qualified Clinical Data Registry - collects and submits of PQRS, eCQM, and other quality measures data on behalf of individual eligible professionals (EPs). QCDR-submitted measures are not included in VM Quality Tiering and are publically reported.

# Definitions

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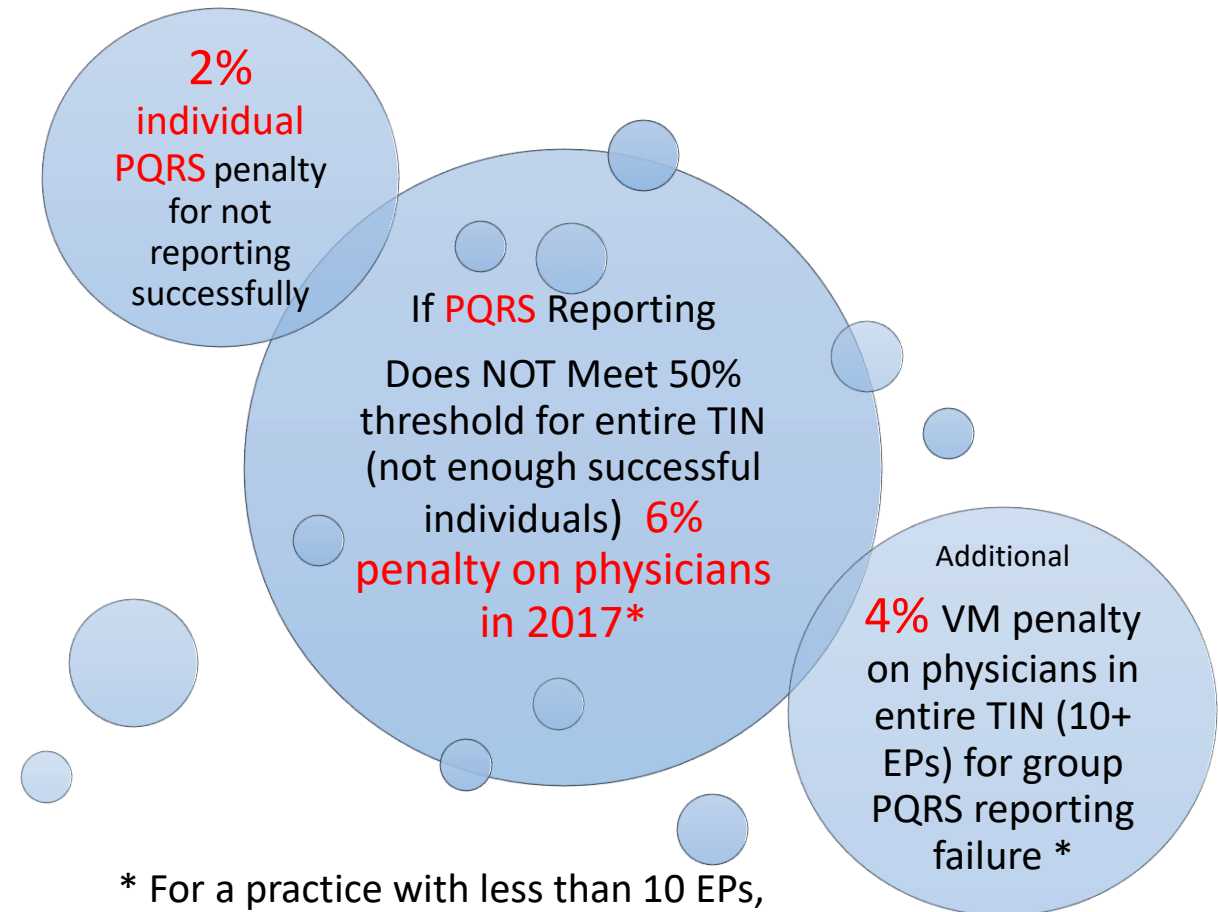
- **Measures Group** – A set of 6 or more individual measures that must be scored at the same time to successfully report the whole group.
- **eCQMs** – Electronic Clinical Quality Measures – these are part of the Meaningful Use program but may also be submitted as PQRS measures through a QCDR – they are scored for the most part in the “background” by gEHRiMed if the patient meets the criteria in the measure.
- **MIPS** – Merit-Based Incentive Payment System – New CMS incentive program that combines MU, PQRS, and VM along with Clinical Practice Improvement Measures – the program begins in 2019.
- **APMs** – Alternative Payment Models – if a practice participates significantly in bundles, ACOs, or other alternative payment models that report quality and cost as a group, they do not have to participate in VM or MIPS.

# Review of the PQRS and VM program relationship

If providers do NOT complete PQRS successfully in 2015, each provider will receive an automatic **2% PQRS penalty** (penalty will be on Medicare reimbursement in 2017).

For providers choosing to report as individuals, if the entire practice does not have at least 50% of eligible providers (physicians, NPs, PA-Cs) reporting PQRS successfully as individuals in 2015, the **physicians** in the practice (10+ EP) will also receive an additional **4% Value Modifier** penalty in 2017. (2% for <10 EPs)

**2017 Physician Total penalty 6%** for a practice (10+ EPs) that chooses not to report PQRS in 2015. NPs and PA-Cs receive a total 2% penalty in 2017 on Medicare reimbursement for the non-reporting practice.



\* For a practice with less than 10 EPs, 2% VM penalty on physicians for PQRS non-reporters + PQRS 2% penalty = 4%

# 2014 VBP modifier for 2016 Payments

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## Your TIN's Value Modifier: Neutral Adjustment

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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	0.0%	0.0%	+1.0 x AF
High Cost	0.0%	0.0%	0.0%



VM penalties start in 2017 based on the 2015 performance year if you have more than one provider

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**TABLE 89: Final CY 2017 VM Payment Adjustment Amounts for Groups with Ten or More Eligible Professionals**

<b>Cost/Quality</b>	<b>Low quality</b>	<b>Average quality</b>	<b>High quality</b>
<b>Low cost</b>	+0.0%	+2.0x*	+4.0x*
<b>Average cost</b>	-2.0%	+0.0%	+2.0x*
<b>High cost</b>	-4.0%	-2.0%	+0.0%

\* Groups eligible for an additional +1.0x if reporting measures and average beneficiary risk score is in the top 25 percent of all beneficiary risk scores, where 'x' represents the upward payment adjustment factor.

# GPM's High Level VM Penalty Expectations

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- Practices successfully reporting PQRS via a Measures Group will avoid the **VM Quality Penalty** <2%> in 2017 & 2018
  - These Practices will not reach the VM 'High Quality' level in 2015 without
    - LUCK
    - SIGNIFICANT EFFORT
- Regardless of any Quality Reporting Strategy it is **nearly impossible** to avoid the <2%> penalty for being 'High Cost' in 2015.
  - CMS solicited comments on the High Cost Status of LTPAC Physicians in the draft 2016 Fee Schedule – but don't expect a 'fix' until 2017.

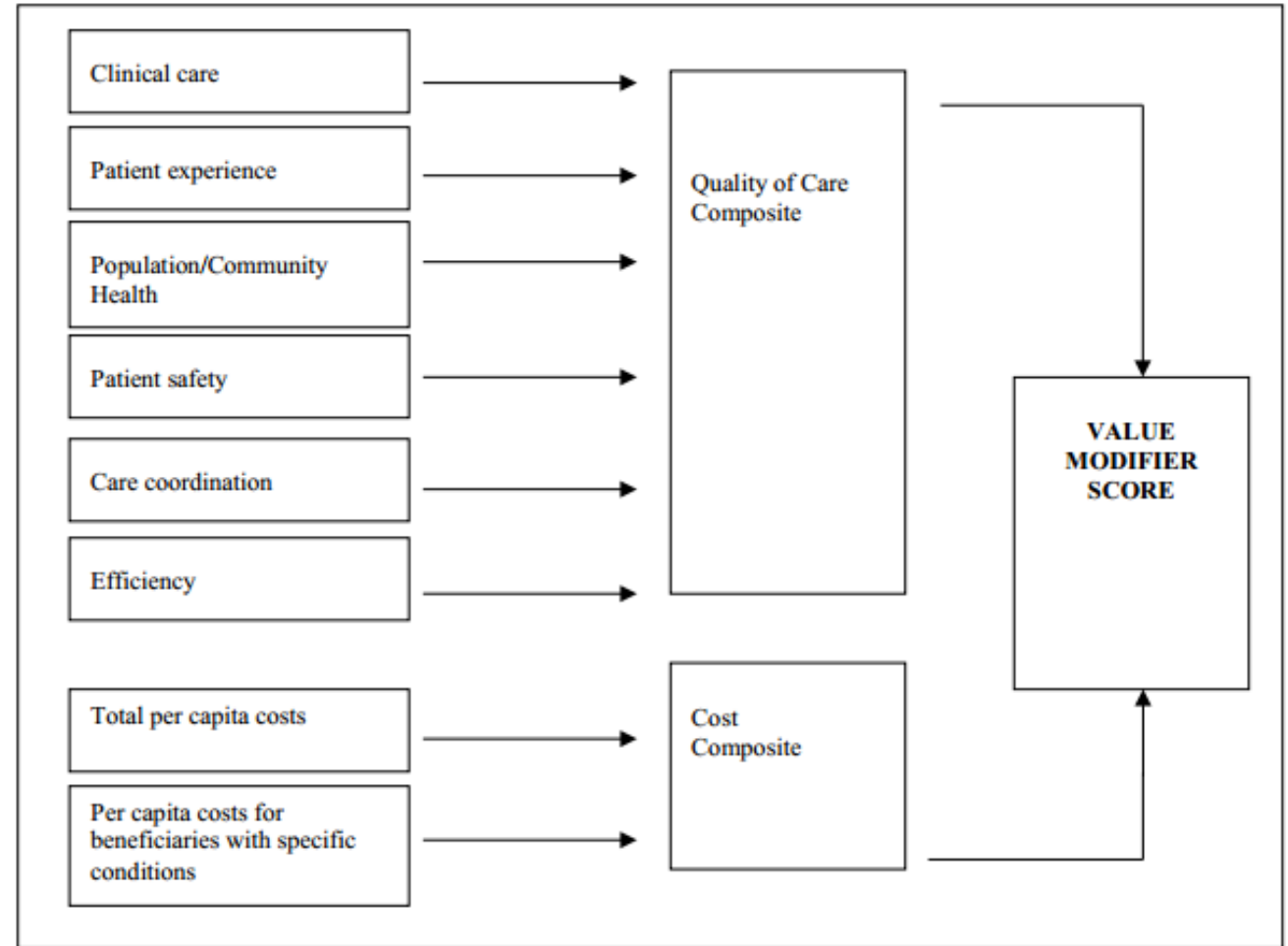
# Value Modifier 101

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6 possible Domains contribute to the Quality of Care Composite

