Physician Value-Based Payment Modifier

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The Affordable Care Act (ACA) requires that the Centers for Medicare & Medicaid Services (CMS) implement a value-based payment modifier that would apply to Medicare fee-for-service payments starting with select physicians on January 1, 2015, and applying to all physicians and groups by January 1, 2017. The value-based modifier (VBM) is intended to pay physicians differentially based on the quality and cost of their care. Below is a summary of CMS’ initial implementation plan.

<table>
<thead>
<tr>
<th>STATUTORY TIMELINE FOR VBM IMPLEMENTATION</th>
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<tbody>
<tr>
<td>Reporting Period</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>2013</td>
</tr>
<tr>
<td>2014</td>
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<td>2015</td>
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Groups with 100 or More Eligible Professionals (EPs)
For 2015 CMS will apply the VBM to groups with ≥100 eligible professionals (EPs). “Group” refers to all EP’s practicing under the same Tax ID Number (TIN). CMS will identify groups with ≥ 100 eligible professionals, who will be subject to the VBM based on a query of Medicare’s Provider Enrollment, Chain, and Ownership System (PECOS) on October 15, 2013. For purposes of identifying group practices, CMS defines EPs as not only physicians, but physician assistants, nurse practitioners, and other advance practice providers. Group practices with 2-99 EP’s will remain unaffected during the first year.

How to Avoid the Value-Based Modifier Penalty for 2013 in Three Easy Steps
To be held harmless under the VBM in 2015, group practices of 100 or more eligible professionals should follow the three easy steps outlined below.

1. **PECOS**
   Since CMS will gather information such as a physician’s specialty and group practice affiliation from PECOS for both the Physician Feedback Reports and the VBM, it is important that you make sure your practice data is up-to-date by visiting [https://pecos.cms.hhs.gov](https://pecos.cms.hhs.gov).

2. **Self-Nominate for PORS**
   Groups of ≥100 EPs have to self-nominate to participate in one of the PQRS Group Practice Reporting Options (GPROMs) by October 15, 2013 via the CMS Communications and Support website. ([https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234](https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234))
3. **Successfully Report PQRS**
   a. Satisfy the reporting criteria for the 2013 PQRS incentive via either the GPRO registry reporting option or the GPRO Web Interface (see [www.acep.org/quality/pqrs](http://www.acep.org/quality/pqrs));
   - **OR** -
   b. Elect to be analyzed under the PQRS **administrative claims-based reporting option by October 15, 2013**

ACEP recommends that all ED-based and Hospital-based groups complete the group practice self-nomination process and elect the administrative claims reporting option to avoid the 2015 PQRS and 2015 VBM penalties AND the members of your group then continue to report the traditional claims-based measures as individuals in order to earn the PQRS incentive in 2014 based on the 2013 reporting period. The administrative claims option means that CMS will review your practice’s claims and abstract certain quality metrics. Since the measures do not apply to emergency department care, your practice will have a denominator of zero for these measures and the practice will avoid the 1% VBM penalty in 2015. ACEP also recommends that groups DO NOT elect the quality tiering option for 2015. The program is still not completely fleshed out and more information will be needed before any recommendation could be made for emergency physicians. For more information for practices that include primary care physicians, hospitalists, or office based specialist as well as the different PQRS reporting options for incentives and potential penalties including the VBM, please see [www.acep.org/quality/pqrs](http://www.acep.org/quality/pqrs). Please see the interaction between the PQRS and the VBM in Figure 1 below.

**Figure 1. Interaction Between PQRS and VBM**

Budget Neutral Quality Tiering
Quality tiering rewards or penalizes a group based on quality and cost. In order to achieve the legislatively-mandated budget neutrality for the program, positive adjustments to groups of physicians would be offset by negative adjustments to other groups of physicians. Since the total sum of downward...
adjustments is unknown at this time, CMS cannot determine specific upward payment amount percentages. Rather, CMS will divide the total quality and cost composite scores for each group practice into three tiers based on whether the score is above, not different from, or below the national mean. As shown in Table 1, CMS will give groups that are high quality and low cost the highest upward adjustment. The value of “x” will depend on the total sum of negative adjustments in a given year. In addition, to ensure that the VBM encourages physicians to care for the severely ill and beneficiaries with complicated cases, CMS will apply an additional upward payment adjustment for groups of physicians furnishing services to high risk beneficiaries.

