2016 PQRS and VBM for Pathology
SUMMARY

Pathology PQRS reporting requirements for 2016 are similar to those in 2015. If 2016 PQRS is not reported, or not reported accurately (a common problem), pathologists in groups of 10 or more providers will see a -6% adjustment to Medicare payments in 2018. Those in smaller groups will see a -4% adjustment.

There are several ways to report PQRS measures but a registry is strongly recommended for pathologists, since CMS is phasing out claims-based reporting and EHR reporting usually isn’t practical. Most important, however, a registry approach can eliminate the risk of the -4% to -6% penalty.

PQRS results also show up on “Physician Compare” and proposed changes will map PQRS performance into a 5 star rating system for consumers by comparing results across providers.

PQRS

To avoid penalties for not reporting PQRS and VBM, pathologists must meet the Basic Reporting Requirements:

- Individuals or groups who report individual measures must complete nine measures for at least 50% of the eligible denominator, and those measures must include three National Quality Strategy Domains.
- One of those measures must be “cross-cutting,” as defined by Medicare: a population-wide measure required for providers who see at least one patient in a “face-to-face” encounter.

However, these requirements do not match well with many pathologists since no cross-cutting measures apply and there is a maximum of 8 measures available to most pathology groups (see below). As a result, pathologists are subject to the “MAV” audit, described below.

PQRS is set to expire after this year (the 2016 PQRS reporting year affects 2018 Medicare payments).
and be replaced by the Merit-Based Incentive Payment System (MIPS) in 2017 (which will affect 2019 payments). MIPS is mandated by MACRA (the Medicare Access and CHIP Reauthorization Act of 2015). MACRA eliminated the annual SGR payment reductions and, among other items, replaces PQRS, Meaningful Use and the VBM (Value Based Modifier) programs.

However, while the name PQRS will eventually disappear, the quality reporting component of MIPS will be heavily based on PQRS, meaning that work done to comply with PQRS will transition into the MIPS environment. Furthermore, non-reporting penalties increase with MIPS, adding additional incentive to have good quality reporting in place.

DEFINITIONS

The following abbreviations are used in this paper, consistent with CMS terminology:
EP – Eligible professional
GP – Group Practice
EHR – Electronic Health Record
QCDR – Qualified Clinical Data Registry

PQRS BASICS

- There is no incentive payment for reporting PQRS measures in 2016. However, bonus payments may be earned via the Value Based Modifier Program (which starts with PQRS data).
- EPs who do not successfully participate in 2016 will receive a -2% PQRS payment adjustment and a -2% or -4% VBM adjustment on their 2018 Medicare payments.
- While there are hundreds of PQRS measures, only 8 typically apply to pathology, as described below.
- PQRS can be reported via claims, registry, EHR, QCDR or GPRO (groups only). The first 4 methods are typically used for individual EPs, even when part of a group. However, claims-based reporting is being phased out by CMS so it is recommended to use one of the other methods.
- For at least 50% of Medicare patients, CMS requires reporting on 9 measures, at least one of which is a so-called “cross-cutting measure”. But many providers, including pathologists, do not have 9 applicable measures, in which case the MAV applies (see below).

It is very important to note that measures are defined on a measure-by-measure basis, not by specialty. That is because two providers in the same specialty may not perform the same services.

MAV

For those who report fewer than nine measures or fewer than three domains, the Measure Applicability Validation (MAV) Audit applies. Medicare compares your PQRS data to its measure specifications to identify other measures which could have been reported, but were not. While the measures they identify may not seem relevant, if they meet Medicare’s definition, they directly affect your PQRS compliance.
Claims-based vs. Registry-based Reporting

In this paper, we focus primarily on claims and registry-based reporting since many pathology groups do not have the ability to use an EHR for EHR-based reporting [and many EHRs do not have the necessary CEHRT certification to report the measures]. QCDR is a broader topic as that reporting method typically requires additional quality measures beyond those in PQRS.

