How Medicare is Moving from PQRS Basics into Value-Based Care: Improving Outcomes with Plan of Care

written by Thomas Dent, M.D. | January 27, 2015

For a number of PQRS measures, Medicare requires that the provider document a Follow-up Plan or Plan of Care to demonstrate that appropriate interventions have been made to reduce risk. This has caused confusion and consternation among some of our clients who may not have clearly documented the follow-up plan or may disagree with Medicare on the plan's criteria.

Nonetheless, documentation of risk-reduction interventions is in keeping with CMS plans to transition all reimbursement into Value-Based Care, so it's essential to understand how to manage this process.

In fact, just this past Monday, January 26, Health and Human Services Secretary Sylvia Burwell announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients.

Given that initiative, what's the most effective way to use Follow-Up Plan or Plan of Care to boost performance and improve outcomes?

A little background: Medicare wishes to see providers "in action" when treating patients with the following risk factors:

- BMI outside of norm

Tobacco users
Women over age 65 with urinary incontinence
Elevated blood pressure
Depression
Pain
Falls
Open angle glaucoma
Elder maltreatment

For these PQRS measures, Medicare requires providers to document in the chart that a Follow-up Plan or Plan of Care was provided to patients falling into these risk groups.

Binary Reporting Responses Limit Analysis of Outcomes

These Plan of Care or Follow-up Plans make sense, because the provider should be trying to work with the patient to reduce risk and improve outcomes. However, this measure requires careful consideration with regards to both reporting and performance. Let's look in detail at how the requirement for Plan of Care or Follow-up Plans applies to the BMI (Body Mass Index) measure, within the Community/Population Health Domain.

BMI is an important intermediate outcome, so tracking and trending it should be part of outpatient quality efforts. Medicare has two ranges for acceptable BMIs, based on the age of the patient:

Normal Parameters

Age 65 years and older: BMI ≥ 23 and < 30 kg/m^2
Age 18–64 years: BMI ≥ 18.5 and < 25kg/m^2

Patients with a BMI outside of normal parameters must have a documented Plan of Care in the chart at the current visit or within the six months prior to the visit. There are several Plan of Care options to choose from:

Documentation of Education

Referral (e.g., a registered dietitian/nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional or surgeon)

Pharmacological Interventions

- Dietary supplements
- Exercise counseling
- Nutrition counseling

Here's the issue: The existence of a Plan of Care is reported as a simple yes or no. But for a provider to be effective in initiating and assessing improvement in the BMI, the measure should capture more granularity regarding what was actually recommended to the patient.

Assess Plan of Care Effectiveness Over Time

This raises a few questions: Shouldn't the measure require follow-up to see if the Plan of Care actually had an impact at the individual or the population level (either good or bad)?

In addition, if the specific Follow-up Plan is known, should the same Follow-up Plan be allowed year after year if there is no noticeable improvement? This means that yearly BMIs should be captured and trended at the patient, provider and practice level.

Speaking of noticeable change, shouldn't the BMI be a continuous variable and require a value? This could be reported using an absolute value, as is required for HGBA1C for ACOs, or just using ICD-9 codes that provide individual BMI values up to 40 kg/m^2 (and thereafter at 10 kg/m^2 increments, up to 70 kg/m^2). This would at least allow the provider to determine if there was incremental improvement, which is not possible when the cut-off for high values is > 25 kg/m^2 (or if patient is 65 year or older, > 30 kg/m^2).

Aside from these issues, the BMI measure is commendable for listing several good exclusions for when a BMI Calculation or Follow-up Plan is unnecessary:

- Patient is receiving palliative care
- Patient is pregnant
- Patient refuses BMI measurement (refuses height and/or weight)
- Any other reason documented in the medical record by the provider why BMI measurement was not appropriate
- Patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient's health status

To be most useful, these exclusions should also be captured individually, rather than in the aggregate.

Reporting is Only Half the PQRS Equation

It is worth remembering that two measurements occur with PQRS—reporting and performance. Reporting at 50 percent or greater of eligible patients is necessary to satisfy the measure requirement for PQRS; credit is given for saying either that the BMI was not measured or a Follow-up Plan was not given to the patient with a BMI out of range. However, to meet the performance standards, the BMI must be in range or, if not, the provider must document a Follow-up Plan.

Performance is what is measured for the Value-Based Payment Modifier, which rewards only those practices that outperform their competition on quality and cost, and penalizes those that fall below average. If patients are excluded from the measurement, there is no adverse impact on the performance score.

Performance and, most importantly, performance improvement efforts are at the core of Population Health and Medicare's new Value-Based Health Care plans. To help providers improve outcomes, BMI and other similar measures with Follow-up Plans must move to more specific reporting on details of the plans and, ultimately, on why they succeed or not, based on both provider and patient feedback, as well as structured interventions.

Founded in 2002, ICLOPS has pioneered data registry solutions for improving population health. Our industry experts provide comprehensive PQRS Reporting with VBPM Consultation and Population Health with Grand Rounds, solutions that help you both report and improve your performance. ICLOPS is a CMS Qualified Clinical Data Registry.

Contact ICLOPS for a Discovery Session.

Photo Credit: SeRVe Photography via Compfight cc