THE HEALTHCARE QUALITY COALITION

Physician Value-based Payment Modifier

CY 2017 Physician Fee Schedule Proposed Rule update

August 10, 2016

Outline

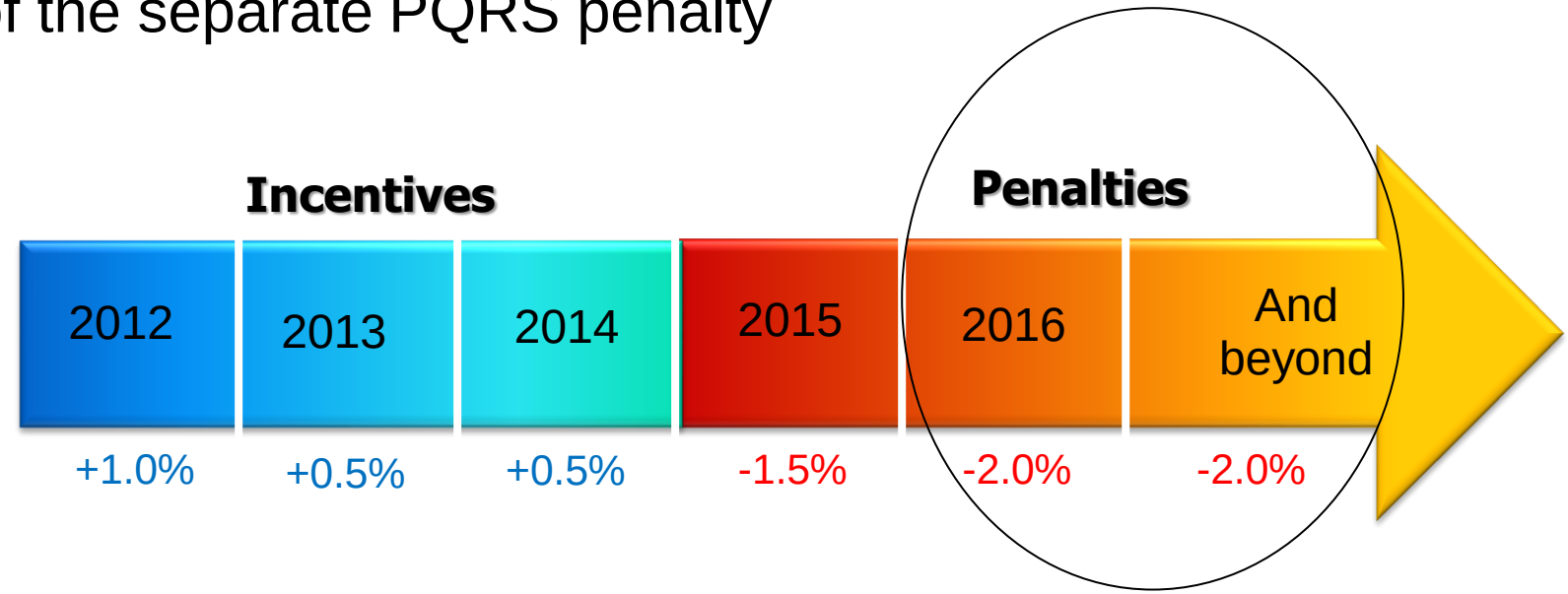
- Physician Value-Based Payment Modifier
  - Overview
  - Past implementation
  - Current proposed rule updates
- How PQRS & value modifier ties into the Merit-based Incentive Payment System
- Conclusion and Next Steps

What is the Medicare Physician VBPM?

- Section 3007 of the Affordable Care Act (ACA)
- Existing physician fee schedule, payment adjustments based on the quality and cost of care
- Considered a payment “at-risk” program
- Like hospital VBP, physician value modifier is budget neutral
- Performance is categorized based on standard deviation(s)
- Gradual implementation, by CY 2017 all Medicare providers will be subject to the value modifier in some way

What is PQRS?

- Commenced as voluntary quality reporting program for physicians since 2007
- Provides incentives and imposes penalties based on satisfactory quality reporting
- Failure to satisfactorily report under PQRS will result in maximum penalty under VBPM, which will be applied on top of the separate PQRS penalty



Physician Value Modifier EPs

- Physicians, Practitioners, Physical or occupational therapists, Qualified speech-language pathologists, Qualified Audiologists

MIPS EPs

Years 1 and 2
Physicians
Physician Assistants
Nurse Practitioners
Clinical Nurse Specialists
Certified Registered Nurse Anesthetists

Years 3 and Beyond *Secretary has authority to expand list of eligible clinicians*
Physical or Occupational Therapists
Speech-language Pathologists
Audiologists
Nurse Midwives
Clinical Social Workers
Clinical Psychologists
Dieticians/Nutrition Professionals

