The CMS Value-Based Payment Modifier: What Medicare Eligible Professionals Need to Know in 2014

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Patrick Hamilton:
Hello. And welcome to the CMS Value-Based Payment Modifier "What Medicare-Eligible Professionals Need to Know in 2014" presentation. My name is Patrick Hamilton from the Centers for Medicare and Medicaid Services. The purpose of today's presentation is to give an overview of the value-based payment modifier, and how it relates to the physician quality reporting system, or PQRS program, so that all Medicare physicians will understand how the value modifier can effect Medicare reimbursement starting in 2015. This MLN Connects video is part of the Medicare Learning Network.

The value-based payment modifier, which was part of the Affordable Care Act of 2010, is a measure of both the quality of care and the cost of that care that is provided to patients by Medicare physicians. CMS has taken a phased-in approach in accessing the value modifier with physicians in groups of 100 or more eligible professionals being the first segment of the Medicare provider population to be subject to the modifier. For this group, the modifier will be assessed in 2015 based on 2013 performance in PQRS. The second, much larger segment of the Medicare provider population will be assessed the value modifier in 2016 based on 2014 performance in PQRS. Individual physicians and physicians in groups of fewer than 10 EPs will be the last to be incorporated into the program in 2017. These are statutory deadlines that were passed in the Affordable Care Act. So for physicians who are part of a group practice of 10 or more professionals, your PQRS performance in 2014 will determine the value modifier that will be added to your Part-B fee for service reimbursement in 2016. CMS has been working vigorously with the Medicare provider community to ensure that you have the most up-to-date knowledge and information available to assist you in understanding the value-based payment modifier.

Today's presentation will include information on a variety of topics that are essential to the value-based payment modifier, including overview of the value modifier, distinction between Medicare physicians and eligible professionals in terms of who will actually be accessed the value modifier, and who is included in determining group size; relation to other quality program incentives and payment adjustments, mainly PQRS and Meaningful Use; the 50 percent threshold option for groups who choose to have their EPs participate as individuals, quality and cost measures that are used in calculating the value modifier, quality tiering, which is mandatory in 2014; and finally, accessing your QRUR report so you can see how you performed in your reporting. We will also be walking through a very detailed decision tree that has been created to help providers ask the necessary questions on determining how the value modifier in 2016 will be affected by their PQRS participation this year.

So what is the value-based payment modifier? The value-based payment modifier is actually found in Section 307 of the Affordable Care Act. The ACA law requires CMS to establish a value modifier that assesses both the quality of care and the cost of that care, furnished under the Medicare physician fee schedule. The value modifier is a per-claim adjustment under the physician free schedule that is applied at the group level, where a group is identified by its Medicare TIN, or tax identification number. The value modifier only applies to physicians that are billing under that TIN, but not to other non-physician eligible professionals. CMS decided that we are going to phase-in the value modifier over the course of the three years. We are required to do a full phase-in by 2017. In terms of the phase-in, in -- during the first year, which is 2015, CMS will be applying the value modifier based on performance in 2013 to groups of physicians with 100 or more eligible professionals. Then, during the second year, which is 2016, we will be applying it to groups of physicians with 10 or more eligible professionals, based on their performance this year in PQRS, 2014. I'll be focusing on policies that will apply to the 2016 value modifier for this presentation. For the third and final year of the phase-in, the Affordable Care Act requires CMS to apply the value modifier to all physicians and groups of all sizes, starting in 2017. You should be looking for our proposals late this summer for meeting the statutory requirement, and exactly how we will be implementing the value modifier in 2017, based on 2015 performance in PQRS.

We're now going to go over the distinction between Medicare physicians and eligible professionals, and to help you better understand how the value modifier is applied only to physicians, but how those non-physician practitioners, the other eligible professionals, play in to the definition of group size to determine when the value modifier will be applied to the physicians in those groups. Slide 6 is the chart that we have developed to give providers a bird's eye view of the eligibility for PQRS and the EHR Incentive program, and also -- and which will be our focus in this presentation -- how providers and physicians are affected by the value modifier. As you can see, when we look in the column under "Value Modifier" that's listed 'subject to the VM,' or value modifier, you'll see that it's only Medicare physicians who will be actually subject to the modifier starting in 2015 through 2017, and beyond. When we determine which physicians will be subject to the value modifier starting in 2015, or starting in 2016, or starting in 2017, we're looking at the size of the group for which that physician is a part.

