The ACA, Value Based Purchasing, ICD-10, and Health System Transformation

Georgia Chapter, ACP
2014 Annual Meeting
Callaway Gardens, GA.

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Chief Medical Officer Atlanta Region
Centers for Medicare and Medicaid

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Discussion

• Affordable Care Act Updates

• Value-based purchasing and quality improvement programs (featuring physician quality resource use reports and value modifier payment, (QRUR-VM))

• Must Participate in PQRS or may receive double penalty.

• ICD-10 Implementation Deadline: October 1, 2015
  www.roadto10.org
ICD 10 Resources/ Deadline

• ICD-10 Implementation Deadline:
  • October 1, 2015  www.roadto10.org

• NO Payments, private or government, will be made after this date if not ICD-10 compliant. (i.e. cash flow=0, zero)

• Road to 10: The Small Physician Practice's Route to ICD-10
  • Want to share your success story or lessons learned? Send it to us and it may be included on this site to help guide other physicians on the Road to ICD-10.
  • CMS has created “Road to 10” to help you jump start the transition to ICD-10.
  • Built with the help of small practice physicians, “Road to 10” is a no-cost tool that will help you:
  • Get an overview of ICD-10 by accessing the links
  • Explore Specialty References by selecting a specialty
  • Click the BUILD YOUR ACTION PLAN box to create your personal action plan
  • To get started and learn more about ICD-10, navigate through the links on the left side of the page. If you’re ready to start building an action plan, select the BUILD YOUR ACTION PLAN box.
The Three Part Aim, Goals of CMS

• Better Care
  – Patient Safety
  – Quality
  – Patient Experience

• Reduce Per Capita Cost
  – Reduce unnecessary and unjustified medical cost
  – Reduce administrative cost thru process simplification

• Improve Population Health
  – Decrease health disparities
  – Improve chronic care management and outcome
  – Improve community health status
Value Based Purchasing Incentives

– Incentivize the best care and improve transparency for Beneficiaries

– Transform CMS from a passive payer to an active purchaser of care

– **Link payment to quality outcomes** and stimulate **efficiencies in care**
Delivery system and payment transformation

**Current State –**
- Producer-Centered
  - Volume Driven
  - Unsustainable
  - Fragmented Care
- FFS Payment Systems

**Future State –**
- Patient-Centered
  - Outcomes Driven
  - Sustainable
  - Coordinated Care

**New Payment Systems**
- Value-based purchasing
- ACOs, Shared Savings
- Episode-based payments
- Medical Homes and care mgmt
- Data Transparency
Discussion

• Value-based purchasing and quality improvement programs - Physician Value Modifier Payments (VM) and Quality Resource Use Reports (QRUR)

• Based on Successful Physician Quality Reporting (PQRS) as well as cost of care.
What is the Value-Based Payment Modifier (VM)?

- Section 3007 of the Affordable Care Act mandated that, by 2015, CMS begin applying a value modifier under the Medicare Physician Fee Schedule (MPFS).

- VM assesses both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule.

- For CY 2015, CMS will apply the VM to groups of physicians with 100 or more eligible professionals (EPs) for 2013 performance year.

- For CY 2016, CMS will apply the VM to groups of physicians with 10 or more EPs for 2014 performance year.

- Phase-in to be completed for all physicians by 2017 for 2015 performance Year.

- Implementation of the VM is based on participation in Physician Quality Reporting System (PQRS).
Quality-Tiering Approach for 2016 (Based on 2014 PQRS Performance)

- Each group receives two composite scores (quality of care; cost of care), 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 cost and quality tiers.

<table>
<thead>
<tr>
<th></th>
<th>Low cost</th>
<th>Average cost</th>
<th>High cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High quality</strong></td>
<td>+2.0x*</td>
<td>+1.0x*</td>
<td>+0.0%</td>
</tr>
<tr>
<td>Average quality</td>
<td>+1.0x*</td>
<td>+0.0%</td>
<td>-1.0%</td>
</tr>
<tr>
<td><strong>Low quality</strong></td>
<td>+0.0%</td>
<td>-1.0%</td>
<td>-2.0%</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% of all beneficiary risk scores.
## Eligibility