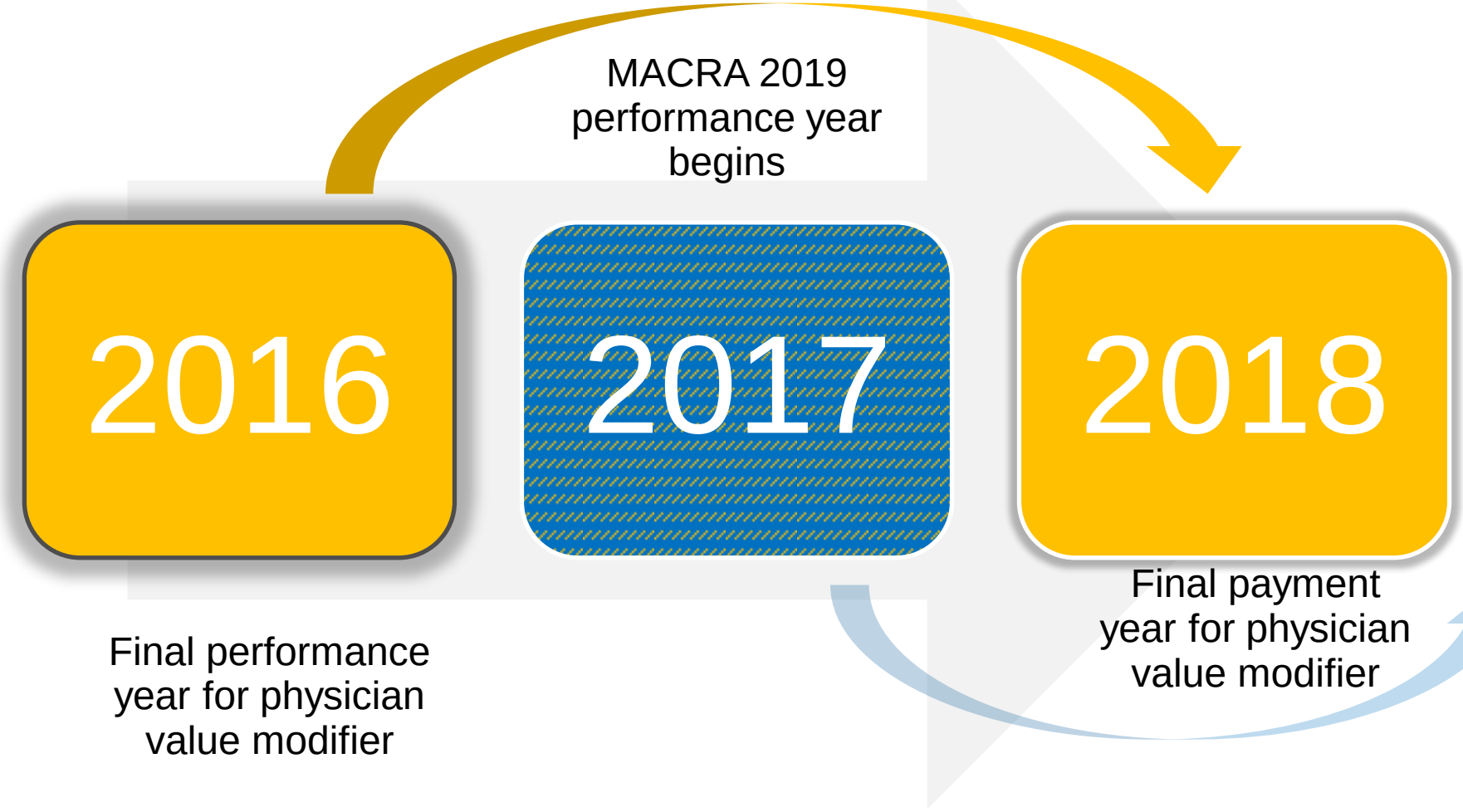
Satisfactorily reporting PQRS

CY 2016 reporting for CY 2018 payment adjustment

Group Size	Available Reporting Mechanisms	Reporting Requirement
2-24 EPs	Qualified Registry EHR Reporting Qualified Clinical Data Registry Certified CAHPS Vendor (voluntary, but must also report 6 non-cahps measures thru other method)	Report 9 measures across 3 NQS Domains QCDR: 2 outcomes
25-99 EPs	GPRO Web Interface Qualified Registry EHR Reporting Qualified Clinical Data Registry Certified CAHPS Vendor(voluntary, but must also report 6 non-cahps measures across 2 NQS domains thru other method)	Web: Populate data fields for first 248 Report 9 measures across 3 NQS Domains QCDR: 2 outcome
100+ EPs	GPRO Web Interface Qualified Registry EHR Reporting Qualified Clinical Data Registry Certified CAHPS Vendor (mandatory for web interface, EHR and qualified registry, must also report 6 non-cahps measures across 2 NQS domains thru other methods)	QCDR: 9 measures across 3 NQS Domains; 2 outcomes