The definition of the group includes all of the eligible professionals that are listed on this slide. So if a physician works in a group that has a mix of MDs, physician assistants, and clinical physiologists, for example, if the total number of those professionals is 10 or greater, then they'll be subject -- those physicians will be subject to the value modifier starting in 2016. But again, the reimbursement for the non-physician practitioners and the therapists listed on this slide, their reimbursement is not affected directly by the value modifier. There is a specific definition for group practice as it pertains to PQRS and the value modifier. And again, the size of the group is determined by how many EPs comprise of that group. The definition that CMS uses for these programs is a single tax identification number, or a group tax identification number that has at least two or more individual EPs who are identified by their NPI numbers, who have reassigned their billing rights to that group TIN number.

An EP is defined as any of the following: a physician, a physician assistant, nurse practitioner, or clinical nurse specialist, certified registered nurse anesthetists, a certified nurse midwife,

clinical social worker, clinical psychologist, or a registered dietician or nutrition professional. Also EPs encompasses physical or occupational therapists or qualified speech language pathologist, and also qualified audiologists. So that is how we determine the size of the group. Who are all the EPs that comprise the group? But again, the value modifier will only be applied to the physician payment in that group. Physicians include MDs and DOs, doctors of dental surgery or doctors of dental medicine, podiatrists, optometrists, and chiropractors. The definition of "physician" is found in the Social Security Act, and it's the common definition that is used in the Medicare program for physicians.

In 2014 your participation in the various quality programs -- again, we're talking mainly here about PQRS and the EHR Incentive program -- will give you the ability to earn incentives for each of those programs, but also put you at risk for payment adjustments in each for not successfully participating. And for the 2015 and for the 2016 value modifier, we have directly tied the value modifier to the physician's participation in PQRS. The charts on the next two slides show all the incentives and the payment adjustments that Medicare physicians, practitioners, and therapists could earn or be subject to for their participation or their non-participation in the various programs. In dealing with PQRS, the incentive is 0.5 percent of the Medicare physician fee schedule allowed charges on the Part-B side, with a possible additional half a percent for a total of 1 percent incentive for physicians who are participating in a maintenance of certification with their specialty board. The payment adjustment in 2016, again, because we're using the idea of a two-year look-back period, would be 2 percent of the Medicare fee service schedule, and that would be based on 2014 PQRS participation.

Moving over to the value modifier, we'll first look at groups of 100 or more EPs, because they were the first group of eligible professionals or physicians that will be assessed the value modifier starting next year in 2015. If physicians in this group decide that they are not going to report on PQRS, not only will they get the 2 percent payment adjustment for PQRS, but they'll get an automatic additional 2 percent reduction for their value modifier, simply for not reporting PQRS measures at all. And that actually goes for physicians in groups of any size of 10 or more. Simply not reporting PQRS yields two payment adjustments; 2 percent for PQRS and another 2 percent for the value modifier.

For those groups who are going to be reporting PQRS, those groups will be subject to mandatory quality tiering. And we'll go through quality tiering a little bit later in the presentation. For groups of 100 or more, since this is their second year in which we're looking at their activity to determine whether or not a value modifier upward, downward, or neutral adjustment will be assessed, if they report PQRS and they are on the higher-tier of quality and cost, then they could actually get an upward adjustment of a factor of two or one -- and we'll explain what that means when we get to the payments -- or they could be subject to a downward adjustment of 1 or 2 percent if they fare poorly on the quality and cost of measures. Most physicians and most groups will probably fall into the neutral category, meaning the value modifier would be 0 percent, neither an upward nor a downward adjustment.

For the new groups, for the groups of 10 through 99, for which 2014 is the first year that we are looking at your PQRS activity to assess the value modifier, you are held harmless against any downward adjustment based on quality tiering, which means so long as you're reporting your

PQRS measures in 2014, you will not get that automatic 2 percent payment adjustment. You could, if you score well in the quality and the cost measures, could get an upward adjustment or you'll get a neutral adjustment or a 0 percent value modifier. And finally, for the EHR Incentive program for physicians who are participating this year based on when you first demonstrated meaningful use, your incentive payment could be anywhere between $4,000 and $12,000 this year; that is if you are participating in the Medicare Meaningful Use program. If you're participating in the Medicaid Meaningful Use Program, your incentive payment will be either $8,500 or $21,250, based on when you start the program. Keep in mind that the 2016 payment adjustment for Meaningful Use is also 2 percent. So the main take-away from this slide is that for physicians who decide not to participate in PQRS and in Meaningful Use in 2014, could see as much as a 6 percent reduction in their payments in 2016.

