Understanding the Implications of Medicare’s Physician Value-Based Payment Modifier

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Agenda

- Introduction
- PQRS v. VBPM
- VBPM Adjustments
- Resources
- Questions & Answers
INTRODUCTION
Don’t Shoot the Messenger!

• This is complicated stuff
• We have less than an hour and cannot cover everything in detail
• Some of the rules are still being developed or may be revised
Introduction

- Value-based payment modifier (VBPM) created by the Patient Protection and Affordable Care Act (PPACA)
- Adjustments to Medicare physician fee schedule (PFS) payments based on:
  - Quality of care
  - Cost of care
- Adjustments may be up, down or neutral
- Budget-neutral payment system, so upside amounts uncertain
Introduction

- Eligible Professionals (EPs) are:
  - Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Dental Surgery, Doctor of Dental Medicine, Doctor of Chiropractic
  - Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist, Certified Nurse Midwife, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Nutrition Professional, Audiologists
  - Physical Therapist, Occupational Therapist, Qualified Speech-Language Therapist
PQRS V. VBPM
PQRS v. VBPM

- Physician Quality Reporting System (PQRS) implemented in 2007
- PQRS provides incentives and, after PPACA, adjustments to PFS for reporting/not reporting quality information
- Not tied to achieving quality – just reporting
- PQRS reporting status impacts VBPM adjustment, but the two adjustments are separate and distinct
- Double hit possible
PQRS v. VBPM

- PQRS applies to all EPs, but can participate as individual or group

- 2013: PQRS incentive of 0.5%

- 2014: PQRS incentive of 0.5% (last year)

- 2015: PQRS adjustment of -1.5% (based on 2013 if did not participate or unsuccessful in reporting)

- 2016: PQRS adjustment of -2.0% (based on 2014 if did not participate or unsuccessful in reporting)
VBPM ADJUSTMENTS
VBPM Adjustments

- Are to **physician payments** under the PFS, not payments to:
  - Non-physician EPs
  - Non-PFS entities: Rural Health Clinics, Federally Qualified Health Centers or Critical Access Hospitals electing method II billing
- Impact Medicare paid amounts, not beneficiary cost sharing amounts
- Impacts non-PAR physicians as well if accept assignment
VBPM Adjustments

• Are made at the tax identification number (TIN) level
• Do not apply to groups in which any of the group’s physicians participate in:
  – Medicare Shared Savings Program ACOs
  – The Pioneer ACO model
  – The Comprehensive Primary Care Initiative
VBPM Adjustments

- Are phased-in starting in 2015 and fully-implemented by 2017
- Phased-in based on group size:
  - 2015: groups of EPs of 100 or more
  - 2016: groups of EPs of 10 or more
  - 2017: all groups and physicians
VBPM Adjustments

• So, for 2015 the adjustment will be based on:
  – Group size (100 or more EPs)
  – PQRS reporting for 2013
  – Election of quality tiering or not
• Group is based on TIN with 2 or more EPs reassigning to the group
• Size determined as of October 15, 2013
• Two-step process:
  – Queried PECOS to identify possible groups
  – Analyzed claims for services in 2013 (claims through February 28, 2014)
• Group removed if did not have 100 or more EPs submit claims under TIN
• Groups not added to original October list
Groups of 100 or more EPs are then separated into two categories based on 2013 PQRS reporting status.

Category 1: PQRS group practice reporting options (GPRO) include:

a. Self-nominate for 2013 PQRS reporting as a group and report at least one measure (via web interface or CMS-qualified registry).

b. Elect PQRS administrative claims option as a group for 2013 (even if individuals report, election must be made as group).
PQRS Reporting

• Category 2: all other 100 or more EP groups, including:
  – Groups that failed to either self-nominate or elect PQRS administrative claims option as a group for 2013
  – Groups that self-nominated but failed to report at least one measure (started out as Cat 1(a) but dropped to Cat 2 due to failure to report)
Election of Quality Tiering

- Category 1 groups had the option of electing to have VBPM determined based on “quality tiering”
- Quality tiering is based on group’s relative cost and quality from 2013 performance
- Making the election results in an VBPM that can be up, down or neutral
- Making no quality tiering election results in a neutral VBPM adjustment for 2015, with no upside or downside
Quality/Cost Determination

