American Association of Neurological Surgeons

CNS

Physician Value-Based Payment Modifier: What Neurosurgeons Need to Know for 2016

Prepared by the:

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Physician Value-Based Payment Modifier

What Neurosurgeons Need to Know for 2016

The Affordable Care Act required CMS to begin applying a value-based modifier (VM) to Medicare physician fee schedule payments for all physicians starting in 2017. The VM adjusts payments to groups of physicians based on their performance on a composite of quality and cost measures.

Value-Based Payment Modifier Timeline

Year	Action
2013	Initial performance period began for large group practices only (≥100 eligible professionals or EPs)
2014	Performance period began for group practices with ≥10 EPs
2015	• Initial application of payment modifier for large group practices only (≥100 EPs based on 2013 performance • Performance period began for ALL physicians
2016	• Application of the payment modifier to group practices with ≥10 EPs based on 2014 performance • Performance period begins for PAs, NPs, CNSs, and CRNAs in groups with ≥2 EPs and solo practitioners
2017	Application of the payment modifier to physicians in groups with ≥2 EPs and physician solo practitioners based on 2015 performance
2018	Application of the payment modifier to physicians, PAs, NPs, CNSs, and CRNAs in groups with ≥2 EPs and solo practitioners based on 2016 performance

**Note: The Medicare Access and CHIP Reauthorization Act (MACRA, P.L. 114-10) sunsets penalties associated with the Value Modifier starting in 2019. However, it also authorizes a new Merit-Based Incentive Payment System (MIPS), which will consolidate current reporting mandates, but continue to tie physician payments to quality and cost performance.*

Determining 2018 Payment Adjustments

Non-PQRS Reporters in 2016

As illustrated below, all physician and select non-physician eligible professionals (EPs) must, at a minimum, satisfy Physician Quality Reporting System (PQRS) reporting requirements in 2016[1] to avoid a separate payment adjustment under the VM in 2018. Failure to do so will result in an automatic Medicare payment penalty of -2.0% to -4.0%, depending on group practice size.

PQRS participation may occur at the individual physician or group practice level. If a group practice does not register to participate in the PQRS Group Practice Reporting Option (GPRO), but ***<u>at least 50%</u>*** of the EPs in the group satisfy PQRS reporting requirements ***as***

[1] *See* AANS and CNS websites for more details on 2016 PQRS reporting requirements in the document titled "Physician Quality Reporting System: What Neurosurgeons Need to Know for 2016."

individuals, CMS will hold the group and its individuals harmless from the automatic PQRS-related penalties, but potentially adjust the group's payments based on their quality and cost performance.

PQRS Reporters in 2016

All physicians, and select non-physician EPs, who satisfy PQRS reporting requirements in 2016 will be subject to a separate mandatory performance-based payment adjustment in 2018, known as the "quality-tiering calculation." Larger groups may receive upward, neutral or downward performance-based adjustments (up to -4%) in 2018 based on 2016 performance. Smaller groups and physician solo practitioners are subject to smaller upward, neutral or downward payment adjustments (up to -2.0%). Groups and solo practitioners consisting only of non-physician EPs may receive neutral or upward performance-based adjustments, but will be held harmless from downward performance-based payment adjustments in 2018.

EPs subject to quality-tiering will receive a payment adjustment based on their performance on a combination of quality and cost measures.