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>PQRS</th>
<th>Value Modifier</th>
<th>EHR Incentive Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Eligible for Incentive</td>
<td>Subject to Payment Adjustment</td>
<td>Included in Definition of “Group” (1)</td>
</tr>
<tr>
<td><strong>Medicare Physicians</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor of Medicine</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Doctor of Osteopathy</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Doctor of Podiatric Medicine</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Doctor of Optometry</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Doctor of Oral Surgery</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Doctor of Dental Medicine</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Doctor of Chiropractic</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Practitioners</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Certified Registered Nurse Anesthetist (10)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Certified Nurse Midwife</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clinical Social Worker</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Registered Dietician</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nutrition Professional</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Audiologists</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Therapists</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Qualified Speech-Language Therapist</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
The VM Will Be Applied to Physician Payment Only

- Physicians include:
  - MDs / DOs
  - Doctor of dental surgery or dental medicine
  - Doctor or podiatric medicine
  - Doctor of optometry
  - Chiropractor
### 2014 Incentives and 2016 Payment Adjustments

<table>
<thead>
<tr>
<th></th>
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<tr>
<td></td>
<td>Incentive</td>
<td>Pay Adj</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10-99 EPs</td>
<td>100+ EPs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PQRS-Reporting</td>
<td>Non-PQRS Reporting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PQR Reporting (Up or Neutral Adj)</td>
<td>PQR Reporting (Down Adj)</td>
</tr>
<tr>
<td>MD &amp; DO</td>
<td>0.5% of MPFS</td>
<td>-2.0% of MPFS</td>
<td>Medicare Inc.</td>
</tr>
<tr>
<td></td>
<td>(1.0% with MOC)</td>
<td>+2.0 (x), +1.0(x), or neutral</td>
<td>Medicaid Inc.</td>
</tr>
<tr>
<td>DDM</td>
<td></td>
<td>+2.0% of MPFS</td>
<td>Medicare Pay Adj</td>
</tr>
<tr>
<td>Oral Sur</td>
<td></td>
<td>-2.0% of MPFS</td>
<td>$8,500 or $21,250 (based on when EP did A/I/U)</td>
</tr>
<tr>
<td>Pod.</td>
<td></td>
<td>+2.0% of MPFS</td>
<td>$8,500 or $21,250 (based on when EP did A/I/U)</td>
</tr>
<tr>
<td>Opt.</td>
<td></td>
<td>+2.0% of MPFS</td>
<td>$4,000-$12,000 (based on when EP 1st demo MU)</td>
</tr>
<tr>
<td>Chiro.</td>
<td></td>
<td>+2.0% of MPFS</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-1.0% or -2.0% of MPFS</td>
<td>-2.0% of MPFS</td>
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<td></td>
<td>$4,000-$12,000 (based on when EP 1st demo MU)</td>
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Reporting Quality Data at the Group Level

- Groups with 10+ EPs may select one of the following PQRS GPRO quality reporting mechanisms and meet the criteria for the CY 2016 PQRS payment adjustment to avoid the 2.0% VM adjustment.

<table>
<thead>
<tr>
<th>PQRS Reporting Mechanism</th>
<th>Type of Measure</th>
</tr>
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<tbody>
<tr>
<td>1. GPRO Web interface (Groups of 25+ EPs)</td>
<td>Measures focus on preventive care and care for chronic diseases (aligns with the Shared Savings Program)</td>
</tr>
<tr>
<td>2. GPRO using CMS-qualified registries</td>
<td>Groups select the quality measures that they will report through a PQRS-qualified registry.</td>
</tr>
<tr>
<td>3. GPRO using EHR</td>
<td>Quality measures data extracted from a qualified EHR product for a subset of proposed 2014 Physician Quality Reporting System quality measures.</td>
</tr>
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</table>
Reporting Quality Data at the Individual Level - 50% Threshold Option

- If a group does not seek to report quality measures as a group, CMS will calculate a group quality score if at least 50 percent of the eligible professionals within the group report measures individually.
  - At least 50% of EPs must successfully avoid the 2016 PQRS payment adjustment
  - EPs may report on measures available to individual EPs via the following reporting mechanisms:
    - Claims
    - CMS Qualified Registries
    - EHR
    - Clinical Data Registries (new for CY 2014)
What **Quality Measures** will be Used for Quality Tiering?

- **Quality Measures** reported through the GPRO PQRS reporting mechanism **selected by the group OR** individual measures reported by at least 50% of the eligible professionals within the group (50% threshold option)

- **Three outcome measures:**
  - All Cause Readmission
  - Composite of **Acute Prevention Quality Indicators** (bacterial pneumonia, urinary tract infection, dehydration)
  - Composite of **Chronic Prevention Quality Indicators** (COPD, heart failure, diabetes)

- **PQRS CAHPS Measures for 2014 (Optional)**
  - Patient Experience of Care measures
  - For groups of 25 or more eligible professionals
What **Cost Measures** will be used for Quality-Tiering?

