2016 Medicare Final Physician Payment Rule: What You Must Know

written by Dave Halpert | November 18, 2015

CMS's push toward value-based care and performance improvement leaves no more room for doubt. In a hefty 1,358 pages, the 2016 Medicare Final Rule expands the role of Qualified Clinical Data Registries for PQRS reporting, dovetailing with the Specialized/Clinical Data Registry component in the Meaningful Use Rules.

Both methods place the focus squarely on how outcomes change over time, across all patients. Tracking outcomes and measuring improvement are no longer optional. Here's what you need to know:

QCDRs Get GPRO Submission Status

As expected, the differentiation between the Final Rule and the Proposed Rule is minor; the most important change for PQRS—the allowing of Qualified Clinical Data Registries (QCDRs) to submit using the Group Practice Reporting Option (GPRO)—has been finalized (p. 752). QCDRs are distinguished by their ability to go beyond simply reporting pre-defined metrics to track outcomes over time, and play a significant role in performance improvement.

Importance for PQRS/VBPM

Adding this option for GPRO is big news for any group that wants to fulfill PQRS requirement using a set of non-PQRS measures, but that isn't willing to risk dissolving the alignment created by group-level reporting. This is particularly true for academic medical centers and other organizations engaged in research, already tracking outcomes over time. Quality departments

go to great lengths to ensure that any and all necessary steps are taken to differentiate their providers from the pack.

In these situations, PQRS (and other programs) are often seen as a nuisance, or worse—diverting efforts and resources away from the larger goal. Bringing QCDRs into the fold, groups can now leverage existing quality efforts, fulfilling PQRS requirements without diverting energy away from other programs.

Importance Beyond PQRS/VBPM

The term "Clinical Data Registry" (or CDR) has made a splash in recent months with the updated rules to Meaningful Use, specifically within the Public Health reporting component. In order to show that you are "meaningfully using" your Electronic Health Record, you must submit data to other entities—not just Clinical Quality Measures (CQMs) to Medicare. One of the options is a Specialized Registry, a precursor to CDRs that can track outcomes and utilization over time.

QCDRs and CDRs look at all patients, not just Medicare Part B. Value-based care is being pushed globally—tracking outcomes and measuring improvement will not be limited to one set of patients. By augmenting QCDR capabilities into PQRS while simultaneously bringing the CDR concept into Meaningful Use, Medicare is steering these programs according to its strategic vision for future value-based care programs, particularly toward these four goals:

> Feedback and data drives rapid cycle quality improvement;
> Public reporting provides meaningful, transparent and actionable information;
> Quality reporting programs rely on an aligned measure portfolio;
> Quality reporting and value-based purchasing program policies are aligned.

VBPM On Its Way Out as a Separate Program—But Quality Tiering Still Impacts Revenues

CMS has pushed major changes in recent years, and even greater changes are on the horizon. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) has already mandated that 2018 will be the last year of the Value-Based Payment Modifier, and it will be tied to PQRS in 2016. It's no surprise that many commenters asked CMS to refrain from making any major changes to PQRS and VBPM. With the exception of the QCDR-for-GPRO provision (which is an advantageous alternative to providers), CMS essentially complied, stating, "We believe these final requirements address these commenters' desire for stable requirements" (p. 740).

Nevertheless, you should not put your program to bed—it will continue to impact your revenues. If you haven't started your program yet, you need to be sure that you fulfill reporting

requirements in 2015. Realistically, it may be too late to make a substantial change in your performance this year, but by getting your processes in place, you will still have a chance to capitalize on quality tiering next year.

What Do You Need to Do in 2016?

1. Fulfill PQRS Reporting Requirements.

There are going to be 281 available measures for the 2016 program year. Some are only available for measures groups, others only for Registry reporting, while still others can only come via EHR-Direct submission.

Some groups have had a particularly challenging reporting year in 2015, especially anesthesiology and emergency medicine. Here's the good news: the proposed measures went through, which will make it much easier for you to report in 2016. Other specialties with new measures include neurology, radiology, and uro-gynecology/oncology.

Each method has its own set of rules, so make sure you are reporting correctly. The general requirements are unchanged, but Medicare will once again take those who fulfilled PQRS reporting requirements and apply its tiering methodology on cost and quality to calculate each group's VBPM.