2 domains contribute to the Cost Composite

Figure 2: Relationship between Quality of Care and Cost Composites and the Value Modifier



## (2) Scoring Methods for Quality-Tiering

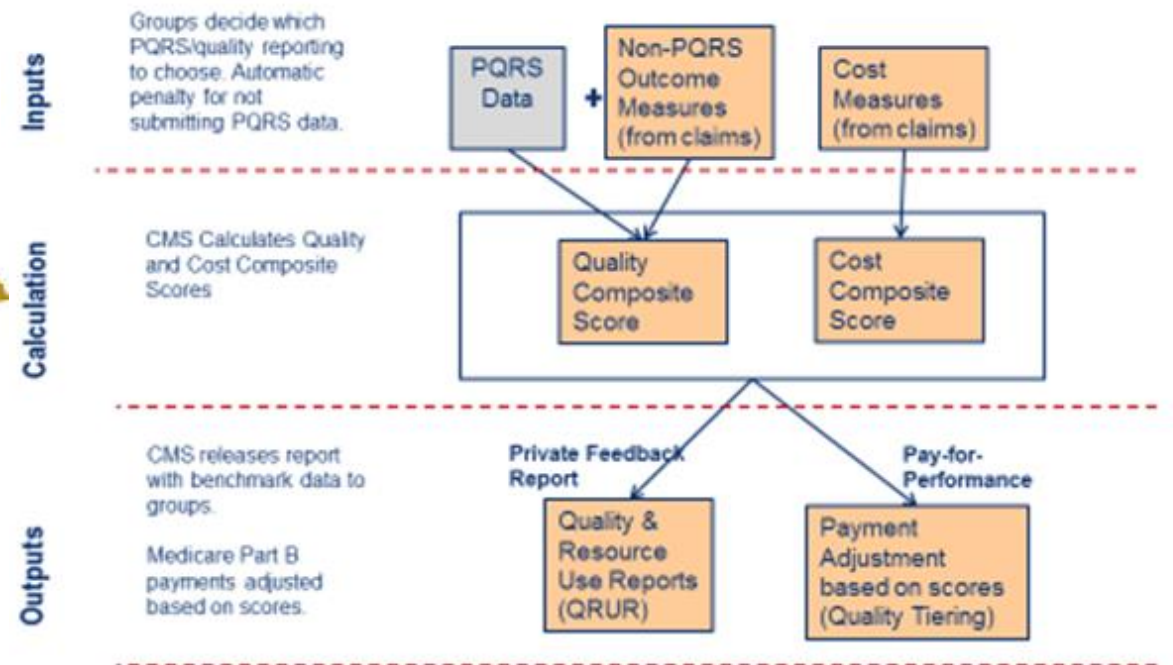
We will establish standardized scores for each quality and cost measure. This approach achieves our policy objective to distinguish clearly between high and low performance and it allows us to create composites of quality of care for groups of physicians that report different quality measures.

# A Note on the Cost Composite

- PALTC providers will likely always have VM penalties because Cost Composite scores are expected to be high due to patient attribution.
- Costs attributed to patients include costs for services provided outside of the TIN (ER, hospital, therapy, nursing home costs, consultants, ambulance, DME etc.).