Table 1. Calculation of the Value Modifier Using the Quality-Tiering

<table>
<thead>
<tr>
<th>Quality/cost</th>
<th>Low cost</th>
<th>Average cost</th>
<th>High cost</th>
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<tbody>
<tr>
<td>High quality</td>
<td>+2.0x*</td>
<td>+1.0x*</td>
<td>+0.0%</td>
</tr>
<tr>
<td>Medium quality</td>
<td>+1.0x*</td>
<td>+0.0%</td>
<td>-0.5%</td>
</tr>
<tr>
<td>Low quality</td>
<td>+0.0%</td>
<td>-0.5%</td>
<td>-1.0%</td>
</tr>
</tbody>
</table>

* 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.

How Beneficiaries are Attributed to a Group for Quality-Tiering

CMS will use a “plurality of primary care attribution method” to assign beneficiaries to the group practices that billed a larger share of office based E/M allowed charges than any other group practice. Therefore, no beneficiaries can be attributed to an emergency department visit for either the care coordination measures or the cost composite measures described above in 2013. CMS recognizes that certain large single specialty groups, such as those that are solely ED-based, will not be attributed beneficiaries under the current methodology.

Quality Domains and Quality Tiering Methodology

CMS will use domains to combine each quality measure into a quality composite and each cost measure into a cost composite as outlined in the diagram below.
VBM Measures Used for Quality Tiering

The quality composite score will be calculated based on measures reported through PQRS. In addition, CMS will also calculate the three composite outcome measures listed in Table 2 for the care coordination domain. Each measure will be weighted equally within each domain, and each domain will be weighted equally to form the quality composite. In cases where a group does not report measures in one or two domains, the remaining domains would be weighted equally, and if the group only reports measures in a single domain, the domain would be weighted 100%.

Table 2. VBM Measures Used to Calculate Care Coordination Domain for Quality Composite

<table>
<thead>
<tr>
<th>Domain of Care</th>
<th>Measures Used to Calculate Care Coordination Domain for Quality Composite</th>
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| Care Coordination | 1. Acute Prevention Quality Indicators (PQIs) Composite  
  - *Bacterial Pneumonia*: # of admissions per 100,000 population  
  - *UTI*: # of discharges for UTI per 100,000 population  
  - *Dehydration*: # of admissions for dehydration per 100,000 population |
| Care Coordination | 2. Chronic Prevention Quality Indicators (PQIs) Composite:  
  - *Diabetes Composite*:  
    - *Uncontrolled diabetes*: # of discharges per 100,000 population  
    - *Short-term diabetes complications*: # discharges per 100,000 population  
    - *Long-term diabetes complications*: # of discharges for per 100,000 population  
    - *Lower extremity amputations for diabetes*: # per 100,000 population  
  - *COPD*: # of admissions for COPD per 100,000 population  
  - *Heart Failure*: % population with admissions for CHF |
| Care Coordination | 3. All Cause Readmissions: rate of provider visits within 30 days of discharge per 1,000 discharges for eligible beneficiaries assigned |

To calculate the cost composite score, CMS will evaluate the five measures listed in Table 3 below.

Table 3. VBM Measures Used to Calculate Cost Composite

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measures Used to Calculate Cost Composite</th>
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<tbody>
<tr>
<td>Cost</td>
<td>1. Total Overall Costs per Beneficiary</td>
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</tbody>
</table>
| Cost   | 2. Total Costs per Beneficiary for Chronic Conditions Composite:  
  - Total Costs per Beneficiary with COPD  
  - Total Costs per Beneficiary with CHF  
  - Total Costs per Beneficiary with CAD  
  - Total Costs per Beneficiary with Diabetes |

While CMS must adhere to certain statutory requirements, to promote shared responsibility and systems-based care, the ACA gives CMS considerable flexibility in terms of implementing the VBM. CMS recognizes this is a large and complex task and continues to look to ACEP for feedback on the most appropriate methodologies and implementation strategies for emergency medicine.