If measure requirements are not fulfilled, CMS will continue to utilize the Measure Applicability Validation (MAV) Audit to determine whether additional measures could have been reported. If the MAV reveals that other options were available, the PQRS non-reporting penalty and maximum VBPM penalty are immediately assessed (unchanged from 2015 PQRS/2017 VBPM):

PQRS Non-Reporting Penalty: 2 percent
VBPM Maximum Penalty (1-9 providers): 2 percent
VBPM Maximum Penalty (10 or more providers): 4 percent

Reporting Requirements: Individual Measures, whether as a Group Practice or individual provider:

Report/complete a measure for at least 50 percent of denominator-eligible instances (check the spec to see if instance=patient, or if a patient may be denominator-eligible multiple times). Measures must be in at least three of the six National Quality Strategy (NQS) Domains, and include at least one cross-cutting measure (there will be a few more options in 2016). Measures with a zero-percent performance rate will not be counted, unless that measure's performance is calculated inversely. If reporting using a QCDR, your measure profile must also include two outcome measures.

Reporting Requirements: Measures Groups

Although the measures may vary, and several new groups were added, requirements remain constant. Those utilizing this option must complete all of the measures within a group for at least 20 patients. Of those 20, at least 11 must be Medicare Part B. As has been the case for several years, each patient must have at least one measure where performance was met, and across the group, each individual component measure must have at least one instance where performance was met.

2. Understand how VBPM Ties to PQRS.

VBPM will apply to everyone, regardless of group size, and this includes Quality Tiering. No one will be "held harmless" in the VBPM for simply reporting for PQRS, even solo practitioners. CMS explicitly states that, with MIPS on the way, it is important to maintain upward, neutral and downward tiering to prepare practices for what's ahead, particularly as the amount at stake continues to rise.

To calculate the Quality Composite for VBPM, Medicare uses your PQRS measures, along with a set of measures calculated by CMS from its claims. PQRS performance is compared to national benchmarks. According to the rule, "the benchmark for each cost measure is the national mean of the performance rates calculated for all groups and solo practitioners that meet the minimum number cases for that measure" (p. 1049).

In other words, there is no specialty or volume adjustment, other than the informal intrinsic limitation to those with enough patients in the measures' denominators. Other measures are related to attributed patients (the two-step method remains in place), focusing on Ambulatory Care Sensitive Condition (ACSC) Admissions and All-Cause Re-Admissions.

Cost Composites are, and will continue to be, calculated by tracking costs for services received by your group's attributed patients. These are broken down into groups: All beneficiaries, and beneficiaries with one of four chronic conditions (diabetes, heart failure, COPD, CAD). In addition, Medicare uses the Medicare Spending Per Beneficiary (MSPB) Measure. However, in the 2016 Rule, Medicare has raised the denominator for eligibility to 125 cases.

The Final Rule establishes the same maximum and minimum tiering amounts and sliding scale for groups, according to whether cost and quality composites are high, average or low, respectively. High quality and low cost groups are eligible for the highest incentive, with groups at the other end facing the largest penalties:

> VBPM Range (1-9 providers): From -2 percent to +2 x Adjustment Factor

VBPM Maximum Penalty (10 or more providers): From -4 percent to +4 x Adjustment Factor

3. Remember that ACO Does Not Guarantee PQRS/VBPM Success.

If your ACO reports successfully (and most do), you are exempted from PQRS. However, if your ACO is among those who fail to avoid PQRS penalties, the Final Rule states that you will be put into the dreaded “Category 2”—those who are penalized for both PQRS and for VBPM.

Of course, it’s not that simple—CMS has tied your ACO’s quality composite to VBPM, as well. CMS reiterated its VBPM-ACO link from the previous rule, stating that if a group is in an ACO, their VBPM will be comprised of the ACO’s quality composite and an “average” cost composite (p. 997).

While this link remains in effect, there was one change that CMS enacted that will surely be well-received by providers: If a group is participating in more than one ACO, for VBPM, CMS will use the highest numerical score for that group’s quality composite (p. 999).

4. Don’t Ignore Your Feedback!

Medicare has left the “informal review” process in place for 2016, and once again, the time period will commence with the release of QRURs, and will remain open for 60 days. In addition to helping you plan for the following year (and make any potential last-minute adjustments), CMS will alert you to potential penalties.

Feedback reports are improving, and CMS wants to hear from you about how to continue this trend. Those who have downloaded the Annual 2014 QRURs will see that the reports have been significantly upgraded from the 2013 versions. This reflects the final component for CMS’s strategic vision: “CMS quality reporting programs are guided by input from patients, caregivers, and healthcare professionals.”

In other words, learn from CMS’s feedback, and then provide your own. This is a pivotal year for CMS reporting programs, and the concepts will hold, regardless of the name given to the next iteration.

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