

### 2018 Value-Based Payment Modifier (VM) Policies- Module 4

Module 4 of this presentation reviews the updates for the 2018 Value based payment modifier.

2016 is the performance year for the application of the 2018 Value Based Payment Modifier, which is a measure of both the quality of care and the cost of that care that is provided to patients by certain Medicare practitioners. CMS has taken a phased in approach in assessing the value modifier to all Medicare physicians between 2015 and 2017. Starting in 2018, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists who are in groups of 2 or more EPs and those who are solo practitioners will be assessed the value modifier.

As with last year's VM, quality tiering will be mandatory in 2018. However, for PAs, NPs, CNSs and CRNAs who are solo practitioners or in a group identified by its Tax Identification Number, that contains only non-physicians in the group, they will be subject to only an upward or neutral adjustment, if they are PQRS reporters. All other physicians (both solo and those in groups), and the four practitioner types mentioned above in groups of 2 or more EPs that include physicians, will be subject to upward, neutral or downward VM adjustments based on quality tiering. Regardless, physicians and the practitioners mentioned in groups of all sizes and solo practitioners will be subject to an automatic downward adjustment for the VM if they do not report PQRS measures via one of the reporting methods discussed earlier. We will detail the amounts of these reductions in a few slides. Keep in mind this would be in addition to the 2% PQRS downward adjustment.

As with PQRS, 2018 is the final year for the assessment of the value modifier in advance of the start of the MIPS program in 2019.

The quality measures that are used to calculate the VM come from a combination of PQRS performance, outcome measures analyzed by claims data, and, if applicable, the CAHPS for PQRS survey. We reviewed in detail the PQRS portion of the quality score in module three.

The outcome measures, which were developed in 2013, continue to be the outcome measures that are used in the program today, those being: all cause hospital readmission; a composite of acute prevention quality indicators that include bacterial pneumonia, urinary tract infection and dehydration; and a composite of chronic prevention quality indicators, which includes COPD, heart failure and diabetes. A minor change will be implemented in 2017 in that the all cause hospital readmission measure will not be applied to groups of 2 9EPs and to solo practitioners.

And groups who elect to have the CAHPS for PQRS survey results included in their quality score for VM purposed will have those results incorporated in their score.

The cost measures that CMS will consider are the same measures that were used in previous years, which is a total per capita costs measure, which are the annual payment standardized and risk adjusted Part A and Part B costs, and the total per capita costs for beneficiaries with the chronic conditions of: COPD, heart failure, coronary artery disease and diabetes; as well as the Medicare spending per beneficiary for all A and B costs during the 3 days before and the 30 days after a Medicare inpatient hospital stay.

The amounts of the upward and downward adjustments in 2018 for physicians, PAs, NPs, CNSs, and CRNAs who are in groups of 10 or more EPs that include physicians in the group are listed in this table. These groups are subject to quality tiering that could yield an upward, neutral or downward VM adjustment. Based on their performance in the quality and cost measures, these groups could receive a downward adjustment of 2 or 4 percent, or an upward adjustment of a factor of 2(x) or 4(x). There is an automatic VM downward adjustment of 4 percent for these groups who do not report PQRS in 2016.

We've indicated what the exact negative adjustments are in this table, 2% and 4%; but we have not indicated exactly what the upward percentages are, because all of the value modifier adjustments have to be budget neutral. So we have to calculate how much money we have available to give for the upward adjustments. In order to ensure budget neutrality, we will first calculate the total amount of downward payment adjustments that will be applied. This includes the automatic downward Value Modifier payment adjustment for the "non PQRS reporters" and also the downward adjustments for those who are subject to quality tiering. Using the total downward payment adjustment amount, we will then solve for the upward payment adjustment factor (x), and apply accordingly.

Additionally, if a group's average beneficiary risk score is in the top 25%, the group could be eligible for an additional upward adjustment of a factor of 1. You can see where your group's risk score falls on your annual QRUR report.