• 17 quality measures based on PQRS reporting
  – 14 process measures
  – 3 outcomes measures
• 5 per capita cost measures
• Beneficiaries are attributed to groups based on Medicare Shared Savings methodology
# Quality Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Steward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-Up After Hospitalization for Mental Illness</td>
<td>NCQA</td>
</tr>
<tr>
<td>Use of High-Risk Medications in the Elderly</td>
<td>NCQA</td>
</tr>
<tr>
<td>Lack of Monthly INR Monitoring for Beneficiaries on Warfarin</td>
<td>CMS</td>
</tr>
<tr>
<td>Use of Spirometry Testing to Diagnose COPD</td>
<td>NCQA</td>
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<tr>
<td>Adherence to Statin Therapy for Beneficiaries with Coronary Artery Disease</td>
<td>CMS</td>
</tr>
<tr>
<td>Lipid Profile for Beneficiaries Who Started Lipid-Lowering Medications</td>
<td>Resolution Health</td>
</tr>
<tr>
<td>Osteoporosis Management in Women ≥ 67 Who Had a Fracture</td>
<td>NCQA</td>
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<tr>
<td>Dilated Eye Exam for Beneficiaries ≤ 75 with Diabetes</td>
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<tr>
<td>HbA1c Testing for Beneficiaries ≤ 75 with Diabetes</td>
<td>NCQA</td>
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<tr>
<td>Urine Protein Screening for Beneficiaries ≤ 75 with Diabetes</td>
<td>NCQA</td>
</tr>
<tr>
<td>Lipid Profile for Beneficiaries ≤ 75 with Diabetes</td>
<td>NCQA</td>
</tr>
<tr>
<td>Lipid Profile for Beneficiaries with Ischemic Vascular Disease</td>
<td>NCQA</td>
</tr>
<tr>
<td>Antidepressant Treatment for Depression</td>
<td>NCQA</td>
</tr>
<tr>
<td>Breast Cancer Screening for Women Ages 40–69</td>
<td>NCQA</td>
</tr>
<tr>
<td>Composite of Acute Prevention Quality Indicators (bacterial pneumonia, urinary tract infection, dehydration)</td>
<td>AHRQ</td>
</tr>
<tr>
<td>Composite of Chronic Prevention Quality Indicators (COPD, heart failure, diabetes)</td>
<td>AHRQ</td>
</tr>
<tr>
<td>All Cause Readmission</td>
<td>CMS</td>
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**Process**

- Follow-Up After Hospitalization for Mental Illness
- Use of High-Risk Medications in the Elderly
- Lack of Monthly INR Monitoring for Beneficiaries on Warfarin
- Use of Spirometry Testing to Diagnose COPD
- Adherence to Statin Therapy for Beneficiaries with Coronary Artery Disease
- Lipid Profile for Beneficiaries Who Started Lipid-Lowering Medications
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- Lipid Profile for Beneficiaries ≤ 75 with Diabetes
- Lipid Profile for Beneficiaries with Ischemic Vascular Disease
- Antidepressant Treatment for Depression
- Breast Cancer Screening for Women Ages 40–69

**Outcome**

- Composite of Acute Prevention Quality Indicators (bacterial pneumonia, urinary tract infection, dehydration)
- Composite of Chronic Prevention Quality Indicators (COPD, heart failure, diabetes)
- All Cause Readmission
Quality Measures

• The 17 quality measures are classified into six domains:
  – Clinical care
  – Patient experience
  – Population/community health
  – Patient safety
  – Care coordination
  – Efficiency

• Domains and measures weighted equally, and composite score developed
Cost Measures

• Total per capita cost (Parts A and B, but not D)
• Per capita cost for beneficiaries with specific chronic conditions
  – Chronic obstructive pulmonary disease (COPD)
  – Heart failure
  – Coronary artery disease
  – Diabetes
• Cost measures classified in two domains
• Domains and measures weighted equally, and composite score developed
Cost Measures

- Based on standardized payment methodology excluding geographic payment differences
- Hierarchical Condition Category (HCC) used to risk adjust cost measures
- Adjusted for specialty mix of EPs in the group
Value Modifier Score

- Clinical Care
- Patient Experience
- Pop/Comm Health
- Patient Safety
- Care Coordination
- Efficiency

Quality of Care Composite

Cost Composite

Value Modifier Score

Total per capita costs
Per capita costs for specific conditions
# Election of Quality Tiering 2015

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<th>Average Cost</th>
<th>High Cost</th>
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<tr>
<td>High Quality</td>
<td>+2.0x*</td>
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<td>Medium Quality</td>
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* Eligible for an additional +1.0x if reporting clinical data for quality measures and average beneficiary risk score is in the top 25% of all beneficiary risk scores

