PQRS 2015: How Your Practice and Patients Can Benefit from New Population Health Measures

written by Theresa Hush | November 18, 2014

Good news for providers who have criticized PQRS as mundane and want to improve assessment of patient outcomes and reduce gaps in care: Medicare's PQRS 2015 Rule is shifting away from rewarding fragmented quality services and toward population health.

With the expansion of the related Value-Based Payment Modifier (VBPM), every group can turn population health into higher Medicare revenues, so long as you have strong, patient-centric processes—and data capture. If you don't, you may suffer penalties.

What's a Cross-Cutting Measure and How Does It Work?

CMS has established a set of Cross-Cutting Measures to provide a broader evaluation of care provided by eligible professionals. The new cross-cutting measure reporting requirement for PQRS will also tie PQRS reporting to quality performance under the VBPM, which has been expanded to all practices (although only those with 10 or more providers may have a penalty risk in 2015).

The application of the measures works like this: A single patient seen in a face-to-face encounter will trigger a cross-cutting measure. Whether the provider reports PQRS individually or as part of a group, the same eligibility rule applies. Even if the provider is not a physician, a personal encounter means that the individual provider or group must report on at least one cross-cutting measure. Providers who use Measures Groups will also see that cross-cutting measures are part of the mix. Face-to-face encounters include all office visits—with specialists, too—as well as surgeries.

At the same time, Medicare is reducing or eliminating some measures that specialty groups have used as the backbone of PQRS reporting. These include two peri-operative antibiotic timing measures—including one for anesthesiology. Adopting cross-cutting measures in specialties, when feasible, will help specialists avoid PQRS non-reporting penalties and also better equip them to work in tandem in networks focusing on coordination of care.

How Many Patients Must Be Reported?

The required use of population health measures means that the number of patients who must be reported grows substantially. Even with the requirement to report at least nine measures across three National Quality Strategy (NQS) Domains, individuals and groups have had the opportunity to limit reporting to a small subset of patients. These providers will need to take a hard look at how the information required to complete these measures can be collected quickly, without upsetting workflow.

In some cases, performing well on these measures will require follow-up action (e.g. plan to reduce high blood pressure). This is often the most difficult part, as providers are often reluctant to focus on issues when they believe another physician is managing care. Medicare has acknowledged this, but says that cross-cutting measures will help to close gaps in care that may not normally be addressed.

What Are the Specific Cross-Cutting Measures?

Measures that make up the Cross-Cutting Measure Set include those that apply to all patients in a practice, as well as to patients with individual conditions. As you review these, note that they strongly align with Meaningful Use, ACO, HEDIS and measures more common to health plans. This is no accident—we are seeing Medicare step back and examine how to construct a program that has greater value for Medicare beneficiaries and builds on new technology incentives. NQS Domains are identified in subheadings; those without a Registry Reporting option are noted.

Effective Clinical Care

Controlling High Blood Pressure
Diabetes: Hemoglobin A1c Poor Control
Hepatitis C: One-Time Screening for Hepatitis C Virus for Patients at Risk

Patient Safety

Documentation of Current Medications in the Record
Falls: Screening for Fall Risk—EMR or GPRO Web Interface only

Communication and Care Coordination

Advance Care Plan
Closing the Referral Loop: Receipt of Specialist Report—EMR only
Functional Outcome Assessment for OT/PT
Medication Reconciliation Following Discharge
Pain Assessment and Follow-Up

Person and Caregiver-Centered Experience and Outcomes

CAHPS for PQRS Clinician/Group Survey—Certified Survey Vendor only

Community and Population Health

Childhood Immunization Status—EMR Only
Pneumonia Vaccination Status for Older Adults
Preventive Care and Screening: BMI Screening and Follow-Up Plan
Preventive Care and Screening: Influenza Immunization
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
Tobacco Use and Help with Quitting Among Adolescents

Who Will Benefit—or Not?

The effects of Medicare's action will hit groups unevenly in 2015, but there will likely be winners and losers. Here's the tally:

Groups that already have an EMR implemented, with good processes for capturing structural data, stand to gain from the shift to these measures. Their investment in technology may finally have a better payoff.
Patients also win, assuming the measures improve coordination of care. The fact that only one cross-cutting measure must be implemented in 2015 is not something for patients to clap about. But if this shift lays the foundation for Medicare's further adoption of outcome measures and population health, patients can look forward to more coordinated care.
Practices that start early in the year to ensure that they have good processes and data capture will fare well under the cross-cutting measures. Because population health reporting requires a larger patient data set and many of the new measures will fall on once-a-year patients, there will be no opportunity to make up the reporting shortfall later in the year.
Groups using EHR-direct reporting will have uncertain results, depending on the tools

available to them, to correct their data prior to reporting. Incentives up to 4 percent (or equivalent penalties) under the VBPM are only possible if reporting is successful and the group has better performance than others in the VBPM quality tiering process; in short, providers must be able to select measures that help them outperform other groups. An EHR-direct reporting that dumps all data to CMS will prove counterproductive. Also, some EHRs have no “early warning systems” to let groups know how they are performing prior to reporting in order to improve results.

Specialists will be challenged to do well under both PQRS and the VBPM. Given the trend toward elimination of easier procedural measures and adoption of population health, some specialties may have difficulty finding even nine measures in three CMS domains to report. The addition of population health measures will challenge some specialists to work successfully within the new system. If coding for patient visits for those with certain diagnoses is not done properly, CMS may attribute the patient to the specialist under the VBPM process, thereby making the specialist also responsible for all beneficiary costs.

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