Practical Guide to the Medicare Physician Value Modifier Program

VISION BEYOND THE NUMBERS

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Introduction

Since long before the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) has been exploring how to reward physicians for providing value, *i.e.*, delivering high quality care for Medicare beneficiaries in an efficient manner. The agency's efforts culminate this year with the rollout of the Medicare Physician Value Modifier Program (VM Program).

The idea behind the VM Program is relatively simple: determine how a physician group compares to others on specific quality and efficiency measures and adjust the group's Medicare Physician Fee Schedule (MPFS) payments up or down based on whether that comparison is positive or negative. As always, the devil is in the detail, and there's a lot of detail.

To sort things out, PYA has developed the following Q&A explaining the VM Program in a simple, straightforward manner. Armed with this practical guide, your group can identify and implement strategies to improve your VM Program scores. As explained below, better scores translate into higher reimbursement and a reputation for providing high quality care in an efficient manner.

Starting this year, we are no longer in the "pre-season," where the games really don't count. The 2017 MPFS payment adjustments for all physicians will be based on 2015 performance. Medicare physician value-based purchasing has officially arrived.

Generally speaking, how does the VM Program work?

Each year, CMS will calculate a quality composite score for each physician group[1] that met Physician Quality Reporting System (PQRS) reporting requirements in the preceding year (known as the "performance year"). (The specific formula CMS uses to calculate this composite score is discussed in the following section.)

Those groups with quality composite scores at least one standard deviation below the mean for all groups in that performance year will be labeled "low quality." Those with scores at least one standard deviation above the mean will be tagged as "high quality." The rest will be identified as "average quality."

CMS also will calculate a cost composite score for these same groups based on Medicare claims data from the performance year. The specific cost measures used in this calculation are discussed further herein.

Those groups with scores at least one standard deviation below the mean for all groups in that performance year will be labeled "low cost." Those with scores at least one standard deviation above the mean will be tagged as "high cost." The rest will be identified as "average cost."

[1] For purposes of the VM Program, a solo practitioner is treated the same as a group.

Thus, there are nine possible categories with a corresponding payment adjustment for the upcoming year:

TABLE 1	Low Quality	Average Quality	High Quality
Low Cost			
Average Cost			
High Cost			

TABLE 1: VM Program Payment Adjustment Categories

Those groups in the average quality/average cost, low quality/low cost, and high quality/high cost categories will not be subject to any VM Program payment adjustment the following year.

Those groups in the high quality/low cost, high quality/average cost, and average quality/low cost categories will see a positive payment adjustment the following year. Also, a group in one of these categories will receive a bonus adjustment if its average beneficiary risk score is in the top 25% of all beneficiary risk scores. The actual amount of these adjustments is discussed further herein.

Those groups in the high cost/low quality, high cost/average quality, and average cost/low quality categories will experience a negative payment adjustment the following year. Again, the amount of these adjustments is discussed further herein.

Because a group's quality composite score is based on its PQRS reporting, CMS cannot calculate this score for a group that does not meet those reporting requirements. **CMS, therefore, automatically assigns non-reporting groups to the high cost/low quality category.** These groups, therefore, will be subject to the largest possible negative adjustment to their MPFS payments the following year, in addition to the 2% penalty for not meeting PQRS reporting requirements.

Are any groups exempt from the VM Program?

For 2015 and 2016, groups participating in the Medicare Shared Savings Program (MSSP), the Pioneer ACO Program, or the Comprehensive Primary Care Initiative are exempt from the VM Program.

Starting in 2017, however, these groups will be subject to the VM Program payment adjustments. All groups participating in the same MSSP Accountable Care Organization (ACO) will receive the same quality composite score based on the ACO's reported quality scores. Also, all MSSP ACOs will be assigned "average cost" due to the differences in the methodology for calculating per capita costs between the MSSP and the VM Program.

How does CMS calculate the quality composite score?

CMS began building the foundation for the VM Program when it introduced the PQRS program eight years ago. Between 2007 and 2012, PQRS reporting was optional for physicians, *i.e.*, an opportunity to earn bonus payments.

Unfortunately, many physicians believe this continues to be the case. However, physicians now are subject to penalties for failure to meet reporting requirements. Failure to report in 2013 will result in a 1.5% reduction in MPFS payments this year; failure to report in 2014 will result in a 2.0% reduction in 2016; the same will be true each year thereafter.

Keep in mind the PQRS penalty is in addition to any penalty imposed under the VM Program. Thus, a group's failure to report in 2015 could mean as much as a 6% reduction in its MPFS payments in 2017 (2% reduction for not meeting PQRS reporting requirements + 4% reduction under the VM Program; more explanation on VM Program reductions is presented further herein).