The table on this slide deals with physicians, PAs, NPs, CNSs and CRNAs who are in groups of 2-9 EPs that include physicians and also to physician solo practitioners only (solo PAs, NPs, CNSs and CRNAs will be represented on the next slide). The cost and quality categories are the same for these groups and solo physician practitioners. As you can see from the chart, practitioners in these groups could see a reduction of 1 or 2%, but conversely can see an upward adjustment of a factor of 1x or 2x, based on their scoring. These groups and physician solo practitioners are also eligible for an additional upward adjustment if the beneficiary risk score is in the top 25 percent.

The final table deals with the PAs, NPs, CNSs and CRNAs who are solo practitioners or who are in groups of any size that DO NOT include physicians. As we've mentioned earlier, these practitioners will not be subject to the downward payment adjustment based on quality tiering in 2017 so long as they report PQRS measures. Practitioners in this category, however, will be subject to the automatic VM downward adjustment of 2% if they do not report for PQRS, in addition to the 2% PQRS adjustment.

2016 is the second performance year for individual EPs and groups participating in the shared savings program. For those EPs, the cost composite will be given a score of "average," similar to last year, while this year's quality composite will be based on quality data that is submitted by the EP or group per the requirements of the shared savings program as well as quality data from the CAHPS for ACOs survey.

If the ACO does not successfully report on the required quality measures per the Shared Savings program, the groups and individual EPs will be subject to the applicable automatic downward VM adjustment.

For solo physicians and physician groups in which at least one EP is participating in the pioneer ACO model, the comprehensive primary care initiative, or other similar Innovation Center models in 2016, will have the 2018 VM waived. CMS will make this determination if at least one EP bills under the TIN of a group participating in one of these programs.

The next two decision trees show how an individual EP's or a group's decision to participate in PQRS in 2016 will determine the VM in 2018. We will start with those EP's or groups who decide NOT to participate in PQRS in 2016. The first question to ask is whether you will report for PQRS this year. If the EP or group does not, and hopefully this is not the decision you will make, we need to determine if you are a physician, PA, NP, CNS or CRNA. If you are not one of these provider types, then you will be subject to the 2018 PQRS payment adjustment of 2.0%, but the value modifier would not apply to you in 2018 since you are not a physician, PA, NP, CNS or CRNA.

If you are a physician, PA, NP, CNS or CRNA, we need to determine if you are a solo practitioner or part of a group. If you are a solo practitioner, you will be subject to the automatic VM downward adjustment since you did not report PQRS in 2016, in addition to the 2 percent payment adjustment for PQRS, for a total adjustment of 4 percent. If you are part of a group, we need to determine if there are physicians included in your group. If there are only non-physicians in the group, then the same adjustments apply as they do to the solo practitioners who do not report PQRS.

If there are physicians included in your group, we need to determine the size of the group to determine the amount of the VM adjustment. If the group is 2-9 EPs, then it is the same adjustment as previously described. If the group comprises of 10 or more EPs, then they are subject to the same 2 percent PQRS payment adjustment, but the VM downward adjustment for these practitioners is 4 percent, for a total of 6 percent.

The next decision tree shows how the VM will be applied in 2018 for those practitioners who do plan to satisfactorily report PQRS in 2016. We must determine if you are a physician, PA, NP, CNS, or CRNA. If you are not one of those practitioner types and are reporting in 2016, then you will avoid the 2018 PQRS payment adjustment of 2 percent. The VM does not apply to you in 2018. If you are a physician, PA, NP, CNS, or CRNA, then we determine if you are a solo practitioner or part of a group. If you are solo, then we ask if you are a solo physician and if so then reporting PQRS in 2016 will avoid the 2018 PQRS payment adjustment, and you would be subject to upward, neutral or downward payment adjustments based on quality tiering. If you are a PA, NP, CNS or CRNA, then you also will avoid the 2018 PQRS adjustment, but you will be held harmless from any downward VM adjustment for poor performance, meaning you will be subject to only an upward or neutral VM adjustment if you satisfactorily report PQRS this year.

