Medicare Value-based Payment Modifier: What ACOs Need to Know for 2016

Background

The Value-Based Payment Modifier (VM) was established as part of the Patient Protection and Affordable Care Act (ACA) and is designed to adjust Medicare physician payments based on cost and quality performance. The VM is part of the Centers for Medicare & Medicaid Services' (CMS) broader effort to move toward physician reimbursement that rewards value over volume in Medicare. The program is required by law to be budget-neutral, meaning upward payment adjustments for higher quality and lower costs must balance out the downward adjustments applied for lower quality and higher costs.

The VM has been phased in over the past few years, beginning with large group practices of 100 or more eligible professionals (EPs) who were evaluated in 2013 for payment adjustments in 2015. At that time, Medicare Shared Savings Program (MSSP) ACOs were excluded from the VM, but they were later added beginning with 2015 reporting, which depending on performance may affect Medicare physician payments in 2017. To learn more about the 2017 VM based on 2015 performance, view this CMS factsheet. This NAACOS resource outlines what ACOs need to know for 2016 performance, which determines 2018 VM payment adjustments.

Overview of 2018 VM

Based on how the ACO's quality and cost performance compares to national benchmarks, CMS will apply an upward, downward, or neutral payment adjustment to the 2018 payments for Medicare Part B covered professional services billed under the Medicare Physician Fee Schedule (PFS). These payment adjustments affect the Medicare paid amounts for items and services billed under the PFS at the Tax Identification Number (TIN) level so that beneficiary cost-sharing is not affected and the adjustments apply to services furnished by physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs). In addition to Physician Quality Reporting System (PQRS) performance, CMS also evaluates outcomes and cost measures as part of an analysis the agency calls "quality-tiering." Similar to the MSSP, CMS assigns beneficiaries based on the plurality of primary care services in a previous year and CMS risk adjusts patients for measure evaluation.

ACOs Affected by the 2018 VM

MSSP ACOs in Tracks 1, 2 and 3 are evaluated based on 2016 performance for potential VM payment adjustments in 2018. The 2018 VM is waived for Pioneer and Next Generation ACOs. The waiver applies if at least one EP bills for PFS items and services under a Pioneer or Next Generation participant TIN during the applicable performance period (i.e., 2016 for the 2018 VM). Because the VM is applied at the TIN level, this waiver also applies to EPs who do not participate in the Pioneer or Next Generation ACOs, but bill under the same TIN as EPs who do participate in these models and for whom the VM is waived.

VM Measures

Overview

The VM evaluates performance on quality and cost measures, including measures reported by providers and those that CMS evaluates based on claims data. ACOs are evaluated on a subset of VM measures and are considered "average" for other measures that are evaluated for providers and groups that are not part of ACOs.

The 2018 VM quality composite score for physicians, NPs, PA, CNSs, and CRNAs participating in an ACO in 2016 will be based on quality data submitted by the ACO for the PQRS Group Practice Reporting Option (GPRO) web interface measures, the ACO's performance on the all-cause hospital readmission measure, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs survey for the 2016 performance period. For the 2018 VM, the cost composite score will be classified as "average."

PQRS Quality Measures

CMS uses the ACO participant TIN list submitted at the beginning of the performance year to determine when a group practice is an ACO participant and should therefore be considered part of the ACO for the purposes of quality reporting under PQRS as well as for the VM. On behalf of its ACO participant TINs, an ACO submits PQRS quality data using the GPRO web interface. Successful reporting allows the ACO, and its participant TINs, to avoid penalties and potentially earn bonuses under PQRS and the VM.

If the ACO does not report PQRS successfully, all ACO participant TINs would be subject to the automatic VM penalty in accordance with their group size. TINs that join an ACO in the middle of a performance year must successfully report PQRS independently from the ACO in order to avoid an automatic VM penalty. For groups and solo practitioners that participate in two or more ACOs during the applicable performance period, CMS will base the VM quality score on the performance of the ACO with the highest quality composite. Beginning with the 2018 modifier, based on 2016 performance, CMS requires the ACO CAHPS survey as an additional component of the VM quality composite for ACOs (and thus their participant TINs).

The VM quality composite score is based on the data submitted by the ACO, but the VM will be applied at the participant TIN level. TINs participating in an MSSP ACO during the 2016 performance period (for a 2018 VM payment adjustment) will be evaluated using the same benchmarks as TINs not participating in an MSSP ACO.

ACOs are required to completely and accurately report quality data used to calculate and assess their quality performance in the MSSP, but ACOs in the first year of their agreement periods must only submit complete and accurate reporting and are not evaluated on performance. Quality performance benchmarks are phased-in during the second and third performance years of the ACOs' agreements. Therefore, first year ACOs satisfy MSSP quality requirements with full and accurate reporting, but measure performance on PQRS GPRO web interface and other quality measures is evaluated for purposes of the VM based on VM-specific benchmarks.

Outcome Measures

CMS will evaluate data from 2016 claims to calculate performance on three outcome measures for providers and groups not part of ACOs. For ACO participant TINs, CMS will only calculate the all-cause hospital readmission measure. Performance on outcome measures is risk-adjusted to account for patient characteristics that may lead to higher costs and lower quality of care.