## Process to Determine QRUR and VM

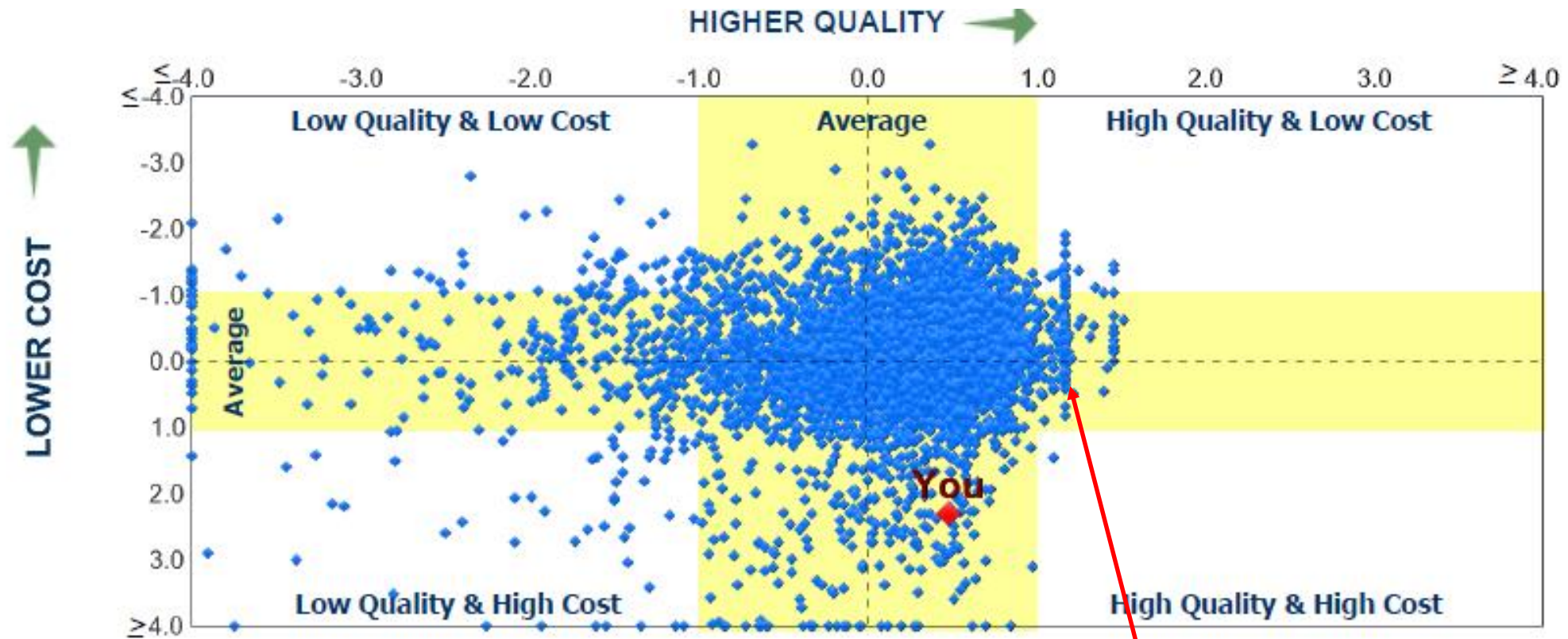


Gray - Data supplied by physician groups

Green - Data supplied by CMS

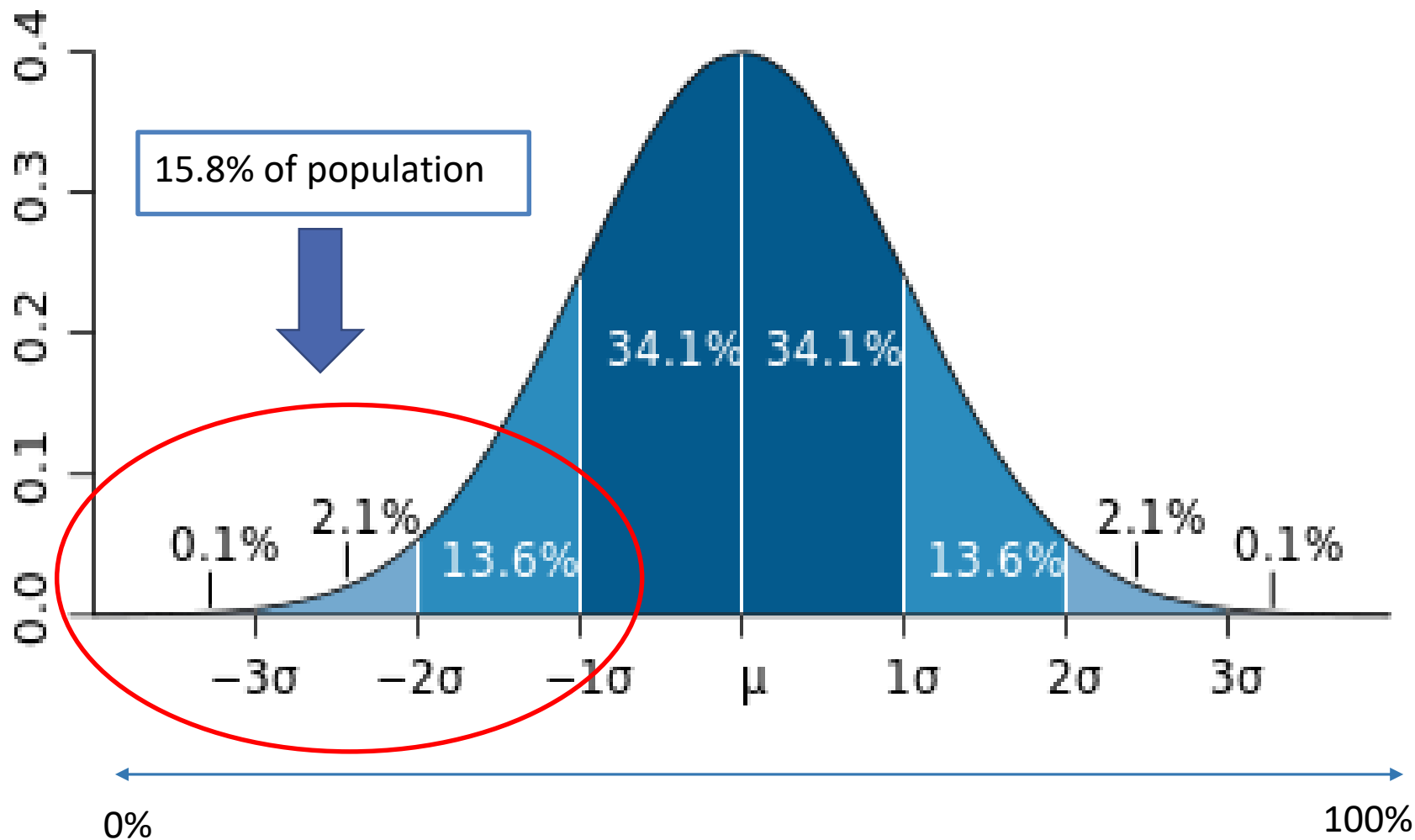


# The Value Modifier is Based on Quality Tiering

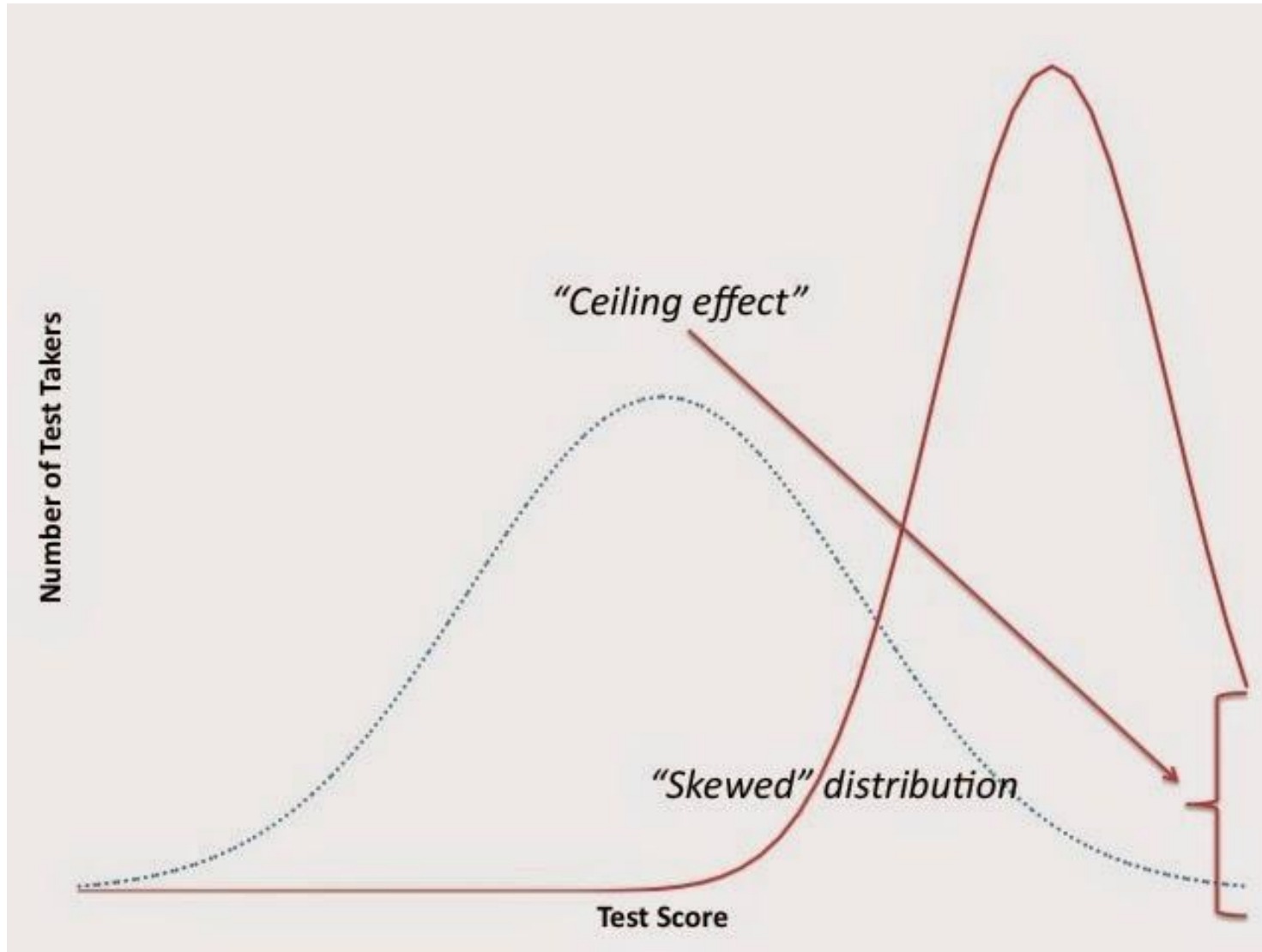


"ceiling effect"

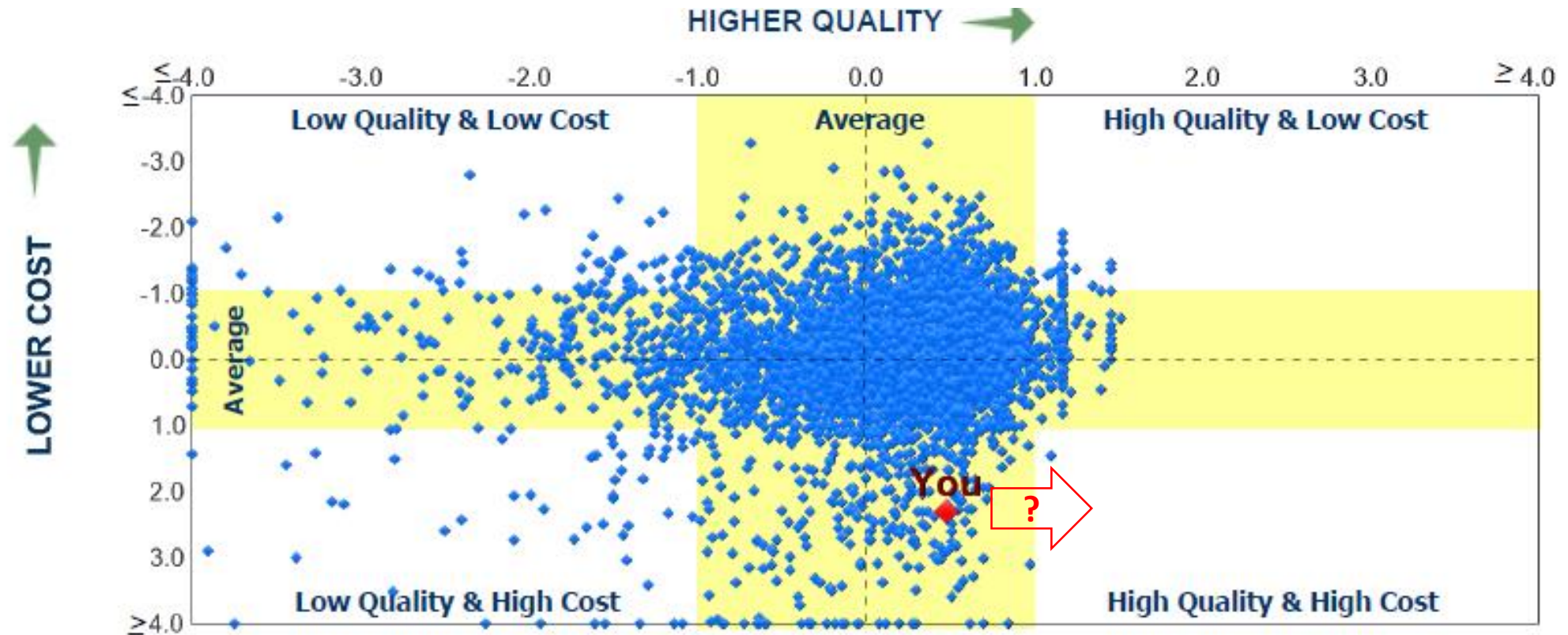
# Grading on the Curve – Setting the Average to the Majority



If the Average score in a QM is 99% it's very difficult to achieve 'high quality'



Question: Can you improve your quality score by paying attention to the domains which contribute to the Quality Composite?

