

# Top 10 Ways to Improve Your Physician Quality Reporting System/Group Practice Reporting Option



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In April 2015, President Obama signed the Sustainable Growth Rate (SGR) formula repeal legislation. Originally, the SGR was calculated by linking Medicare expenses to economic growth, and Congress simply passed “doc fixes” to keep Medicare reimbursement at a steady rate.<sup>1</sup> The new legislation, on the other hand, has changed the payment methodology entirely; beginning in 2019, physician payment will be tied to value-based payment structures.<sup>1</sup>

Whether physicians join an alternative payment model (APM) or get placed into a Merit-Based Incentive Payment System (MIPS), they will have to complete the Physician Quality Reporting System (PQRS) or the Group Practice Reporting Option (GPRO). Both are quality metrics submitted to the government, which encompass patient experience, chronic condition management, and population health arenas so that reimbursement can be tied to performance.<sup>2</sup> The only difference between the quality metric programs is that when physicians are in an APM like an accountable care organization, they report as one entity via GPRO rather than individually reporting via PQRS.<sup>2</sup> If a physician is reporting PQRS the results will dictate the physicians’ fee schedule for the subsequent year.<sup>2</sup> If physicians are reporting GPRO, then the portion of shared savings attained will be adjusted based on the overall metric reporting.<sup>2</sup> Since this reporting is universal for Medicare providers, it would be of best interest to adopt processes that will guarantee the highest possible quality outcomes to receive increased payment. Listed below are 10 proactive ways to accurately improve your PQRS/GPRO in an effort to succeed in the value-/merit-based world:

## 1. Obtain Your Quality and Resource Use Reports

Since 2014, every Medicare-paid physician has a Quality and Resource Use Report (QRUR) that can be accessed by their Taxpay-

er Identification Number (TIN) through the Provider Enrollment, Chain, and Ownership System (PECOS).<sup>3</sup> This is how the CMS ranks a physician’s performance against other physicians in the market. The value modifier that dictates how independent physicians are paid is determined by measuring performance quality indicators (PQI) for up to 6 quality and 2 cost domains via claims data, then computing benchmarks for quality and cost based on prior-year performance, standardizing the performance scores, calculating composite scores for average TIN performance, and then categorizing the TIN by performance as high, average, or low.<sup>4</sup>

In order to succeed, one must know which category they are in so as to make the proper fixes either in quality and/or cost/utilization measures, as necessary. Once a physician is aware of their performance, as viewed by the government, they must begin to change their work flow and processes in an effort to keep the fee schedule positive. The QRUR may prove to be disheartening to many since it is scored on a curve, which, by definition, means that it is rare for a physician to be one deviation away from the mean. In an effort to reawaken the competitive nature that exists within each physician, administration and physicians should obtain and interpret these reports. Tierney et al discuss how data transparency to physicians can dramatically change their behavior for example, when physicians are shown the actual price of the labs they are the ordering, they tend to order fewer than when the cost is undisclosed.<sup>5</sup> The QRUR is a first step in the creation of transparency.

## 2. Decide If You Would Do Best in MIPS or APMs Because of Value-Based Modification in 2017

MIPS is similar to the old fee-for service payment structure, except the government is going to gradually adjust the reimburse-

ment based on the physician's quality scores, meaningful use attainment (relating to use of electronic health records), and practice efficiency and improvement. Improvement will be measured either against the physicians' previous years' performance or against the performance of the physicians' peers. By 2019, physicians enrolled in MIPS can experience a payment range from a down swing of 3.5x% to an upswing of 4.5x%, which will incrementally increase to  $\pm 9x\%$  by 2022.<sup>6</sup>

If a physician chooses to get paid by an APM (like an accountable care organization [ACO]), they will be entitled to the highest possible reimbursement. An automatic 5% bonus will be added to the fee schedule just for being in an APM, and an additional upswing can be added if the practice is a certified patient-centered medical home. Since this model has the potential for the higher reimbursement, it also has the largest risk because earned shared savings will not be returned if metric standards are not met and even if they are met, if it is not 100%, then the ACO will receive a portion relative to the quality score.<sup>6</sup>

