MLN Connects™

National Provider Call

The Physician Value-Based Payment Modifier under the 2014 Medicare Physician Fee Schedule

December 3, 2013

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Agenda

- Discuss finalized policies to continue to phase in and expand application of the Value Modifier (VM) in 2016 based on performance in 2014.
- Explain how the VM is aligned with the reporting requirements under the Physician Quality Reporting System (PQRS).
- Review the cost measures included in the VM
- Answer questions about the VM policies and phase-in.

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
- Implementation of the VM is based on participation in Physician Quality Reporting System
- For CY 2015, we will apply the VM to groups of physicians with 100 or more eligible professionals (EPs)

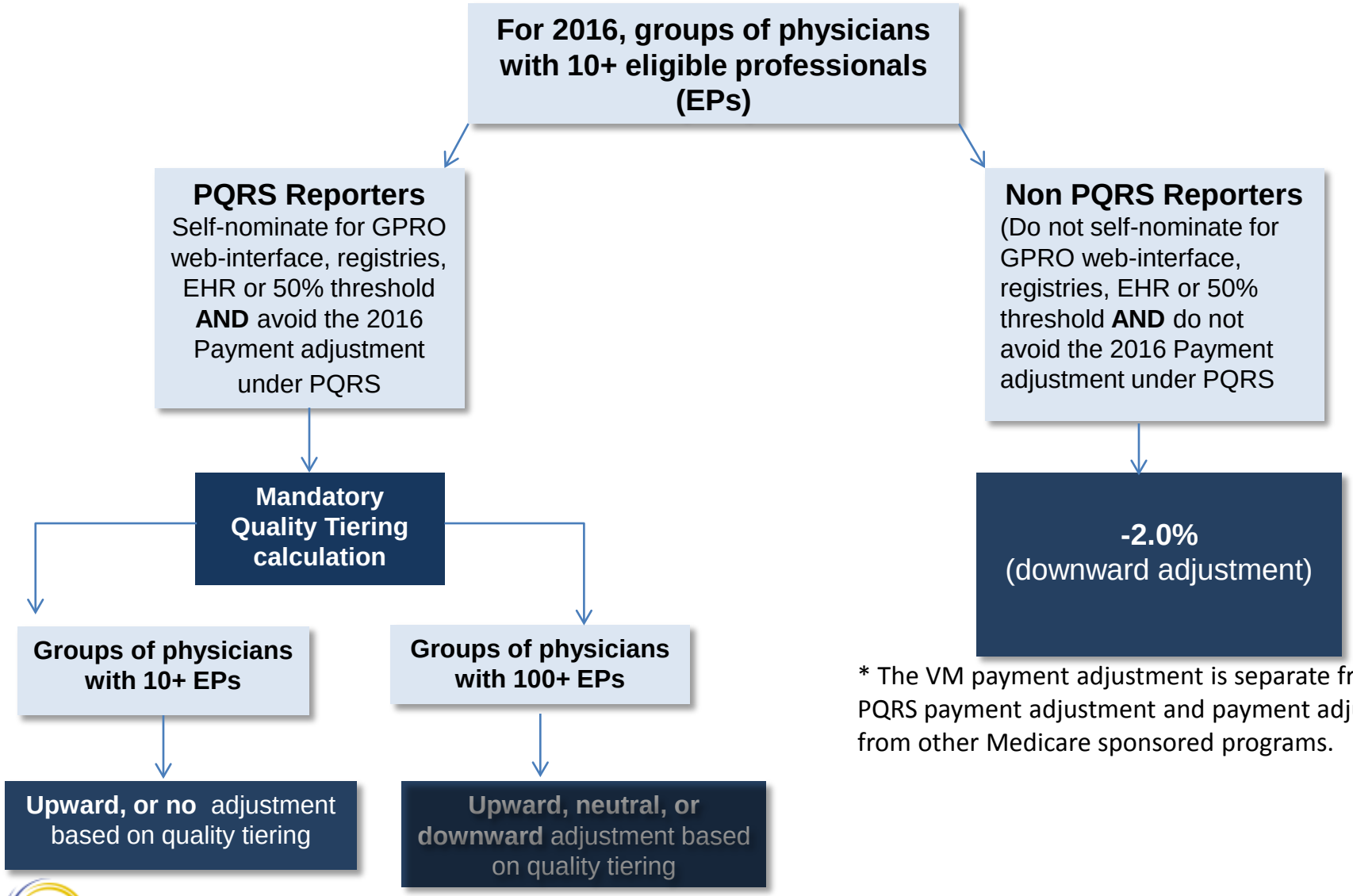
Value Modifier Policies for 2015 & 2016

Value Modifier Components	2015 Finalized Policies	2016 Finalized Policies
Performance Year	2013	2014
Group Size	100+	10+
Available Quality Reporting Mechanisms	GPRO-Web Interface, CMS Qualified Registries, Administrative Claims	GPRO-Web Interface, CMS Qualified Registries, EHRs, and 50% of EPs reporting individually
Outcome Measures NOTE: The performance on the outcome measures and measures reported through the PQRS reporting mechanisms will be used to calculate a quality composite score for the group for the VM.	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 (COPD), heart failure, diabetes)	Same as 2015
Patient Experience of Care Measures	N/A	PQRS CAHPS: Option for groups of 25+ EPs

Value Modifier Policies for 2015 & 2016 (continued)

Value Modifier Components	2015 Finalized Policies	2016 Finalized Policies
Cost Measures	Total per capita costs measure (annual payment standardized and risk-adjusted Part A and Part B costs) Total per capita costs for beneficiaries with four chronic conditions: COPD, Heart Failure, Coronary Artery Disease, Diabetes	Same as 2015 and Medicare Spending Per Beneficiary measure (includes Part A and B costs during the 3 days before and 30 days after an inpatient hospitalization)