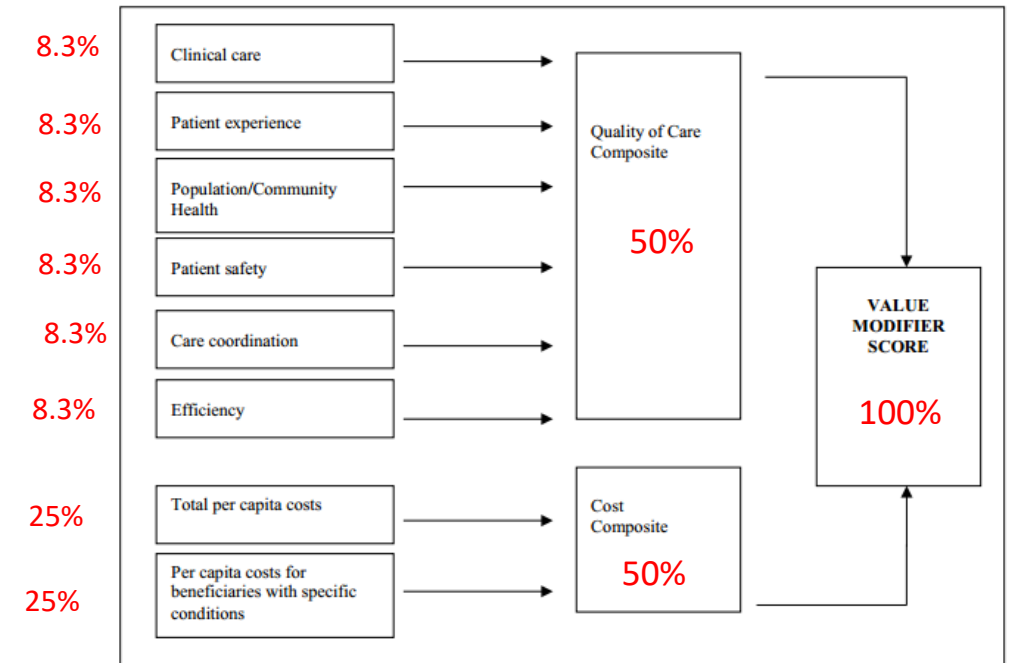




# What is the Quality of Care Composite?

- Successfully reporting PQRS adds measures to quality composite domains.
- For PQRS measure to be included in a domain, 50% of the eligible patients per provider must have that measure scored (50% threshold) for individual measures or 20 cases must be scored for measures groups (at least 11 of which are for Medicare patients).
- **All measures are equally weighted in each domain.**
- Measures scores are compared to the benchmark from the previous year to get standardized performance scores for each domain.

Figure 2: Relationship between Quality of Care and Cost Composites and the Value Modifier



(2) Scoring Methods for Quality-Tiering

We will establish standardized scores for each quality and cost measure. This approach achieves our policy objective to distinguish clearly between high and low performance and it allows us to create composites of quality of care for groups of physicians that report different quality measures.

# Each Domain Score is an Average of the Standardized Quality Measures

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Quality measure	Individual Group Performance Score	Benchmark (National Mean)	Individual Group Score Minus Benchmark	Standard Deviation	Standardized Score (Diff/St Dev)
Measure 1	95.0%	93.5%	1.5	3.3%	+0.47
Measure 2	71.4%	86.3%	-14.9	13.9%	-1.07
Measure 3	100.0%	60.6%	39.4	13.2%	+2.98
Domain Score (average std score)					<b>0.79</b>

Graphic from

<http://www.ucdenver.edu/academics/colleges/medicalschool/departments/medicine/GIM/education/ContinuingEducation/Documents/GPRO%20Presentation%20GIM%20Grand%20Rounds%20081313.pdf>

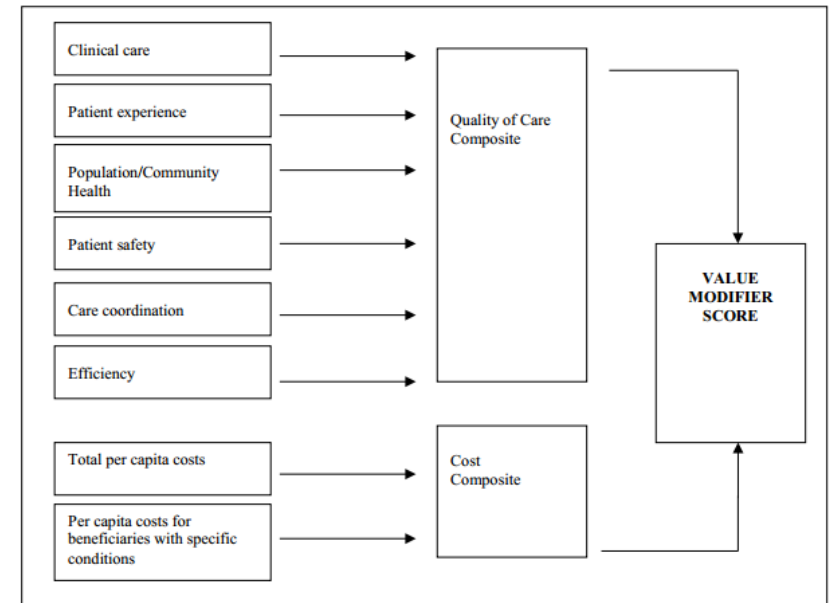
# Domains are then Averaged Equally to Produce the Quality Composite Score

- This Quality of Care Composite Score is then compared to a national mean.
- Where that score falls in relation to the mean (more than 1 standard deviation) indicates the percentage of the quality penalty or incentive (if average, 2% VM penalty (due to high cost)).

Exhibit 5. Your TIN's Performance in 2014, by Quality Domain

Quality Domain	Number of Quality Measures Included in Composite Score	Standardized Performance Score (Quality Tier Designation)
Quality Composite Score	10	0.48 (Average)
Effective Clinical Care	3	0.44
Person and Caregiver-Centered Experience and Outcomes	0	—
Community/Population Health	2	1.40
Patient Safety	1	0.23
Communication and Care Coordination	4	-0.29
Efficiency and Cost Reduction	0	—

Figure 2: Relationship between Quality of Care and Cost Composites and the Value Modifier



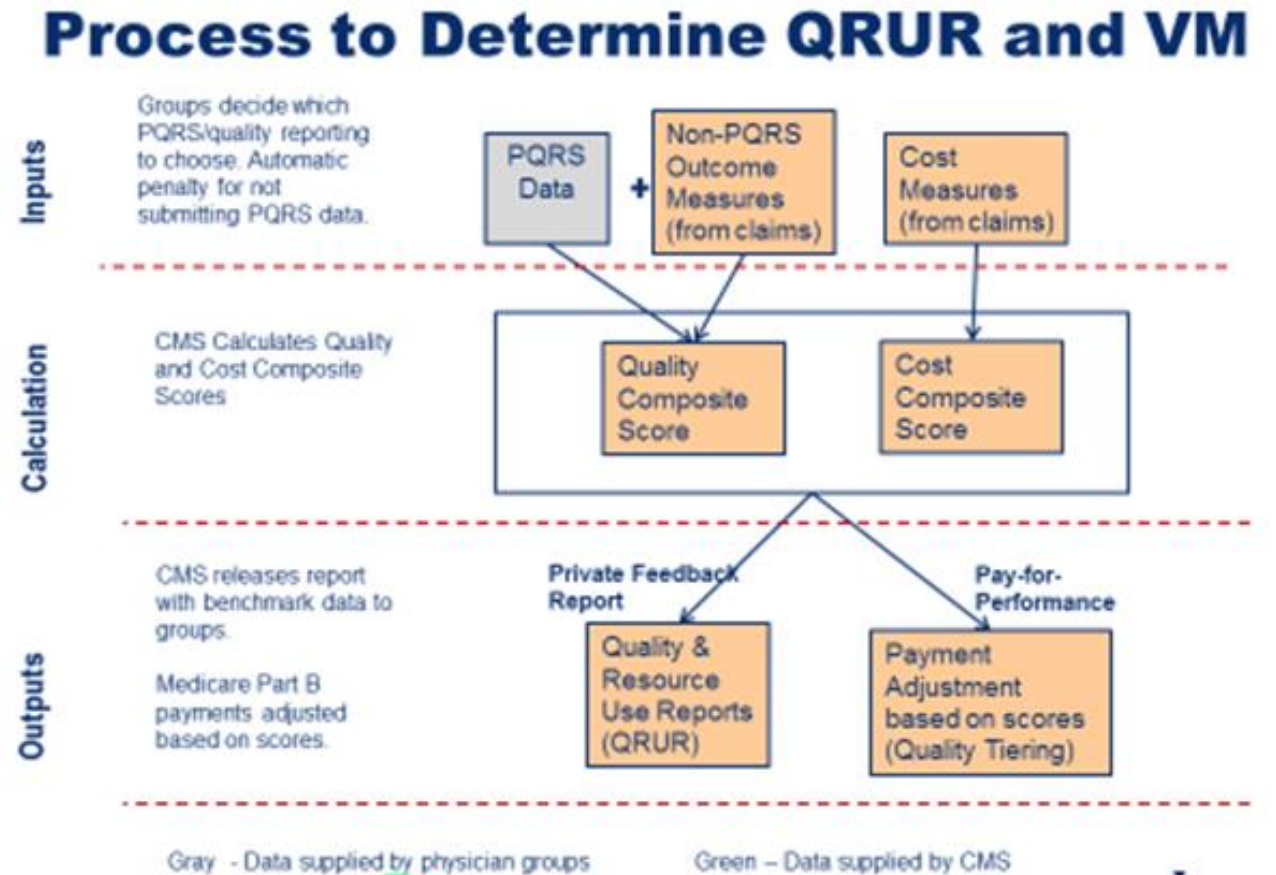
(2) Scoring Methods for Quality-Tiering

We will establish standardized scores for each quality and cost measure. This approach achieves our policy objective to distinguish clearly between high and low performance and it allows us to create composites of quality of care for groups of physicians that report different quality measures.

$$(0.44 + 1.40 + 0.23 - 0.29) / 4 = 0.45$$

# PQRS Measures Contribute to the Quality Score but are Not the Only Factor for Quality

- PQRS measures submitted by a practice are only a part of the Quality Composite Score.
- Non-PQRS Outcome Measures (from claims) are added to the PQRS measures you report. These Outcome Measures from claims populate the Care Coordination Domain.