More information on requirements

Performance Period and Payment Year



Value Modifier Cost and Quality Measures

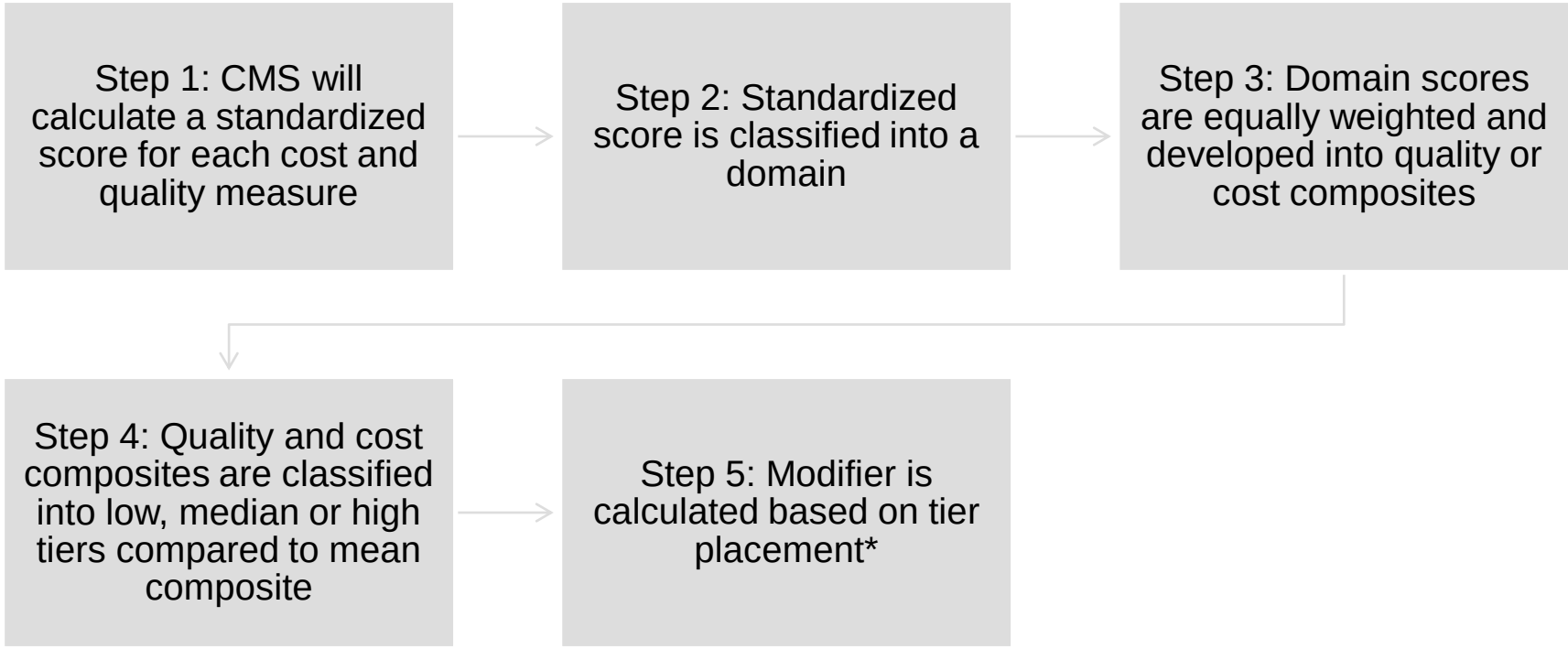
Cost/Efficiency

- 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
- Medicare Spending Per Beneficiary measure
- Minimum 125 cases

Quality

- Quality composite based on PQRS measures submitted
- 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)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Basic Overview of VBPM Scoring Methodology

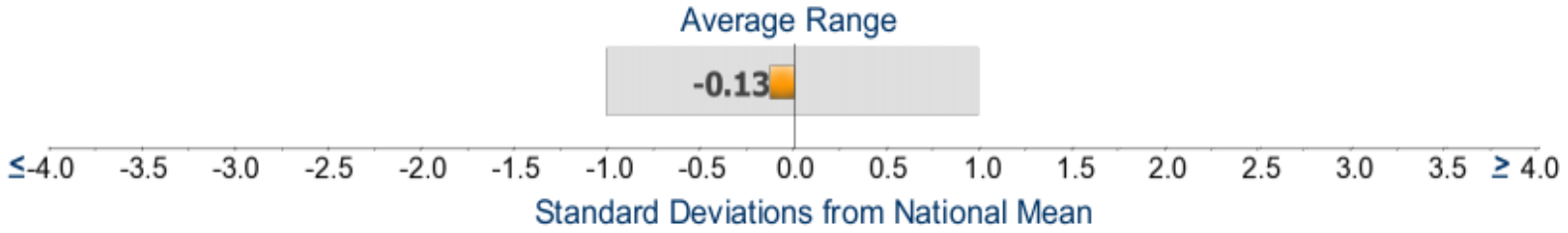


*Informal review process occurs within 60 days following release of Quality and Resource Use Reports

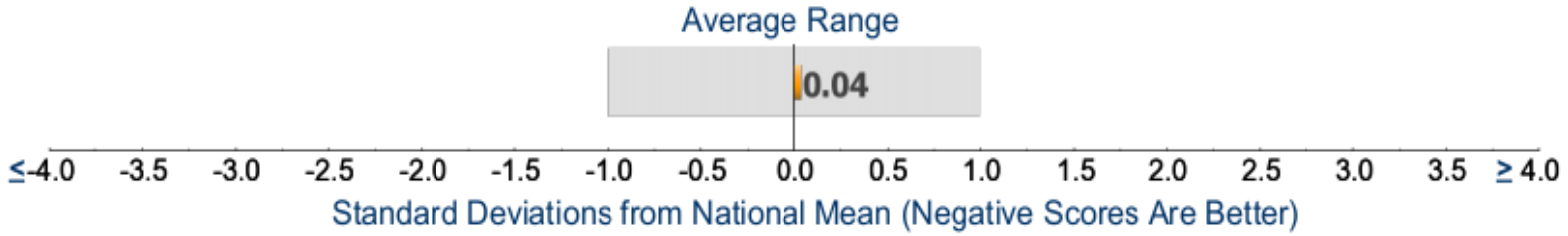
Physician Value Modifier Example Score

PERFORMANCE HIGHLIGHTS

YOUR QUALITY COMPOSITE SCORE: AVERAGE



YOUR COST COMPOSITE SCORE: AVERAGE



Quality Tiering Sample

Best performers

Lowest performers

Adjustment as Illustrated on Sample QRUR

YOUR VALUE-BASED PAYMENT ADJUSTMENT BASED ON QUALITY TIERING

- Based on 2012 performance, electing the quality tiering approach would result in a payment adjustment of +0.0%.