### 3. Ensure Patient Access to the Office to Accommodate an Increased Volume of Annual Wellness Visits

Medicare introduced the annual wellness visit (AWV) to incentivize physicians to conduct preventive screenings and help beneficiaries to become healthier. Results from the AWV are used to create an individual care plan for the patient, which can be edited any time that medically relevant changes occur. The majority of AWV can be delivered by a nonphysician practitioner, which allows the physician to have more time to deliver an associated plan and generate additional income.<sup>7</sup> Besides the obvious income quickly generated from the AWV, it easily captures 11 of the 33 quality measures required for PQRS/GPRO. If less than 70% of a physician's patient panel does not have the AWV completed by the end of the year, then the chances of having enough quality metrics completed to get paid the shared savings in full can have decreased dramatically. Completion of the AWV is a key performance indicator for any group taking on risk because the physician cannot be deemed accountable for their panel unless they regularly keep track of preventive screenings and wellness domains. Lastly, because the AWV reimburses at a higher fee than a normal evaluation and management visit, Medicare is more inclined to assign those patients to the physicians who have completed AWVs. Physicians need to keep their attributed patients within the panel for better risk-taking abilities.

Once the physician understands the importance of the AWV, the next step is making sure there is enough access for the patients to make the appointments. Offices that cannot schedule appointments within 3 weeks of inquiry will most likely not be able to accommodate extra AWV appointments. For those offices that experience a lack of access due to high patient volumes and an insufficient amount of staff or patient rooms to carry out such operations, perhaps the physician should consider outsourcing the service. There are many external vendors in the field that will hire a physician extender practitioner from the community and have them use an office within the physician's practice for AWVs exclusively. In addition,

many of the vendors are willing to be paid retroactively by taking a portion of the reimbursement the physician would be getting if they completed the AWV themselves. Even though using a vendor diminishes the revenue, the physician is still benefitting from the attribution and completion of quality metrics, which would not have been done otherwise.

### 4. Make Your Denominators More Accurate in PQRS/GPRO

There are a few quality measures that can be impacted greatly by understanding the true metric.

*ACO PQI #9.* Measure 9 is for ambulatory care-sensitive conditions: admissions for chronic obstructive pulmonary disease (COPD) or asthma in older adults. This metric is a ratio of observed to expected discharges of patients with COPD/asthma. A score lower than 1.00—the highest possible score—indicates that the rate is low, which is ideal.<sup>8</sup> A common issue with this quality metric seems to be that the ratio is too high because physicians are identifying the denominator (expected discharges from an acute care hospital with COPD/asthma in a patient aged >40 years) only when a patient already has an admission with the principal diagnosis of COPD/asthma.<sup>8</sup> In order to have a lower number for the metric, one must increase the denominator, which means that the physicians need to accurately diagnose their patient population with COPD/asthma and not just capture the diagnosis once they have already been admitted.

The one way to appropriately increase the correct diagnosis of COPD/asthma of the patient panel is by stratifying the population by those who have been marked on the AWV as a smoker. All smokers who have been asked if they are ready to quit and those who have indicated “no,” should be prescribed a pulmonary function test. Showing a smoker that their lung function is frighteningly low and that each year it is expected to decrease exponentially helps patients put their bad habit into perspective. Additionally, conducting spirometry appropriately on all smokers helps to diagnose patients with COPD who have not been admitted yet.

*ACO PQI #5 and #6.* These measures correspond to mammography and colorectal screening, which are 2 preventive services that have historically scored low in PQRS/GPRO submissions. The breast cancer screening is the percentage of women aged 50 through 74 years who have had a mammogram within 27 months of the date of the AWV. The colorectal cancer screening is the percentage of all adults aged 50 through 75 years who have had appropriate screening within 7 years of the date of the AWV.<sup>9</sup> Many patients refuse to get these two preventative tests done due to a number of reasons, including lack of transportation to imaging facilities, disbelief that early detection guarantees successful treatment or extension of life, and simply because the physician never did a routine breast or rectal exam. Physicians not doing these routine physical exams they once did regularly may just be the reason why this metric is typically low. In order to increase the amount of preventive screening, such as mammography or colorectal screening, physicians should complete

physical breast and rectal exams. Examining the patient garners trust and motivation, as well as a personalized discussion so that the patient feels motivated to obtain the appropriate tests.

