CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2014 Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO)

Value-based Payment Modifier (VM)

Training Presentation

Program Year 2014

Disclaimer

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Your PQRS GPRO Support Team

- **CMS**
  - Lisa Lentz, GPRO Lead
  - LeTonya Smith, VM Lead
- **QualityNet Help Desk**
  - (866) 288-8912 or (TTY 1-877-715-6222)
  - qnetsupport@hcqis.org

Agenda

- What is the Value-based Payment Modifier (VM)
- Physician Quality Reporting System (PQRS) and the VM
- Quality-Tiering
- Timeline for VM
- Actions and Next Steps
- Resources and Where to Call for Help

Purpose

- This presentation will cover the Value-based Payment Modifier (VM) that will be applied to Physician Quality Reporting System (PQRS) eligible professionals (EPs)
- For 2015 and 2016 the VM does ***not*** apply to groups of physicians in which any of the group's physicians participate in the Comprehensive Primary Care Initiative (CPC) or Accountable Care Organization (ACO), including Medicare Shared Savings Program (SSP) and Pioneer ACO Model

2014 PQRS GPRO

What is the Value-based Payment Modifier (VM)?

What is the VM?

- VM assesses both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule (PFS)
  - 2016 VM does ***not*** apply to groups of physicians in which any of the group's physicians participate in the Shared Saving Program, Pioneer ACO or the CPC
- The VM is a per-claim adjustment under the Medicare PFS that is applied at the group (Taxpayer Identification Number or TIN) level and varies by calendar year
  - For the 2016 VM, physicians in groups of 10-99 EPs are subject to an upward or neutral payment adjustment.
  - For the 2016 VM, physicians in groups of 100 or more EPs are subject to receive a neutral upward, neutral, or downward payment adjustment
  - The VM downward adjustment is separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs

Resource: VM page of the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

PQRS and the VM

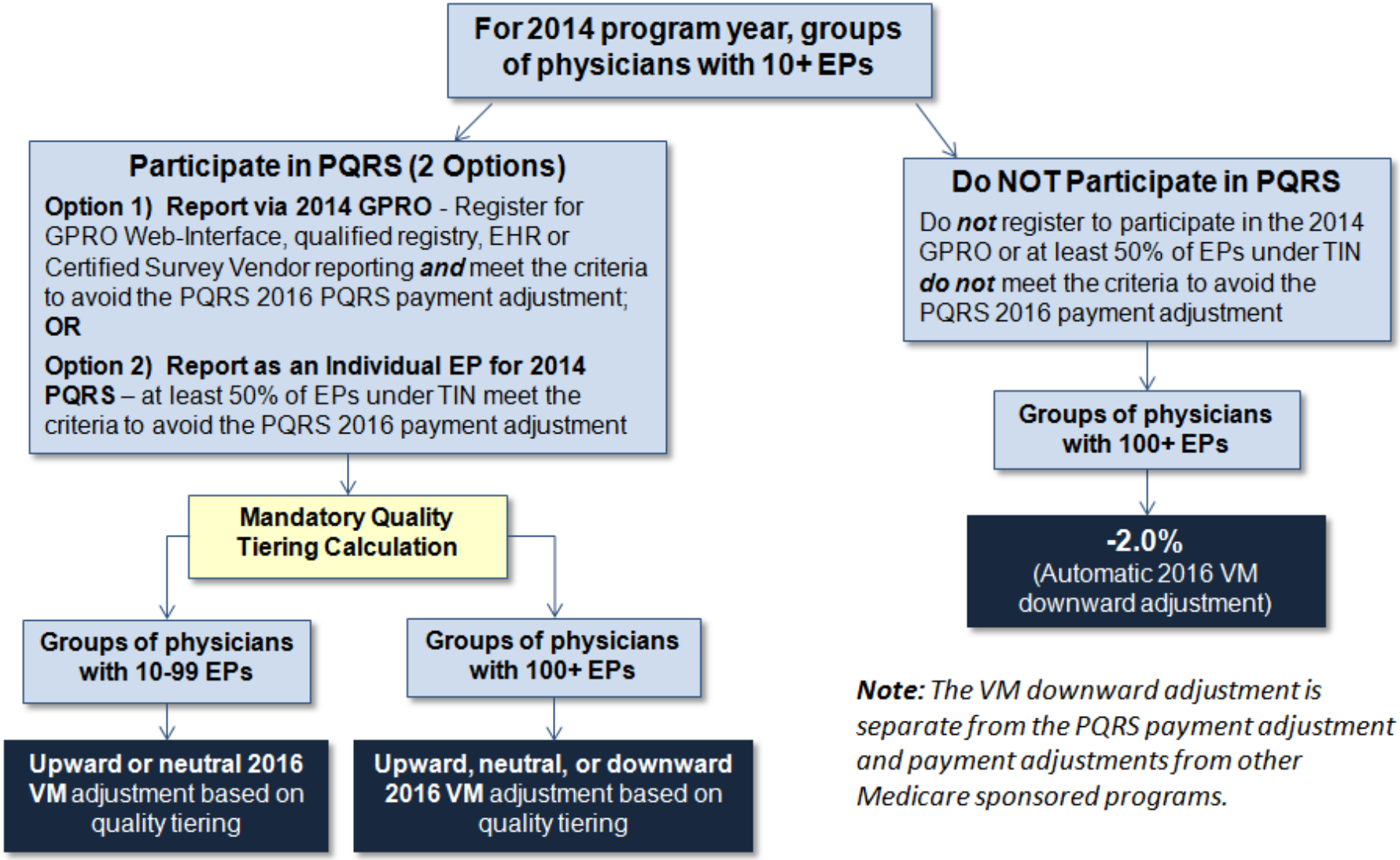
- VM is based on participation in PQRS
  - CMS urges solo practitioners and physicians in smaller groups to participate in PQRS now because the VM will apply to all physicians in 2017
  - Groups of physicians with 10 or more EPs must use the PQRS reporting mechanisms available to them in 2014 for purposes of the 2016 VM
- VM adjustments are applied two years after the PQRS reporting period
  - CY 2015 – CMS will apply the VM to groups of physicians with 100 or more EPs based on 2013 PQRS performance
  - CY 2016 – CMS will apply the VM to groups of physicians with 10 or more EPs based on 2014 PQRS performance
  - CY 2017 and beyond – CMS is required to apply the VM to all physicians and groups of physicians