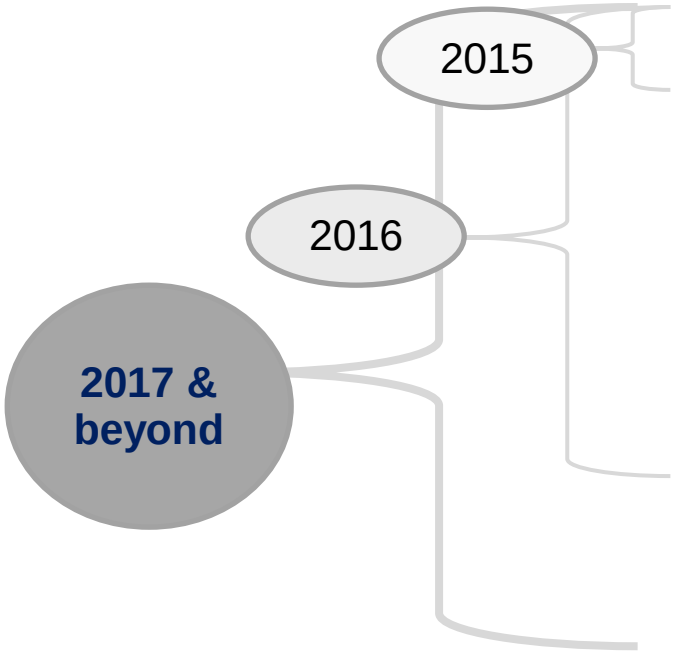
Payment adjustments for each level of performance are shown below:

	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+2.0x%	+3.0x%
Average Cost	-0.5%	+0.0%	+2.0x%
High Cost	-1.0%	-0.5%	+0.0%

Note: x refers to a payment adjustment factor yet to be determined due to budget neutrality requirements.

Physician Value-Based Payment Modifier Implementation Timeline

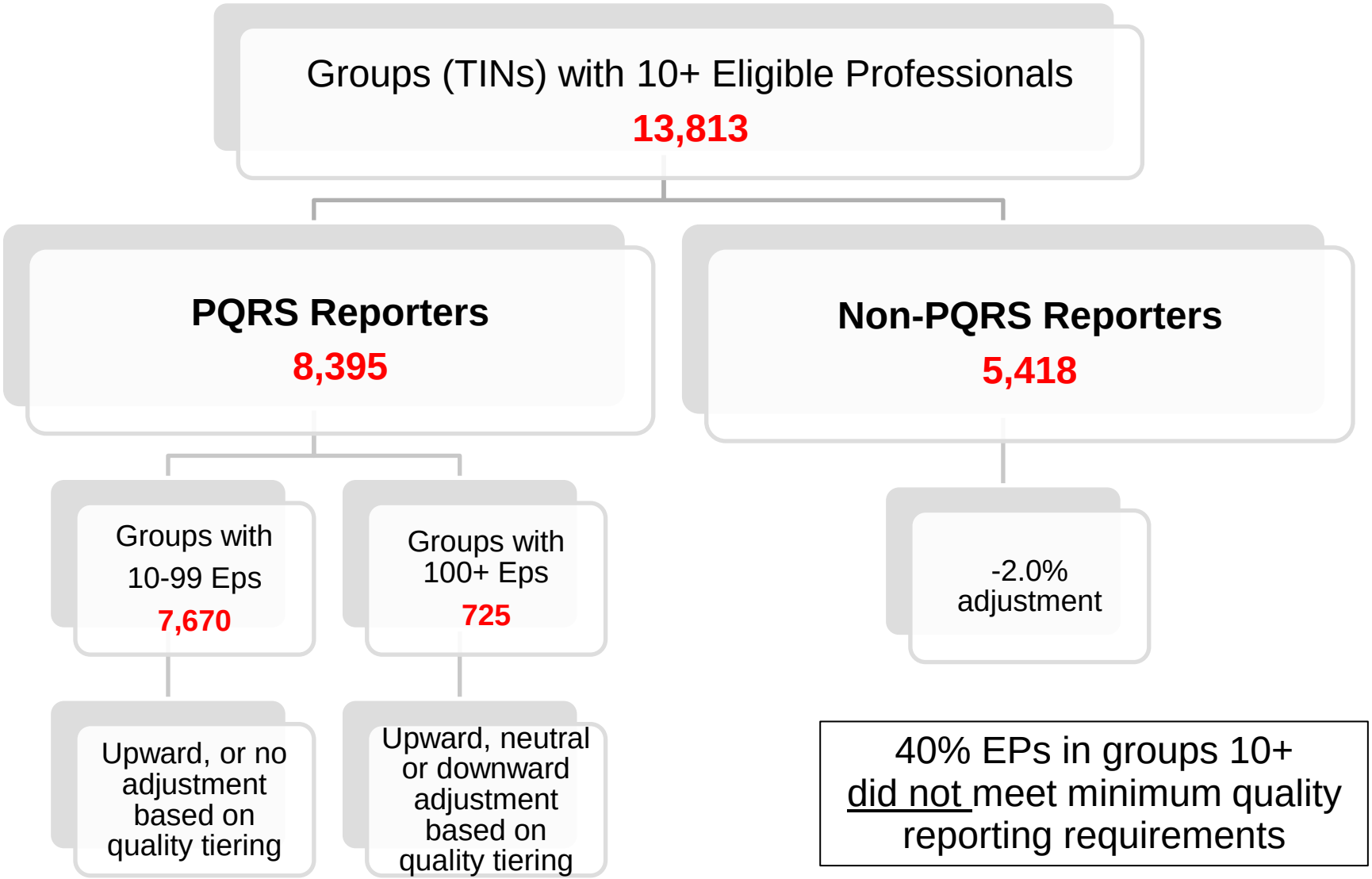
The value-based payment modifier will apply to all physicians and other non-physician practitioners by 2017



