FACT SHEET

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Physician Value-based Payment Modifier and the Physician Feedback Program

OVERVIEW

On July 6, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (MPFS) on or after Jan. 1, 2013. The proposed rule also proposes changes to several of the quality reporting initiatives that are associated with MPFS payments – the Physician Quality Reporting System (PQRS), the Electronic Prescribing (eRx) Incentive Program, and the PQRS-EHR Incentive Pilot – as well as changes to the Physician Compare tool on the Medicare.gov website. Finally, the proposed rule includes proposals for implementing the physician value-based payment modifier (Value Modifier) required by the Affordable Care Act that would affect payment rates to physician groups based on the quality and cost of care they furnish to beneficiaries enrolled in the traditional Medicare Fee-for-Service program.

This fact sheet discusses the proposals for phasing in the Value Modifier, beginning in CY 2015 with groups of physicians with 25 or more eligible professionals. In this fact sheet, whenever a reference is made to “groups of physicians,” it means those groups with 25 or more eligible professionals.

Separate fact sheets, also issued today, discuss the proposed changes to payment policies and payment rates for services furnished under the MPFS, and the proposed changes to the quality reporting programs.

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VALUE MODIFIER FOR SERVICES PAID UNDER THE MPFS

Section 1848(p) of the Act, as established by section 3007 of the Affordable Care Act, requires the Secretary of Health and Human Services ("Secretary") to establish a Value Modifier that provides for differential payment to a physician or group of physicians under the MPFS based upon the quality of care furnished to Medicare beneficiaries compared to the cost of that care during a performance period. Further, the statute requires the Secretary to begin applying the Value Modifier on Jan. 1, 2015, with respect to items and services furnished by specific physicians and groups of physicians (as determined by the Secretary of the Department of Health and Human Services) and to apply it to all physicians and groups of physicians beginning not later than Jan. 1, 2017. The statute also requires that the Value Modifier be implemented in a budget neutral manner meaning that upward payment adjustments for high performance will balance the downward payment adjustments applied for poor performance.

IMPLEMENTING THE VALUE MODIFIER

In developing its proposals for the Value Modifier, CMS has focused on providing physicians choices as to how their quality of care will be measured and how their payments will be adjusted. Physician groups can avoid all negative adjustments simply by participating in the PQRS. Physicians seeking to be paid according to their measured cost and quality may elect to do so for 2015. CMS' proposals are also designed to align with other CMS quality initiatives to reduce the burden of submitting information, and promote shared physician accountability for beneficiaries.

Proposed Performance Period

CMS previously established CY 2013 as the performance period for the determination of the Value Modifier to be applied in CY 2015 and proposes to use CY 2014 as the performance period for the Value Modifier to be applied in CY 2016. CMS is proposing to apply the Value Modifier at the Tax Identification Number (TIN) level to items and services paid under the MPFS to physicians under that TIN. This means that if a physician moves from one group to another between the performance period (2013) and the payment adjustment period (2015), the physician's payment will be adjusted based on the Value Modifier earned by the TIN where the physician is practicing in 2015.

Proposed Election on How the Value Modifier is Calculated for 2015

In this first phase of implementation, CMS is proposing that groups of physicians with 25 or more eligible professionals would be included in the Value Modifier framework. These groups, however, would have options, depending upon whether they satisfactorily report under the PQRS, regarding how their Value Modifier would be calculated for CY 2015 payment.

Proposals for Measuring Quality of Care and Cost in the Value Modifier

The law requires CMS to measure quality of care furnished as compared to cost using composites of appropriate quality and cost measures. In the MPFS final rule for CY 2012, CMS adopted both a total per capita cost measure for all beneficiaries, as well as four total per capita cost measures for beneficiaries with certain chronic conditions (chronic obstructive pulmonary disease, heart failure, coronary artery disease, and diabetes) to be used under the Value Modifier.