Benchmarks	Group Comparison	Specialty Adjusted Group Cost
Quality Tiering	Optional	Mandatory Groups of 10-99 EPs receive only the upward adjustment, no downward adjustment. Groups of 100+ both the upward and downward adjustment apply.
Payment at Risk	-1.0%	-2.0%

Value Modifier and the Physician Quality Reporting System (PQRS)



* The VM payment adjustment is separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs.

Reporting Quality Data at the Group Level

- Groups with 10+ EPs may select one of the following PQRS GPRO quality reporting mechanisms and meet the criteria for the CY 2016 PQRS payment adjustment to avoid the 2.0% 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. GPRO using EHR	Quality measures data extracted from a qualified EHR product for a subset of proposed 2014 Physician Quality Reporting System quality measures.

Reporting Quality Data at the Individual Level - 50% Threshold Option

- If a group does not seek to report quality measures as a group, CMS will calculate a group quality score if at least 50 percent of the eligible professionals within the group report measures individually.
  - At least 50% of EPs must successfully avoid the 2016 PQRS payment adjustment
  - EPs may report on measures available to individual EPs via the following reporting mechanisms:
    - Claims
    - CMS Qualified Registries
    - EHR
    - Clinical Data Registries (new for CY 2014)

What Quality Measures will be Used for Quality-tiering?

- Measures reported through the GPRO PQRS reporting mechanism selected by the group OR individual measures reported by at least 50% of the eligible professionals within the group (50% threshold option)
- Three outcome measures:
  - All Cause Readmission
  - Composite of Acute Prevention Quality Indicators (bacterial pneumonia, urinary tract infection, dehydration)
  - Composite of Chronic Prevention Quality Indicators (COPD, heart failure, diabetes)
- PQRS CAHPS Measures for 2014 (Optional)
  - Patient Experience of Care measures
  - For groups of 25 or more eligible professionals

What Cost Measures will be used for Quality-tiering?