Group size	Percent of physicians	Cumulative percentage
100+	26	26
50-99	9	35
25-49	10	45
20-24	3	48
10-19	10	58
2-9	21	79
1	21	100

CY 2016 Value Modifier Results

2016 Value Modifier Results



CY 2016 Performance Breakdown

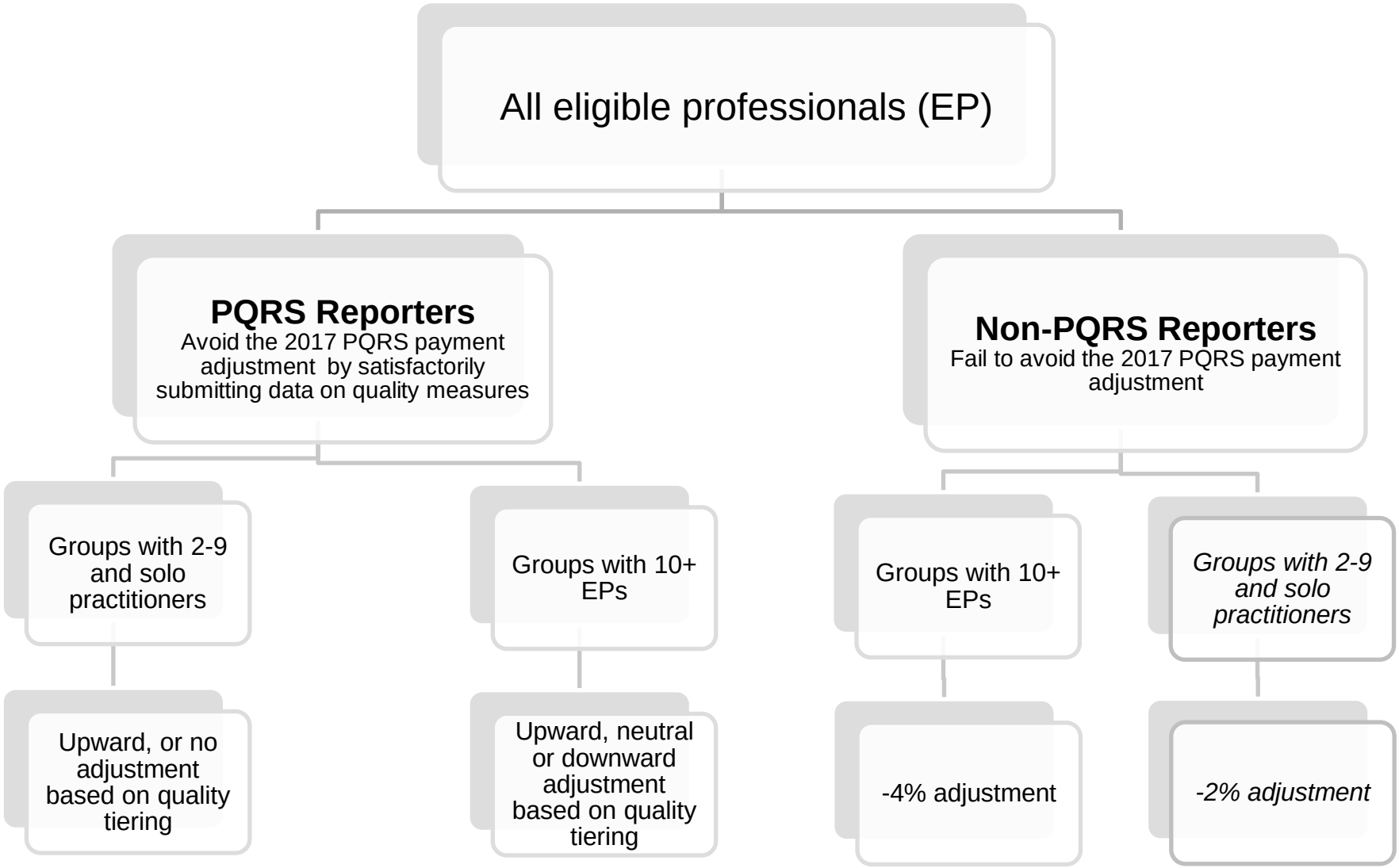
	Low Quality	Average Quality	High Quality
Low Cost	0.0% (6)	+1.0x = +15.92% (35) +2.0x* = +31.84% (38)	+2.0x = +31.84% (0) +3.0x* = +47.76% (0)
Average Cost	0.0%**/-1.0% (644)	0.0% (7,351)	+1.0x = +15.92% (35) +2.0x* = +31.84% (20)
High Cost	0.0%**/-2.0% (39)	0.0%**/-1.0% (226)	0.0% (1)

*These TINs were eligible for an additional +1.0x adjustment to their Medicare payments for treating high-risk beneficiaries.

