Public Policy
By Rod Baird

This article is written specifically for post-acute and long-term care medical practices assessing options for participation in the Physicians Quality Reporting System (PQRS) and the Value-Based Payment Modifier (VM) program. In the author’s opinion, many acceptable PQRS reporting strategies become impractical in the absence of a dedicated office staff. If more than 30% of your care is delivered in an office setting, then the following advice may not be optimum for your practice.

Are you participating in PQRS for 2014? Have you thought about VM? If your answer is yes, congratulations—it is estimated that 25%-30% of AMDA members are preparing for those major Centers for Medicare & Medicaid Services policy initiatives.

This month’s column covers the changes CMS is proposing to these programs in 2015. The final rule on the Physician Fee Schedule was published Oct. 31. Although it was too late to include a full analysis in this column to plan your 2015 participation strategy, please be aware that the rules are becoming more complex and the consequences resulting from poor performance ramp up. Full AMDA analysis of the rule is published at http://www.amda.com/advocacy/feeschedule.cfm, with continued updates on program changes and advocacy efforts.

I believe these programs are burdensome, intrusive, and disconnected from the quality of care in PA/LTC settings. This column is written to help PA/LTC providers assess their 2015 PQRS and VM strategies or possibly consider the question for the first time. Providers who fail to satisfy participation requirements in 2015 will see Medicare Part B payments reduced in 2017. The magnitude of those reductions depends on the group size.

Potential Reductions, Bonuses
All eligible professionals are subject to a 2% penalty if they fail to meet minimum participation levels. The minimum reporting level for all medical professionals is satisfactorily reporting of nine individual measures for 50% of eligible patients. There are additional requirements for the types of measures that must be included in the nine chosen. Alternately, one measures group (MG) can be reported for a minimum of 20 patients. There are no remaining PQRS incentive payments.

If you work in a medical group with 10 or more providers, your group is subject to an additional penalty of up to 4% under VM if fewer than half of the group doesn’t satisfactorily report for the PQRS program. One significant change for 2015: this VM penalty for groups of 10 or more will apply to nurse practitioners and physician assistants under the draft rules. Under the 2014 rules, only physicians were subject to the penalty.

The two penalties for nonparticipation are additive—that means large groups can have their 2017 Medicare Part B reimbursement cut 6% if they fail to satisfy the 2015 PQRS and VM reporting requirements.

Groups of 100 or more: All of the measures required for participation in PQRS, VM, and the cumulative number of measures employed by a group during the calendar year 2015:

- Anyone wanting to avoid penalties must satisfactorily participate in PQRS during 2015. CMS recognized up to 26 possible ways to meet those reporting requirements—but there are only two kinds of measures: (1) basic reporting options and (2) strategies based on group size.

1. Basic Reporting Options

- Individual measures: This option requires reporting of nine measures. Depending on the measures used, submission can be made by claims for the individual encounter, via a registry, or through your electronic health record (EHR). The EHR users may have the ability to use electronic clinical quality measures (eCQMs) in lieu of, or in addition to, individual PQRS measures. In 2014, 41 individual PQRS measures could be reported for CPT codes 99360-99318. AMDA’s quality committee assessed those measures and recommended only 11 were clinically appropriate for our patient population. For 2015, CMS proposes retiring two of those 11 measures that are best suited for the PA/LTC population.

- The eCQM: Providers using a certified EHR may have a larger number of reportable measures—all eCQMs are also PQRS measures. The EHR developers were recently informed that 54 eCQMs could be “mapped” to face-to-face nursing facility encounters. Providers must check with their EHR vendor to determine if this optional mapping is available.

- Measures Groups: This option requires successfully reporting on one MG for a minimum of 20 patients. MGs can only be reported through a registry. Providers must select an appropriate MG that applies to PA/LTC patients. In 2014, seven MGs included skilled nursing facility/nursing facility CPT codes as criteria.

- A report on the selected MG for each eligible professional requires a threshold of 20 patients or 80% of all eligible patients seen by the provider. However, one defective record out of the 20 required would negate the entire report, so the Extended Care Physicians group and other LTC groups in the Vision Group recommend capturing data on at least 30 patients to improve the chances of having 20 complete sets of data. To ease the paperwork burden: if two or more providers see the same patient, each can use the same laboratory or test data for PQRS reporting.

- In past years, these groups have recommended the coronary artery disease MG for primary care providers working in PA/LTC. Other long-term care groups preferred the heart failure MG.

- The draft rule adds new complexity to MG reporting. Each LTC-related measure requires documentation of a complete medication list for every encounter during the year. In past years, the clinician only needed to focus on PQRS reporting for a single encounter per patient. Now the patients enumerated in the MG require added medication documentation on every visit—not too big a problem for an EHR user, but a real challenge to paper-based medical record users.