Presently, there are more than 250 approved measures across six quality domains (clinical care, patient experience, population/community health, patient safety, care coordination, and efficiency) on which physicians may report based on specialty and other considerations. Reports may be submitted at the individual physician or group level, with different reporting methods for each option. CMS makes available several resources to assist physicians with measures selection and reporting.

With the VM Program, a group is rewarded – or penalized – based on its actual scores on selected measures as compared to its peers. If a group reports at the group level, CMS uses that report to calculate the group's quality composite score.

Otherwise, CMS compiles data from the individual reports made by eligible professionals (EPs) in the group, but only if at least 50% of those EPs submit individual reports. (How the number of EPs in a group is calculated is discussed below.) **If fewer than 50% of the group's EPs report individually – and the group does not submit a group report – CMS automatically assigns the maximum negative payment adjustment to that group.**

To calculate a group's quality composite score, CMS compares the group's score on its reported quality measures against the performance benchmarks the agency establishes based on the prior year's PQRS reporting. For example, to calculate a group's quality composite score for 2017, CMS will use the group's 2015 PQRS reports (to be submitted in early 2016) and measure the group's performance against 2014 benchmarks.

Each group is graded on a curve, compared to all other groups regardless of size, location, or patient population. Because performance is relative, a group that maintains the same scores year after year likely will find itself falling behind as other groups step up their performance. In light of this, a group must monitor its performance on its selected quality measures on an ongoing basis and seek ways to continuously improve those scores.

How does CMS calculate the cost composite score?

CMS automatically calculates a group's cost composite score based on claims data the agency compiles during the performance year. **Specifically, CMS calculates total cost of care on a per capita basis for those beneficiaries attributed to the group. Stated another way, CMS totals the amount paid to all providers (not just the group) for services furnished to each beneficiary attributed to the group.**

The formula CMS uses to attribute beneficiaries to a group is relatively simple, although it requires the agency to do a great deal of data crunching. Each year, CMS attributes each Medicare beneficiary to a single group based on claims data. Specifically, CMS assigns a given beneficiary to the group that includes the primary care physician (PCP) who rendered the most primary care services to that beneficiary during that year. If a given beneficiary receives no primary care services from any PCP during that year, CMS assigns that beneficiary to the group that includes the EP (regardless of type or specialty) who rendered the most primary care services for that beneficiary that year.

Presently, there are two equally weighted measures that comprise the cost composite score:

1 | Per capita costs (*i.e.*, total cost of care) for all attributed beneficiaries.

2 | Per capita costs for those attributed beneficiaries with certain chronic conditions (diabetes, coronary artery disease, chronic obstructive pulmonary disease, and heart failure).

To calculate per capita costs, CMS standardizes pricing and makes other adjustments based on the group's beneficiary risk score.[2] A group's composite score is compared to peer group performance in the same performance year (peer groups are determined based on group size). Based on its adjusted composite score, a group will be placed in one of three cost categories: high, average, or low cost.

[2] These risk scores are based on hierarchical condition codes (HCCs), which in turn are based on the diagnoses reported for attributed beneficiaries. Thus, it is to a practice's advantage to accurately document and report all diagnoses for its patients, as this can increase the group's risk score. Strategies for accomplishing this are the subject of a separate discussion.

When will VM Program payment adjustments take effect?

The VM Program payment adjustments will be phased in between 2015 and 2017, based on the number of EPs in the group. Eligible professionals include physicians, non-physician practitioners (*i.e.*, nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and physician assistants), and therapists.

In 2015, those groups that had **at least 100 EPs** submitting claims to Medicare under a single tax identification number (TIN) in 2013 are subject to the VM Program. CMS calculated these groups' 2015 quality and cost composite scores based on their 2013 performance. However, a group is subject to an upward or downward adjustment in 2015 only if it elected in advance to participate in "quality tiering." This election applies in 2015 only.

In 2016, the VM Program expands to groups with **at least 10 EPs** (based on the number of EPs who submitted claims under the group's TIN in 2014) based on their 2014 performance. Those groups with at least 100 EPs will be subject to both upward and downward adjustments, while groups with 10-99 EPs will not be subject to downward adjustments.

By 2017, all groups will be subject to the VM Program based on 2015 performance. Those groups with **two to nine EPs, along with solo practitioners**, that meet the requirements for reporting under PQRS will be eligible for upward adjustments only. Everyone else will be subject to both upward and downward adjustments.

