Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2013 Final Rule

Physician Feedback and Value-Based Modifier Program
National Provider Call
November 28, 2012
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• Describe policies for calculating and applying the Value Modifier (VM)

• Explain how participation in the Physician Quality Reporting System (PQRS) affects the VM calculation

• Describe the VM and PQRS deadlines

• Answer questions about the VM policies
What is the Value-Based Modifier?

• VM assesses both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule

• Begin phase-in of VM in 2015, phase-in complete by 2017

• For 2015, apply VM to physician payment in groups of 100+ eligible professionals (EPs)

• Performance period for 2015 VM is calendar year 2013
Value Modifier Implementation Principles

• Encourage physician measurement by aligning with the PQRS

• Offer choice of quality measures and reporting mechanisms

• Encourage shared responsibility and system-based care

• Provide actionable information
Who is an Eligible Professional (EP)?

• **Physicians**
  • MD, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Dental Surgery, Doctor of Dental Medicine, Doctor of Chiropractic

• **Practitioners**
  • Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist, Certified Nurse Midwife, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Nutrition Professional, Audiologists

• **Therapists**
  • Physical Therapist, Occupational Therapist, Qualified Speech-Language Therapist
Defining a Group and Determining its Size

Definition of a group of physicians:
• A single Tax Identification Number (TIN)

Determination of group size:
• Step 1: Query Medicare’s Provider Enrollment, Chain and Ownership System (PECOS) to identify groups of physicians with 100+ EPs as of October 15, 2013
• Step 2: Remove groups from the October 15, 2013 list if the groups did not have 100+ EPs that billed under the group’s TIN during 2013.
  • We will NOT add groups to the October 15 list
The Value Modifier Will Not Apply to:

Physicians who are NOT paid under the Medicare Physician Fee Schedule:

- Rural Health Clinics
- Federally Qualified Health Centers
- Critical Access Hospitals (for physicians electing method II billing)

For 2015 and 2016, to groups of physicians participating in:

- Medicare Shared Savings Program ACOs
- Pioneer ACO model
- Comprehensive Primary Care Initiative
Value Modifier and the Physician Quality Reporting System (PQRS)

Groups of physicians with ≥ 100 eligible professionals

PQRS Reporters
(Groups self-nominating for GPRO web-interface, registries, or administrative claims)

- Elect Quality-Tiering calculation
  - Upward, no, or downward adjustment based on quality-tiering

Non PQRS Reporters
(groups not self-nominating to participate in the PQRS GPRO and not reporting at least one measure)

- No Election
  - 0.0% (no adjustment)

- -1.0% (downward adjustment)

Reporting is a necessary first step towards improving quality.
Timeline for VM that Applies to Payment Starting January 1, 2015

December 1, 2012 - January 31
Self-nominate for PQRS GPRO and eRx GPRO

July – October 15
Self-nominate for PQRS GPRO; elect quality-tiering approach to the VM

1st Quarter
Complete submission of 2013 information for PQRS

January 1
VM applied

2013

Mid-September
Retrieve 2012 Physician Feedback report

2014

3rd Quarter
Retrieve 2013 Physician Feedback report

2015
Groups with 100+ EPs MUST select one of the following PQRS quality reporting mechanisms to avoid the -1.0% VM adjustment.

<table>
<thead>
<tr>
<th>PQRS Reporting Mechanism</th>
<th>Type of Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. GPRO Web interface</td>
<td>Measures focus on preventive care and care for chronic diseases (aligns with the Shared Savings Program)</td>
</tr>
<tr>
<td>2. GPRO using CMS-qualified registries</td>
<td>Groups select the quality measures that they will report through a PQRS-qualified registry.</td>
</tr>
<tr>
<td>3. Administrative Claims Option for 2013</td>
<td>Measures focus on preventive care and care for chronic diseases (calculated by CMS from administrative claims data)</td>
</tr>
</tbody>
</table>
## 2015 Link Between the VM (Groups 100+) and PQRS Reporting

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Self-nominates for PQRS GPRO</td>
<td>Meets criteria for PQRS incentive</td>
<td>N/A</td>
<td>0.0%*</td>
<td>0.5%</td>
</tr>
<tr>
<td>Self-nominates for PQRS GPRO</td>
<td>Submits at least one PQRS measure</td>
<td>N/A</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Self-nominates for PQRS GPRO</td>
<td>Does not submit PQRS measures</td>
<td>N/A</td>
<td>-1.0%</td>
<td>-1.5%</td>
</tr>
<tr>
<td>Self-nominates PQRS for Admin. Claims</td>
<td>Does not submit PQRS measures</td>
<td>Meets criteria for PQRS incentive</td>
<td>0.0%*</td>
<td>0.5%</td>
</tr>
<tr>
<td>Self-nominates PQRS for Admin. Claims</td>
<td>Does not submit PQRS measures</td>
<td>Does not meet criteria for PQRS incentive</td>
<td>0.0%*</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

- If the group elects quality-tiering, the VM could be positive, zero, or negative based on performance.
## 2015 Link Between VM and PQRS for Groups (100+) that do not Self-Nominate for PQRS Reporting

<table>
<thead>
<tr>
<th>Individual EP Reporting Action</th>
<th>VM</th>
<th>PQRS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meets PQRS reporting requirements</td>
<td>-1.0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Submits at least one PQRS measure</td>
<td>-1.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Elects Admin Claims option</td>
<td>-1.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Does nothing</td>
<td>-1.0%</td>
<td>-1.5%</td>
</tr>
</tbody>
</table>
What Quality Measures will be Used for Quality-Tiering?

