Value Based Payment Modifier

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

Successfully Navigating the Centers for Medicare & Medicaid Services (CMS) Value Based Payment Modifier (VM)

What is the Value Based Payment Modifier (VM)?

The VM assesses both quality of care furnished, and the cost of that care, under the Medicare Physician Fee Schedule (MPFS). CMS has begun with a phase-in of the VM in 2015, which will be completed by 2017. Implementation of the VM is based on participation in Physician Quality Reporting System (PQRS). In 2013, the VM applied to groups of physicians with 100 or more eligible professionals (EPs). **In CY 2014, CMS is expanding this to groups with 10 or more EPs.**

Overview of VM Program in 2013 and 2014 Reporting Periods

Value Modifier Components	2015 Finalized Policies	2016 Finalized Policies (take effect in 2014)
Performance year	2013	2014
Group Size	100+	10+
Quality Reporting Mechanisms	GPRO-Web Interface, CMS Qualified Registries, Administrative Claims	GPRO-Web Interface, CMS Qualified Registries, EHRs, OR 50% of EPs reporting individually ***Note: CMS expects to raise this % threshold in future years***
Quality / Outcome Measures	• Measures reported through the GPRO PQRS reporting mechanism selected by the group OR individual measures reported by at least 70% of the EPs within the group • 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)	These requirements are the same for CY 2014 reporting, however, CMS also: • Finalized that groups of physicians with 25 or more eligible professionals will be able to elect to have the patient experience of care measurs collected through the PQRS CAHPS for CY 2014 included in their payment modifier for CY 2016. • If all the EPs in the group satisfactorily participate in a PQRS qualified clinical data registry in CY 2014 and CMS cannot receive quality performace data from such registry, CMS will classify the group's quality composite score as "average" because they would not have data to reliably indicate whether the group should be classified as high or low quality.
Patient Experience Measures	N/A	PQRS CAHPS: Option for groups of 25+ EPs
Cost Measures	1) Total per capita costs measure (annual payment) standardized and risk-adjusted Part A and Part B costs) 2) Total per capita costs for beneficiaries with four chronic conditions: COPD, Heart Failure, CAD, 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 CMS also finalizes a specialty adjustment that allows for peer group comparisons related to the new cost measure for CY 2015.
Quality Tiering	Optional	Mandatory Groups of 10-99 EPs receive only the upward or neutral adjustment, no downward adjustment. groups of 100+ are subject to an upward, neutral or downward adjustment. ***Note: Groups of 100+ that furnish high quality care at high cost, for CY2014 reporting, will not be subject to a payment penalty.***
Payment at Risk	-1.0%	-2% if you do not participate in PQRS -2% if you are 100+ and provide low quality/high cost care -1% if you are 100+ and provide either low quality/average cost or average quality/high cost care.
Physician Feedback Reports (QRURs)	Reports sent to 24,000 providers in Iowa, Kansas, Missouri and Nebraska.	On September 16, 2013 groups with 25+ EPs received Quality Resource Use Reports (QRURs) which reflect their performance on quality and cost reporting measures based on their 2012 PQRS reporting. All physicians can expect QRURs in late summer of 2014

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How are my Quality and Cost Scores Calculated?

Quality Scores are comprised of:

- Clinical care
- Patient experience
- Population / community health
- Patient safety
- Care coordination
- Efficiency

Cost Scores are comprised of:

- Total per capita costs (plus Medicare Spending Per Beneficiary)
- Total per capita costs for beneficiaries with specific conditions

Each group then 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%

How are Patients Attributed to my Group for Purposes of Cost Calculation?

Step 1: Identify all beneficiaries who have had at least one primary care service rendered by a physician in a group.

Step 2: Assign beneficiaries who have had a plurality of primary care services (allowed charges) rendered by primary care physicians.

Step 3: For beneficiaries that remain unassigned, assign beneficiaries who have received a plurality of primary care services (allowed charges) rendered by any EP.

Exclusions: Patients that are part year beneficiaries (including those new to Medicare), died during the year, or had one or more months of Medicare Advantage are excluded from the attribution for calculating costs.

What Role to the Physician Feedback (QRURs) Reports Play in This?

The QRUR reports distributed by CMS to physicians play a crucial role in informing providers and groups impacted by the VM on areas that present opportunities for improvement as it relates to their quality and cost scores. The bottom half of the timeline below shows when the reports are releases and who will receive them. Those groups (25+ EPs) receiving the reports in September of this year will notice new features in the report, including:

- Drill down table including all beneficiaries attributed to the group, their resource use, specific chronic disease
- Drill down table including all hospitalizations for attributed beneficiaries
- Drill down table of individual EP PQRS reporting (December 2013)

All groups and solo practitioners will receive QRURs in late summer of CY 2014

What groups of 10+ EPs need to do to be successful in CY 2014?

Step 1: Choose a PQRS Reporting Mechanism

- Web interface (GPRO)- Group must self-nominate/ register (May 2014- September 2014)
- CMS Qualified Registry (such as the Academy's PQRSWizard)
- EHR
- Utilize 50% Individual Reporting Option

Under the individual reporting option, each provider in your group can choose how they wish to report on PQRS. All measure performance for the group is then rolled together and 70% of the EPs in the group must meet PQRS criteria for CY 2016 payment adjustment in order to meet the 2016 VM requirements. Groups do not have to self-nominate for this option. Individuals can report via Claims, EHR, CMS Qualified Registries, or new Qualified Clinical Data Registries (QCDRs).

Visit our VM webpage to access your QRUR reports and to self-nominate/register to participate in the VM program.
If you have questions regarding the value based modifier, please contact the Academy at healthpolicy@entnet.org