Next we look at the scenarios for these practitioners who are reporting as a group. And when we say "group," we mean either a group that registers for the group practice reporting option, or meets the 50 percent threshold, that is, a group identified in PECOS as a group but does not choose to register for the GPRO, but rather have at least 50 percent of the EPs under the group TIN satisfactorily report for PQRS as individuals, we need to determine again if there are physicians in the group, as that will determine the size of the adjustments, both upward and downward. If there are no physicians in the group, then

then the same adjustments that apply to solo PAs, NPs, CNSs and CRNAs apply here. If there are physicians in the group, we must determine the size of the group. If there are 2 9EPs in the group, then they avoid the 2018 PQRS adjustment and are subject to upward, neutral or downward adjustments in the amounts shown in the box. For groups of 10 or more EPs, for satisfactorily reporting PQRS in 2016, they avoid the 2018 PQRS adjustment, however they are subject to the higher VM adjustments as shown in the box.

The next five slides give an overview of the VM policies from 2016 through 2018 that we have discussed, for your reference. As mentioned earlier, 2018 is the final year for the payment adjustments associated with the Value based payment modifier, with the Merit based Incentive Payment System, or MIPS starting in 2019. This is in addition to payments made under the new Alternative payment models, or APMs. In terms of the benchmarks, on the quality side, CMS established for the 2017 VM that the peer group for the All Cause Hospital Readmissions measure would be defined as all groups, identified by their TINs, with 10 or more EPs that had at least 200 eligible cases. For the other quality measures, the peer group is defined as all groups, identified by their TINs, nationwide that had at least 20 eligible cases for each measure. For the 2018 VM, this policy will continue, and CMS will additionally create separate eCQM benchmarks, based on the CMS eMeasure ID and exclude eCQM measures from the overall benchmark for a given measure.

For the cost measures, the 2018 policy is the same as for the 2017 policy. For the Medicare Spending per Beneficiary measure, the peer group will be defined as all TINs nationwide with 10 or more EPs that had at least 200 eligible cases. For the other cost measures, the peer group is defined as all TINs nationwide that had at least 20 eligible cases for each measure.

It is important to note that the timeline for requesting an informal review will be based on the release date of the group's Quality and Resource Use Report, or QRUR, so it is imperative that groups obtain the reports when they are made available, generally in the fall. An informal review request must be submitted within 60 days of the release date of the QRUR.

In terms of those instances when an informal review determines an error was made by CMS or a third party, the quality and cost composites will be recomputed in the event that an error was determined to have been made by CMS or a third party. Additionally, CMS will reclassify a TIN as a successful PQRS reporter if it is determined that at least 50 percent of the TIN's EPs met the successful reporting requirements as individuals in the 2016 PQRS, or participated in a QCDR.

This slide details all of the actions that EPs should take in 2016 so that you can satisfactorily report for PQRS and avoid the payment adjustments we discussed in this presentation. First, if you have not already done so, be sure to report your data for the 2015 PQRS by the deadlines established for the reporting mechanism that you have chosen. If you have not reported PQRS in the past, please review the reporting options that are available to you and choose the one that best pertains to your scope of practice. Keep in mind that not all measures are available to be reported using all of the reporting options, so you need to be sure you choose a reporting option that includes the measures you are able to report.

Also, if you have not already done so, download and review your 2014 QRUR report that was made available in September of 2015. This report gives ample detail about your quality and cost performance and shows where how you fared under quality tiering, along with much more detailed information. Announcements will be made when the 2015 mid-year and annual QRUR reports will be available. Remember, the timeframe in which to request an informal review for any potential errors is 60 days after the release of the annual report, so be sure to review it when it becomes available to you.

CMS has help desks for providers who have questions for each of the programs included in this module. Providers should contact these call centers as their primary contact with inquiries regarding PQRS, the Value Modifier and the ACO programs.

A list of online resources available on the CMS website for each of the programs is found on this slide. You can find links to these sites in the Description section below this video.

That concludes Module four of the Medicare Quality Reporting Programs presentation for 2016. Thank you for watching. To view the remaining modules of this presentation, please see the links in the "Descriptions" section of this video.