How to Turn 2016 PQRS Success into Better Care (and a MIPS Win)

written by Dave Halpert | March 1, 2017

March has arrived. The submission window for PQRS shuts on March 31. It's the moment of truth for providers, practices and Registries. Are you ready to report, ready to panic or somewhere in-between?

It's probably too late to implement an initiative designed to improve your PQRS measures, but with the right Registry partner, there is still a path to 2016 PQRS success, even if you aren't "PQRS Ready." More importantly, if you follow these three steps, you'll also create a pathway to success in the Quality Payment Program (either through MIPS or an APM)—both by avoiding penalties, as well as tailoring the new program around your ability to improve patient care.

Step 1: Review Charts and Documentation

If you are short of the reporting requirements, scour your patients' records and use your

Registry or QCDR to add responses in cases where they were previously missed. For those in this group, work quickly, but be careful! The text in the measure title may be misleading, so you should read the measure specifications carefully before entering your response. These documents include definitions and guidelines, and some are very strict.

For example, "shared decision making" prior to a procedure isn't just a documented discussion with a patent—by attesting to having completed this measure, you are stating that there is documentation of "empirical, personalized risk assessment based on the patient's risk factors with a validated risk calculator using multi-institutional clinical data," and that you can produce the name of the risk calculator you used. Not only that, all of this was discussed with the patient and/or patient's family.

When CMS audits records (and they do), if you are unable to produce the documentation that the action was performed, you may fail the audit, which would enable CMS to recoup incentive money or retrospectively penalize practices.

Yes, the measure is complicated, but it's a great example of one that can make a difference to a patient and to the patient-provider relationship. Clinicians, consider past instances when you have performed a procedure with an optimal outcome, only to find that the patient and/or family are still upset with the results. All too often, patients and family members feel unprepared for the effects of a procedure, either in the short-term (post-operative delirium) or the long-term (ongoing pain levels, range of motion, necessary lifestyle modifications, etc.). This disconnect between providers, patients and their families is a perfect example of how a quality measure can be used to fulfill a program's requirements as well as improve patient experience and care.

Step 2: Confirm Providers and Results

Double-check your participation list, and not just by looking at names and spelling. In both PQRS and MIPS, providers are defined by the combination of two numbers: individual provider NPI and practice Tax Identification Number (TIN). This is different from Meaningful Use, so make sure that providers are identified correctly, using each program's rules. Fortunately, that conflict will end for the 2017 MIPS performance year, as the Quality component (formerly PQRS) and the Advancing Care Information component (formerly Meaningful Use) are now under the same program.

Once you've confirmed who is under measurement, look closely at the results. Are measure denominators reflective of your practice? Do they appear to be tied to the correct providers? Look at the measure specifications before responding, as each requires a different set of

denominator criteria, and these result in some quirks. For example, a provider may have a large population of patients with asthma, but a comparatively smaller group who are between the ages of five and fifty and on Medicare Part B. Checking to see if the services provided match the types of measures being reported can help to confirm that data is flowing correctly from the point of care to data submission . . . or not. For instance, if primary care providers are reporting on surgical measures, that should raise a red flag.

Isolate and resolve these issues now, as they will become exponentially more difficult to fix in coming years. This will be critical for your next step:

Step 3: Strategically Select Measures (and Understand the Implications)

There are almost 200 measures with Registry Reporting options and PQRS, and even more under MIPS; remember that what you report has implications beyond PQRS.

For the 2016 PQRS, CMS will use your performance compared to others on those measures in order to categorize you as high, average or low quality, which will account for half of the calculation behind your Value Modifier in 2018. This can have a positive, neutral or negative impact on your reimbursement rates. In 2017, the process is similar—the 2017 reporting period will affect 2019 reimbursement—but it will all be under MIPS, rather than the multiple (but related) programs.

You should also consider your public profile. CMS is expanding what is available on the Physician Compare website, including the measures that were reported for PQRS. Reporting on measures that are not clinically relevant may be easier for you in the short-run, as there are likely to be fewer patients in the denominator. In the long run, however, you may find that you've damaged your public image and made yourself less appealing to patients compared to similar practices.

How? As Physician Compare becomes more robust, it will become a research tool for patients and families seeking clinicians who specialize in a particular type of care. Newly-empowered patients will be able to see what measures providers have reported, as well as quality results. When looking side-by-side at providers who perform those services, a patient will more likely find comfort in seeing that the provider has voluntarily reported on related metrics to the government, compared to one who did not.

Under MIPS, patients will have even greater access to quality and outcomes information. MIPS requires that at least one outcome measure or high-priority measure is reported, which will

make it more challenging to stand on the results of process measures—which, in many cases, are measures of documentation, rather than of care. The goal of MIPS is to break free of this trap, giving patients the ability to dig deeper.

Rather than looking at anecdotal evidence online, they can, for example, browse potential surgeons to see who had a higher rate of unplanned re-admissions within 30 days. Outcomes data is far more illuminating than seeing the rate at which antibiotics were discontinued in a given timeframe, which is often a standing order. This outcomes data will be even more comprehensive than PQRS, as MIPS requires reporting on all patients, which will help to standardize results. Reporting outcomes for a larger patient pool may eliminate many provider and patient complaints that a Medicare-only program is only important for Medicare patients, and that different standards of care are in no one's interest when trying to improve the health care delivery system as a whole.

Learning from 2016 PQRS

There is an important distinction here—succeeding in 2016 PQRS may be largely retrospective, but there are lessons to learn from PQRS that will help you succeed in MIPS. More importantly, MIPS can offer clinicians the opportunity to use quality measures as tools to improve patient care, rather than as administrative documentation templates. Done right, MIPS success will also mean healthier patients.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Thomas Richter