What is an Eligible Professional?

- **Physician**
  - Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Oral Surgery, Doctor of Dental Medicine, and Doctor of Chiropractic
- **Practitioner**
  - Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist* (and Anesthesiologist Assistant), Certified Nurse Midwife, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Nutrition Professional, Audiologists
- **Therapists**
  - Physical Therapist, Occupational Therapist, Qualified Speech-Language Therapist

Resource: 2014 PQRS List of Eligible Professionals at
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_List-of-EligibleProfessionals_022813.pdf

Will My Group be Subject to 2016 VM?



Note: *The VM downward adjustment is separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs.*

Participate in PQRS Option 1 GPRO Reporting

Groups participating through the GPRO must meet the reporting criteria to avoid the 2016 PQRS payment adjustment to avoid the -2.0% VM downward adjustment in 2016

Reporting Period	Reporting Mechanisms	Group Size	Satisfactory Reporting Criteria/Satisfactory Participation Criterion
12-month (Jan 1 — Dec 31, 2014)	GPRO Web interface	25-99 EPs	Report on all measures included in the web interface; AND Populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100 percent of assigned beneficiaries.
12-month (Jan 1 — Dec 31, 2014)	GPRO Web interface	100+ EPs	Report on all measures included in the web interface; AND Populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100 percent of assigned beneficiaries. In addition, the group practice must report all CG CAHPS survey measures via certified survey vendor.

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Participate in PQRS Option 1 GPRO Reporting (cont.)

Groups participating through the GPRO must meet the reporting criteria to avoid the 2016 PQRS payment adjustment to avoid the -2.0% VM downward adjustment in 2016

Reporting Period	Reporting Mechanisms	Group Size	Satisfactory Reporting Criteria/Satisfactory Participation Criterion
12-month (Jan 1 — Dec 31, 2014)	Qualified Registry	2 + EPs	Report at least 3 measures covering at least 1 of the NQS domains, OR, if less than 3 measures covering 1 NQS domain apply to the group practice, report 1—2 measures covering 1 NQS domain for which there is Medicare patient data, AND report each measure for at least 50 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. For a group practice who reports fewer than 3 measures covering 1 NQS domain via the registry-based reporting mechanism, the group practice would be subject to the MAV process, which would allow us to determine whether a group practice should have reported on additional measures.
12-month (Jan 1 — Dec 31, 2014)	Direct EHR product that is CEHRT/ EHR data submission vendor that is CEHRT	2 + EPs	Report 9 measures covering at least 3 of the NQS domains. If a group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.