The second chart focuses on non-physician practitioners and therapists. They will most likely be focusing on participating in PQRS, so that they can earn the incentive and avoid the payment adjustment in 2016. The value modifier is not tacked-on to their reimbursement. Again, keep in mind that the number of eligible professionals, including the practitioners and therapists, will be the determining factor in the size of the group. The next two slides give a very broad overview of the policies for the value modifier as they exist right now, both for the application of the 2015 value modifier and for the 2016 value modifier. The performance here -- again, this should not be a surprise to anybody -- keeping in tradition with our two year look-back period for 2015, we were looking at the participation for -- in 2013 for groups of 100 or more. For the 2016 policy, we are looking -- or for the 2016 value modifier, we are looking at performance in PQRS for 2014 for groups of 10 or more.

In 2013 the way that groups could report their quality measures were either through the GPRO web interface, through registries, or the administrative claims option. In this year, groups have a number of new options to report their PQRS data. If the group has 25 or more EPs, they can also utilize the GPRO web interface; they can also use the CMS qualified registries; they also can use their certified EHR systems. So a number of new ways that groups can submit quality data to CMS. We're also going to be talking about the 50 percent threshold option. And that is going to be for groups who are -- that comprise of 10 or more EPs, but for a variety of reasons may choose to have their individuals EPs report PQRS individually.

The outcome measures in 2016 will be the same as the outcome measures for 2015, and they are all cause readmission a composite of acute preventive quality indicators, which include, bacterial pneumonia, urinary tract infection, and dehydration; and also a composite of chronic prevention quality indicators, which include, chronic obstructive pulmonary disease, or COPD, heart failure, and diabetes. Now, it's important to note that with these outcome measures, there is no more responsibility on the part of EPs to report data as it relates to these outcome measures. These will all be done administratively by CMS. So your sole responsibility, in terms of the value modifier, is to get your quality data in through the PQRS system. With patient experience care measures they were not included in the 2015 policy, but for 2016, groups who wish to include results from the CG-CAHPS survey would be able to include that in their PQRS data reporting, if they so choose. However, for groups of 100 or more that are using the GPRO web interface, they are required to include the results of the CAHPS survey.

The cost measures in 2016 are the same for -- or the same as in 2015, which are a total per capita costs, which is an annual payment, which we standardize and risk adjust for Part-A and Part-B costs, and does not include anything under Part-D; and then also a total per capita costs for beneficiaries with four specific chronic conditions: COPD, heart failure, CAD, and diabetes. In addition, in 2016 we're using those five measures in addition to the Medicare spending for beneficiary measure. This measure includes all of the A and B charges or costs during the three days before and the 30 days after an inpatient hospitalization. Again, providers in groups are not responsible for submitting any additional information as it relates to cost measures; CMS will analyze those claims administratively.

In terms of the bench marks, in 2015, we did group comparison; we're moving to a specialty adjusted group cost for this year's policy -- or for the 2016 policy. Quality tiering in 2015 was optional. So the groups of 100 or more EPs who were first made aware of the value modifier, had the option of either selecting to have a 0 percent modifier, so long as they submitted their PQRS data, or they could have opted to go through quality tiering. For the 2016 program -- and again, based on your 2014 PQRS -- the quality tiering is going to be mandatory. And again, groups of 10 through 99 will be subject only to an upward or neutral adjustment; they're held harmless against any negative adjustment, so long as they're reporting PQRS. Groups of 100 could be subject to the upward, neutral, or downward adjustment. The maximum payment that was at risk for the 2015 policy is 1 percent. That's increased to 2 percent in 2016.

