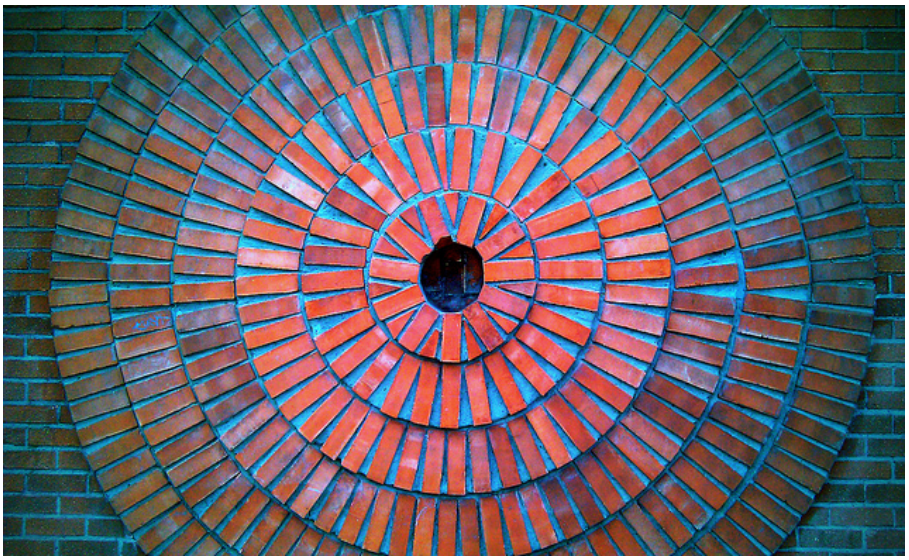
Does Your EMR Tell Medicare the Right Story About Your Patient Quality?

written by Theresa Hush | June 10, 2015



Reporting physician quality to Medicare through an EMR is an easy and affordable approach—at least on the surface. But be careful when using EHR Direct Reporting for PQRS 2015, so you don't cost your organization as much as 4 percent in Medicare penalties or create an unappealing profile of your quality in Medicare's public reporting.

Navigating successfully through the maze of Medicare's new Value-Based Purchasing requires a thorough understanding of how all the different reporting and performance programs interact. Unless you have a good grasp of how your EMR reports your quality data, you risk setting yourself up for costly failure.

The Four Ways to Report Physician Quality to Medicare

Setting aside differences in the actual quality measures and whether you report as individual providers or as a group, there are essentially four different avenues for submitting quality data to Medicare to meet PQRS requirements:

Report to Medicare through codes you provide with claims;
Report all of your measure data through your EMR;
Submit your own data for the patient sample assigned you by CMS under the Group Reporting Web Interface option;
Report through a Registry.

While many practices originally used the claims option, that choice triggered a lot of surprise letters from CMS last December, applying penalties for inadequate PQRS reporting. Those unwelcome letters revealed the big problem with reporting on your own—no way to know

whether you've reached the Medicare reporting and performance targets. In response, many groups scrambled for EMRs or a Registry to give them better results at the end of the reporting year. But those two methods are quite different, each with distinct advantages and disadvantages.

Why EHR Direct Reporting Is Efficient and Easy, But Can Impact Your VBPM

When your EMR submits quality data to Medicare, they send all the quality data in your system that's been programmed to quality measures. *As long as your providers are tracking quality measures through the EMR,* using the EMR to capture this data is a fine idea, because it's essentially automatic. You also usually don't have to do anything extra for the EMR to send the data.

But, there are three disadvantages to using EHR Direct Reporting. The most important is how you will fare under the CMS cost-quality scores under the Value-Based Payment Modifier (VBPM) compared to other groups of your size category. For groups over 10, you could face a penalty of 4 percent if your performance on quality and cost compare unfavorably with other groups' performance. This isn't your EMR's fault, but simply a byproduct of the reporting method.

Why is this a uniquely EHR Direct Reporting issue? Because EHR Direct does not selectively send best-performing measure data to CMS—it sends everything. Let's examine how this works:

Let's say that your group of 125 providers is multispecialty and that the patients are triggering 50 PQRS measure criteria, such as office visits during the calendar year, Medicare Part B coverage and diagnosis. The patients' results on all of those measures will vary widely between measures, and some of the aggregate results are below the Mean that CMS has calculated for all groups in your size category, over 100 providers. By reporting all measure results, your EMR has inadvertently lowered your aggregate performance. When CMS compares your results against other groups for the VBPM, your results could earn you a penalty.