To obtain the quality data, CMS is proposing that groups of physicians with 25 or more eligible professionals satisfactorily submit data using one of the proposed PQRS quality reporting mechanisms for groups of physicians: (1) a common set of quality measures based on clinical data and that focus on preventive care and care for prevalent and costly chronic conditions in the Medicare population; (2) quality measures of their own selection that they report through claims, registries, or EHRs, or (3) a common set of quality measures that focus on preventive care and care for chronic conditions that CMS would calculate from administrative claims data that require no action for the physician group beyond notifying CMS that the group elects this option.

Additionally, CMS is proposing to assess each such group of physicians with 25 or more eligible professionals on quality measures relating to reducing potentially preventable hospital admissions for specific chronic and acute conditions, reducing hospital readmission rates, and increasing the frequency of hospital post-discharge visits.

Value Modifier Payment Adjustments

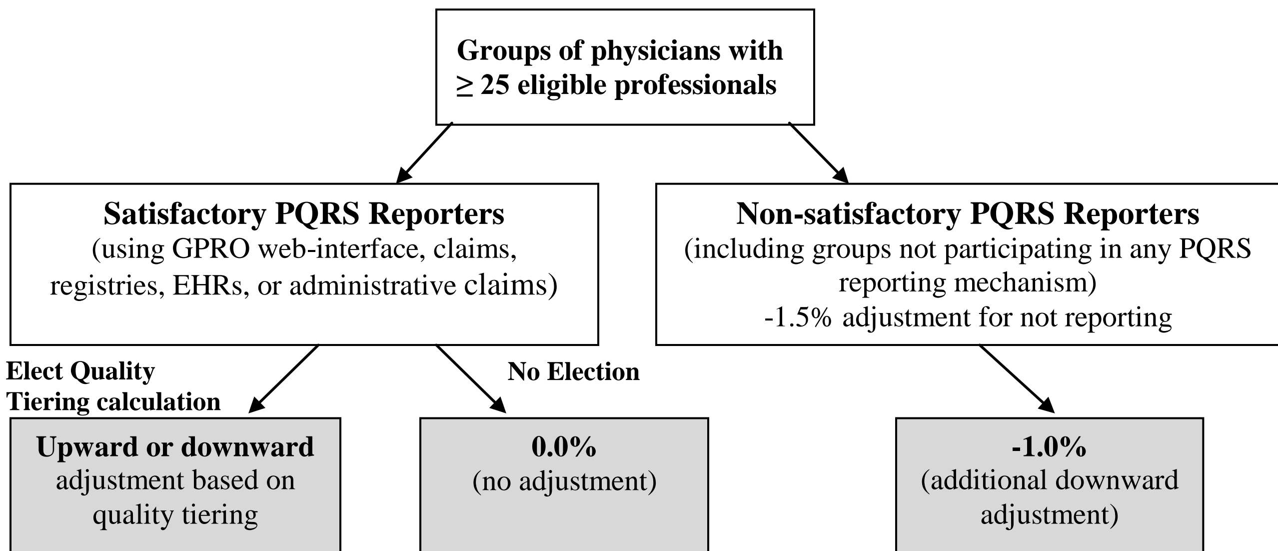
To balance the goals of beginning the implementation of the Value Modifier in a way that is consistent with the legislative requirements and to give CMS and the physician community experience in its operation, CMS proposes to separate groups of physicians into two categories. The first category would include those groups of physicians that have met the criteria for satisfactory reporting for an incentive under the options available to groups of physicians under the PQRS Group Practice Reporting Option. In addition, this category includes groups that elect the new PQRS administrative claims-based reporting option. CMS proposes to set the Value Modifier at 0.0 percent for these groups of physicians, meaning that the Value Modifier would not affect their payments under the MPFS, unless such groups of physicians elect the further evaluation of quality and cost of care described below.

CMS proposes to provide groups of physicians that are satisfactory PQRS reporters with the choice of having their value-based payment modifier calculated using a quality tiering approach. Choosing this option would allow these groups of physicians to earn an upward payment adjustment for high performance (high-quality tier and low-cost tier), and be at risk for a downward payment adjustment for poor performance (low-quality tier and high-cost tier). In

2013, CMS will provide Physician Feedback reports to groups of physicians with 25 or more eligible professionals that preview their Value Modifier (based on 2012 data), prior to the deadline for electing the quality-tiering approach.