So if you are in a group that has 10 or more eligible professionals, then the group can chose to report PQRS quality data at the group level. There are three reporting mechanisms that you can chose from if you're reporting as a group. They are the GPRO web interface, which again, can only be used by groups that have 25 or more eligible EPs; the GPRO can also use CMS-qualified registries; and they can also use their EHR system, either directly through the system or through a data submission vendor that is certified. The GPRO web interface measures focus on preventive care and care for chronic diseases. The GPRO that uses a CMS-qualified registry gets to select the quality measures they will report through a PQRS-qualified registry. And for the groups who use the EHR, the quality measure's data will be extracted from a qualified EHR product from a subset of PQRS measures. Again, with EHR, there are 64 measures within the total population of PQRS measures that you can choose.

So if you're a specialty group and you want to report at the group level, mechanism number two, the qualified registry, probably will make the most sense, because you would be able to pick from any of the quality measures that are in PQRS that may be relevant to your specialty, and you can report them at the group level. Again, groups must register to participate as a GPRO no later than September 30th. Since the 2016 value modifier is being applied to groups of 10 or more based on their 2014 participation, we can easily identify groups of physicians who elect to participate in PQRS through GPRO. And again, there's no statutory requirement for groups that exist as a group in PECOS to participate in PQRS under the GPRO. There may be many reasons why a group may not -- may elect to participate as individuals as opposed to groups. For example, if there is a wide specialty mix in the group as it exists under the tax identification number, it could be difficult for the group as a whole to find common quality measures.

However those groups, if you are going to report as an individual, still need to be identified in order for the value modifier to be properly assessed in 2016. So CMS came up with the 50 percent threshold option. If you are in a group of 10 or more eligible professionals, and your group decides not to report at the group level, then the eligible professionals in your group can still report PQRS data individually. In this case, CMS will calculate a group quality score if at least 50 percent of the eligible professionals in that group report PQRS individually and successfully to avoid the 2016 PQRS payment adjustment. Obviously, if they are reporting to earn the incentive, then they automatically also avoid the payment adjustment. In 2014 EPs can report using one of four individual reporting mechanisms, which include claims, CMS-qualified registries, EHR, which is either directly through your EHR system or through a data-submission vendor, or though the clinical data registries, the qualified clinical data registries, which is new in 2014. As I mentioned previously, if the group wants to report at the group level, they have to tell CMS that they are registering as a group by September 30th. If they don't tell us, if the registration is not submitted by September 30th, then CMS will apply the 50 percent threshold option by default. So the group does not have to register for this option. If the group is going to make the decision to partake in the 50 percent threshold option, they simply do not register for GPRO.

So how will CMS determine whether a group of physicians has ten or more EPs? We came up with a two-step process that works as follows. First, on or about October 15th, we will make a query of the PECOS system to identify groups of physicians with 10 or more EPs. So we'll go into PECOS, we'll basically say, "Give us the list of all of the groups per the group TIN number that has at least 10 or more EPs through their individual NPI." So that's going to be our master October 15th list. After the year is over, on or about February 28th, CMS will then analyze the claims that were submitted by those groups through the group's TIN number, and we'll make a determination if at least 10 individual providers, though their rendering individual NPI number, actually billed services under that group TIN. We will only be looking at the groups that were part of that October 15th master list. We won't add any groups after we make the October 15th query. So if a group is on the list and on February 28th -- on or about February 28th of 2015, if it is determined that that group TIN number did not have at least 10 unique NPIs that billed under that TIN, that group will come off the list and that group -- the physicians in that group will not be subject to the value modifier in 2016.

As I mentioned in the beginning of the presentation, the value modifier is a combination of quality of care and the cost of that care, and both quality and cost have measures. And now we're going to discuss the measures that are used for both quality and cost for quality tiering. Let's first look at the quality measures that will be used in quality tiering. The quality measures -- and again, this would be the only information, the only responsibility that you as an EP or group would have in terms of submission -- are the quality data that is reported to CMS through the PQRS system, either through the GPRO or through the 50 percent threshold option, if reporting as individuals. We will use the PQRS measures that are reported either at the group level or individually as the basis of your quality measures.