Through 2017, adjustments will be made only to payments for services billed under a physician's provider number. Starting in 2018, payments for services furnished by non-physician practitioners and therapists also will be subject to adjustments. Keep in mind the adjustments apply only to the payments received from CMS; beneficiary co-insurance amounts will not be adjusted up or down.

How will groups be informed of VM Program payment adjustments?

In September 2014, CMS made available to every group a Quality and Resource Use Report (QRUR) (or Physician Feedback Report) detailing the group's 2013 quality and cost performance results.[3] In addition to reporting the group's scores on specific measures, each 2013 QRUR identifies the group's quality/cost category (*e.g.*, high quality/low cost) and the corresponding payment adjustment for 2015. With the exception of those groups with 100+ EPs that elected quality tiering, however, no group will have its payments adjusted in 2015. Thus, the 2014 QRURs primarily are a preview of things to come.

In the fall of 2015, CMS will release the 2015 QRURs that will report groups' 2014 performance results, including their quality/cost categories and corresponding payment adjustments for 2016. The 2016 QRURs will be released in the fall of that year, reporting 2015 results and detailing 2017 payment adjustments. This cycle will continue thereafter: a group's payment adjustment in a given year will be based on its performance on quality and cost measures two years earlier.

In addition to the high-level information, the QRUR includes detailed, beneficiary-level data, quality measure information, and much more to help a group understand the underlying causes of its composite scores. Also of note: CMS also uses the QRUR to report quality and cost measures that are not currently factored into composite scores, but will be included in subsequent years. It is important to preemptively monitor these new measures to make sure that you are prepared for any changes to composite score calculations.

[3] If your group has not obtained its 2013 QRUR, the report is available through the CMS Enterprise Portal. There are several CMS resources available explaining the QRUR in detail.

How significant are the VM Program payment adjustments?

For 2015, the maximum upward/downward adjustments to MPFS payments are as follows:

TABLE 2	Low Quality	Average Quality	High Quality
Low Cost	0.0%	+1.0x	+2.0x
Average Cost	-0.5%	0.0%	+1.0x
High Cost	-1.0%	-0.5%	0.0%

TABLE 2: CY2015 VM Program Payment Adjustments

By statute, the VM Program is budget-neutral; the total amount of upward adjustments must be offset by the total amount of downward adjustments. Thus, while the downward adjustments are set percentages, the percentages for the upward adjustments will vary based on the number of groups subject to negative adjustments (including those that fail to meet PQRS reporting requirements).

Once the amount of the penalty pool is determined, CMS will calculate the adjustment factor (identified on the table as "x") to be applied to groups receiving an upward payment adjustment. Also, as noted above, those groups that qualify for an upward adjustment and have the highest average beneficiary risk scores also will receive a bonus adjustment.

For 2016, the downward adjustments become more significant, at -2.0%:

TABLE 3	Low Quality	Average Quality	High Quality
Low Cost	0.0%	+1.0x	+2.0x
Average Cost	-1.0%	0.0%	+1.0x
High Cost	-2.0%	-1.0%	0.0%

TABLE 3: CY2016 VM Program Payment Adjustments

By 2017, the adjustments ramp up to +4.0x%/-4.0% for groups with 10 or more EPs:

TABLE 4	Low Quality	Average Quality	High Quality
Low Cost	0.0%	+2.0x	+4.0x
Average Cost	-2.0%	0.0%	+2.0x
High Cost	-4.0%	-2.0%	0.0%

TABLE 4: CY2017 VM Program Payment Adjustments

For groups of two to nine EPs and solo practitioners, the following adjustments will apply:

1 | Those that do not meet PQRS reporting requirements will be subject to a -2.0% reduction.

2 | Those classified as high quality/low cost will receive a +2.0x% upward adjustment; those classified as either average quality/low cost or high quality/average cost will receive a +1.0x% upward adjustment.

3 | All others will be held harmless from downward adjustments.

How do VM Program payment adjustments relate to other CMS programs?

The VM Program negative payment adjustments are in addition to any negative adjustments to which a physician may be subject for failure to meet PQRS reporting requirements and/or failure to achieve meaningful use of an electronic health record. (While the VM Program makes adjustments at the group level, these other payment adjustments are made at the individual provider level.)

By 2017, a physician could experience a total downward payment adjustment of -9.0% under these three programs. That number grows to -10.0% in 2018 and -11.0% in 2019 as the meaningful use penalty increases.

Will a group's VM Program payment adjustment be publicly reported?