- Measures reported through the PQRS reporting mechanism selected by the group
- Three outcome measures:
  - All Cause Readmission
  - Composite of Acute Prevention Quality Indicators (bacterial pneumonia, urinary tract infection, dehydration)
  - Composite of Chronic Prevention Quality Indicators (chronic obstructive pulmonary disease, heart failure, diabetes)
What Cost Measures will be used for Quality-Tiering?

- 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

- All cost measures are payment standardized and risk adjusted
How are Beneficiaries Attributed to a Group for Quality-Tiering?

• Attribution is based on the group that provides the plurality of primary care services to the beneficiary

• **Minimum of one primary care service with a physician**
  • A primary care service can include an office based, home health or nursing E&M as well as certain other codes defined by CMS.

• **Same attribution methodology as the Shared Savings Program**

• **If a group of 100+ EPs does not provide primary care services (e.g., radiology groups), the group will not be attributed beneficiaries**
Quality-Tiering Methodology

Use domains to combine each quality measure into a quality composite and each cost measure into a cost composite.

- Clinical care
- Patient experience
- Population/Community Health
- Patient safety
- Care Coordination
- Efficiency

Quality of Care Composite Score

Cost Composite Score

VALUE MODIFIER AMOUNT
Quality of Care and Cost Composites

• Create a standardized score for each quality and cost measure

• Weigh each score equally by domain

<table>
<thead>
<tr>
<th>Quality measure</th>
<th>Group Performance Score</th>
<th>Benchmark (National Mean)</th>
<th>Standard Deviation</th>
<th>Standardized Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure 1</td>
<td>96.0%</td>
<td>95.0%</td>
<td>1.0%</td>
<td>+1.0</td>
</tr>
<tr>
<td>Measure 2</td>
<td>70.0%</td>
<td>80.0%</td>
<td>10.0%</td>
<td>-1.0</td>
</tr>
<tr>
<td>Measure 3</td>
<td>100.0%</td>
<td>80.0%</td>
<td>5.0%</td>
<td>+4.0</td>
</tr>
<tr>
<td>Domain Score</td>
<td></td>
<td></td>
<td></td>
<td><strong>1.33</strong></td>
</tr>
</tbody>
</table>

• Measure 1 standardized score = (96% - 95%) / 1.0% = 1
• Positive score because the group’s performance is greater than the benchmark
Quality-Tiering Scoring

Classify each group’s quality and cost composite scores into three tiers: (high, average and low)

<table>
<thead>
<tr>
<th></th>
<th>Low cost</th>
<th>Average cost</th>
<th>High cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High quality</td>
<td>+2.0x*</td>
<td>+1.0x*</td>
<td>+0.0%</td>
</tr>
<tr>
<td>Average quality</td>
<td>+1.0x*</td>
<td>+0.0%</td>
<td>-0.5%</td>
</tr>
<tr>
<td>Low quality</td>
<td>+0.0%</td>
<td>-0.5%</td>
<td>-1.0%</td>
</tr>
</tbody>
</table>

* Eligible for an additional +1.0x if: (1) reporting quality measures via the web-based interface or registries and (2) average beneficiary risk score in the top 25 percent of all beneficiary risk scores
1. Participate as a GROUP in PQRS in 2013
   • Self-nominate as a group either from December 1, 2012 – January 31, 2013 or during a second period from July-October 15, 2013

2. Select a PQRS GPRO reporting mechanism
   • Web interface
   • CMS-qualified registry
   • Administrative claims
   Note: Groups whose physicians participate as individuals in PQRS must self nominate as a group and elect administrative claims for the VM

3. Decide whether to elect the quality-tiering approach to calculate the VM by October 15, 2013
Assess the Potential Impact of Electing Quality-Tiering

• Physician choice on which quality measures to report data, and how to report that data, to show high-quality care

• Methodology focuses on statistically significant outliers (at least one standard deviation from mean)

• Additional upward incentive for groups treating high-risk patients and reporting via web-interface or registry
Physician Feedback Reports (Quality and Resource Use Reports)

December 2012 – April 2013
• Reports available to physicians groups of 25+ EPs in nine states (CA, IA, IL, KS, MI, MO, MN, NE and WI) based on 2011 data
• Groups of physicians that reported measures via the PQRS GPRO web interface during 2011
• Reports preview some VM information (PQRS and administrative claims measure comparisons to national benchmarks)

September 2013 – February 2014
• Reports for groups of 25+ EPs based on 2012 data
• Preview VM quality and cost composites.
• Informs quality-tiering election for groups of 100+ EPs
Does CMS have Your Current Information?

Information for the VM and Physician Feedback reports comes from the Provider Enrollment, Chain and Ownership System (PECOS)

• Your medical specialty
• The state in which you practice
• The location of your practice
• Group practice affiliations
• How to contact you

Please update your information at: https://pecos.cms.hhs.gov
Where to Call for Help

• For questions related to the Value-based Payment modifier:
  Contact QRUR@cms.hhs.gov

• For questions related to PQRS:
  QualityNet Help Desk at 866-288-8912 or qnetsupport@sdps.org
Time for comments and questions.
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