Report on MSRDP-PQRS #14-110

We have completed our audit of Medical Service Research and Development Plan (MSRDP). This work was performed to review UTHealth’s efforts to comply with guidelines for the Centers for Medicare and Medicaid Services (CMS) Physician Quality Reporting System (PQRS). This consulting engagement was performed to provide a perspective of existing PQRS operations at each UT Health institution. It also serves to satisfy the requirement of the annual audit of the MSRDP.

BACKGROUND

In 2007, CMS established the Physician Quality Reporting Initiative (PQRI) as required by the 2006 Tax Relief and Health Care Act. This initiative established financial incentives to motivate eligible healthcare professionals to participate in voluntary quality reporting on Medicare Part B fee for service claims. The Medicare Improvements for Patients and Providers Act of 2008 made the PQRI program permanent, with incentive payments authorized through 2010. PQRI was renamed PQRS with passage of the Patient Protection and Affordable Care Act (ACA).

PQRS includes a series of quality measures developed by leading physician organizations to evaluate the level of care being provided by eligible providers. Measures consist of a denominator and numerator. The denominators describe the eligible cases for each measure and the numerator describes the clinical action required by the measure for reporting and performance. The 2013 PQRS quality measures address areas such as preventive care, chronic- and acute-care management, procedure-related care, and care coordination. The overall goal of PQRS, according to CMS, is to collect meaningful data that can help lead to improved patient care. In addition, the PQRS program reflects CMS’ goal of gradually shifting the Medicare reimbursements toward physician reimbursement that rewards value rather than volume.

To encourage reporting of quality measures, CMS has provided incentives for eligible providers and physician groups. These incentives have been available every year since 2007 and end in calendar year (CY) 2014. For CY 2013, eligible providers, individually or as a group, can earn bonus payments of 0.5% on all of their Medicare Part B claims. Under ACA, the incentives will be replaced with penalties to be levied annually against the physician fee schedule. Though voluntary for CY 2013, not reporting PQRS measures could result in a 1.5% penalty against the 2015 physician fee schedule. Not reporting for CY 2014 would result in a 2% penalty against the 2016 physician fee schedule. Not reporting PQRS measures for subsequent periods would also result in a 2% penalty.
Groups with more than 100 eligible providers that bill Medicare for Part B services under a single Tax Identification Number (TIN) have three options to report PQRS measures to CMS for CY 2013:

1. A CMS-provided Group Practice Reporting Option (GPRO) Web-interface,
2. An approved third-party Registry, or
3. By requesting CMS calculate the group’s performance from 2013 administrative claims.

The due date for reporting the PQRS measures for CY 2013 using options one and two above was February 28, 2014. CMS did not provide any incentive for groups that selected option three.

There are additional penalties for not reporting PQRS measures. For CY 2013, groups of 100 or more eligible providers who submit claims to Medicare for Part B services under a single TIN will be subject to a value-based payment modifier to be determined in 2015. The value modifier provides for differential payments under the Medicare physician fee schedule based upon the quality of care furnished compared to the cost of care. Physician groups were required to register to report as a group by October 18, 2013, to avoid an additional 1% reduction to their fee schedules. According to CMS, “the Value Based Modifier Program will provide comparative information to physicians as part of Medicare’s efforts to improve the quality and efficiency of medical care.”

OBJECTIVES

The purpose of this consulting engagement was to report upon University of Texas Health Science Center at Houston’s (UTHHealth’s) efforts to report PQRS measures to CMS. To achieve this purpose, we:

- Reported the methodology management selected to report PQRS measures and the reason that particular method was selected;
- Gained an understanding and reported upon the level of management’s oversight and monitoring of quality and patient safety independent of PQRS measures;
- Gained an understanding and reported upon the level of management’s oversight and monitoring of PQRS measures;
- Determined whether management has processes and procedures in place to report accurate and complete PQRS information to CMS and whether any challenges exist for doing so;
- Determined whether management has been able to determine any lessons learned from PQRS measures to improve quality and patient safety;
- Determined whether management has adequate processes in place to ensure information reported to CMS is complete and accurate; and
- Provided recommendations to address reportable observations, if any, from procedures performed to address the objectives above.