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Participate in PQRS Option 1 GPRO Reporting (cont.)

Groups participating through the GPRO must meet the reporting criteria to avoid the 2016 PQRS payment adjustment to avoid the -2.0% VM downward adjustment in 2016

Reporting Period	Reporting Mechanisms	Group Size	Satisfactory Reporting Criteria/Satisfactory Participation Criterion
12-month (Jan 1 — Dec 31, 2014)	CMS-certified survey vendor + qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface	25+ EPs	Report all CG CAHPS survey measures via a CMS-certified survey vendor, AND report at least 6 measures covering at least 2 of the NQS domains using a qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface.

Participate in PQRS Option 2 Individual Level - 50% Threshold Option

- If a group does ***not*** register to participate through the GPRO, CMS will calculate a group quality score, referred to as the 50% Threshold
- If at least 50% of the EPs within the group report measures individually then physicians within the group will avoid the 2016 VM downward adjustment
  - Individual EPs may report on measures via the following reporting mechanisms:
    - Claims
    - Qualified registry
    - EHR product with CEHRT
    - Quality Clinical Data Registry (QCDR)
  - The group does NOT have to register for individual EP reporting
- Complete information about available reporting methods and requirements for Individual EPs is available on the PQRS page of the CMS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How_To_Get_Started.html

2014 PQRS GPRO

QUALITY-TIERING

What is Quality-Tiering?

- Quality-tiering will determine if a group's performance is better, the same, or worse than their peers and identifies statistically significant outliers
  - Based on quality of care and cost of care measures
  - Is the analysis used to determine the type of adjustment (upward, downward or neutral) and the range of adjustment based on performance
- All groups with 10 or more EPs will undergo quality-tiering analysis for 2016 VM

What Quality Measures will be Used for Quality-Tiering?

- Measures reported through the GPRO PQRS reporting mechanism OR individual measures reported by at least 50% of the EPs within the group (50% threshold)
- Three outcome measures:
  - All Cause Readmission
  - Composite of Acute Prevention Quality Indicators (bacterial pneumonia, urinary tract infection, dehydration)
  - Composite of Chronic Prevention Quality Indicators (COPD, heart failure, diabetes)
- CAHPS for PQRS Measures for 2014
  - Patient Experience of Care measures
  - Required for groups of 100+ EPs reporting via the Web Interface
  - Optional for groups of 25-99 EPs participating in PQRS GPRO via any reporting method and for groups of 100+ EPs participating in PQRS GPRO via qualified registry, direct EHR product, or EHR data submission vendor
  - Can select during the Registration period (closes 9/30/2014)
- Uses a 2 step attribution process

What Cost Measures will be used for Quality-Tiering?

- Total per capita costs measures (Parts A & B)
- Total per capita costs for beneficiaries with 4 chronic conditions:
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Heart Failure
  - Coronary Artery Disease
  - Diabetes
- All total per capita costs measures are attributed using a 2-step process
- Medicare Spending Per Beneficiary measure (spanning from 3 days prior to an inpatient hospitalization through 30 days post discharge) attributed to the group providing the plurality of Part B services during the hospitalization
- All cost measures are payment-standardized and risk-adjusted
- Each group's cost measures adjusted for specialty mix of the EPs in the group