Value of “x” will depend on total sum of negative adjustments in year

Additional upward payment adjustment for high-risk beneficiaries
Summary of VBPM for 2015

Groups of EPs >= 100

Category 1(a) & (b) groups
- Elect Quality Tiering
  - Adjustment -1.0% to +2.0x

Category 2 groups
- No Election
  - Adjustment 0.0%

- Adjustment -1.0%
## Impact of VBPM & PQRS in 2015

<table>
<thead>
<tr>
<th>Group Reporting Status</th>
<th>Group Reporting Action</th>
<th>Individual Eligible Reporting</th>
<th>VBPM Adjust. 1/1/2015</th>
<th>PQRS Incentive for 2013</th>
<th>PQRS Adjust. 1/1/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cat 1(a): self-nominated</td>
<td>Report &amp; meet PQRS incentive criteria</td>
<td>N/A</td>
<td>0.0% or -1.0% to +2.0x for group (tiering election)</td>
<td>0.5% for group</td>
<td>0.0% for group</td>
</tr>
<tr>
<td>Cat 1(a): self-nominated</td>
<td>Submit only one PQRS measure</td>
<td>N/A</td>
<td>0.0% for group</td>
<td>0.0% for group</td>
<td>0.0% for group</td>
</tr>
<tr>
<td>Cat 1(a): self-nominated</td>
<td>Submit but unsatisfactory PQRS reporting</td>
<td>N/A</td>
<td>0.0% for group</td>
<td>0.0% for group</td>
<td>-1.5% for group</td>
</tr>
<tr>
<td>Cat 2: self-nominated but failed to report</td>
<td>No PQRS submission</td>
<td>N/A</td>
<td>-1.0% for group</td>
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<td>Cat 1(b): Register for PQRS Admin Claims as group</td>
<td>No action</td>
<td>Individuals reporting separately</td>
<td>0.0% or -1.0% to +2.0x for group (tiering election)</td>
<td>0.5% for individuals meeting criteria</td>
<td>0.0% for group</td>
</tr>
<tr>
<td>Cat 1(b): Register for PQRS Admin Claims as group</td>
<td>No action</td>
<td>Individuals not reporting separately</td>
<td>0.0% or -1.0% to +2.0x for group (tiering election)</td>
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<tr>
<td>Cat 2</td>
<td>N/A</td>
<td>Individuals reporting separately</td>
<td>-1.0% for group</td>
<td>0.5% for reporting individuals meeting criteria</td>
<td>0.0% for individual</td>
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<tr>
<td>Cat 2</td>
<td>N/A</td>
<td>Submits only one measure or does not meet criteria</td>
<td>-1.0% for group</td>
<td>0.0% for individual</td>
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<tr>
<td>Cat 2</td>
<td>N/A</td>
<td>Elect Admin Claims option as individual but no reporting</td>
<td>-1.0% for group</td>
<td>0.0% for individual</td>
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<tr>
<td>Cat 2</td>
<td>N/A</td>
<td>Does nothing</td>
<td>-1.0% for group</td>
<td>0.0% for individual</td>
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VBPM Adjustments for 2016

• For 2016 the VBPM will be based on:
  – Group size (10 or more EPs)
  – PQRS reporting for 2014

• CMS estimates this will result in 17,000 groups/60% of physicians subject to VBPM in 2016
VBPM Adjustments for 2016

- Quality tiering is no longer elective, but rather mandatory
- Downside adjustment is increased for groups of 100 or more EPs
- No downside adjustment for smaller groups that are PQRS reporting (only neutral to upside)
# Quality Tiering 2016: EPs >= 100

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Additional upward payment adjustment for high-risk beneficiaries
# Quality Tiering 2016: EPs >= 10 but < 100

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Value of “x” will depend on total sum of negative adjustments in year

Additional upward payment adjustment for high-risk beneficiaries
Summary of VBPM for 2016

Groups of EPs >= 10

2014 PQRS Reporting

EPs < 100

Adjustment 0.0% to +2.0x

EPs >= 100

Adjustment -2.0% to +2.0x

2014 Non-PQRS Reporting

Adjustment -2.0%
2017
VBPM RESOURCES
Resources

- **CMS Fact Sheet:**

- **CMS Summary of 2015 VBPM:**

QUESTIONS & ANSWERS