PQRS Measure Number and Name	Your Performance		Peer Group Performance		
	Eligible Cases	Performance Rate	Benchmark Rate	Average Range	
				Benchmark -1 Standard Deviation	Benchmark +1 Standard Deviation
<b>Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care-Sensitive Conditions</b>					
Acute Conditions Composite (links to CMS-1** data table)	3,255	19.79	8.38	1.99	14.77
- PQI-11 Bacterial Pneumonia**	3,255	29.49	12.37	1.66	23.08
- PQI-12 Urinary Tract Infection**	3,255	19.84	8.11	0.00	16.76
- PQI-10 Dehydration**	3,255	9.99	4.61	0.00	9.61
CMS-2** Chronic Conditions Composite (links to data table)	2,186	57.96	54.02	26.82	81.22
- Diabetes (composite of 4 indicators)**	1,204	54.84	18.94	0.00	39.27
- PQI-5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma**	975	60.70	78.06	28.12	127.99
- PQI-8 Heart Failure**	1,331	96.13	100.70	48.52	152.89
<b>Hospital Readmissions</b>					
CMS-3** All-Cause Hospital Readmissions (links to data table)	2,061	16.39%	16.43%	14.99%	17.86%

# What Strategies Should We Adapt?

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- Use 2016 (and possibly 2015) to test multiple reporting strategies to try to improve quality:
  - Too many possible paths for any one group to manage.
  - Results of any test won't be know until September of following year.
  - Only logical strategy is to have multiple groups test various options simultaneously.
  - GPM Proposes to work with any client who wants to participate on the following terms(@ no additional charge beyond standard registry fees)

# GPM's Proposal to Users

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- Applies to any group using the GPM Registry Service for PQRS Reporting.
  - Collaboratively Design one or more test strategies for VBP Reporting
- Group will confidentially share QRUR reports w/ GPM for analysis
  - GPM will anonymize data and build analytical models – include linking with group's gEHRiMed data.
- GPM will accumulate results from multiple groups and attempt to identify the 'best' available reporting strategies for each group.
  - Feedback to groups on their performance vs. peers, and possible data to lobby CMS on Cost Benchmarks.

# Proposed PQRS Reporting Strategy to Improve Your Quality Profile

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- **Strategy 1:** Meet successful PQRS reporting to avoid 2% PQRS penalty with one measures group for each provider
- **Strategy 2:** *Dilute Care Coordination Domain* with other Care Coordination Individual Measures (50% threshold required) and/or Measures Group selection
- **Strategy 3:** Report in 2 additional Domains to further decrease influence of hospitalizations (Care Coordination)
  - Continue to address re-admissions and hospitalizations clinically and in QAPI processes



# Strategy 1: Successfully report PQRS to avoid 2% PQRS penalty with one measures group for each provider

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- Report a measures group by registry.
- Strive to complete early in the year.
- 30 patients/provider/year gives you some wiggle room if providers choose “performance not met” answers or patients are not insured by Medicare (don’t need to score measures more than once per patient/provider)
- Documentation should be in gEHRiMed notes or in the facility chart to support the PQRS answers selected
- 4 Measures Groups available
  - Dementia – we recommended for ease of scoring and number of Care Coordination domain measures
  - HF
  - CAD
  - Diabetes

# The Dementia group has 3 Care Coordination Measures

Domain	Number	2013 Mean	2013 Standard Deviation	2015 PQRS MEASURES IN DEMENTIA MEASURES GROUP:
<b>Communication and Care Coordination</b>	#47	53.42%	33.40%	Care Plan
<b>Communication and Care Coordination</b>	#280	?		Dementia: Staging of Dementia
<b>Effective Clinical Care</b>	#281	94.66%	16.44%	Dementia: Cognitive Assessment
<b>Effective Clinical Care</b>	#282	95.09%	14.04%	Dementia: Functional Status Assessment
<b>Effective Clinical Care</b>	#283	90.86%	21.05%	Dementia: Neuropsychiatric Symptom Assessment
<b>Effective Clinical Care</b>	#284	91.40%	21.57%	Dementia: Management of Neuropsychiatric Symptoms
<b>Effective Clinical Care</b>	#285	89.97%	20.92%	Dementia: Screening for Depressive Symptoms
<b>Patient Safety</b>	#286	?		Dementia: Counseling Regarding Safety Concerns
<b>Effective Clinical Care</b>	#287	87.42%	27.02%	Dementia: Counseling Regarding Risks of Driving
<b>Communication and Care Coordination</b>	#288	88.38%	25.13%	Dementia: Caregiver Education and Support

# The HF Group has 1 Care Coordination Measure

Domain	Number	2013 Mean	2013 Standard Deviation	2015 PQRS MEASURES IN HEART FAILURE (HF) MEASURES GROUP
<b>Effective Clinical Care</b>	#5	77.33%	25.82%	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
<b>Effective Clinical Care</b>	#8	80.50%	22.49%	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
<b>Communication and Care Coordination</b>	#47	53.42%	33.40%	Care Plan
<b>Community/Population Health</b>	#110	40.89%	27.69%	Preventive Care and Screening: Influenza Immunization
<b>Patient Safety</b>	#130	87.36%	22.21%	Documentation of Current Medications in the Medical Record
<b>Community/Population Health</b>	#226	83.11%	24.97%	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

# CAD Measures Group also available (no care coordination measures)

Domain	Number	2013 Mean	2013 Standard Deviation	2015 PQRS MEASURES IN CORONARY ARTERY DISEASE (CAD) MEASURES GROUP
<b>Effective Clinical Care</b>	#6	83.89%	20.35%	Coronary Artery Disease (CAD): Antiplatelet Therapy
<b>Effective Clinical Care</b>	#7	66.92% ?	23.57% ?	Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)
<b>Community/Population Health</b>	#128	54.58%	23.30%	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
<b>Patient Safety</b>	#130	87.36%	22.21%	Documentation of Current Medications in the Medical Record
<b>Community/Population Health</b>	#226	83.11%	24.97%	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
<b>Effective Clinical Care</b>	#242	88.40%	20.53%	Coronary Artery Disease (CAD): Symptom Management

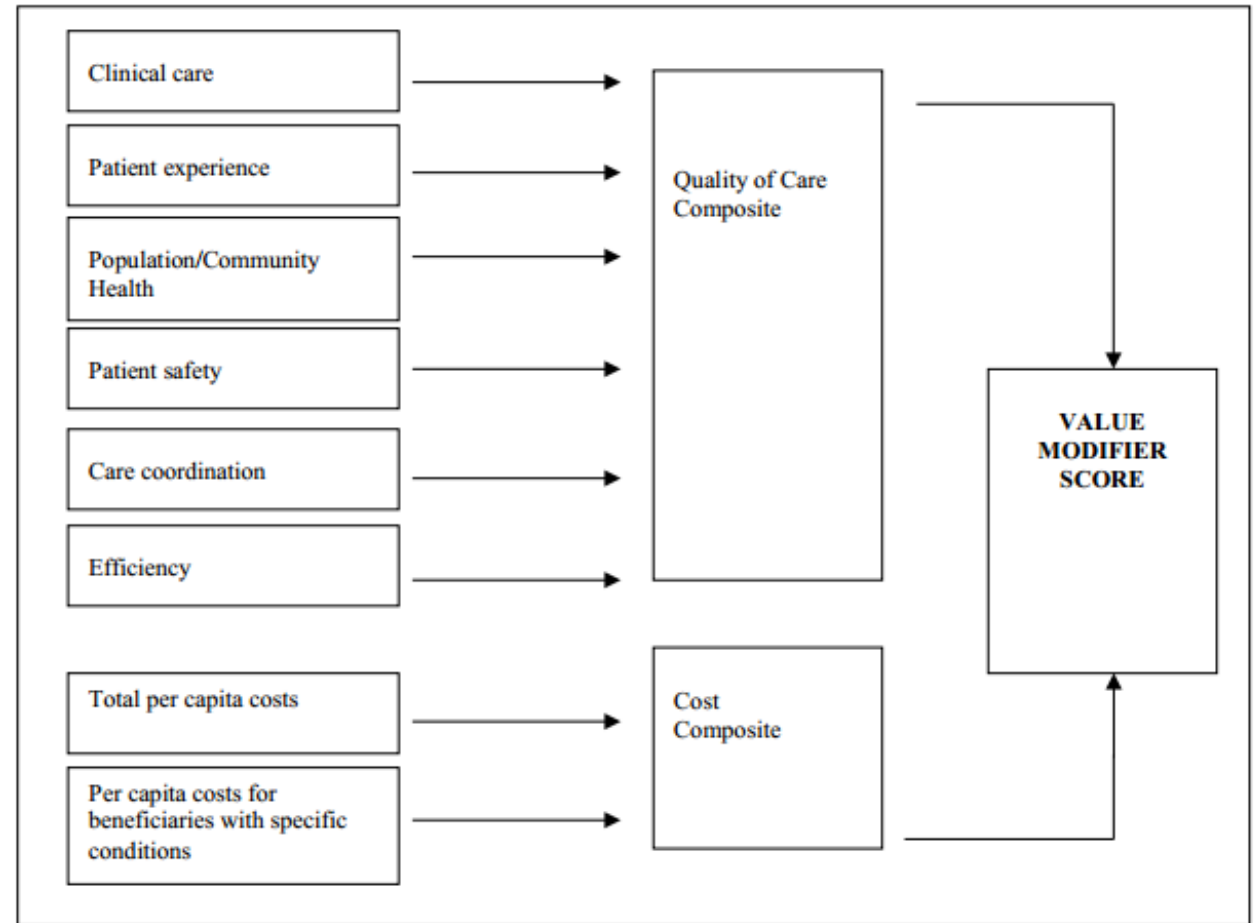
# In which domains are you reporting?