In terms of the outcome measures, again, we will also calculate three outcome measures from administrative claims. So CMS will be doing this on our own. And these, again, include all cause readmission, and a composite of acute prevention quality indicators, and a composite of

chronic prevention quality indicators. Groups do not need to do anything to select the outcome measures; CMS calculates them from administrative claims. So, again, no additional reporting requirements are needed here. Thirdly, if a group with 25 or more eligible professionals registers for the PQRS group reporting option, they can also elect to include the CAHPS measures with their PQRS measures. The CAHPS measures consist of patient experience measures, and these count for three of the nine measures for the PQRS incentive for 2014. The group may select the CAHPS option during the registration process. You should note that the CAHPS is optional for groups with 25 or more eligible professionals unless the group has 100 or more EPs and selects the GPRO web interface reporting mechanism, in which case, the CAHPS survey is required.

So now we'll take a look at the cost measures that are used for quality tiering. In total, there are six cost measures. Five of them look at total per capita cost for each of the beneficiaries. When we talk about per capita cost, we are referring to all Medicare Part A and Part B spending for beneficiaries. We do not include Part D, only A and B spending. I want to especially point out that it's not only your group's charges that are reflected in total per capita costs measures, but the charges from all the providers that the beneficiary has seen during the year that get included. So the total per capita costs measure includes all Part A and Part B spending for the beneficiaries who've been assigned to the group. So it's more than just what the group provides, it's the total spending for the beneficiaries. And then we take a look at total per capita costs for beneficiaries with four chronic diseases, which are chronic obstructive pulmonary disease, or COPD, heart failure, coronary artery disease, and diabetes. So the five per capita cost measures are, one, the overall total per capita cost measures; and then the four other measures broken down to beneficiaries with those four specific chronic conditions. I'll cover the attribution methodology used for the per capita cost measures on the next slide.

For the 2016 value modifier, we've added a new cost measure which we call the Medicare spending per beneficiary, or MSPB measure. The MSPB measure is a measure of cost around a hospitalization. So we look at total Part A and Part B spending from the three days prior to the in-patient hospitalization, all the way through 30 days after the patient has been discharged from the in-patient setting. We attribute that episode to the group of physicians that had a plurality of Part B services during the hospitalization. So the group that basically was responsible for most of the charges during the hospitalization will be the one who's attributed the beneficiary. So this MSPB measure is the sixth cost measure, and as I mentioned earlier, it's new to 2016. The other five were part of the program last year.

All the cost measures are payments standardized, meaning that we take out geographic adjustments so that when we make comparisons between -- let's say -- Lincoln, Nebraska and New York City, they are equal in terms of Medicare rates. We also risk-adjust for beneficiary characteristics. In 2016, we will also be adjusting all six cost measures to reflect the specialty mix of the eligible professionals in the group. This is something that we finalized and is new, again, for 2016, and a further adjustment to make sure that we're really doing an apples to apples comparison.

So we mentioned that there is beneficiary attribution to groups. And this slide talks about the methodology that we use for the five total per capita cost measures in the three outcome measures. And it's a two-step assignment process that focuses on the delivery of primary care

services by physicians. First, it looks at what group TIN provides the plurality of primary care services. So we first do what is sometimes called the pre-step. We identify all the beneficiaries who have had at least one primary care service rendered by a physician within the group. Then, from that, we follow two steps. First, we assign beneficiaries who've had a plurality of primary care services, as can be based on allowed charges, rendered by primary care physicians of the group. After that, for the beneficiaries who remain unassigned, we'll assign those who have received a plurality of primary care services rendered by any EP in the group. This can include specialist physicians and certain non-physician practitioners.

So what we're doing is focusing on primary care physicians, which makes sense, because these are total per capita cost measures, and the primary care physicians are arguably in the best position to manage cost throughout the year, as well as to manage the three outcome measures. The outcome measures, similar to the cost measures, are in some ways very primary care-oriented or preventive care-oriented. And so we looked at the group that is providing the plurality of primary care services, because they're in a good position to be responsible for managing these metrics on behalf of their patients. And that is the same rationale that we use for the cost measures, too, because, you know, it's a total per capita cost, it's an annual cost for the beneficiary. Who's in the best position? Probably the group that provides the plurality of primary care services to that beneficiary during the year. That works for the CAHPS survey too. We use the same attribution method in administrating the CAHPS survey.