Two Step Attribution Process

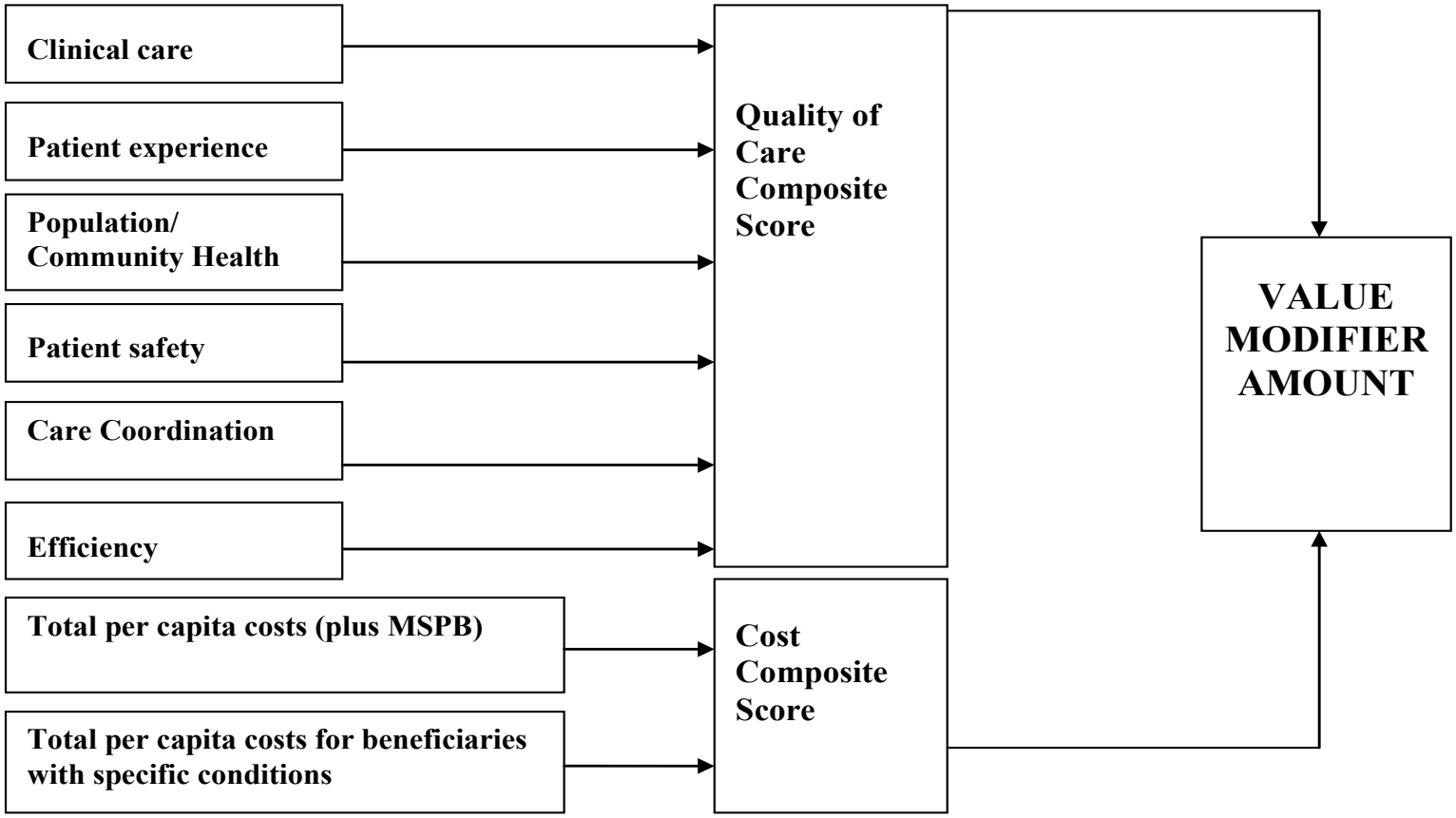
- 5 Total Per Capita Cost Measures and 3 Outcome Measures
  - Identify all beneficiaries who have had at least one primary care service rendered by a physician in the group.
  - Followed by a two-step assignment process
    - First, assign beneficiaries who have had a plurality of primary care services (allowed charges) rendered by primary care physicians.
    - Second, for beneficiaries that remain unassigned, assign beneficiaries who have received a plurality of primary care services (allowed charges) rendered by any eligible professional
    - This is the same attribution method used in the Medicare Shared Savings Program.

How Does CMS Use the Quality and Cost Measures to Create a VM Adjustment?