With PQRS penalties now significant [-4% to -6% when combined with the VBM penalty], registry reporting is becoming almost essential. This is because claims-based reporting doesn’t provide any MAV insight, until it is too late. Furthermore, the process to review claims-filed PQRS data is cumbersome, at best. In 2015, those who used claims-based reporting spent countless hours trying to determine what data CMS actually had. And even when bad data was appealed, penalties were still applied. Registry reporting provides ongoing feedback and, importantly, provides feedback on how an EP or group will fare in a MAV Audit. In addition, with a registry, PQRS data can be updated or even replaced, something that is impossible with claims-based filing. As a result, using a registry eliminates MAV and PQRS penalty risks.

PATHOLOGY PQRS MEASURES FOR 2016

For pathology, there are no PQRS measure changes for 2016 versus 2015. The 2016 measures, as identified by CAP, are shown here. Note that these are the possible measures, but each EP and group needs to determine which apply to their circumstances:

- Breast Cancer Resection Pathology Reporting
  - Measure #99 – pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade

- Colorectal Cancer Resection Pathology Reporting
  - Measure #100 – pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade

- Barrett’s Esophagus
  - Measure #249 – Esophageal biopsies with a diagnosis of Barrett’s esophagus that also include a statement on dysplasia

- Radical Prostatectomy Pathology Reporting
  - Measure #250– Reports include the pT category, the pN category, the Gleason score and a statement about margin status

- Immunohistochemical (IHC) Evaluation of HER2 for Breast Cancer Patients
  - Measure #251 – Quantitative HER2 evaluation by IHC uses the system recommended by the ASCO/CAP guidelines

- Lung cancer reporting [biopsy/cytology specimens]
  - Measure #395 – Pathology reports based on biopsy and/or cytology specimens with a diagnosis of non-small cell lung cancer classified into specific histologic type or classified as NSCLC-NOS with an explanation included in the pathology report
- Lung cancer reporting (resection specimens)
  - Measure #396 - Pathology reports based on resection specimens with a diagnosis of primary lung carcinoma that include the pT category, pN category and for non-small cell lung cancer, histologic type

- New Melanoma reporting
  - Measure #397 – Pathology reports for primary malignant cutaneous melanoma that include the pT category and a statement on thickness and ulceration and for pT1, mitotic rate

Details for each measure are available in the CMS Individual Measures Guide, available as a download at this [CMS page](#).

**VALUE-BASED PAYMENT MODIFIER (VBM)**

Like PQRS, the Value-Based Modifier (VBM) affects Medicare payments with a one-year delay. Hence, performance in 2015 has already determined PQRS and VBM payment adjustments for 2017. And performance during this year (2016) will determine adjustments for 2018 payments.

For 2015, [CMS](#) described the VBM as follows: “In order to be eligible for upward, downward, or neutral payment adjustments under the Value Modifier quality-tiering methodology and to avoid an automatic negative two percent (“-2.0%”) (for physician groups with between 2 to 9 EPs and physician solo practitioners) or negative four percent (“-4.0%”) (for physician groups with 10 or more EPs) Value Modifier payment adjustment in CY 2017, EPs in groups and solo practitioners MUST participate in the PQRS and satisfy reporting requirements as a group or as individuals in CY 2015. Quality-tiering is mandatory for groups and solo practitioners subject to the Value Modifier in CY 2017. Groups with 10 or more EPs are subject to upward, neutral, or downward adjustment under quality-tiering, and groups with between 2 to 9 EPs and physician solo practitioners are subject to only upward or neutral adjustment under quality-tiering in 2017.”

While the precise rules for 2016 are not clear on the CMS website, it appears that groups under 10 providers are now subject to a -2% VBM penalty, and continue to be eligible for a +2x incentive, based on their quality and cost results. But this assumes that the group reports its PQRS measures. Any group under 10 providers that does not report PQRS successfully will definitely see a -4% penalty.

In addition, for 2016, non-physician practitioners (NPPs) are included in the VBM: PAs, NPs, etc. As in previous years, these providers new to the program are not subject to downward adjustments, but that applies only to solo NPPs or those in a group of only NPPs. Solo physicians and groups of two or more physicians and/or NPPs are subject to payment adjustments (up or down) based on their ratio of quality to cost as compared to other providers in the Medicare program.

To summarize, the upward or downward payment adjustment factors and percentages for 2016 VBM are as follows:
- For solo physicians and groups up to nine providers: +2.0x and -2.0%.
- For groups with 10 or more providers: +4.0x and -4.0%.