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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Presentation Overview

- 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

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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

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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

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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

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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

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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

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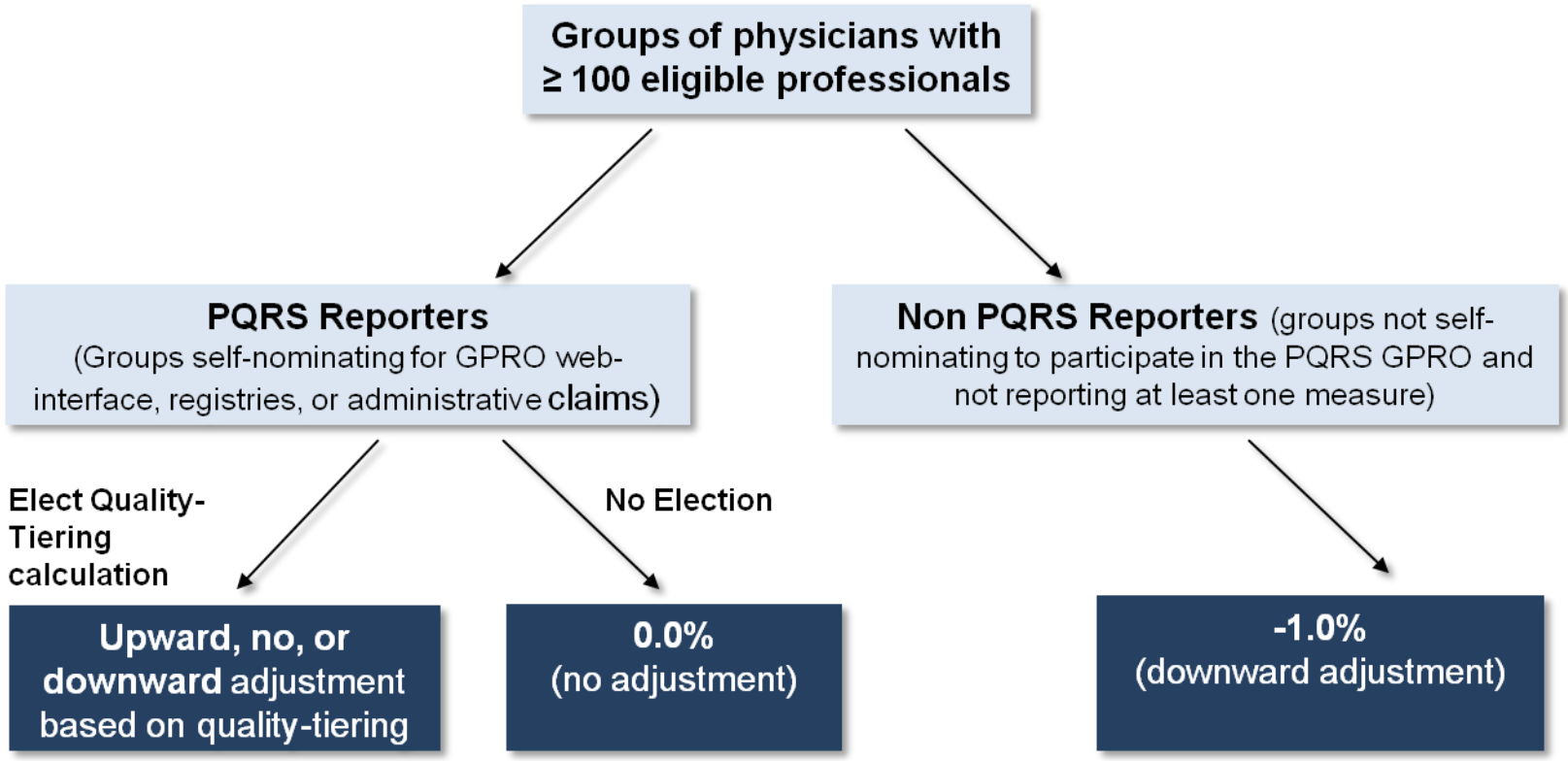
Value Modifier and the Physician Quality Reporting System (PQRS)



Reporting is a necessary first step towards improving quality.