** TINs with 10-99 EPs do not receive downward adjustments under quality-tiering in 2016.

Implementation for CY 2017

2017 Value-Based Payment Modifier: Mandatory Quality Tiering



CY 2017 Quality Tiering

Quality/Cost	Low cost	Average Cost	High Cost
High Quality	+4.0x*	+2.0x*	+0.0%
Average Quality	+2.0x*	0.0%	-2.0%
Low Quality	+0.0%	-2.0%	-4.0%

Groups 2-9 and solo practitioners held harmless
x* represents an undefined bonus factor for treating top 25% of high-risk patients

CY 2017 Applying Value Modifier to MSSP Accountable Care Organizations

Quality/Cost	Low cost	Average Cost	High Cost
High Quality	+4.0x*	+2.0x	+0.0%
Average Quality	+2.0x*	0.0%	-2.0%
Low Quality	+0.0%	-2.0%	-4.0%

- Quality composite score based on quality data submitted by ACO during performance period and applied to all TINs participating in ACO
- Cost composite score will not be calculated and all TINs participating in ACO will be considered “average cost”
- Additional +1.0x for groups that care for 25% high-risk patients
- ACO TINs with 2-9 EPs and solo practitioners held harmless for negative adjustments in 2017

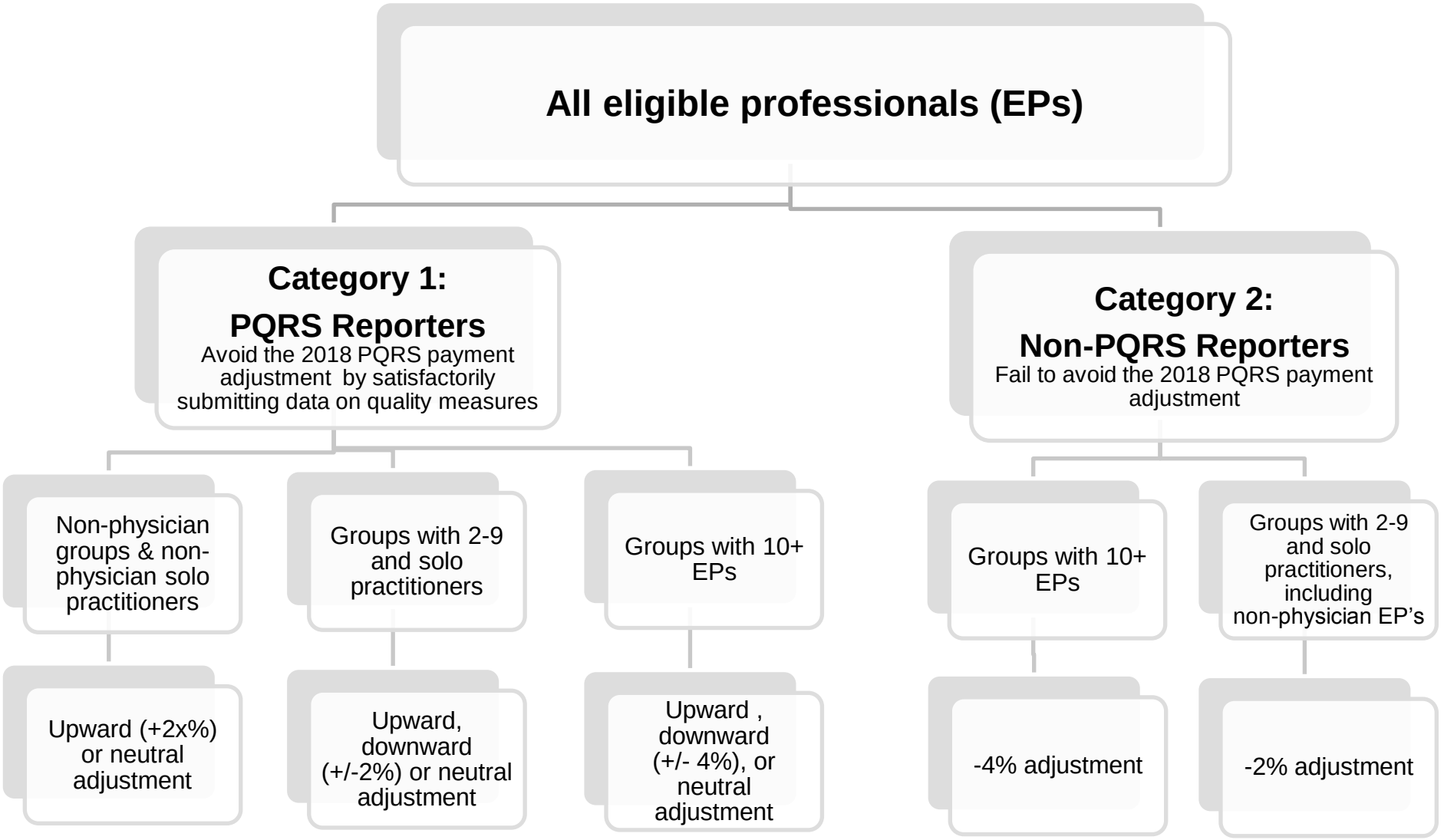
Applying Value Modifier to Participants in Pioneer ACOs, the Comprehensive Primary Care Initiative, and "Other Similar Innovation Center Models or CMS Initiatives"

Quality/Cost	Low cost	Average Cost	High Cost
High Quality	+4.0x*	+2.0x	+0.0%
Average Quality	+2.0x*	0.0%	-2.0%
Low Quality	+0.0%	-2.0%	-4.0%

- Groups and solo practitioners in these models will be classified as "average cost" and "average quality"
- Modifier will apply to all physicians billing under a group's TIN
- **CMS finalized to completely "waive" application of the value modifier in CY 2017 and CY 2018**

CY 2018 Value Modifier

CY 2018 Application



CY 2018 Applying Value Modifier to MSSP Accountable Care Organizations

Quality/Cost	Low cost	Average Cost	High Cost
High Quality	**+4.0x***	**+2.0x**	**+0.0%**
Average Quality	**+2.0x***	**0.0%**	**-2.0%**
Low Quality	**+0.0%**	**-2.0%**	**-4.0%**