All-Cause Readmission

The 30-day All-Cause Hospital Readmission measure is a risk adjusted readmission rate per 1,000 discharges for beneficiaries age 65 or older who were hospitalized at a short-stay acute care hospital and experienced an unplanned readmission for any cause to an acute care hospital within 30 days of discharge. Further details on this measure are available here.

Additional Outcome Measures NOT Applicable to ACOs
Ambulatory care sensitive condition composite measures are the risk adjusted rates at which Medicare beneficiaries are hospitalized for an established set of chronic and acute ambulatory care-sensitive conditions. After applying certain exclusions, all beneficiaries who are attributed to a TIN during the performance period and have one or more of the four associated chronic conditions or have a hospitalization with one of more of the primary diagnosis codes below would be included in the calculation of these measures. Further details on these measures are available here.

Cost Measures (NOT applicable to ACOs for 2018 VM)
Beginning with the 2018 modifier (based on 2016 performance) CMS will not evaluate ACOs on VM cost measures and will provide ACOs an "average" VM cost composite score, meaning cost performance will not help or hurt the ACO's VM performance.

For providers not in ACOs, CMS will calculate these cost measures as part of the VM quality-tiering analysis:

1) Total per capita costs, which includes payments under Medicare Part A and Part B, but do not include Medicare payments under Part D.
2) Total per capita costs for beneficiaries with the following four chronic conditions (Chronic Obstructive Pulmonary Disease, heart failure, coronary artery disease and diabetes)
3) Medicare spending per beneficiary measure (MSPB). An MSPB episode spans from three days prior to an index admission at a subsection (d) hospital through 30 days post discharge, with some exclusions.

For the cost measures, CMS makes a specialty adjustment to account for the cost differences that stem from various specialty compositions within a TIN. Details on this methodology are available here.
More information on the VM cost measures is available on this CMS website.

Evaluating performance on VM measures

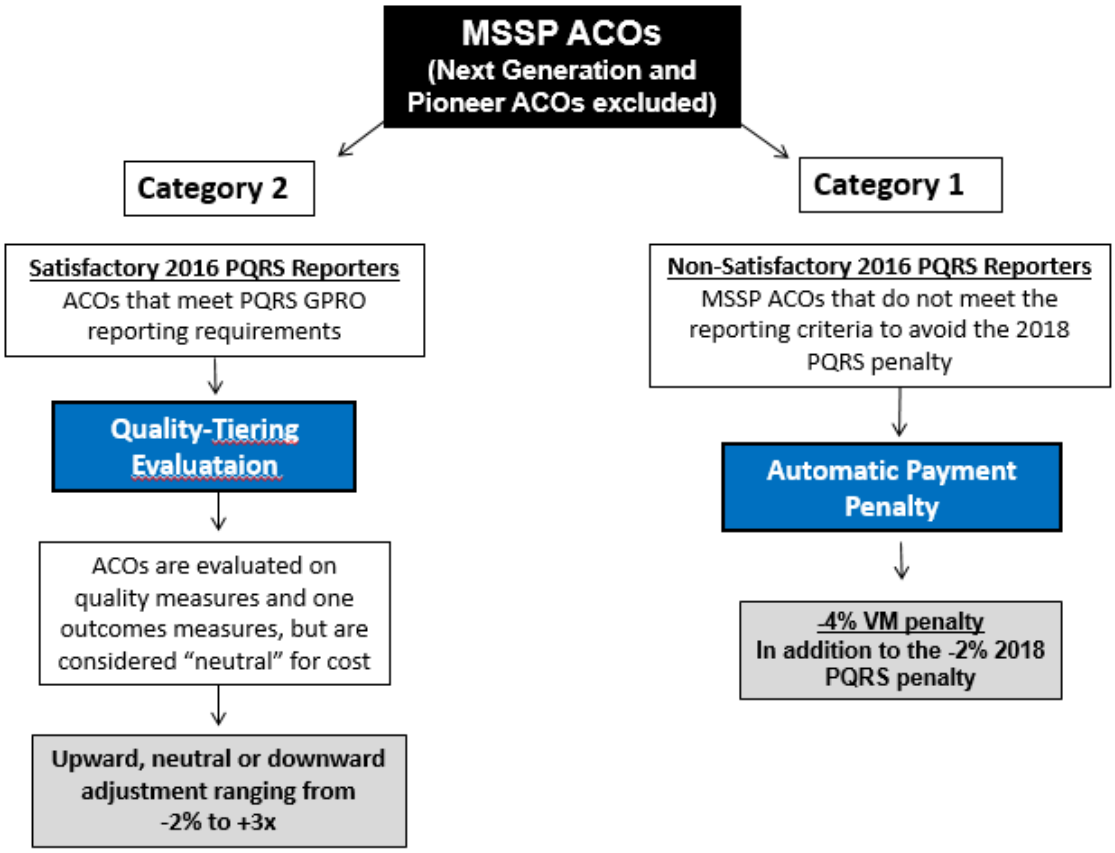
VM benchmarks for quality measures are based on the performance of all solo practitioners and groups nationwide one year prior to the performance year, which is three years prior to the VM payment adjustment year (e.g., 2015 data is used to establish benchmarks for the 2016 performance year, which affects 2018 VM payment adjustments). TINs participating in an MSSP ACO during the performance period (i.e., 2016 for the 2018 VM) will be evaluated using the same quality benchmarks as TINs not participating in an ACO, with the exception for the all-cause hospital readmission measure. For MSSP ACO TINs, the performance of the ACO (rather than the individual performance of each TIN) is used to calculate the all-cause hospital readmission measure benchmark.