As it stands, **CMS will not release QRURs publicly nor otherwise disclose a group's VM Program payment adjustment. However, CMS plans to significantly increase the information available through *Physician Compare***, the public searchable database with consumer-facing information on EPs, including scores on quality and cost measures.

Additionally, there is no prohibition on requiring a group to disclose its payment adjustment or provide a copy of its QRUR as a condition of contracting. For example, a hospital or insurance company may require a group to furnish this information. Thus, the best strategy for the VM Program is to prepare and act as if all data will be publically available.

Does the VM Program have impact beyond MPFS reimbursement?

The VM Program is designed to financially reward the best of the best and penalize the worst of the worst. Most groups will see no financial impact in either direction. Also, adjustments apply only to MPFS payments; Medicare Advantage, Medicaid, and commercial insurance payments are not affected. However, one of a group's most valuable assets – its reputation – also is on the line with the VM Program.

Consider how the availability of objective data will impact healthcare decision-making. With more objective data available through *Physician Compare*, consumers will use this information to select a provider, instead of relying on subjective referrals. Primary care physicians will make referral decisions based on similar data. Commercial payers will look to scores on quality and cost measures in making contracting decisions, and hospitals and health systems will do the same for credentialing decisions. And, finally, competitors will use this objective data to gain any advantage they can.

While one may argue VM Program measures do not actually reflect a group's quality or efficiency, a group cannot escape the fact decision-makers will rely on the objective data available to them. Being categorized under the VM Program as "high cost/low quality" – or even as "average cost/average quality" – can undo years of hard work invested in building a strong reputation.

Even if you believe you can weather a 4% reduction in Medicare payments (the maximum negative adjustment under the VM Program), you cannot ignore the much broader "reputational" impact of the VM Program "scorecard" on your access to patients, regardless of payer.

What specifically should you do now?

1 **Update PECOS.** CMS will rely on a group's Provider Enrollment, Chain, and Ownership System's (PECOS) entry to identify the EPs who are part of the group. Be sure your PECOS entry is up-to-date for your TIN.

2 **Educate and engage your EPs.** The VM Program is not a back-office issue. Improving your group's quality and cost composite scores will require all EPs to row in the same direction. Every EP in your group should have a basic understanding of how the VM Program works and the effect of poor scores on the group's reputation and business opportunities. Every EP should be engaged in developing and implementing performance improvement strategies.

3 **Master PQRS.** The first step to success under the VM Program is identifying the most appropriate PQRS measures on which your group will report. There are many factors to consider in making these selections: the specialties in which your EPs practice, patient volumes, common diagnoses, ability to improve performance, ease of capturing data needed for reporting.

Once you have identified the most appropriate measures, the next step is to identify and implement processes to improve scores on those measures. This includes a willingness to take action against those EPs unwilling to "get on the bus." Every EP's performance impacts the group's scores, and thus each EP should be accountable to the group for his or her performance.

The third step is to select the manner in which the group will report its scores on its selected measures. Different reporting methods require data be gathered in different ways. The timing for submission of data also varies. Also, careful consideration should be given to how data will be captured and organized for reporting purposes.

4 **Take charge of total cost of care.** Until now, providers have had little reason to be concerned about the cost of services furnished to their patients by other providers. Now, with the cost composite score measuring how well EPs manage the care of their attributed patients, there is reason to be concerned.

The services furnished within the group likely will have minimal impact on patients' total costs of care; it is referrals to high-cost providers (*e.g.*, for diagnostic testing, hospitalization, post-acute care), that can "break the bank." EPs in your group should have access to cost information to assist them in making referral decisions.

Another contributor to higher costs of care is lack of communication with patients regarding the costs and benefits of specific high-cost interventions. EPs should have available to them information to assist patients in making informed decisions.

5 **Study your QRUR.** The best way to improve performance is to review data reported on the QRUR and understand the impact of specific measures and scores. Use the QRUR to identify high-cost beneficiaries and evaluate ways to better manage the care for these patients. Learn which PQRS measures are helping the quality composite score and which measures are dragging down that score. This information should be communicated to providers as part of a group's education strategy.

6 **Don't hope this will all just go away.** The VM Program and other value-based purchasing programs – from both CMS and commercial payers – are here to stay. If there are areas for improvement in your group, do not hesitate to communicate potential issues and resolve them as quickly as possible. Starting in 2015, each year is a year of being graded. If you aren't making improvements, another group may pass you by.

PYA can assist your group by providing educational sessions tailored to your group's needs, analyzing your QRUR for opportunities, and developing and implementing a PQRS success strategy. Additionally, PYA can design and help deploy a "reputation defender" program for your group in the face of value-based purchasing.

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