- Quality composite score based on quality data submitted by ACO during performance period, including all-cause hospital readmissions measure and applied to all TINs participating in ACO
- Include CAHPS for ACO's survey in quality composite
- Cost composite score will not be calculated and all TINs participating in ACO will be considered "average cost"
- Eligible for additional +1.0x for groups that care for 25% high-risk patients
- If ACO does not successfully report quality data as required by MSSP, all groups/practitioners classified as "Category 2" in PQRS and penalized

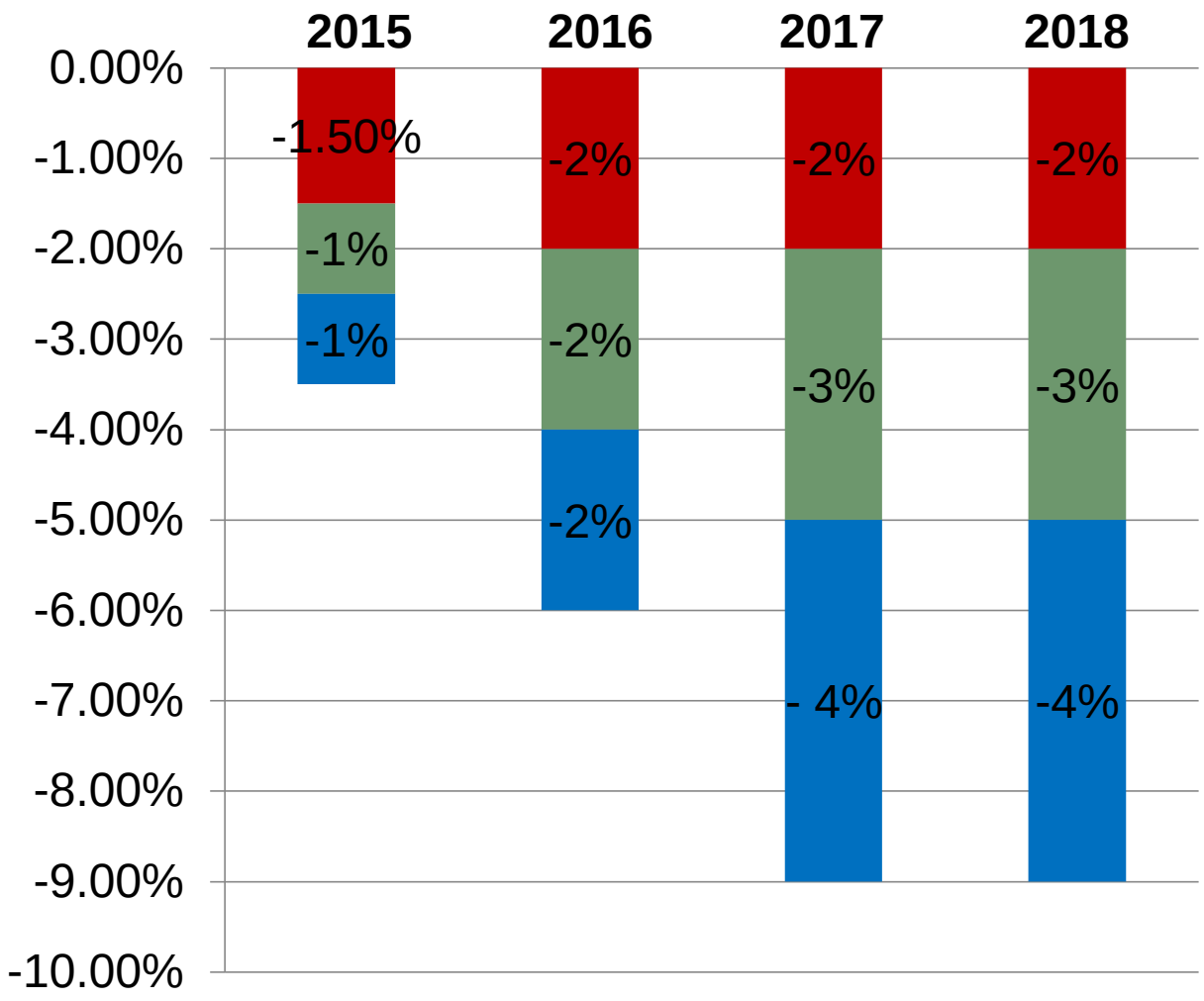
Review Process & Corrections (Proposed)

CMS' stated goal in the proposed rule is to "close out" as many informal reviews as possible before the VM payment factor is calculated, "lend confidence" to the adjustment factor, "provide finality" for clinicians, and "minimize claims reprocessing."

TABLE 38—PROPOSED QUALITY AND COST COMPOSITE STATUS FOR TINS DUE TO INFORMAL REVIEW DECISIONS AND WIDESPREAD QUALITY AND COST DATA ISSUES

	Scenario 1: TINS moving from Category 2 to Category 1 as a result of PQRS or VM informal review process		Scenario 2: Non-GPRO Category 1 TINs with additional EPs avoiding PQRS payment adjustment as a result of PQRS informal review process		Scenario 3: Category 1 TINs with widespread quality data issues		Scenario 4: Category 1 TINs with widespread claims data issues	
	Initial composite	Revised composite	Initial composite	Revised composite	Initial composite	Revised composite	Recalculated composite	Revised composite
Quality	N/A	Average	Low	Average	N/A	Average	Low	Average.
	N/A	Average	Average	Average	N/A	Average	Average	Average.
	N/A	Average	High	High	N/A	Average	High	High.
Cost	Low	Low	Low	Low	Low	Low	Low	Low.
	Average	Average	Average	Average	Average	Average	Average	Average.
	High	Average	High	High	High	Average	High	Average.