Measure benchmarks for the VM are established separately from measure benchmarks in the MSSP. The methodologies used for these programs are detailed in these CMS resources:

- *Medicare Shared Savings Program Quality Measure Benchmarks for the 2016 and 2017 Reporting Years* available here.
- *Benchmark for Measures Included in the Performance Year 2015 Quality and Resource Use Reports (QRURs)* available here. See pages 70-71 for a description of the VM quality benchmark methodology. CMS intends to update this resource to reflect 2016 QRURs, which are the reports outlining performance on VM and other measures.

According to CMS, if a group's composite score is at least one standard deviation higher or lower than the composite average, then, in order for the physician group to have sufficient data, the physician group's composite score must also be statistically significantly different from the composite average. If a physician group's composite score is within one standard deviation of the composite average, then the physician group will always be considered average if it has at least 20 eligible cases for at least one measure that is part of the composite.

Overview of How the VM Works



The automatic four percent penalty under category one would only be two percent for ACO TINs that have between two and nine EPs. The group size associated with a given TIN is determined by CMS based on the lower of the number of EPs indicated by the information in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) or CMS' claims analysis. Based on the quality-tiering evaluation from 2016 performance, CMS will apply the following VM payment adjustments in 2018. Since ACOs are considered average for cost measures, those in quality-tiering would be eligible bonuses of 2.0x. The highlighted row in the table below reflects potential ACO payment adjustments under the VM.

2018 Value Modifier Payment Adjustment for TINs with 10 or more EPs

Cost / Quality	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%**

* Groups and solo practitioners will be eligible for an additional +1.0x if average beneficiary risk score is in the top 25 percent of all beneficiary risk scores.

How Does the VM Payment Adjustment Work and What Is "x"?

The 'x' factor represents the VM upward payment adjustment factor, which would be applied to providers that perform well under the quality and cost measures evaluated as part of the VM quality-tiering methodology. The "x" factor is unknown until after the close of the performance period. It is based on the sum of penalties collected under the VM, which is then apportioned to high performers based on their performance and how many other providers are eligible for payment increases. If an ACO successfully reports on quality measures, then the VM for the participant TINs under the ACO will be calculated using the quality-tiering methodology. The maximum

upward adjustment under quality-tiering in 2018 would be +2.0x for physicians, NPs, PAs, CNSs, and CRNAs in ACO TINs containing physicians with 10 or more EPs. TINs receiving an upward adjustment are eligible for an additional +1.0x if the ACO in which the TIN participated in during 2016 has an attributed patient population with an average beneficiary risk score in the top 25 percent of all beneficiary risk scores nationwide under the VM methodology. The maximum upward adjustment for ACO TINs with 10 or more EPs would be +3.0x. The maximum ACO downward adjustment under quality-tiering in 2018 would be 2.0 percent for physicians, NPs, PAs, CNSs, and CRNAs in ACO TINs with 10 or more EPs.

Patient Attribution

Patient attribution for the VM is used for the purposes of certain quality, outcomes and cost measures. ACOs are excluded from cost measures and all but one outcomes measure. VM patient attribution is based on the plurality of primary care services a physician or non-physician practitioner (NPP) provides to a beneficiary. Medicare beneficiaries are attributed to a physician's or NPP's group practice if the physician or NPP furnished a plurality of the beneficiary's primary care services. Similar to the MSSP ACO patient attribution methodology, beneficiaries are first attributed based on primary care services furnished by primary care physicians and certain NPPs. If a beneficiary is not assigned in the first step, CMS attributes the beneficiary to a group practice or physician that provided the plurality of primary care services, regardless of specialty. This CMS resource further explains the VM patient attribution methodology.

Risk Adjustment

CMS uses risk adjustment when calculating relative performance on the cost and outcomes measures to account for differences in beneficiary-level risk factors that can affect quality outcomes or medical costs, regardless of the care provided. While risk adjustment for most VM measures entails a comparison of actual performance to expected performance, its implementation differs from measure to measure. Further details on the VM risk adjustment process are available here.

Minimum Cases

For measures other than the MSPB cost measure, which does not apply to ACOs, CMS uses a minimum case size of 20 in order for a measure to be included in the quality of care or cost composite. If below that threshold for a particular measure, it would not be counted and the remaining measures in the domain would be given equal weight. To the extent that CMS cannot develop a quality of care composite or cost composite, it would not calculate a VM for quality-tiering purposes and the group's payment would not be affected.

Additional Questions?

NAACOS members who have questions about the VM may contact us at advocacy@naacos.com