Now we're going to go into the methodology that is used to do quality tiering to determine the value modifier amount. As mentioned before, CMS is required to create two components for the value modifier, quality composite, and a cost composite for each group. So how do we do that? So let's look first at the quality measures. Groups, especially on the quality side, are reporting different measures. We give the option to choose any of the measures so long as you can report nine that come from the three of six quality domains. But how do we make sure that we're comparing apples to apples? What we basically do is we create a standardized score for each measure that has at least 20 eligible cases to find out how far the group's performance on a measure by measure basis is from the mean, given the underlying distribution of performance on that measure. So every measure that can be chosen for PQRS is standardized and there is a score that is assigned to it. So from a math perspective, we take the group performance rate, subtract it from the benchmark, and divide that difference by the standard deviation to get the standardized score for a measure. And if you remember your basic statistics, anything above one means that you are more than one standard deviation away from the mean, which means that you're high. Anything below negative one means you're on the lower side, more than one standard deviation away from the mean.

Then we classify each of the quality measures into one of six domains, and these are the six domains that are part of PQRS and Meaningful Use. For example, we'll put all of the clinical care measures into one domain, and we'll go through the domains in a second. Within each domain, we weighed each measure's standardized score equally to create a domain score so that groups have equal incentives to improve care delivery on all measures within the domain. We use a measure standardized score in the calculation of the domain score only if the standardized score either falls within one standard deviation of the benchmark, or is statistically significantly different from the benchmark. We then weight each domain score equally to form a quality of

composite score, and then we applied the same rules to calculate the cost composite. The quality composite would be based on group or individually reported PQRS data, the three outcome measures, and the optional CAHPS measures if the group is submitting the CAHPS survey. And then the cost composite would be based on the six cost measures.

This slide gives an overview of exactly how the value modifier amount is determined - we have the quality of care composite and we have the cost composite. With the quality of care, you see the six domains that are listed on the left hand side. By the way, the three outcome measures that are going to be administratively analyzed by CMS will all fall under the care coordination domain. As for the quality measures that you will report to CMS, either through the GPRO reporting option or individually if you're using the 50 percent threshold option, your measures will fall into three of the six categories -- at least three of the six categories. For example, if you had three clinical care measures in the clinical care domain, each of those measures -- and again, we explained how the scores for each of those measures are determined -- the scores for those measures are all equally weighted. So in our example, there were three clinical care measures, they're each weighted 33-and-a-third percent to come up with a clinical care domain score.

Now, of these six quality domains that are included in your quality of care composite score, for example, let's say that four domains are represented in your score, then each of those domain scores are weighted 25 percent to give you a quality of composite score. Similarly, with the cost composite score, your score for total per capita costs and the costs for the four diseases that we talked about -- and again, CMS will administratively analyze your claims data to come up with those scores -- each of those two scores are equally weighted to come up with your cost composite score. Then, once we get your quality of care and your cost scores, each of those scores are weighted equally, 50 percent, and that's how we come up with the value modifier amount.

This slide shows, what CMS does to calculate the value modifier, once we've calculated your quality composite score and the cost composite score for your group. First, we classify each score into high, average, or a low, based on whether that score is one standard deviation away from the mean score. So what we're doing is identifying who are the outliers, both high and low. Then we put them into three buckets, high, average, and low for cost and quality, and then we plot it on the table shown in this slide. Quality is on one axis, cost is on the other axis. And obviously, the best place you want to be is in the upper left hand corner, which is low-cost and high-quality. And the worst place where you don't want to find yourself is in the bottom right hand corner, which is high-cost and low-quality.

We also give it an additional bump up of 1x -- and I'll explain what that x means in a second -- for groups that had beneficiaries that are in the top 75 percent of risks scores. So what that means is that the group is caring for beneficiaries with the most chronic diseases -- the most frail, the most complex patients -- we are actually trying to give them an incentive to provide high-quality, low-cost care to their beneficiaries by giving them an additional bump up in their value modifier. Now, we were able to indicate what the exact negative adjustments are in this table, 1 percent, and 2 percent -- negative 1 percent, negative 2 percent -- but we've not indicated exactly what the upward percentages are, because all the value modifier adjustments have to be budget neutral. And this was also contained in the Affordable Care Act.