- Each group receive two composite scores (quality and cost)
- CMS uses the following steps to create each composite:
  - Create a standardized score for each measures (performance rate – benchmark / standard deviation)
  - Equally weight each measure's standardized score within each domain.
  - Equally weight each domain's score into the composite score

Quality-Tiering Methodology

Use domains to combine each quality measure's standardized score into a quality composite and each cost measure's standardized score into a cost composite



Quality-Tiering Approach for 2016

- Each group receives two composite scores (quality of care; cost of care), based on the group's **standardized performance** (e.g., how far away from the national mean)
- This approach identifies statistically significant outliers and assigns them to their respective cost and quality tiers

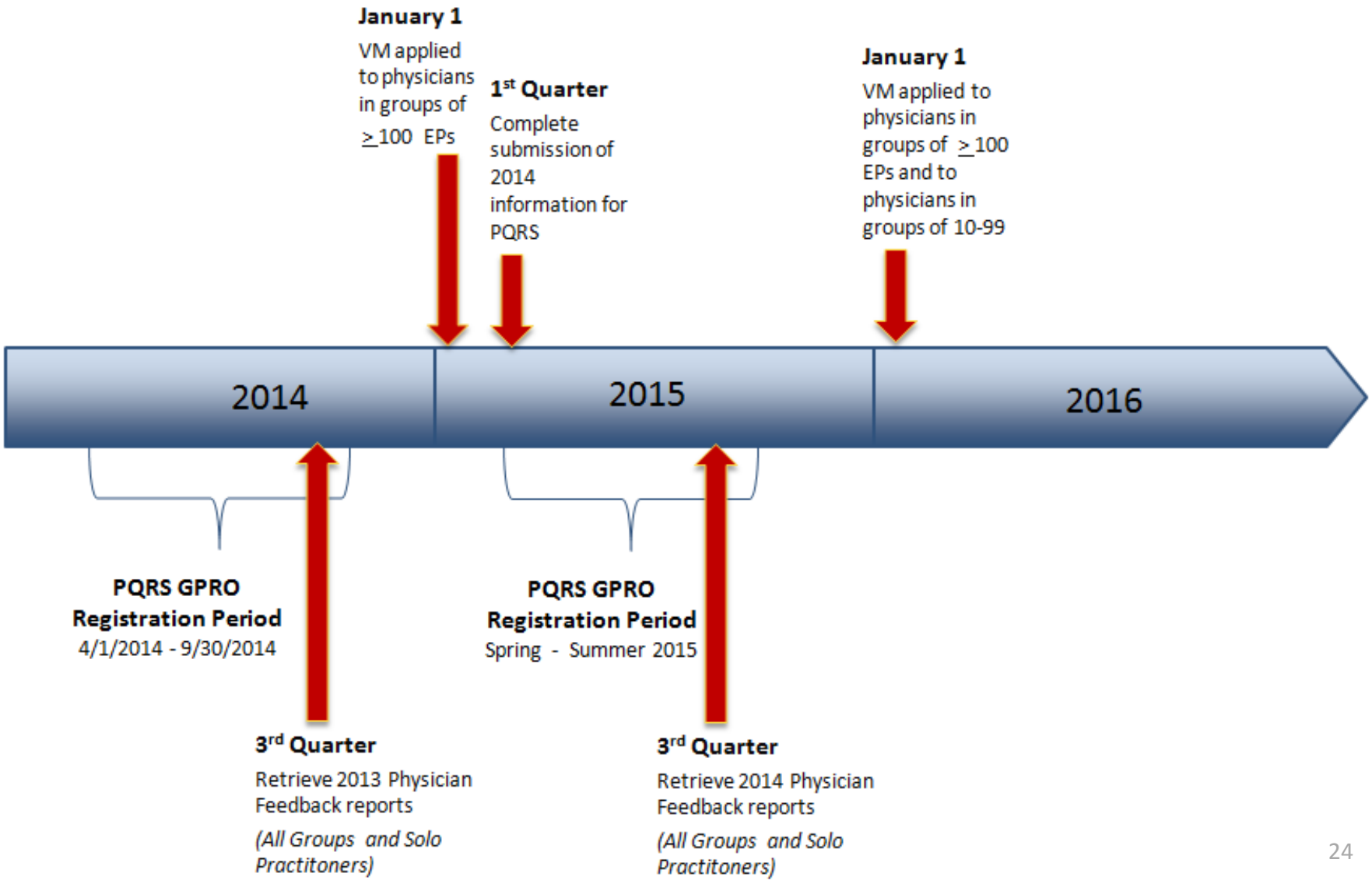
	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Average quality	+1.0x*	+0.0%	-1.0%
Low quality	+0.0%	-0.5%	-2.0%