A second disadvantage is that most EMRs do not have an ongoing method of showing groups how they stand with completion and performance on their quality measures. So whether your providers are actually tracking quality measures through the EMR is an unknown, unless your EMR has a Registry component that displays it. That means that you could be putting yourself at risk of non-reporting without knowing it, and you have no method of correcting the situation before the end of the year. For some, the convenience of EHR Direct Reporting comes at the cost of proactively working toward success.

Finally, unless you have an ongoing effort to monitor data and measure validity in your EMR, and unless you have seen measure results, you're leaving a lot to chance regarding how well your EMR has mapped the data to CMS Measure responses. EHR Direct Reporting does not get you off the hook for understanding and evaluating your real patient quality, so it's a good practice to review this data regularly.

How Registry Reporting Optimizes All Medicare Value-Based Revenues, If You Choose Wisely

Registry Reporting gives you the advantage of ongoing monitoring and validating of your quality data and patient outcomes. And more importantly, you can select measures to report to Medicare that will create the most beneficial calculation of your group's performance compared to the CMS mean, assuring you of not facing penalties under the VBPM. You can also make corrections or additions in data up until the Registry finalizes its reporting, based on the gaps you see in the data.

But, not all Registries are equal. Some Registries limit measures for reporting, and some act as portals, reporting only Measures Groups and relying on your correct and complete input of data. So you need to be very careful in your selection if your goal is not simply to avoid a PQRS non-reporting penalty, but to avoid all penalties—or, better yet, achieve an incentive—under other programs such as VBPM.

To get the most of Registry Reporting, you should evaluate the most important characteristics that will ensure flexibility and fit with your current quality programs. These are some features that will optimize your Medicare revenues:

> EMR and Practice Management Data Aggregation: You've invested in the EMR, so you should be able to take advantage of its wealth of data. Select a Registry that can collect and use data from your EMR inexpensively.
> Group Practice Reporting Option (GPRO): This is an important tool for evaluating your group performance. Make sure your Registry is authorized for GPRO, even if you decide it is not your best method of reporting, because VBPM data is evaluated on a group basis; displaying your data by the group will give you a good indication of your VBPM comparisons.
> Authorized for Reporting Measures and All Specialties: A Registry that limits measures may make it harder for you to submit high-performing measures to Medicare. To maximize your VBPM results, ensure that your Registry covers everything.
> VBPM Consultation: If your Registry also has consultation services to evaluate your Medicare QRUR reports and recommend actions to improve your quality or cost score, this is a definite plus to improving your results. Only by evaluating your QRUR data, as

well as your source data, can a Registry make good recommendations on the measures you should actually report so that you are in the upper quartile of the CMS rankings.
VBPM Measures: Additional Registry features that help you improve your VBPM comparisons, such as ambulatory care sensitive conditions, are a good investment, but most registries will not have them. Your goal for Medicare should go beyond PQRS now, or you will continue to be penalized under the VBPM.
QCDR Authorization: A Qualified Clinical Data Registry gives you an additional mechanism to report quality to Medicare as part of your all-patient quality initiatives. Not all Registries are qualified as QCDRs, and reporting this way does not mean that you can sidestep the VBPM process, as these programs are separate.

Before You Choose a Reporting Mechanism, Ask These Key Questions

You can successfully navigate the Medicare Value-Based Health Care terrain. But pay close attention to whether your choice of reporting mechanisms meets all of the individual programs simultaneously. The devil is in the details.

Here are five questions to ask your EMR and prospective Registry before you decide which method is best for you:

Is it possible for the vendor to submit selective measures to Medicare based on your performance?
How can you monitor your reporting and performance before the submittal date?
How can you validate the data being sent to Medicare?
What services are offered to guide you in measure selection?
What measures are available for reporting through the specific EMR or Registry, and what measures are not?

Download your free copy of the ICLOPS *Insider's Guide to PQRS 2015 Reporting: How to Succeed in the Value-Based Health Care Environment.*

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