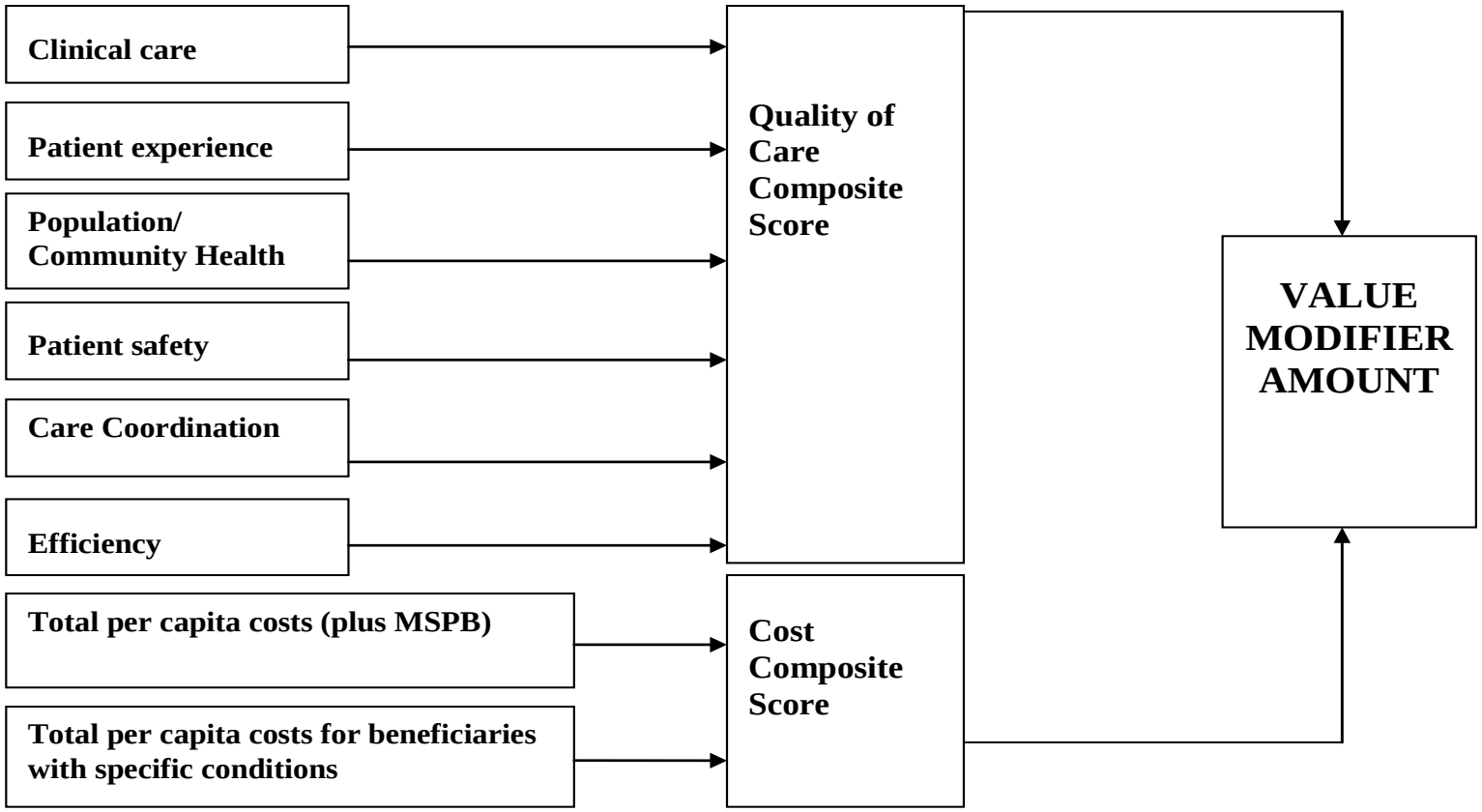
- Total per capita costs measures (Parts A & B)
- Total per capita costs for beneficiaries with 4 chronic conditions:
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Heart Failure
  - Coronary Artery Disease
  - Diabetes
- Medicare Spending Per Beneficiary measure (3 days prior and 30 days after an inpatient hospitalization) attributed to the group providing the plurality of Part B services during the hospitalization
- All cost measures are payment standardized and risk adjusted.
- Each group's cost measures adjusted for specialty mix of the EPs in the group.

Cost Measure Attribution

- 5 Total Per Capita Cost Measures
  - Identify all beneficiaries who have had at least one primary care service rendered by a physician in the group.
  - Followed by a two-step assignment process
    - First, assign beneficiaries who have had a plurality of primary care services (allowed charges) rendered by primary care physicians.
    - Second, for beneficiaries that remain unassigned, assign beneficiaries who have received a plurality of primary care services (allowed charges) rendered by any eligible professional
- MSPB measure – attribute the hospitalization to the group of physicians providing the plurality of Part B services during the inpatient hospitalization.

