CMS Proposals for the Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule

CMS National Provider Call
Physician Feedback and Value-Based Modifier Program
Wednesday, August 1, 2012

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Purpose of this National Provider Call

- To share CMS proposals for calculating the Value Modifier (VM) as outlined in the Proposed Physician Fee Schedule rule published in July 2012.
- To explain how your participation in the Physician Quality Reporting System (PQRS) affects your Value Modifier.
- To describe the proposed timeframes and deadlines facing groups of physicians related to the Value Modifier.
- To address any questions about the proposals.

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What is the Value-Based Modifier?

- The Affordable Care Act requires that Medicare phase in a value-based payment modifier (VM) that would apply to Medicare Fee for Service Payments starting in 2015, phase-in complete by 2017.
- The VM assesses both quality of care furnished and the cost of that care.
- We propose to apply the VM to physician payment in all groups of 25 or more eligible professionals (EPs) starting in 2015.
- The proposals
  - Encourage physician measurement and alignment with PQRS
  - Offer choice of quality measures
  - Encourage shared responsibility and systems-based care
  - Provide actionable information

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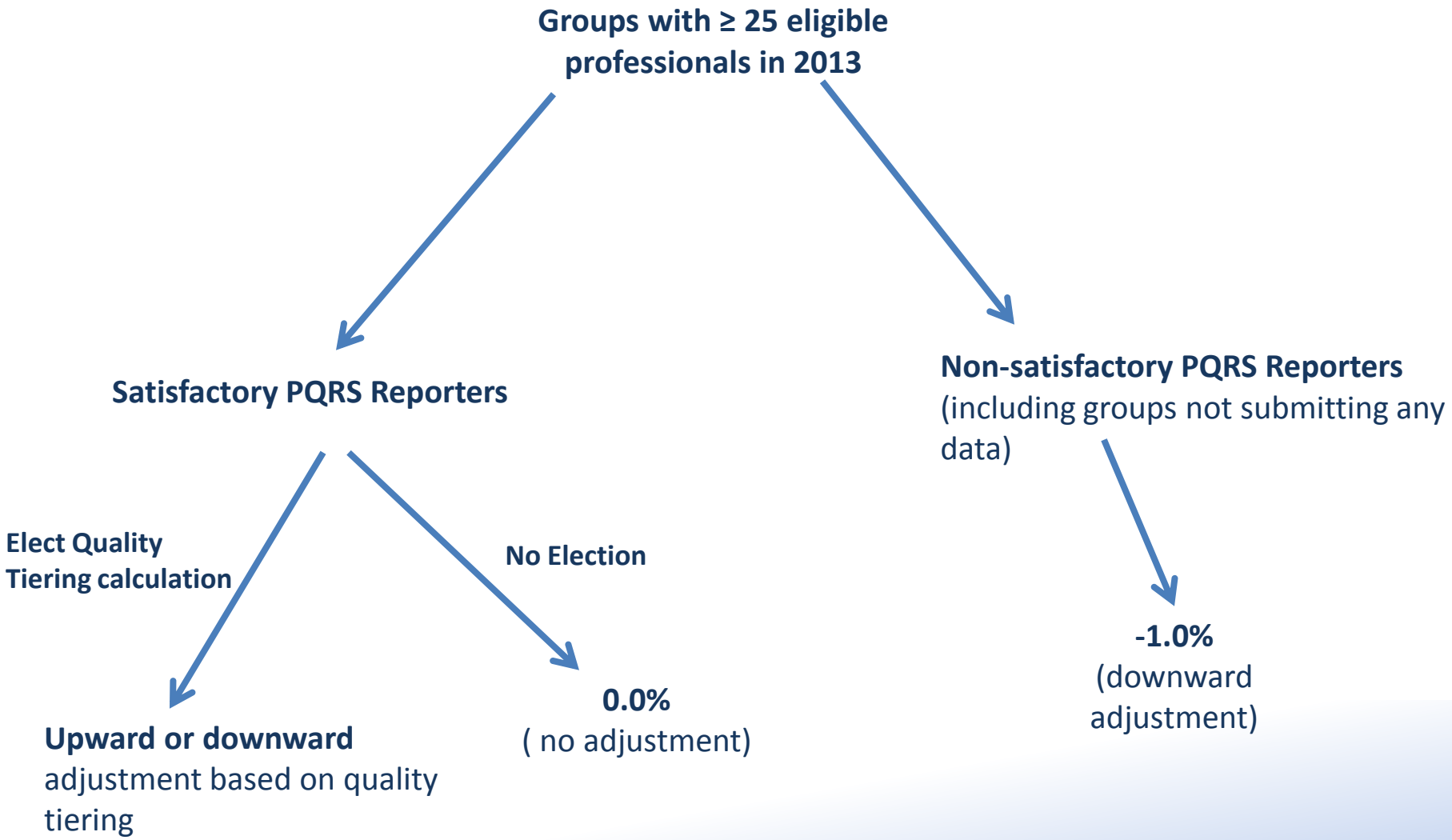
Value Modifier and the Physician Quality Reporting System (PQRS)