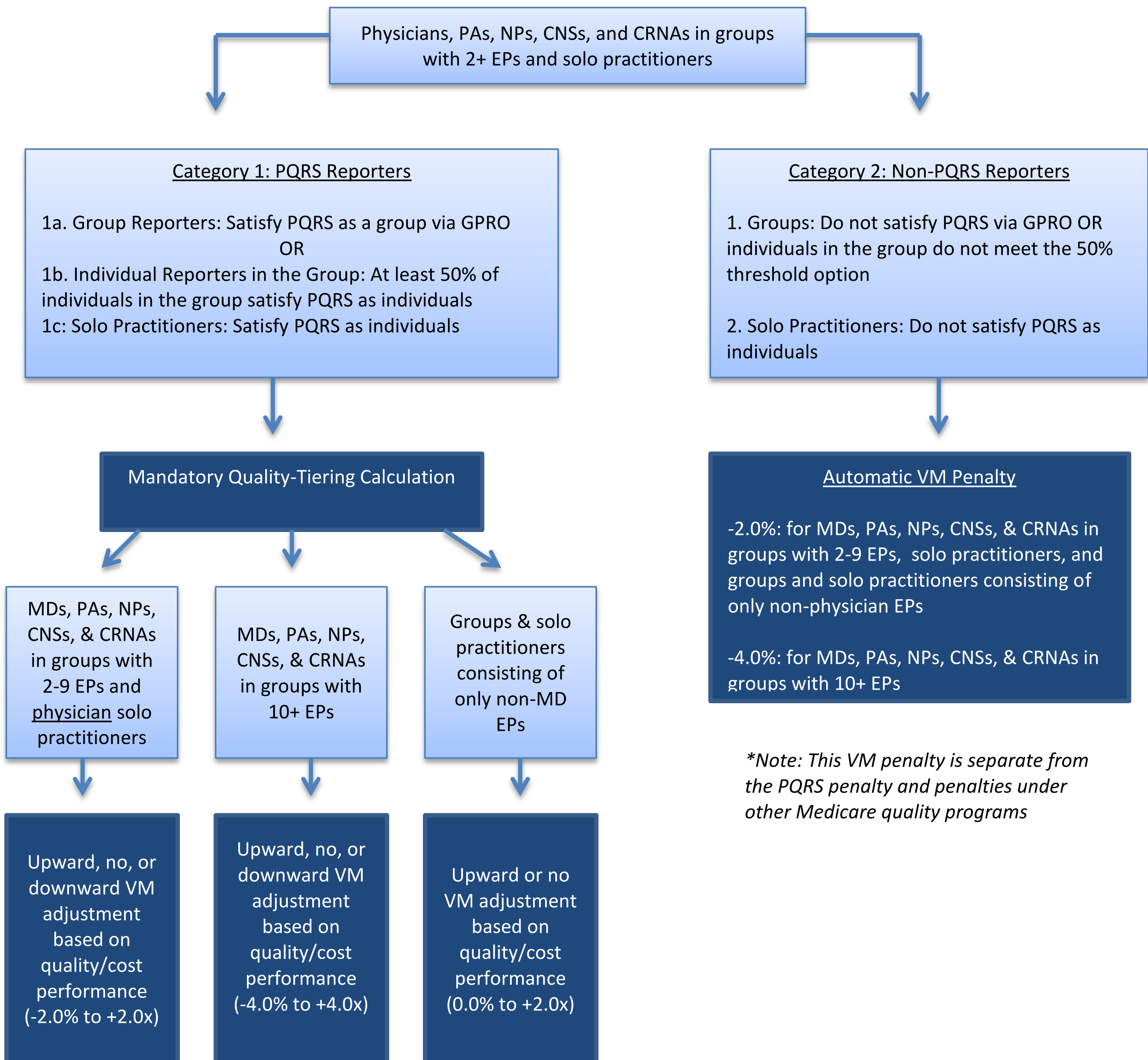
To calculate the ***quality composite score***, CMS will consider performance on the following measures:

- Any PQRS measures reported by the group or individual
- 3 outcome measures that CMS will automatically calculate based on claims:
  - All-cause readmissions
  - Acute preventive quality indicator composite (bacterial pneumonia, UTI, dehydration)
  - Chronic preventive quality indicator composite (COPD, HF, DM)

To calculate the ***cost composite score***, CMS will consider performance on the following measures:

- Total per Capita Costs for All Beneficiaries: Evaluates all Medicare Part A and B costs associated with any beneficiary over a year. Beneficiaries are attributed to the group that provided the plurality of primary care services to that individual.
- Total per Capita Costs for Select Conditions: Evaluates a Part A and B costs for patients with specific conditions (HF, CAD, COPD, DM). Beneficiaries are attributed to the group that provided the plurality of primary care services to that individual.
- Medicare Spending per Beneficiary: Evaluates Part A and B costs spanning 3 days prior to and 30 days after an inpatient hospitalization. Beneficiaries are attributed to the group that provided the plurality of Part B services during the inpatient stay.