### 5. Understand Patient Behavior

Many Medicare patients tend to fall into seasonal patterns. For example, patients with diabetes who have managed their glycated hemoglobin throughout the year may become unmanaged during the first and fourth quarter of the year when the holidays are in full swing. Understanding patients' lifestyle patterns is key for knowing, for example, when to draw labs for the patients before their historically uncontrolled period. Patients may even be classified as a "snow bird," one who generally lives in the northern parts of the country half a year and then fly south during the winter months. These so-called snow birds are notorious for seeing multiple practitioners for the same health-related problems in different states. If you know that your patient is a snow bird, it would be best to set up pre- and posttransitioning office visits so that patients have enough medication and feel comfortable health-wise before they leave their usual realm of care. This special attention to detail can help to keep those quality metrics in check by assisting in areas such as LDLs, medication reconciliation, and anticoagulation therapy.

Another behavioral aspect that physicians should consider is the strategy behind increasing medication adherence and increasing preventive care services. Puschel et al speak to the importance of calling patients (a low level of intensity) or calling and e-mailing patients (a high level of intensity) to impact mammography screenings.<sup>10</sup> By simply putting in effort to contact patients multiple times, the mammography screening rates increased significantly from 6% in the control group to 51.8% in the low-intensity group and up to 70.1% in the high-intensity group.<sup>10</sup> Patients are most likely unwilling to have procedures done unless there is a more-than-minimal persuasion effort from the physician or physician's office.

### 6. Reward Primary Care Physicians Openly and Regularly

Economic behavior science proves that giving shared savings payments to physicians by hand to increase recognition rather than by a check sent to the office, gives the physician personal satisfaction.<sup>11</sup> Many times, physicians completing PQRS/GPRO and meeting shared savings do not even know they have been paid for the completion of health services, as little recognition is granted to the physician. Incentives for physicians need to be reorganized so as to align in a manner that drives behavioral change.

### 7. Offer Chronic Care Management

Chronic care management (CCM) is a new service that began in January 2015 that allows physicians to bill Medicare for non-face-to-face care provided to patients with 2 or more chronic conditions.<sup>12</sup> CMS released this service to reimburse physicians who put in great effort on a population health level. The non-face-to-face care is typically a phone call made by a care coordinator who seeks to fulfill and implement a comprehensive care plan that is relayed back to the primary care physician. By implementing care coordi-

nation, physicians are able to improve continuity of care and maintain better control of patients' health between office visits. The program has tremendous benefits, but should be implemented slowly, as a step-by-step introduction allows for any corrections to be made before it is applied on a large scale. All new program initiatives should be rolled out to a pilot, then applied across a larger subgroup.

CCM can certainly assist with PQRS/GPRO since the care coordinators are touching base with patients regularly. The conversation can capture information, such as confirmation of smoking cessation class or if a patient doesn't like the medication they are on, etc. The care coordinator can pick up information that would assist in the quality metrics, and additionally, they can reiterate the importance of the AWV and other preventive continuity during phone calls to patients.

### 8. Increase Patient Awareness of Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

PQRS/GPRO have a patient satisfaction component (ie, the CAHPS Survey) that covers topics that focus on quality and communication skills of the providers.<sup>13</sup> Since surveys have historically only been filled out by individuals who are unhappy with the services they have received, the physician is typically doomed to have bad scores. In order to proactively address this potential issue, physician offices should create awareness of the surveys during the months they are conducted, as well as reiterate the importance of completing the survey appropriately.

### 9. Make Sure You Are ICD-10-CM Savvy

Although staff education of proper coding is often considered low priority, it can be a major source of lost income. October 2015 marked the start of the switch from the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* to the *Tenth Revision (ICD-10-CM)*, and with that, come many obstacles. Since healthcare is moving toward a value-based system, *ICD-10-CM* is able to capture greater detail for quality metrics, new technology, and procedures. *ICD-10-CM* even has the capability of expanding codes of medical complications and medical safety issues.<sup>14</sup> Physicians must ensure proper coding has been implemented with both the EHR and billing.

### 10. Save PQRS/GPRO Results

Once PQRS or GPRO has been submitted, the results are sent to the government for review. The problem for groups, such as an ACO or independent physician association, is that the results are not created on the individual practice or physician level. In order to improve one's own metric performance, they would need the GPRO results saved prior to submission. Having the first year's results allows for a baseline to be individually created for continuous improvement. Improvement against the previous year's results is an actionable report for a physician since the mean of the group may appear unattainable or not applicable for the physician or practice.

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