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Besides the Care Coordination domain (Outcomes from claims)....

Reporting on one measures group per provider may not cover enough domains to improve low or average quality.

**Figure 2: Relationship between Quality of Care and Cost Composites and the Value Modifier**



## *(2) Scoring Methods for Quality-Tiering*

We will establish standardized scores for each quality and cost measure. This approach achieves our policy objective to distinguish clearly between high and low performance and it allows us to create composites of quality of care for groups of physicians that report different quality measures.

# 3 Hospitalization Rate outcome measures – CMS-1, CMS-2, and CMS-3 are part of the Care Coordination Domain

Hospitalizations prior to even admitting our patients are attributed to us if we provide most of their care

Exhibit 4-CC. 2012 Performance on Quality Indicators in the Care Coordination Domain  
Care Coordination Domain Score = 0.41

Performance Measures		Your Medical Group Practice's Performance		Performance of All 1032 Least 100 Eligible Pr	
		Number of Eligible Cases	Performance Rate	Benchmark Rate	Average - 1 Standard Deviation
<b>Mental Health</b>					
Follow-Up After Hospitalization for Mental Illness					
1. Percentage of Patients Receiving Follow-Up Within 30 Days		39	64.1%	64.1%	52.3%
2. Percentage of Patients Receiving Follow-Up Within 7 Days		39	33.3%	36.1%	24.9%
<b>Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care Sensitive Conditions</b>					
CMS-1	Acute Conditions Composite*	7,835	5.6	8.2	5.0
	PQI-11 Bacterial Pneumonia*	7,835	6.0	12.4	7.6
	PQI-12 Urinary Tract Infection*	7,835	7.1	7.5	3.5
	PQI-10 Dehydration*	7,835	3.7	4.7	2.7
CMS-2	Chronic Conditions Composite*	3,883	41.7	58.6	45.6
	Diabetes (Composite of 4 Indicators) *	1,837	12.7	20.5	10.0
	PQI-5 COPD or Asthma*	1,086	61.9	82.5	58.4
	PQI-8 Heart Failure*	960	76.8	108.6	82.7
<b>Hospital Readmissions</b>					
CMS-3	All-Cause Hospital Readmissions*	1,768	16.5%	16.1%	14.8%

\*Lower performance rates on these measures indicate better performance. However, the domain score for this domain has been calculated such that positive performance and negative scores indicate worse performance.

Exhibit 3. Your Medical Group Practice's Performance by Quality Domain in 2012

Quality Domain	Number of Quality Indicators	Standardized Score
<b>Standardized Quality Composite Score</b>	<b>17</b>	<b>0.71* (Average)</b>
Average Domain Score	17	0.44
Clinical Process/Effectiveness	11	1.21
Patient Safety	2	-0.29
Care Coordination	4	0.41

CMS 'DUMMY' Data – not a LTPAC Group Report!

- All Cause Readmission
- Composite of Acute Prevention Quality Indicators (bacterial pneumonia, UTI, dehydration)
- Composite of Chronic Prevention Quality Indicators (COPD, heart failure, diabetes, CAD)

## Strategy 2: Dilute Care Coordination with other Care Coordination Individual Measures

Because measures are equally weighted in each domain, there may be a chance to improve the Care Coordination average by adding additional Care Coordination measures.

Other Care Coordination Individual Measures (50% threshold required) can be used and/or you can select measures groups that contain measures from the Care Coordination domain.

For average quality, the penalty will be only 2% due to our high cost. For high quality, there will be no penalty despite our high cost.

**TABLE 89: Final CY 2017 VM Payment Adjustment Amounts for Groups with Ten or More Eligible Professionals**

<b>Cost/Quality</b>	<b>Low quality</b>	<b>Average quality</b>	<b>High quality</b>
<b>Low cost</b>	+0.0%	+2.0x*	+4.0x*
<b>Average cost</b>	-2.0%	+0.0%	+2.0x*
<b>High cost</b>	-4.0%	-2.0%	+0.0%

\* Groups eligible for an additional +1.0x if reporting measures and average beneficiary risk score is in the top 25 percent of all beneficiary risk scores, where 'x' represents the upward payment adjustment factor.

# Strategy 2: Dilute Care Coordination domain with other Care Coordination Individual Measures

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- Care Coordination:
    - All Cause Readmission
    - Composite of Acute Prevention Quality Indicators (bacterial pneumonia, UTI, dehydration)
    - Composite of Chronic Prevention Quality Indicators (COPD, heart failure, diabetes, CAD)
    - Dementia Measures Group Measures # 47
    - Dementia Measures Group Measures #280
    - Dementia Measures Group Measures #288
    - **#155 Falls: Plan of Care (reported with #154: Falls Screen)**
    - **Measure #47: Care Plan**
- } Dementia Measures Group



Individual Measure	NQS Domain	Registry Only	Measures Group(s)
# 1 (NQF 0059): Diabetes: Hemoglobin A1c Poor Control	Effective Clinical Care		Diabetes
# 6 (NQF 0067): Coronary Artery Disease (CAD): Antiplatelet Therapy	Effective Clinical Care	Registry Only	CAD
# 47 (NQF 0326): Care Plan	Communication and Care Coordination		Dementia HF
# 48: Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	Effective Clinical Care		
# 50: Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	Person and Caregiver-Centered Experience and Outcomes		
# 110 (NQF 0041): Preventive Care and Screening: Influenza Immunization	Community/Population Health		Diabetes HF
# 111 (NQF 0043): Pneumonia Vaccination Status for Older Adults	Effective Clinical Care		
# 119 (NQF 0062): Diabetes: Medical Attention for Nephropathy	Effective Clinical Care		Diabetes
# 121 (NQF 1668): Adult Kidney Disease: Laboratory Testing (Lipid Profile)	Effective Clinical Care	Registry Only	
# 154 (NQF: 0101): Falls: Risk Assessment	Patient Safety		
# 155 (NQF: 0101): Falls: Plan of Care	Communication and Care Coordination		
# 181 Elder Maltreatment Screening and Follow Up Plan	Patient Safety		
# 326 (NQF 1525): Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	Effective Clinical Care		
# 332: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)	Efficiency and Cost Reduction	Registry Only	

# Strategy 2: Dilute Care Coordination domain with other Care Coordination Individual Measures: Falls Plan of Care and/or Care Plan

Domain	CAD	HF	Dementia
Effective Clinical Care	✓ ✓ ✓	✓ ✓	✓ ✓ ✓ ✓ ✓ ✓
Patient Experience			
Community/Population Health	✓	✓ ✓	
Care Coordination	#155: Falls Plan of Care #47: Care Plan	✓	✓ ✓ ✓
Patient Safety	✓ ✓	✓	✓ ✓
Efficiency			

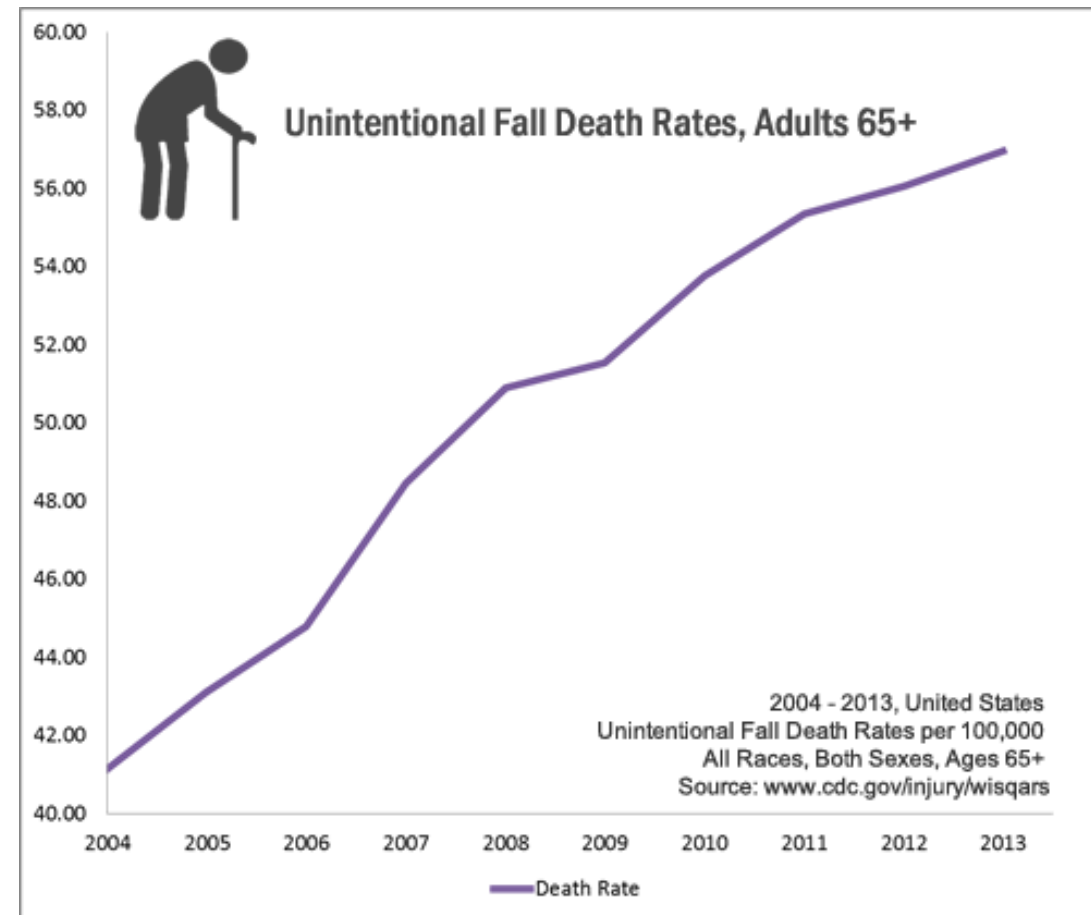
Falls Plan of Care (Care Coordination domain) scored together with Falls Screen (Patient Safety domain)