Application of the 2018 Value Modifier



**Note: This VM penalty is separate from the PQRS penalty and penalties under other Medicare quality programs*

Calculation of the 2018 Value Modifier Using the Quality-Tiering Approach

Since this is a budget neutral program, spending on upward adjustments for high performers cannot exceed spending on downward adjustments for low performers. As shown in the tables below, CMS will divide the total scores for all physicians into three tiers based on whether their score is above, not different from, or below the national mean.

Those who are high quality/low cost will receive the greatest upward adjustment and those who are low quality/high cost will receive the greatest downward adjustment. Once the performance period has ended and the aggregate amount of downward adjustments for 2018 is known, CMS will apply an adjustment factor ("x") to determine upward payments. To ensure that the VM does not discourage practices from providing care to more complex or sick patients, CMS also will apply an additional upward payment adjustment for groups treating high-risk beneficiaries.

Physicians, NPs, PAs, CNSs, & CRNAs in Groups with ≥ 10 EPs

Cost/Quality	Low Quality	Ave 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%

Physicians, NPs, PAs, CNSs, & CRNAs in Groups with 2-9 EPs and Physician Solo Practitioners

Cost/Quality	Low Quality	Ave Quality	High Quality
Low Cost	0.0%	+1.0x*	+2.0x*
Average Cost	-1.0%	0.0%	+1.0x*
High Cost	-2.0%	0.0%	0.0%

** Eligible for an additional +1.0x if average beneficiary risk score is in the top 25% of all beneficiary risk scores*

How is Group Practice Defined?

A group is defined as a single Tax Identification Number (TIN) with 2 or more individual EPs, identified by Individual National Provider Identifier (NPI), who have reassigned their billing rights to the TIN. For purposes of determining group size for the VM, EPs are defined as:

- Physician
- Physician assistant
- Nurse practitioner or clinical nurse specialist
- Certified registered nurse anesthetist
- Certified nurse-midwife
- Clinical social worker
- Clinical psychologist
- Registered dietitian or nutrition professional
- Physical or occupational therapist or a qualified speech-language pathologist
- Qualified audiologist

As such, smaller group practices that rely on ancillary staff could easily fall under the category of 10 or more eligible professionals and could be subject to higher and downward performance-based penalties in 2018 based on 2016 reporting.

Quality and Resource Use Reports

The Quality and Resource Use Reports (QRURs) are annual reports that CMS provides to group practices with the following information:

- Comparative information about the quality and cost of care furnished to their Medicare FFS patients
- Beneficiary-specific information to help coordinate and improve the quality and efficiency of care furnished
- Information on how the group would fare under the VBM

In the late summer of 2015, CMS disseminated 2014 QRURs to all groups and solo practitioners. These reports indicate how a TIN's payments will be affected under the VM in 2016, based on 2014 performance data.

In April 2016, CMS also released 2015 Mid-Year QRURs (MY-QRURs) to groups and solo practitioners nationwide who billed for Medicare-covered services under a single TIN. The MY-QRURs cover the performance period from July 1, 2014 through June 30, 2015, and are available for practices who had at least one eligible case for one of the claims-based quality outcome or cost measures included in the MY-QRURs. The MY-QRURs provide interim data on the measures that CMS will use to calculate the 2017 VM. The data in these reports are for informational purposes only and will not affect a TIN's Medicare Physician Fee Schedule payments.

It is important to review your QRURs since they will serve as a preview of the VM methodologies CMS will apply to your practice in the coming years. You should use this opportunity to:

- Verify the accuracy of EPs billing under your group's TIN
- Determine how your group would fare under the VM (see "Performance Highlights")
- Examine the number of patients attributed to your group and the basis for their attribution
- Evaluate how your group's performance compares to other groups and which attributed beneficiaries are driving your group's cost and quality measures

How to Get Started with the Value-Based Payment Modifier

The VM does not require any additional action other than satisfying PQRS reporting requirements. Therefore, neurosurgeons will want to make sure that they:

- Participate in the PQRS in 2016 through either:
  - Group reporting - Register for the 2016 PQRS GPRO by **June 30, 2016**
  - Individual reporting – No registration necessary
- Review their annual and mid-year QRURs, including quality measure benchmarks to understand what is required for above average performance.

Additional Information

Click here for additional information on the VM, including more detailed fact sheets.