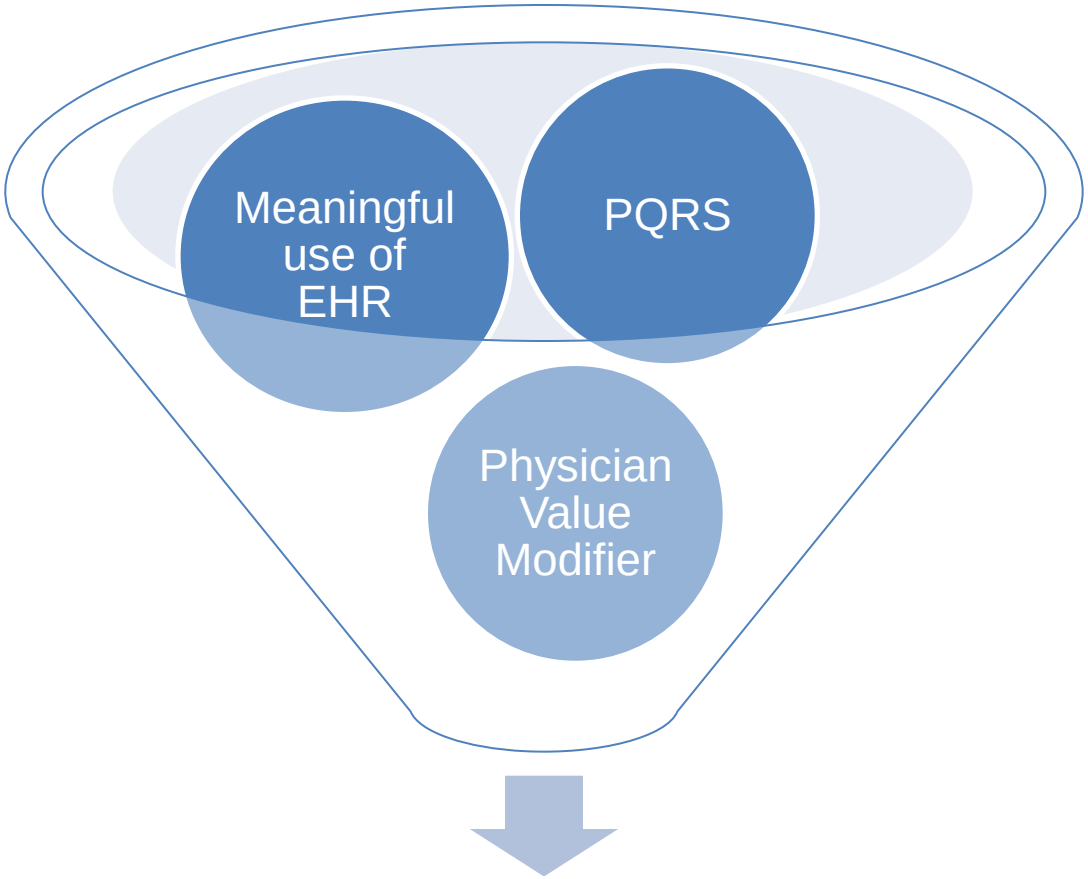
Potential penalties through 2018



Separate programs sunset on December 31, 2018

PREPARING FOR MACRA

MIPS streamlines existing FFS payment incentive programs

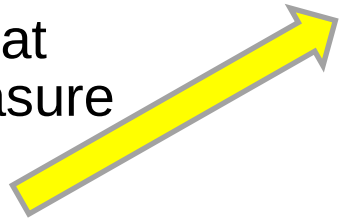


Merit-Based Incentive Payment System (MIPS)

Quality Reporting Requirements

Reporting obligation

- Any 6 measures from list, or a specialty measure set
- Selection must include at least one outcome measure (or other "high priority" measure if no outcome measure is applicable) and one cross-cutting measure
- CMS may increase required number of outcomes/high priority measures in future years



- What are "high priority" measures?
  - Outcome
  - Appropriate use
  - Patient experience
  - Safety
  - Care coordination
  - Efficiency

CMS is proposing incentives for "end-to-end" electronic reporting

Reporting mechanism	Quality	RU	ACI	CPIA	Submission Deadline
Claims	X (individual only)				
Admin. claims (no submission required)	X	X		X	
Attestation			X	X	March 31, 2018
QCDR (All-payer)	X		X	X	
Qualified Registry (All-payer)	X		X	X	
EHR (All-payer)	X		X	X	
CMS Web Interface	X (groups ≥25)		X (groups ≥25)	X (groups ≥25)	8 weeks after close of performance period
CAHPS Survey Vendor (voluntary)	X (groups ≥ 2)				

Bonus points

Bonus points

Resource Use Measures and Attribution

Measure	Attribution
Medicare Spending per Beneficiary	TIN providing plurality of Medicare Part B claims (20 minimum cases)
Total per Capita Cost	Two-step process: (20 minimum cases) 1. TIN of PCP providing plurality of primary care services 2. TIN of specialist providing plurality of primary care services
Episode-based measures 	For acute condition episodes, attributed to all clinicians that bill at least 30% of E&M visits during the trigger event; more than one clinician can be attributed For procedural episodes, attributed to all clinicians billing a part B claim with a trigger code during the trigger event

Conclusion & Next Steps

- 2016 is final performance year for Physician Value Modifier and PQRS as stand-alone programs
- Merit-based Incentive Payment System (MIPS) builds on PQRS reporting infrastructure and value modifier measures
- Comment Letter Process
  - Not very substantive, value modifier final year
  - Focus on messaging and importance of aligning with MACRA
  - Draft out August 19, feedback until August 31st

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