- Total per capita costs measures (Parts A & B)
- Total per capita costs for beneficiaries with 4 chronic conditions:
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Heart Failure
  - Coronary Artery Disease
  - Diabetes
- Medicare Spending Per Beneficiary (MSPB) measure (3 days prior and 30 days after an inpatient hospitalization) attributed to the group providing the plurality of Part B services during the hospitalization
- All cost measures are **payment standardized and risk adjusted**.
- Each **group’s** cost measures **adjusted for specialty mix of the EPs in the group**.
Cost Measure Attribution

- 5 Total Per Capita Cost Measures
  - Identify all beneficiaries who have had at least one primary care service rendered by a physician in the group.
  - Followed by a two-step assignment process
    1. Assign beneficiaries who have had a plurality of primary care services (allowed charges) rendered by primary care physicians.
    2. For beneficiaries that remain unassigned, assign beneficiaries who have received a plurality of primary care services (allowed charges) rendered by any eligible professional.

- MSPB (Medicare Spending Per Beneficiary) measure – attribute the hospitalization to the group of physicians providing the plurality of Part B services during the inpatient hospitalization.
Quality-Tiering Methodology

- Use domains to combine each quality measure into a quality composite and each cost measure into a cost composite.
Quality-Tiering Approach for 2016 (Based on 2014 PQRS Performance)

- Each group receives two composite scores (quality of care; cost of care), 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 cost and quality tiers.

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Quality and Resource Use Reports (QRURs)

- The QRURs are annual reports that provide groups of physicians with:
  - Comparative information about the quality of care furnished, and the cost of that care, to their Medicare fee-for-service (FFS) patients
  - Beneficiary-specific information to help coordinate and improve the quality and efficiency of care furnished
  - Information on how the provider group would fare under the value-based payment modifier (VBM)

- 2012 QRURs are produced and made available to all groups of physicians with 25 or more eligible professionals (EP)

- Late Summer 2014: QRURs for all Groups and Solo Practitioners
How Can I Access My Report and Drill-Downs?

1. Navigate to the Portal
   • Go to https://portal.cms.gov

2. Login to the Portal
   • Select Login to CMS Secure Portal
   • Accept the Terms and Conditions and enter your IACS User ID and Password to login.

3. Enter the Portal
   • Click the PV-PQRS tab, and select the QRUR-Reports option.
How Can I Use the QRUR?

• Verify the EPs billing under your group’s TIN during performance period
• Determine how your group would fare under the Value Modifier (Performance Highlights)
• Examine the number of beneficiaries attributed to your group and the basis for their attribution
• Understand how your group’s performance on quality and cost measures compares to other groups
• Understand which attributed beneficiaries are driving your group’s cost measures
• Understand which beneficiaries are driving your group’s performance on the three hospital-related care coordination quality measures
• Identify those beneficiaries that are in need of greater care coordination
What Information Is Included on the Performance Highlights Page?

1. Your Quality Composite Score
2. Your Cost Composite Score
3. Your Beneficiaries’ Average Risk Score
4. Your Quality Tiering Performance Graph
5. Your Payment Adjustment Based on Quality Tiering

(payment adjustments in example based on 2015 VM implementation)
Where to Call for Help

• **QualityNet Help Desk:**
  - Portal password issues
  - PQRS/eRx feedback report availability and access
  - IACS registration questions
  - IACS login issues
  - PQRS and eRx Incentive Program questions

  866-288-8912 (TTY 877-715-6222)
  7:00 a.m.–7:00 p.m. CST M-F or qnetsupport@sdps.org
  You will be asked to provide basic information such as name, practice, address, phone, and e-mail

• **Provider Contact Center:**
  - Questions on status of 2012 PQRS/eRx Incentive Program incentive payment (during distribution timeframe)
  - See Contact Center Directory at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

• **EHR Incentive Program Information Center:**
  888-734-6433 (TTY 888-734-6563)
More information:

- [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html)
- [www.cms.gov/ehrincentiveprograms](http://www.cms.gov/ehrincentiveprograms)

THANK YOU
ACA Resources

- **Healthcare.gov**
  - Enrollment and information for individuals, families, and small businesses (SHOP)

- **Marketplace.cms.gov**
  - Information for individuals, physicians, immigrants etc.
  - A wealth of resources for teaching, and sharing for enrollees, physicians, patients etc.

- **Marketplace.cms.gov/c2c**
  - Coverage to Care new patient to health insurance information initiative, new patient preparation, action, and learning roadmaps to engage care and caregivers.

Thank You

Questions?