Proposed Timeline for VM that Applies to Payment Starting Jan 1, 2015

2012	2013	2014	2015
November: Finalize VM policies	**First quarter:** Self nominate as a group for PQRS and select a PQRS reporting method (5 choices). **Third Quarter:** Retrieve Physician Feedback report that shows 2012 performance and how the VM would apply based on 2012 data. **December:** Deadline for electing "Quality Tiering" calculation approach for VM that starts 1/1/2015	**First Quarter:** Complete submission of 2013 information for PQRS . **Third Quarter:** Retrieve Physician Feedback report showing 2013 performance and how VM applies starting 1/1/2015. Informal review process available	**January 1:** VM applies to payment for items and services provided by physicians in groups of 25 or more eligible professionals

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Reporting Quality Data at the Group Level

Groups must select one of the five PQRS quality reporting methods and that information will be used for the VM

Reporting Method	Type of Measure	Group Size Requirement
1. PQRS GPRO Web interface	22 measures that focus on preventive care for chronic disease	Groups ≥ 25
2. PQRS GPRO using claims	Groups select the quality measures that they will report	Groups between 25-99
3. PQRS GPRO using registries	Groups select the quality measures that they will report	Groups between 25-99
4. PQRS GPRO using EHRs	Groups select the quality measures that they will report	Groups between 25-99
5. PQRS Administrative Claims Option for 2013 and 2014	15 measures that focus on preventive care and care for chronic diseases (calculated from administrative claims data)	Groups ≥ 25

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Quality Measures for All Groups

For groups of >25 eligible professionals, we propose to calculate four outcome measures:

- 30 day Post Discharge Visit
- All Cause Readmission
- Composite of Acute Prevention Quality Indicators
  - Bacterial Pneumonia
  - Urinary Tract Infection (UTI)
  - Dehydration
- Composite of Chronic Prevention Quality Indicators
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Heart failure
  - Diabetes Composite
    - Uncontrolled Diabetes
    - Short term Diabetes Complications
    - Long term Diabetes Complications
    - Lower extremity amputation for diabetes

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Interaction Between Group and Individual PQRS Reporting

- To avoid all PQRS penalties, groups of 25 or more eligible professionals must report at the group level. EPs include:
  - Physicians
  - Practitioners
  - Therapists

- If the group reports at the individual level and not at the group level, the group will be subject to the VM at -1.0%.

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Calculating Cost Measures

- To calculate cost measures for groups of physicians with 25 or more eligible professionals, CMS proposes to use:
  - Total per capita costs measures (Parts A & B)
  - Total per capita costs for beneficiaries with four chronic conditions:
    - Chronic Obstructive Pulmonary Disease (COPD)
    - Heart Failure
    - Coronary Artery Disease
    - Diabetes

- Proposed Attribution Method: Plurality of charges with a minimum of two Evaluation and Management (E/M) services.