** Eligible for an additional +1.0x if reporting clinical data for quality measures and average beneficiary risk score in the top 25% of all beneficiary risk scores*

2014 PQRS GPRO

TIMELINE FOR VM

Timeline for VM that Applies to Payment Starting January 1, 2016

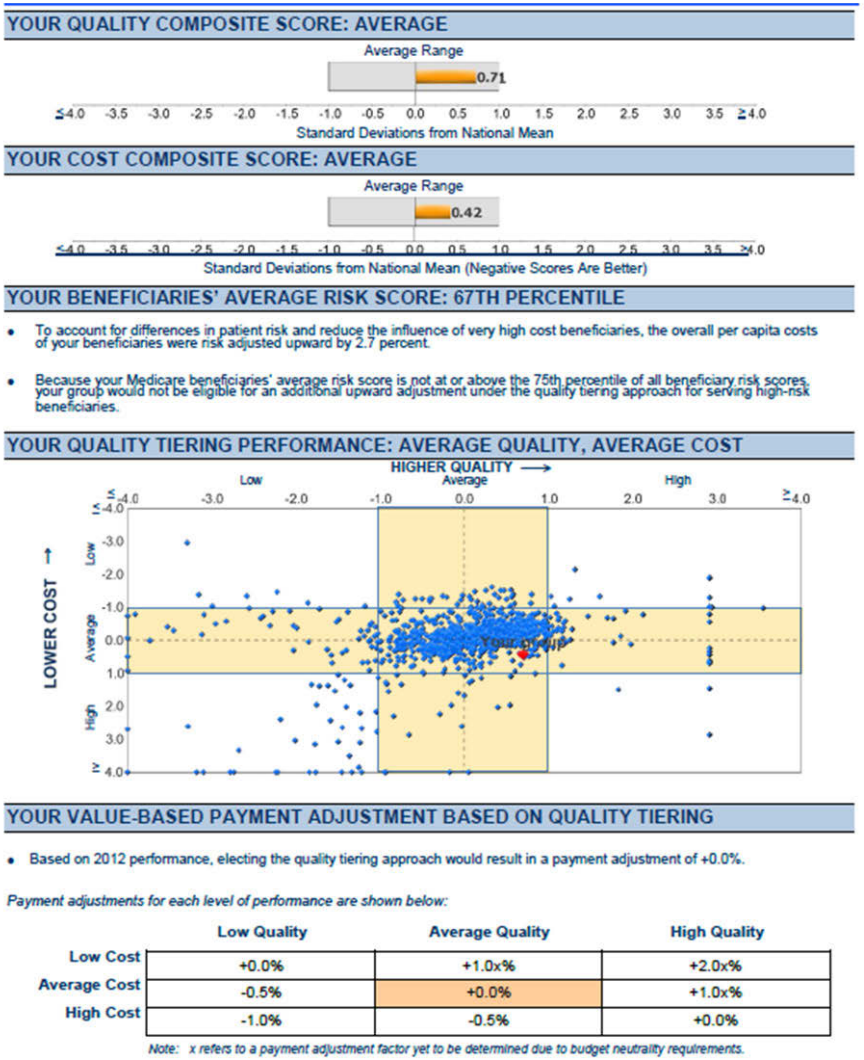


Physician Feedback Reports

- Quality Resource Use Reports (QRURs) will be available for all groups who participated in GPRO and Individual EPs (including solo practitioners) late Summer 2014
- Drill down tables including beneficiaries attributed to the group, their resource use (costs), specific chronic diseases
  - Drill down table including all hospitalizations for attributed beneficiaries
  - Drill down table of individual EP PQRS reporting

2012 QRUR: Performance Highlights Page

1. **Your Quality Composite Score**
2. **Your Cost Composite Score**
3. **Your Beneficiaries' Average Risk Score**
4. **Your Quality Tiering Performance Graph**
5. **Your Payment Adjustment Based on Quality Tiering**