So what we have to do is we have to calculate how much money we have available to give for the upward adjustments. And in order to ensure that budget neutrality, we'll first calculate the total amount of downward payment adjustments that will be applied. So this is not only including the 1 percent and the 2 percent payment adjustments on this chart based on quality tiering, but it also includes the automatic downward adjustment of 2 percent for those non-PQRS reporters. So, for groups that have physicians or EPs that are not reporting PQRS, they get that automatic 2 percent downward adjustment -- that's put into the pot of the money that will eventually go over to the upward adjustment side. Using the total downward adjustment payment -- the down -- using the total downward payment adjustment amount, we'll then solve for the upward payment adjustment factor for x. So, basically, we're doing basic algebra. So we will figure out how much -- we'll get a dollar amount of how much the total amount we have reduced per downward adjustment. That pot of money will then be dished out according to the indicators on the chart.

In terms of those payment adjustments in 2016, the value modifier in 2016 will be applied to the Medicare paid amounts to items and services billed under the physician fees schedule Part B at the TIN level. So it's not charges, it's the paid amounts. And that ensures that beneficiary cost sharing is not effected. So after deductibles and co-insurance, and all of that, it's what Medicare actually pays you for your services that the value modifier will come into effect. And again, it's applied to the items and services billed by the physicians under the TIN, but not to the other eligible professionals. Finally, if a physician changes from one group, or one TIN, in the performance years -- so if we're talking about 2014 -- to a new group in the payment adjustment year of 2016 -- so they make a move between 2014 and 2016 -- the value modifier would be applied to the second TIN for the physician's items and services billed under the TIN during calendar year 2016, meaning that if the physician was a part of a group that did not meet the requirements to avoid the value modifier downward adjustment, but he's now working for a group that does, that penalty will not follow the provider to the new practice. Again, it is a TIN-NPI combination.

The next two slides are decision trees that we've created for the value modifier to help providers determine when, and how, and if, the value modifier applies to them for 2014. And the first decision tree that we're going to go through are for individual EPs and for groups of two through nine. And by this point in the presentation, you're hopefully aware that the value modifier does not apply to you this year, in that the value modifier will be applied to these physicians in 2017, most likely based on your 2015 activity. So what you will want to do is to ask yourself if the EP of the group meets the criteria for the PQRS incentive payment, and if they do, then all of the EPs in the group receive the PQRS incentive, and they also automatically avoid the 2016 PQRS payment adjustment.

If the group cannot fully meet the criteria to earn the incentive, then we would ask if the EP or the group would be able to meet the criteria to avoid the PQRS payment adjustment. Again, we give EPs and groups the opportunity to report on just three measures on 50 percent of their patients during their reporting period, and if they can meet that criteria, then they will avoid the 2016 PQRS payment adjustment. But if they don't, in 2016, all of the EPs in the group will be subject to be the 2016 PQRS payment adjustment only, which is 2 percent. Again, EPs and

groups of this size two through nine EPs are not subject to the value modifier in 2016, but will be subject in 2017. More information coming later in the year.

For our groups of 10 or more EPs, the first question to ask is whether or not you plan to report for PQRS in 2014. And simply put -- and we hope that this is not the answer that you would give -- but the answer is no, you don't plan to report in PQRS, then all of the EPs in the group will be subject to the 2016 PQRS payment adjustment of 2 percent, and the physicians in the group will be subject to the additional 2 percent automatic downward adjustment for the value modifier. So not reporting PQRS for the EPs who are non-physicians, it's a 2 percent penalty. For the physicians in this group of 10 or more that are not reporting PQRS this year, it would be a total of a 4 percent penalty. If you do plan to report PQRS, then we would ask whether or not you plan to report as a group through the GPRO or the group practice reporting option. And if you do plan to report as a group, and if you plan to meet the 2014 PQRS incentive, then all the EPs in the group, or the group as a whole, will earn the PQRS incentive, and they will avoid the 2016 PQRS payment adjustment.

If the group is going to participate in PQRS, but cannot meet the incentive criteria, we would ask if the group plans to at least do the minimum required to avoid the 2016 PQRS payment adjustment. And if so, then the group would do the reporting necessary, three measures, to avoid the 2016 PQRS payment adjustment. But if the group does not, then as you can see, the EPs will get the payment adjustment of 2 percent and the physicians get the extra 2 percent downward adjustment for the value modifier. For groups who are not planning to report as a group, but rather to partake in individual reporting, we would ask if you plan to meet the 50 percent threshold. And if the answer is yes, and if at least 50 percent of the individual EPs in the group report satisfactorily and meet the criteria to avoid the PQRS payment adjustment, then that's what they will do. If they will not meet the payment threshold, the 50 percent threshold option, then we go back to the situation in which the EPs get the 2 percent payment adjustment for PQRS, and the physicians get the additional 2 percent downward adjustment for the value modifier.