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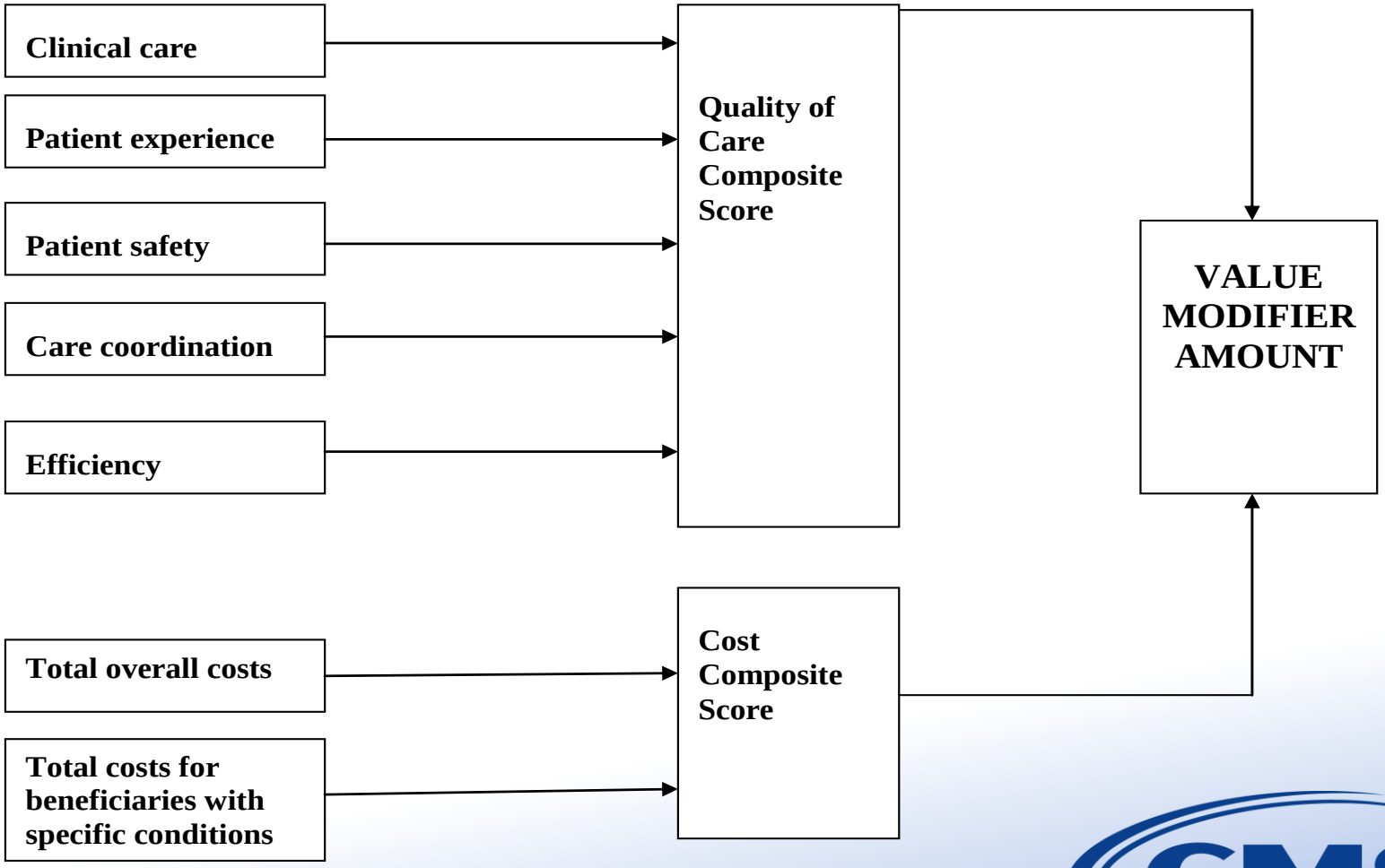
Value Modifier Scoring

Combine each quality measure into a quality composite and each cost measure into a cost composite using the following domains:



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How to Calculate the Quality of Care and Cost Composites

- Create a standardized score for each measure
- Equally weight each measure's score in the relevant domain
- Example of standardized scores in one domain

Quality measure	Group Performance Score	Benchmark (National Mean)	Standard Deviation	Standardized Score
Measure 1	96.0%	95.0%	1.0%	+1.0
Measure 2	70.0%	80.0%	10.0%	-1.0
Measure 3	100.0%	80.0%	5.0%	+4.0
Domain Score				**1.33**

- Calculate quality composite score by equally weighting each domain
- Create a cost composite using the same methodology

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Quality Tiering Option

Divide each group's quality and cost composite scores into three tiers based on whether the score is above, not different from, or below the mean (e.g., the outliers)

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

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

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Assess the Potential Impact of Quality Tiering

- Allows physician choice on which quality measures to report data, and how to report that data, to show high quality care.

- Quality Tiering rewards
  - High quality
  - Low costs

- The proposed methodology focuses on outliers and most groups' composite scores will be classified as average.

- Additional upward incentive for groups treating high-risk patients.

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What the Groups of Eligible Providers Need to Do

Participate in PQRS

- Self nominate as a group in the PQRS Group Practice Reporting Option (GPRO)
- Select one of five PQRS GPRO reporting methods
- Satisfactorily report the required number of measures for the required number of beneficiaries

Decide Whether to Choose the Quality Tiering Approach to Calculate the VM

- Determine whether your group provides care that is high quality/low cost or low quality/high cost

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Physician Feedback Reports

- Plan to provide to physicians in 9 states (CA, IA, IL, KS, MI, MO, MN, NE, and WI) in Fall 2012, based on 2011 data

- Plan to provide to all groups >=25 eligible professionals in 2013 based on 2012 data
  - Includes VM information
  - Disseminate in Fall 2013

- Physician Compare
  - For Fall 2013 based on 2012 data , will include group practice data only

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Question and Answer Session

In the interest of time, please limit your question to one so that we may hear from as many participants as possible.

You may enter *1 to re-enter the queue and we will address follow-up questions as time permits.

Thank you for your cooperation.

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Outstanding Comments & Questions

If we were unable to hear your comment or address your question on today's call, please email it to QRUR@cms.hhs.gov for our consideration.

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To complete the evaluation, visit http://npc.blhtech.com/ and select the title for today's call from the menu.

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We appreciate your feedback!

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Thank you for your participation in today's call.

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