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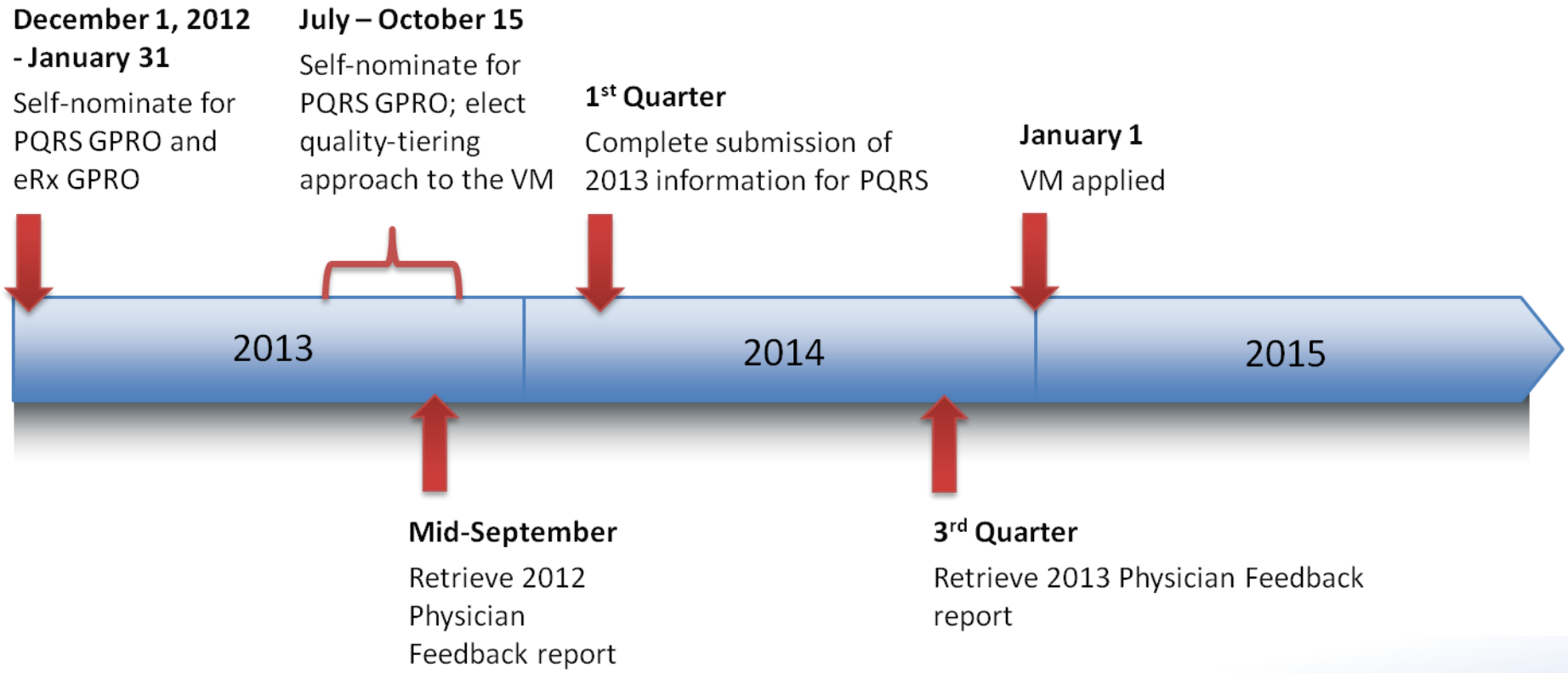
Timeline for VM that Applies to Payment Starting January 1, 2015



Reporting Quality Data at the Group Level

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

PQRS Reporting Mechanism	Type of Measure
1. GPRO Web interface	Measures focus on preventive care and care for chronic diseases (aligns with the Shared Savings Program)
2. GPRO using CMS-qualified registries	Groups select the quality measures that they will report through a PQRS-qualified registry.
3. Administrative Claims Option for 2013	Measures focus on preventive care and care for chronic diseases (calculated by CMS from administrative claims data)

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2015 Link Between the VM (Groups 100+) and PQRS Reporting

Group Self-Nomination Action	Group Reporting Action	EP Reporting Action	VM	PQRS
Self-nominates for PQRS GPRO	Meets criteria for PQRS incentive	N/A	0.0%*	0.5%
Self-nominates for PQRS GPRO	Submits at least one PQRS measure	N/A	0.0%	0.0%
Self-nominates for PQRS GPRO	Does not submit PQRS measures	N/A	-1.0%	-1.5%
Self-nominates PQRS for Admin. Claims	Does not submit PQRS measures	Meets criteria for PQRS incentive	0.0%*	0.5%
Self-nominates PQRS for Admin. Claims	Does not submit PQRS measures	Does not meet criteria for PQRS incentive	0.0%*	0.0%

- If the group elects quality-tiering, the VM could be positive, zero, or negative based on performance.