# Fall Plan of Care

## (Completed Within the Fall Screen Measure)

- Care Coordination Domain (and Patient Safety for Fall Screen)
- Two measures are scored together
- For patient 65 and older
- Selected providers will need to score for the whole year to ensure 50% threshold (recommend 65%)

Patient has been screened for future fall risk, has had no falls in the past year or only one fall without injury in the past year and is not at risk for falls. (normal)



# Care Plan

- Selected providers will need to score for the whole year to ensure 50% threshold (recommend 65%)

The screenshot displays a medical dashboard with a sidebar of PQRs and a main content area for PQR #47. The sidebar lists various PQRs with their completion status (0% completed). The main content area shows the details for PQR #47, including a description, a note, and three radio button options for the response. Below the options is a table with columns for 'Normal' and 'Previous' status, and a 'Code Status' section with a text area for 'Do Not Attempt Resuscitation (DNR/no CPR)'.

**Measures** CAD Dementia Diabetes Heart Failure

PQRS #121  
Adult Kidney Disease: Laboratory Testing (Lipid Profile)  
0 out of 0 completed (0%) Ineligible

PQRS #326  
Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy  
0 out of 0 completed (0%) Ineligible

**PQRS #47  
Care Plan**  
0 out of 0 completed (0%) Eligible

PQRS #1  
Diabetes: Hemoglobin A1c Poor Control  
0 out of 0 completed (0%) Ineligible

PQRS #181  
Elder Maltreatment Screen and Follow-Up Plan  
0 out of 0 completed (0%) Eligible

PQRS #154/155  
Falls: Risk Assessment  
0 out of 0 completed (0%) Eligible

PQRS #111  
Pneumonia Vaccination Status for Older Adults  
0 out of 0 completed (0%) Eligible

PQRS #48  
Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older  
0 out of 0 completed (0%) Ineligible

**PQRS #47 / NQF #0326** 0 out of 0 completed (0%)

Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

NOTE: A qualifying CPT code must be added for these responses to be valid.

Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record. [1123F] Previous: 0

Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan, or patient's cultural and/or spiritual beliefs preclude this discussion. [1124F] Previous: 0

Advance Care Planning NOT documented, reason not otherwise specified. [1123F 8P]

Clear Answers

	Normal	Previous
Room Number	-	-
Allergy List	○	-
Medication List	○	-
✓ Code Status	✓	○
PCP	-	-
Facility Attending	-	-
Hospital Preference	-	-

Information > Code Status

Format B I U

Do Not Attempt Resuscitation (DNR/no CPR)

# If a Practice Chooses the Dementia Group to Meet PQRS, At Least One Provider Will Also Need to Score HF or CAD to Have measures in the Population Health Domain



Domain	CAD	HF	Dementia
Effective Clinical Care	✓ ✓ ✓	✓ ✓	✓ ✓ ✓ ✓ ✓ ✓
Patient Experience			
Community/Population Health	✓	✓ ✓	
Care Coordination		✓	✓ ✓ ✓
Patient Safety	✓ ✓	✓	✓ ✓
Efficiency			

Or score # 110 (NQF 0041): Preventive Care and Screening:  
Influenza Immunization with one or more providers all year long

# Individual Measures Count, too!

Exhibit 6-PCE is not displayed because your TIN did not have at least one eligible case for at least one measure in this domain.

**Exhibit 6-CPH. Community/Population Health Domain Quality Indicator Performance**

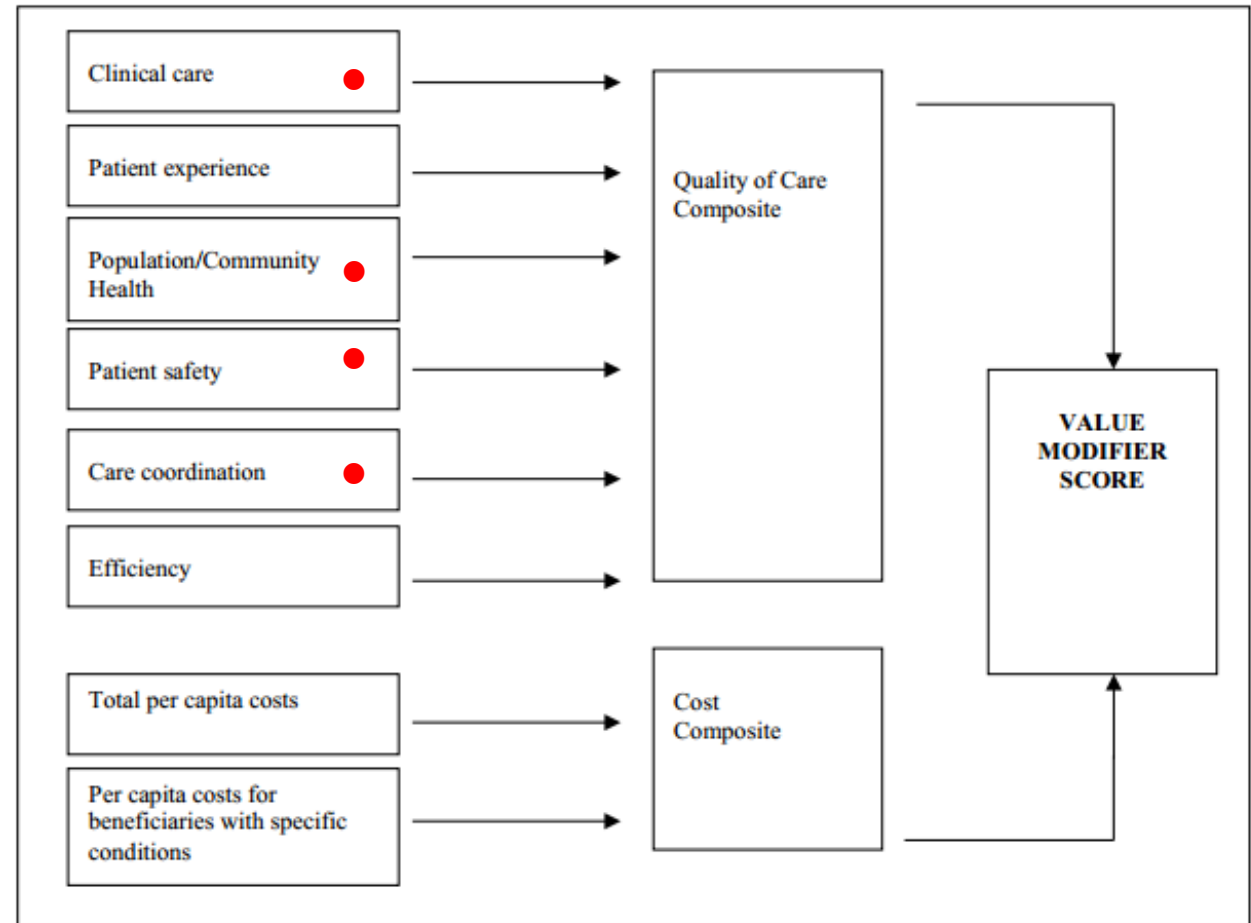
Measure Reference	Measure Name	Your TIN's Eligible Cases	Your TIN's Performance Rate	Benchmark	Benchmark -1 Standard Deviation	Benchmark +1 Standard Deviation	Standardized Score	Included In Domain Score?
110 (GPRO Prev-7, CMS147 v2)	Preventive Care and Screening: Influenza Immunization	5,247	99.85%	40.89%	13.21%	68.58%	2.13	Yes
226 (GPRO Prev-10, CMS138 v2)	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	1,569	99.94%	83.11%	58.14%	100.00%	0.67	Yes

Tobacco Use – this measure lowered the group performance because it is ‘topped-out’.

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Reporting more than one Measures Group per practice will add additional measures to TIN domains without requiring a 50% threshold but will not add Patient Experience or Efficiency Domains.

Care Coordination domain will remain at 25%.