YOUR QUALITY COMPOSITE SCORE: AVERAGE

Average Range

0.71

≤-4.0 -3.5 -3.0 -2.5 -2.0 -1.5 -1.0 -0.5 0.0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 ≥4.0

Standard Deviations from National Mean

YOUR COST COMPOSITE SCORE: AVERAGE

Average Range

0.42

≤-4.0 -3.5 -3.0 -2.5 -2.0 -1.5 -1.0 -0.5 0.0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 ≥4.0

Standard Deviations from National Mean (Negative Scores Are Better)

YOUR BENEFICIARIES' AVERAGE RISK SCORE: 67TH PERCENTILE

- To account for differences in patient risk and reduce the influence of very high cost beneficiaries, the overall per capita costs of your beneficiaries were risk adjusted upward by 2.7 percent.
- Because your Medicare beneficiaries' average risk score is not at or above the 75th percentile of all beneficiary risk scores, your group would not be eligible for an additional upward adjustment under the quality tiering approach for serving high-risk beneficiaries.

YOUR QUALITY TIERING PERFORMANCE: AVERAGE QUALITY, AVERAGE COST

HIGHER QUALITY →

Low Average High

≤-4.0 -3.0 -2.0 -1.0 0.0 1.0 2.0 3.0 ≥4.0

LOWER COST ↑

Low Average High

≤-4.0 -3.0 -2.0 -1.0 0.0 1.0 2.0 3.0 ≥4.0

Your Group

YOUR VALUE-BASED PAYMENT ADJUSTMENT BASED ON QUALITY TIERING

- Based on 2012 performance, electing the quality tiering approach would result in a payment adjustment of +0.0%.

Payment adjustments for each level of performance are shown below:

	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0x%	+2.0x%
Average Cost	-0.5%	+0.0%	+1.0x%
High Cost	-1.0%	-0.5%	+0.0%

Note: x refers to a payment adjustment factor yet to be determined due to budget neutrality requirements.

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ACTIONS AND NEXT STEPS

Actions Groups of 10+ EPs Should Take in 2014 for the 2016 VM

1. Register as a GROUP in the Physician Value-Physician Quality Reporting System (PV-PQRS) Registration System during the period of April 1, 2014 - September 30, 2014
   - The registration system can be accessed at https://portal.cms.gov using your IACS User ID and password
2. Select a PQRS GPRO reporting mechanism
   - Web interface
   - CMS-qualified registry
   - Direct CEHRT product/ CEHRT data submission vendor
   - CMS-certified survey vendor (in addition to another reporting mechanism)
     - Required for groups of 100+ EPs reporting via the Web Interface
   - *Note: Reporting mechanism cannot be changed after the close of registration*

What Should a Physician Group Do Next?

- Decide whether and how to participate in the PQRS for 2014
  - PQRS GPRO or Individual EP Reporting
    - If PQRS PRO, register between **April 1, 2014 - September 30, 2014** at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html
    - Get an IACS account or modify an existing account as soon as possible at: https://applications.cms.hhs.gov/
    - Once a group practices registers to participate in 2014 PQRS GPRO they cannot withdraw their registration
  - Decide which PQRS measures to report and understand the measure specifications for the selected reporting method
  - Review quality measure benchmarks at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html
- Obtain your QRUR – available late summer of 2014

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RESOURCES & WHERE TO CALL FOR HELP

Technical Assistance Information

- For questions about the VM, please contact the Physician Value Help Desk:
  - Monday – Friday: 7:00 am - 7:00 pm CT
  - E-mail: pvhelpdesk@cms.hhs.gov
  - Phone: 1 (888) 734-6433, press option 3 (TTY 888-734-6563)
  - Fax: (469) 372-8023

- For assistance with the IACS sign up process or registering in the PV-PQRS Registration System, please contact the QualityNet Help Desk:
  - Monday – Friday: 7:00 am - 7:00 pm CT
  - E-mail: qnetsupport@hcqis.org
  - Phone: (866) 288-8912 or (TTY 1-877-715-6222)
  - Fax: (888) 329-7377

Resources

- Quick reference guides for obtaining PV-PQRS Registration System roles in IACS and for registering in the PV-PQRS Registration System : http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html
- PQRS page on the CMS website:

  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html
- GPRO page on the CMS website:

  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html
- VM and Quality-tiering: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html