Quality-tiering Methodology

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



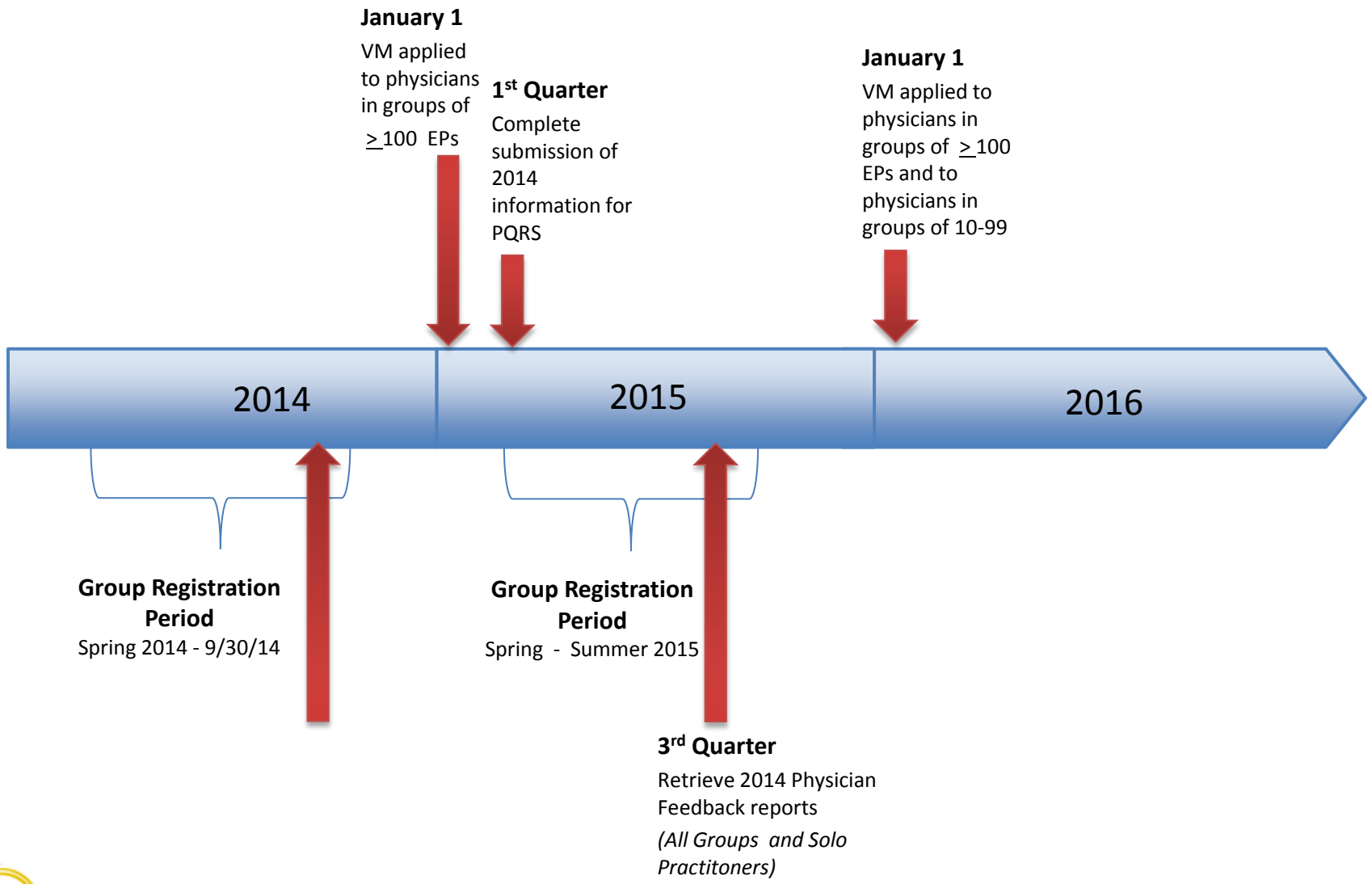
Quality-tiering Approach

- Each group receives two composite scores (quality and cost), based on the group's **standardized performance** (e.g. how far away from the national mean.)
- Group cost measures are adjusted for specialty composition of the group.
- This approach identifies statistically significant outliers and assigns them to their respective quality and cost tiers.

Quality/cost	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Medium quality	+1.0x*	+0.0%	-1.0%
Low quality	+0.0%	-1.0%	-2.0%

* 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.

Timeline for VM that Applies to Payment Starting January 1, 2016



Physician Feedback Reports

- Late Summer 2014 : QRURs for all Groups and Solo Practitioners
- Drill down tables including beneficiaries attributed to the group, their resource use, specific chronic diseases
  - Drill down table including all hospitalizations for attributed beneficiaries
  - Drill down table of individual EP PQRS reporting (December 2014)

Question and Answer Session

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