SCOPE AND METHODOLOGY

To meet our engagement objectives we:

- Determined who has direct oversight for quality and patient safety;
• Interviewed the Manager of Billing Integrity Programs;
• Gained an understanding of how the institution monitors and provides oversight for quality and patient safety;
• Requested Medicare Part B Claims for CY 2009 to CY 2013;
• Requested total amounts earned from past incentives;
• Gained an understanding of the history of reporting PQRS measures to CMS;
• Determine methodology selected by management to report PQRS;
• Performed tests to determine whether submitted PQRS information was complete and accurate; and
• Other tests as deemed necessary to meet our objectives.

AUDIT RESULTS

PQRS History at UTHealth
UTHealth received the following incentives:

Individual Provider Reporting (PQRI)
2007 - $1,622
2008 - $5,313
2009 - $31,044

GPRO (Large Group Practice)(PQRS)
2010 - 2.0% = $433,469
2011 - 1.0% = $242,814
2012 - 0.5% = $134,223
2013 - 0.5% - The CY 2013 reporting period is January 27, 2014 – March 21, 2014 with the incentive payment expected between August and September of 2014.
2014 - 0.5% - CY 2014 is the last year to receive an incentive payment. Reporting takes place in the 1st quarter of the year following the measurement year (2015) and the incentive payment will be paid in the fall of 2015.

UTHealth received the following Medicare Part B payments:

2010- $17,497,356
2011 - $19,381,845
2012- $22,240,818
2013- $25,719,845

In 2007 CMS required individual reporting for the doctors. Because very few of the providers participated, UTHealth chose to switch to group reporting as soon as it became available in 2010.

Oversight and Monitoring Quality and Safety
CMS provided a 2012 Quality and Resource Use Report and Physician Quality Reporting System Feedback Report, which provided details of each beneficiary assigned to the modules, results and costs. The report was deleted on May 1, 2014, per the Data Use Agreement (DUA) with CMS. The DUA is a signed agreement required by CMS, which mandates all data with PHI be completely purged from the computer System in a timely manner after the close of the reporting window.
Data with no PHI such as the instructions, a copy of the transmission, and a copy of the final results are kept on file. No further data is required in our records because only the most recent patient data can be used for the next period’s submission.

The Quality and Resource Use Report and Physician Quality Reporting System Feedback Report, which outlines UT Physicians performance for each measure but does not include beneficiary information, is retained for prior years. An Excel spreadsheet for the current reporting period is retained until the official report is released.

All information is processed and retained by the manager of billing integrity programs. Since the manager is the only person to enter and report the data, an error could be made and not caught. We suggest adding a review of work completed before submitting the data to CMS. Currently the only review is done by CMS, who has the option to penalize the institution if a gross error were found.

The process is centralized and mature. The PQRS-GRPO measures and reporting processes are reviewed with the departmental and division chairs, and are presented in the respective faculty meetings. If necessary, data is reviewed with faculty directly at the chair’s discretion. The reporting information cannot be traced back to the departmental level; it is an overview of the institution’s activities as a whole. As a result, management has not found these reports to be useful.

**PQRS Reporting Methodology**

UTHealth uses the GPRO Web interface reporting methodology. The Web interface option was selected because the reporting window is only open for eight weeks and this method is more expeditious.

The reporting process begins when CMS assigns each patient a ranking based on their health conditions. CMS places a file on a secure online site containing all patients that would be allowed in the sample based on their review of submitted claims. The file contains a ranking of each patient based on their conditions and the types of claims they submitted. It is required that UTHealth report on all patients that CMS ranked as 411 and above. CMS does provide several alternate patients in case one of the first 411 is ineligible due to allowable exclusions. Some allowable exclusions include: the patient being out of the country; the patient being under hospice care; or the institution’s inability to locate patient records. CMS ranks patients based on their Medicare claim data, so it is also possible that the patient saw a UTHealth doctor for an unrelated event, and we would not have specific medical data needed for the required measure.

The manager of billing integrity programs searches in the electronic health record (EHR) for the required data for each patient. The manager then enters the data into the CMS required reporting form. After all 411 patients have been entered, the report is submitted and a confirmation of our submission is kept on file. Once CMS has reviewed the submitted data, a report is sent to the manager showing where the institution ranks as compared to other institutions. As soon as the report is received, all patient data is purged from the computer in accordance with the DUA.

**CONCLUSION**

The PQRS reporting at UTHealth is mature and functioning as intended; however, we suggest adding a review of work completed before submitting the data to CMS.
We would like to thank the members of management who assisted us with our review.

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