PQRS Homestretch: Finish Line In Sight (But You Haven't Crossed It Yet)

written by Dave Halpert | November 30, 2016

It's almost time to bid farewell to PQRS (formerly PQRI), and say hello to the Merit-based Incentive Payment System (MIPS). But PQRS hasn't ended yet; even when it does, financial implications will not be felt until 2018.

Those who do not report PQRS are at risk of being penalized twice, once for PQRS and once for the Value Modifier (VM). Those who do report may earn incentives, penalties or be held neutral, depending on cost and quality results. Ideally, you are already using PQRS as a stepping-stone to succeed in the Quality Payment Program, but even if you haven't, there are still steps you may take to avoid PQRS and VM penalties in 2018.

What Is Still Possible?

Some doors have already closed. New initiatives are unlikely to impact PQRS reporting or

performance under the VM. Now is a great time to start planning for MIPS or your Advanced Alternative Payment Model (and most importantly, for your patients!), but there is not enough time to improve performance at this stage for a 2016 calendar-year program (like PQRS).

For those who have striven all year (and maybe longer) to demonstrate improved outcomes, what have you seen? This is the point where you should be taking stock of what you tried and determine whether or not it worked.

Did you spend an exorbitant amount of money on services and staff, only to see flat-line outcomes? If so, stop and regroup. If your patients did improve, congratulations! Your job now is to replicate what worked, and lay the groundwork for implementing an Advanced Alternative Payment Model (APM). Those who can move into this group have the potential to earn incentives through your APM's payment structure (e.g. Shared Savings) and through the lump sum bonus paid to Qualified APM participants.

Regardless of whether you identify with the first or second group, however, you haven't crossed the finish line yet. To avoid forfeiting the gains you've made, pause and confirm that no hidden pitfalls lurk between you and PQRS success.

Verify Your Reporting Method

Do you know whether you are registered for Group Practice Reporting? If so, what method did you select? While there are advantages to Group Practice Reporting, this option is not for everyone, and many practices chose to report as individuals.

Here's the catch: What's best for you and what's been selected (or not selected) don't always coincide. Each year, there are some practices that plan on Group Practice Reporting but never register, or think that they're reporting as individuals, only to learn that someone registered them as a Group. Be sure to confirm which method has been selected, as the requirements differ for each.

Note, too, that a successful Group Practice does not automatically mean its individual providers are successful, if graded individually. Likewise, a collection of successful individuals does not mean that, if a Group Practice submission is suddenly required (e.g. a submission error linked to an individual NPI who should be submitted in a Group Practice), that the submission would be successful.

You can confirm your reporting method by using your EIDM account to log into the CMS enterprise portal to confirm how CMS expects you to report. Those who registered as Group Practices should also have received an email indicating that registration was successful and the

method that their Group Practice will be using to submit (Registry, QCDR, EHR, Web Interface). If you find that your selection in June doesn't look good now (e.g. you picked EHR-Direct and learned that your EHR was not offering that service), contact the QualityNet Help Desk right away. Even if you find yourself in this position, you can still make a successful submission, but only if you catch this early.

Remember the Administrative Tasks

If a vendor is submitting data to CMS for PQRS on behalf of your providers (either as a Group Practice or as individuals), CMS requires that the vendor have your authorization on file—we are not allowed to submit without this information. If reporting as individuals, each individual provider must sign off. Groups are only required to have one authorization, at the TIN level. If you have a large group of providers reporting as individuals, it can be a challenge to get authorizations from each—the sooner they've been completed, the less likely it is that a provider's submission will need to be withheld.

You should also double-check that your vendor has accurate individual NPI numbers and practice Tax Identification Numbers. This is the only method that CMS uses to identify providers for PQRS, and one transposed number can mean the difference between a successful submission with potential Value Modifier incentives and a pair of automatic penalties for PQRS and the VM.

Finally, confirm that your vendor has the same provider list that you have in PECOS, and that these lists sync up with claims billed under your group's Tax Identification Number. CMS uses PECOS and claims to determine who should be reporting for PQRS. When you, your vendor and CMS are all working from the same list (including identical NPI/TIN numbers), penalties may be avoided.

Ensure that Reporting Meets Requirements

Did you know that, if reporting via QCDR, you need two outcome measures, or an outcome measure and a high-priority measure? or that your measure denominators must include all patients?

If reporting via QCDR or Registry, did you confirm that the measures you are reporting this year (and the data needed to fulfill them) reflect any changes made by CMS and Measure Developers?

Some measures moved from one Domain to another; some have been revised and require different information, or may even include different patients. One measure (Measure #24, Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for

Men and Women Aged 50 Years and Older) has seven pages worth of changes in the 2016 Release Notes!

Your takeaway: make sure that your reporting is not only complete, but also meets this year's program requirements. Those requirements range from the macro-level (variable reporting requirements, depending on reporting mechanism) down to the micro-level (individual measure numerators), and it only takes one error to derail a successful submission.

Monitor Results

Ideally, you know where you have fulfilled requirements and where additional effort will be necessary. This is the time to plan and document the concrete actions that will take PQRS from "work in process" to "complete." Here are some questions to guide you:

> Will you need manual input to bring measures up to the 50 percent completion target? If so, whose job is it to add this information, and what support will be required?
> Will you be able to achieve performance targets in your measures, or will you need to find substitutions?
> Does the data interface between you and your vendor reflect the results you would expect? If you are missing anything, is it more likely a gap in care, or a gap in data? If the former, it may be too late. There may be time to fix the latter.

A final word of caution to those who are reporting individual measures, either as individuals or in a group practice: *measure denominators must reflect what has occurred during the calendar year.* It may look like you're all done in December, but there are still denominator-eligible instances that can change your numbers. If you've completed 50 out of 95 patients, your completion rate is above target. However, if ten more patients become denominator-eligible in December and are not addressed, your completion rate for that measure dips below 50 percent. Claims rejections, corrections and re-submittals will continue to affect 2016 denominators into 2017, so don't begin to celebrate until you've actually crossed the finish line.

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