The second proposed category would include those groups of physicians with 25 or more eligible professionals that have not met the PQRS satisfactory reporting criteria identified above, including those groups that do not submit any data on quality measures. Because CMS would not have quality measure performance rates on which to assess the quality of care furnished by these groups of physicians, CMS proposes to set their Value Modifier at -1.0 percent. This downward payment adjustment for the 2015 Value Modifier would be in addition to the -1.5 percent payment adjustment that is required under the PQRS for failing to meet the satisfactory reporting criteria. Groups of physicians with 25 or more eligible professionals that fail to meet the PQRS satisfactory reporting criteria would, therefore, be subject to downward adjustments during 2015 of 1.5 percent (for not being a satisfactory reporter under the PQRS) and 1.0 percent (for the Value Modifier).

How the Value Modifier is Assessed



Value Modifier Quality-Tiering Methodology

For groups of physicians that request to have their Value Modifier calculated using a quality-tiering approach, CMS proposes to examine which groups of physicians have performance that is significantly above or below the national mean on each quality and cost measure using a standardized score approach. This proposed approach takes into account the varying

distributions of scores among physicians across different quality and cost measures. This method would focus the Value Modifier on the outliers in measures of both quality and cost.

CMS is proposing to combine the standardized score for each quality measure into a quality composite using the domains included in the National Quality Strategy (clinical care, patient experience, population/community health, patient safety, care coordination, and efficiency). In addition, CMS is proposing to combine the cost measures into a cost composite. CMS proposes to differentiate the quality composite scores and cost composite scores into three performance tiers – high, average, and low – based on whether the composite score is significantly above or below the national mean.

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 is not proposing specific upward payment amount percentage. Rather, as shown in the table below, CMS is proposing to 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 Value Modifier encourages physicians to care for the severely ill and beneficiaries with complicated cases, CMS is proposing an additional upward payment adjustment for groups of physicians furnishing services to high risk beneficiaries.

Proposed Calculation of the Value Modifier using the Quality-Tiering Approach

Quality/cost	**Low cost**	**Average cost**	**High cost**
High quality	+2.0x*	+1.0x*	+0.0%
Medium quality	+1.0x*	+0.0%	-0.5%
Low quality	+0.0%	-0.5%	-1.0%

* 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.

PHYSICIAN FEEDBACK REPORTS

Since 2010, CMS has provided confidential Physician Feedback reports to certain physicians and groups of physicians. The reports quantify and compare the quality of care furnished and costs among physicians and physician group practices, relative to the performance of their peers. Starting in 2013, CMS anticipates using these reports to inform groups of physicians about their Value Modifier score.

In September, 2011, CMS provided Physician Feedback reports (also known as "Quality and Resource Use Reports") to the 35 large medical group practices (each with 200 or more physicians) that participated in the Physician Quality Reporting System Group Practice

Reporting Option in 2010. In March 2012, CMS disseminated feedback reports to 23,730 individual Medicare fee-for-service physicians in Iowa, Kansas, Missouri, and Nebraska. The individual physician reports, in summary, showed that approximately 20 percent of beneficiaries received care from multiple physicians without a single physician directing their overall care, based on proportion of visits or costs. These beneficiaries were also the highest risk and highest cost populations. CMS believes the proposals for the Value Modifier encourage high quality and less fragmented care for these beneficiaries.

CMS intends to include episode-based cost measures for several conditions in the Physician Feedback reports. CMS is studying how "episode groupers" that would connect all claims for a beneficiary during a certain timeframe may be used in the reports and will seek input from stakeholders on the development and use of episode groupers before phasing these measures into the Value Modifier.

The proposed rule will appear in the July 30, 2012 Federal Register. CMS will accept comments on the proposed rule until Sep. 04, 2012, and will review and respond to all comments in a final rule with comment period to be issued by Nov. 1, 2012.

For more information, see:

http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

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