2. Strategies Based on Group Size

- For 2015, solo providers and small groups employing nine or fewer staff are exempt from VM penalties. Their maximum penalty for nonparticipation comes from PQRS at 2%. For groups at the lower end of the range, without an EHR, it will be extremely hard to report on nine individual measures via claims. The more complex MG reporting, which involves documenting the patient’s medications list on each encounter, may be too burdensome. It may be easier to accept the 2% penalty and spend 2015 selecting and implementing an EHR.

- Groups between 10 and 99 cumulative medical staff. These providers will experience a 2% reduction in 2017 reimbursement if they fail to satisfactorily participate in PQRS, this failure guarantees they will also receive an additional 4% payment reduction under the VM program. These groups probably have a significant incentive to identify a successful PQRS strategy—one that requires their providers to exhibit high quality. The only practical strategy for accomplishing this is by using an EHR system. Use of an EHR that is certified for ambulatory use under Office of the National Coordinator standards may open a broader array of automated eCQMs that satisfy both PQRS and the need to demonstrate high quality for VM.

- Groups of 100 or more: All of the requirements for groups between 10 and 99 apply, in addition to another requirement—these groups must participate in the CMS GPRO program. This requirement will apply to groups between 10 and 99 in 2016. It’s perversely amusing that this is called an “option” when its use is mandatory. The problem with GPRO is its requirement that a sample of the practice’s patients receive a Consumer Satisfaction Survey—Consumer Assessment of Healthcare Providers and Systems. The mandate survey is designed for the use of ambulatory primary care practices (medical homes). Most of the questions...
WASHINGTON – Medicare Part B should pay physicians to administer vaccines in their offices, according to resolutions passed at the annual congress of delegates of the American Academy of Family Physicians.

The AAFP’s policymaking body voted to advocate that the Centers for Medicare & Medicaid Services pay physicians under Medicare Part B to administer the shingles vaccine and all other vaccines recommended by the Advisory Committee on Immunization Practices.

Payment should be retroactive to when the ACIP first recommends a particular vaccine, according to a resolution introduced by the New York State chapter.

The Mississippi delegation urged the delegates to approve a resolution to have Medicare pay for the cost of insulin pens, as many patients with diabetes and vision issues cannot appropriately use vials and syringes, which are covered by Medicare. The AAFP congress backed this resolution, also.

The congress also voted against advocating for a single-payer health care system, and referred to the AAFP board a proposal to rescind the marketing approval of the long-acting opioid Zohydro.

A hotly contested resolution called for the AAFP to advocate for a ban on diagnostic testing by pharmacists. An initiative in Michigan is allowing pharmacists to test for conditions like strep and then prescribe appropriate medications. The Michigan chapter urged the congress to take a strong stand against this expansion of scope-of-practice for pharmacists, saying that it would likely spread to other states.

Many delegates said that pharmacists did not have extensive clinical training and that patient safety could be jeopardized. Others said that they did not want to be viewed as engaging in a turf battle against pharmacists.

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are not appropriate for PA/LTC medical practices; patients and families are destined for confusion, and answers will place us in a bad light (e.g., low scores relative to ambulatory groups).

For 2015, groups using a 2014 certified ambulatory EHR and reporting PQRS via their EHR’s eCQMs should consider the following:

▶ It is critical to verify your EHR is up-to-date and using 2014 eCQMs. There are several versions of CQMs available – check with your vendor to determine that the ones in use are certified for 2014 PQRS reporting; those will work for 2015, too. An eCQM is eligible for use as a PQRS measure, but an individual PQRS measure is not an eCQM.

▶ Each EHR is certified for a minimum of nine eCQMs. The eCQMs are reported to CMS through your vendor or a special type of registry. The eCQMs don’t use CPT codes or CPT II codes as part of their definition. This is what prevents them from being reported like traditional PQRS measures.

▶ EHRs can also include traditional PQRS measures that are reported on claims or via registry.

▶ Plan your reporting strategy – you have to report on at least 50% of all eligible patients for the year. If you don’t start using your 2014 EHR early in 2015, you may miss hitting the 50% threshold, and that is particularly problematic for the influenza measure, which only counts patients seen from Oct. 1, 2014 to March 31, 2015. Meaningful use of stage 1 may only require reporting for 90 consecutive days during the year – that is a different threshold than PQRS’ full-year requirement.

▶ Remember that you have to have at least one patient in the eCQM for use as a PQRS measure, and at least one patient has to meet the measure’s performance test to use it as a PQRS measure.

This information was current as of October 2014. CMS’s final rule may alter these recommendations. If you want to engage in a more in-depth discussion for PQRS reporting, this is a topic AMDA is covering in the AMDA Health Policy Advisor, on the AMDA website, and at the 2015 AMDA annual conference.

Happy New Year!

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