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2015 Link Between VM and PQRS for Groups (100+) that do not Self-Nominate for PQRS Reporting

Individual EP Reporting Action	VM	PQRS
Meets PQRS reporting requirements	-1.0%	0.5%
Submits at least one PQRS measure	-1.0%	0.0%
Elects Admin Claims option	-1.0%	0.0%
Does nothing	-1.0%	-1.5%

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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)

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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**

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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**

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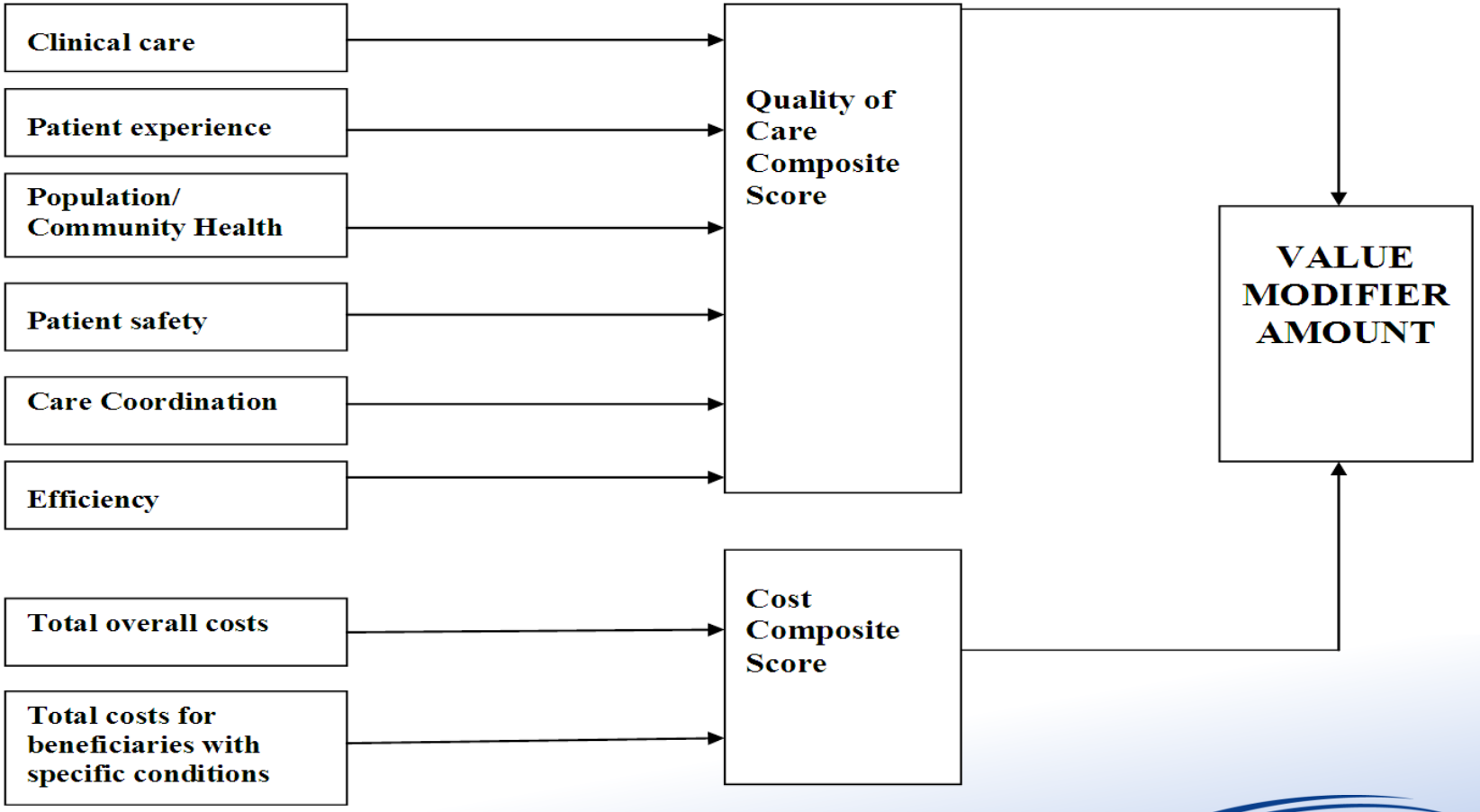
Quality- Tiering Methodology

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



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Quality of Care and Cost Composites

- Create a standardized score for each quality and cost measure
- Weigh each score equally by 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**

- Measure 1 standardized score =(96% - 95%) / 1.0% = 1
- Positive score because the group's performance is greater than the benchmark

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Quality-Tiering Scoring

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

	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 : (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

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Actions for Groups of 100+ Eligible Professionals

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**

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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

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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

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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

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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

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Comments & Questions

Time for comments and questions.

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Thank you for your participation in today's call.

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