Finally, physicians in groups of 10 through 99, if you are reporting PQRS, you are then subject to quality tiering. For the groups that are new to the program this year, 10 through 99, you would be subject only to that upward bump that we talked about, or a neutral or 0 percent adjustment. For physicians in groups of 100 or more, this is your second year in the program, so you can be subject to that upward bump, the neutral, or the downward adjustment of either 1 or 2 percent, based on where you fall in the grid that we described earlier.

Before we wrap up, we want to make sure the providers in groups know how they can access their quality and resource use reports, or QRURs. If you're not familiar with the QRUR reports, think of it as your quality report card. These are annual reports that are generated by CMS that give groups of physicians a lot of information, including comparative information about the quality of care and the cost of that care that they are furnishing to their Medicare fee for service beneficiaries. It also gives beneficiaries specific information that helps providers to coordinate and improve the quality and the efficiency of the care they're providing; and it also gives the group information specifically about how they would fare under the value based payment modifier. The 2012 QRURs have been produced and they've been made available to all groups

of physicians who have 25 or more EPs within the group. CMS expects by late summer or early fall of 2014 to produce these reports for groups of all sizes, and also for all solo practitioners.

The next few slides give you a quick rundown of how you can actually access and download the reports, and then we'll also give you an example of what a page of the report looks like. The reports are found on the CMS portal, which you can find at the website listed here: https://portal.cms.gov. You are then going to log into the portal using your IACS user ID and password. And if you do not have a user ID, or if you've forgotten your password, you can go to the IACS website in order to reregister. Once in, you're going to click the PVPQRS tab, a drop down menu will appear, and you will select QRUR-reports. After you select QRUR reports, you are then going to be asked to complete your role attestation -- so basically, how you plan to use the data. And then in step five, you're going to navigate to the folder's report. You'll see 'access your QRUR,' which is the general report, and then you'll also see the opportunity to access drill down reports. These drill down reports are the individual eligible professional performance reports that are on the right-hand side.

Now, you may have to select your medical group practice if your IACS account is associated with multiple TIN numbers. If you do have multiple TIN numbers, for step number six, you will get a list of all the groups that physicians are tied to. You'll want to click on the group of physicians that you want, they'll move over to the right-hand side of the screen, and in the bottom left-hand corner, you hit 'run report,' and then you'll actually get your report generated for you. Steps seven and eight show how you can export both the QRUR report and the drill down reports. The QRUR report generally is downloaded as a PDF file. The drill down reports can be downloaded as Excel files in case you need to do any type of internal data manipulation or reconfiguration on the report.

So, once you have accessed and downloaded and exported your report, how will you use the QRUR? You can do it for a number of things. You can verify that Medicare did it right in terms of identifying which eligible professionals actually billed under the group's TIN, you can see how the group would have fared under the value modifier, you can look to see the number of beneficiaries and who they are, and you can also get the identity of the beneficiaries that have been attributed to your group. You'll be able to understand your performance on the cost and quality measures and how they compare to other groups, you can understand which attributed beneficiaries are driving your cost measures, and who may be in greater need of care coordination; and you can also see which beneficiaries are driving your group's performance on three hospital-related care coordination outcome measures that we prepare for every group. And again, they are specifically related to the value based payment modifier.

We would strongly encourage all physicians and group practices, when they become available, to access your QRUR report. This slide shows the performance highlights page from a 2012 report, and here you can see the group's quality and cost composite scores, the groups beneficiaries' average risks score, the graph that shows where the group's performance stands in relation to all other groups of 25 or more EPs, and you can also determine on this graph, where an adjustment would have been made, or if an adjustment would have been made, to the groups payment based on quality tiering for the value modifier.

And with that look at how to access your QRUR reports that will conclude our presentation. Thank you for viewing this MLN Connects video on the value based payment modifier. This MLN Connects video is part of the Medicare Learning Network. Information in this presentation was correct as of the date it was recorded. This presentation is not a legal document. Official Medicare program legal guidance is contained in the relevant statutes, regulations, and rulings. [music playing]

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