## Strategy 3: Report Additional Measures to Score as Many of the 6 Domains as Possible for best Quality Composite Score, report 6 domains, Care Coordination gets 17% weight

17%

**Effective Clinical Care** (CAD Measures Group #6, #7, #242; HF Measures Group #8 and #5; Dementia Measures Group #281-285 and #287 )

17%

**Community/Population Health** (CAD Measures Group #128, HF Measures Group #226 and #110)

17%

**Patient Safety** (CAD Measures Group #130 and #226, HF Measures Group #130, Dementia Measures Group #286 and #154: Falls Screen)

17%

**Care Coordination** (3 hospitalization scores, #155 Falls: Plan of Care, Measure #47: Care Plan, 3 dementia group measures, 1 HF measure)

17%

Can we try for **Efficiency** too? #332 Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)

17%

**Patient Experience** (Measure #50: Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older)

(Report 5 domains, Care Coordination get 20% weight; report 4 domains, Care Coordination gets 25% weight)



# Adding Individual Measures: Urinary Incontinence

Domain	CAD	HF	Dementia
Effective Clinical Care	✓ ✓ ✓	✓ ✓	✓ ✓ ✓ ✓ ✓ ✓
Patient Experience	#50 Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older		
Community/Population Health	✓	✓ ✓	
Care Coordination		✓	✓ ✓ ✓
Patient Safety	✓ ✓	✓	✓ ✓
Efficiency			

Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older (ALF & RH only) (Patient Experience domain) scored with Incontinence Screen

# #50 Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older (ALF & RH only)

- Patient Experience domain
- Involves providers in a small number of ALF/RH facilities
- Measure #48 Screen should also be done if you score this measures: Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older (Effective Clinical Care domain)
- Plan of care for urinary incontinence must be documented at least once within 12 months in your notes or the facility chart:
  - May include behavioral interventions (eg, bladder training, pelvic floor muscle training, prompted voiding), referral to specialist, surgical treatment, reassess at follow-up visit, lifestyle interventions, addressing co-morbid factors, modification or discontinuation of medications contributing to urinary incontinence, or pharmacologic therapy.
  - When including incontinence in your diagnosis list – simply indicate how you are treating it

## PQRS #48 / NQF #0043

Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months.

NOTE: A qualifying CPT code must be added for these responses to be valid.

Presence or absence of urinary incontinence assessed. [1090F]

Urinary Incontinence: Any involuntary leakage of urine.

Presence or absence of urinary incontinence not assessed, for medical reason(s) documented in the medical record. [1090F 1P]

Presence or absence of urinary incontinence not assessed, for reason not otherwise specified. [1090F 8P]

## PQRS #50 / NQF #0100

0 out of

Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months.

NOTE: A qualifying CPT code must be added for these responses to be valid.

Urinary incontinence plan of care documented. [0509F]

Plan of Care: May include behavioral interventions (e.g., bladder training, pelvic floor muscle training, prompted voiding), referral to specialist, surgical treatment, reassess at follow-up visit, lifestyle interventions, addressing co-morbid factors, modification or discontinuation of medications contributing to urinary incontinence, or pharmacologic therapy.

Urinary incontinence plan of care not documented, reason not otherwise specified. [0509F 8P]

# Adding Individual Measures: Sinusitis

Domain	CAD	HF	Dementia
Effective Clinical Care	✓ ✓ ✓	✓ ✓	✓ ✓ ✓ ✓ ✓ ✓
Patient Experience			
Community/Population Health	✓	✓ ✓	
Care Coordination		✓	✓ ✓ ✓
Patient Safety	✓ ✓	✓	✓ ✓
Efficiency	<div style="border: 1px solid red; padding: 5px;">                     Individual Measure #332: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)                 </div>		

Individual Measure #332: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use) [\(Efficiency Domain\)](#)

# gEHRiMed's Efficiency Domain PQRS Measure

added in ICD-10 release

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- Individual Measure #332: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)

Small number of eligible patients

**Measure #332: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use) – National Quality Strategy Domain: Efficiency and Cost Reduction**

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**  
**REGISTRY ONLY**

**DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis

**INSTRUCTIONS:**

This measure is to be reported a minimum of **once per reporting period** for patients with acute bacterial sinusitis during the reporting period. 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**

ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes 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.



**Summary:** At least one provider scores HF or CAD to have measures in the Population Health Domain. All providers add some Patient Experience and Efficiency Domain measures to reduce Care Coordination to 17% weight in the Quality Composite Score. Care Coordination is additionally supplemented with Falls Plan of Care and/or Care Plan.

Domain	CAD	HF	Dementia
Effective Clinical Care	✓ ✓ ✓	✓ ✓	✓ ✓ ✓ ✓ ✓ ✓
Patient Experience	#50 Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older		
Community/Population Health	✓	✓ ✓	
Care Coordination	#155: Falls Plan of Care #47: Care Plan	✓	✓ ✓ ✓
Patient Safety	✓ ✓	✓	✓ ✓
Efficiency	Individual Measure #332: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)		

**Choose measures to report carefully – with registry reporting, you can submit the highest quality scores, considering their benchmarks.**

# Two or More Providers May Help Reach the 20 Patient Threshold if each provider covers 50% of patients

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- # 332: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)

- Provider A has 10 patients with sinusitis and meets the measure successfully for 6 of the 10. Registry reports these 6 patients.
- Provider B has 20 patients with sinusitis and meets the measure successfully for 11 of 20 (chooses the poor quality answer for 2 of 20 patients). Registry reports 11 patients.
- Provider C has 6 sinusitis patients and meets the measure successfully for 3 patients. Registry reports 3 patients.

6  
+  
11  
+  
3  

---

20

“To be included in 2016 Value Modifier calculations, each measure must have at least 20 eligible cases after applying any measure-specific exclusions. For PQRS measures reported by individual eligible professionals, **the total number of eligible cases across all eligible professionals submitting the measure under the TIN is used to determine whether the 20-case threshold was reached.**” <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2014QRUR-2016VM-DetailedMethodology.pdf>

# Use the PQRS Reports Generated Each Monday to Evaluate All Providers' Performance on PQRS

Measures Group	Measure Number	Measure	Numerator	Denominator	Completion Rate	Performance Rate
	1	Diabetes: Hemoglobin A1c Poor Control	8	8	100	0
	6	Antiplatelet Therapy	0	29	0	
	47	Care Plan	240	278	86.33	100
	48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	50	67	74.63	100
	50	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	2	2	100	100
	110	Preventive Care and Screening: Influenza Immunization	218	243	89.71	100
	111	Pneumonia Vaccination Status for Older Adults	101	148	68.24	100
	119	Diabetes: Medical Attention for Nephropathy	0	8	0	
	121	Adult Kidney Disease: Laboratory Testing (Lipid Profile)	7	7	100	83.33
	154	Falls: Risk Assessment	240	285	84.21	100
	155	Falls: Plan of Care	154	154	100	100
	181	Elder Maltreatment Screen and Follow-Up Plan	0	278	0	
	326	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	50	54	92.59	95.45
CAD	6	Antiplatelet Therapy	0	29	0	
CAD	7	Beta-Blocker Therapy--Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)	0	29	0	
CAD	128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	0	29	0	
CAD	130	Documentation of Current Medications in the Medical Record	0	29	0	
CAD	226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	0	29	0	
CAD	242	Symptom Management	0	29	0	
Dementia	47	Care Plan	18	34	52.94	100
Dementia	280	Staging of Dementia	23	34	67.65	100
Dementia	281	Cognitive Assessment	23	34	67.65	100

# Performance Rates

[https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015 PQRS Registry Reporting Made Simple.pdf](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_PQRS_Registry_Reporting_Made_Simple.pdf)

- Individual measures with a 0% performance rate and **measures groups containing a measure with a 0% performance rate** will not be counted as satisfactorily reported. The recommended clinical quality action must be performed on at least 1 patient for each individual measure reported (and at least one patient for all applicable measures in a measures group) for the measure to count.
- Note when a lower rate indicates better performance (inverse measure), such as Measure #1: Diabetes: Hemoglobin A1c Poor Control, a 0% performance rate will be counted as satisfactory reporting (100% performance rate would not be considered satisfactory reporting).
- **Performance exclusion quality-data codes are not counted in the performance denominator.** If the registry submits all performance exclusion quality-data codes, the performance rate would be 0/0 (null) and the measure would be considered satisfactorily reported. **But, the measure won't impact your domain scores.**

## SAMPLE CALCULATIONS:

### Reporting Rate=

$$\frac{\text{Performance Met (a=4 patients)} + \text{Performance Exclusion (b=1 patient)} + \text{Performance Not Met (c=2 patients)}}{\text{Eligible Population / Denominator (d=8 patients)}} = \frac{7 \text{ patients}}{8 \text{ patients}} = 87.50\%$$

### Performance Rate=

$$\frac{\text{Performance Met (a=4 patients)}}{\text{Reporting Numerator (7 patients) - Performance Exclusion (b=1 patient)}} = \frac{4 \text{ patients}}{6 \text{ patients}} = 66.66\%$$



# How Many Providers Should Help Populate Domains?

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- For each TIN and measure, rates are rolled up to the TIN level as follows:
  - For each EP within the TIN, the performance rate is multiplied by the denominator cases. The TIN numerator is then calculated as the sum across all EPs within the TIN that reported the measure.
  - The TIN denominator is calculated as the sum of the denominator cases across all EPs within the TIN that reported the measure.
  - Each TIN's performance rate on the measure is calculated as the TIN numerator divided by the TIN denominator.
- So long as primarily “performance met” and not all “exclusion” PQRS answers are selected and reported, it should not matter how many providers report a measure to populate an isolated domain; BUT, if measures are reported with primarily “performance not met” answers, then it would be important to have a large denominator to dilute the poor quality answers.

# New Measures That Do Not Have Benchmarks Will Not Count In Your VM Calculations

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- *“We also will use the year prior to the performance year as the year for calculating the benchmark. If a measure is new to the PQRS, we will be unable to calculate a benchmark, and therefore, performance on that measure will not be included in the quality composite.”*

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/CY2015ValueModifierPolicies.pdf>

<b>Measure</b>	<b>2013 Mean</b>	<b>2013 Standard Deviation</b>
#154 Falls: Risk Assessment	73.21%	38.45%
#155 Falls: Plan of Care	74.52%	38.15%
#47 Advance Care Plan	53.42%	33.40%
# 50 Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	94.09%	17.30%

## #332: Sinusitis

Dementia Measures Group  
 HF Group Measures Group  
 CAD Measures Group

**Added to Effective Clinical Care domain in 2014 – should have a benchmark for 2015 despite change to Efficiency Domain**

All measures have 2013 benchmarks