# Making Reporting Easy

*Value-Based Payment Modifier (VBM)*

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This white paper is written to help practices and solo practitioners understand the Value-Based Payment Modifier.

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The Value-Based Payment Modifier (VBM) Program provides for differential payment to a physician or group of physicians based upon the quality of care provided and the cost of care during a performance period. This is how CMS is turning Pay-for-Reporting into Pay-for-Performance. The VBM Program compares a practice's cost of care and the quality of care to their peers. A composite score is created for both cost and quality.

The cost of care composite score is derived from all Medicare Part A and B claims submitted by all providers who treated attributed Medicare beneficiaries under the TIN. Medicare Part D is not included in the cost of care calculation. The cost scores are risk-adjusted for the patient population. The goal is to have lower costs than your peers resulting in a cost composite score lower than average.

The quality of care composite score is derived from PQRS measure performance on quality indicators across up to 6 equally weighted quality domains. The 6 domains are the National Quality Strategy (NQS) domains: Patient Safety; Person and Caregiver-Centered Experience and Outcomes; Communication and Care Coordination; Effective Clinical Care; Community/Population Health; Efficiency and Cost Reduction. The goal is to have high measure performance rates resulting in a quality composite score greater than average.

CMS then takes your Cost Composite Score and Quality Composite Score and, after comparing them to all other TINs, gives each TIN a Standardized Cost Composite Score and a Standardized Quality Composite Score. These Standardized Scores are presented as the distance, in standard deviations, from the national average. Based on these standardized scores, performance is revealed and the TIN is quality-tiered.

Groups sized 2-9 Eligible Professionals, Solo Practitioners, and Non-Physician Practitioners can either be neutrally adjusted or upward adjusted based on their Standardized Composite Scores. Groups of this size cannot be downward adjusted.

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

*Reference:* 2015 Updates to the Physician Quality Reporting System (PQRS) & the Value-Based Payment Modifier. Philadelphia Regional Office of CMS. 7 April, 2015. Centers for Medicare & Medicaid Services.

Groups of 10 or more Eligible Professionals can be upward adjusted, neutrally adjusted, or downward adjusted based on their Standardized Composite Scores.

| 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% |

*Reference:* 2015 Updates to the Physician Quality Reporting System (PQRS) & the Value-Based Payment Modifier. Philadelphia Regional Office of CMS. 7 April, 2015. Centers for Medicare & Medicaid Services.

## Understanding the Value-Based Payment Modifier:

It is important to select a reporting data submission pathway that gives you the best chance to receive the highest possible quality score. Your future value modifier is, in part, based on the quality score you submit to CMS. The other part is based on cost. Quality and Resource Use Reports

(QRURs) will be released and will include your two composite scores (quality of care; cost of care) based on your groups standardized performance (e.g. how far away your scores are from the national average). For example, if your QRUR shows low cost and high quality composites in comparison to the national mean, then you may want to consider the same measure selections for the current reporting year as it may result in an upward adjustment. On the same note, if you have high cost and low quality it could result in a downward adjustment. In this circumstance, consider changing your data collection and reporting pathways and align outliers with health coaches or case managers to help with population health management as it pertains to the measures.

## Understanding CAHPS:

Consumer Assessment of Healthcare Providers and Systems (CAHPS) are defined as surveys that ask patients to report on and evaluate their experiences with healthcare. The CAHPS for PQRS program is mandatory for all GPROs over 100 Eligible Professional and is optional for all other sized GPRO practices. The Survey administration takes place from November 2015 thru February 2016. The number of beneficiaries surveyed depends on the size of the practice.

By reporting CAHPS for PQRS, the PQRS program reporting requirements change. CAHPS reporting is equal to, and takes the place of, 3 Individual PQRS Measures and 1 National Quality Strategy (NQS) domain. So, each practice that is reporting CAHPS for PQRS only have to report on 6 Individual Measures that cross at least 2 NQS domains. If an Eligible Professional under the TIN has a face-to-face encounter, one of the 6 PQRS measures must be a cross-cutting measure.

The CAHPS for PQRS survey reporting option is selected during the GPRO registration process (January 1, 2015 – June 30, 2015). Each GPRO that selects to report on CAHPS for PQRS will also have the option to include the CAHPS survey results included in the Value-Based Payment Modifier (VBM) calculation if desired.

**Recommendations:**

Selecting an experienced registry, selecting optimal measures, and making sure you register for GPRO (if appropriate) will all lead to revenue retention and possible bonus payments for 2017. However, it is the long range planning and applications that will help practices manage performance per the PQRS measure specifications that will ultimately pay practices the largest reward. Team up with a quality firm that has been doing PQRS reporting and submission to help navigate the PQRS GPRO pathway. Use a firm that has been reporting for more than 7 years. Look for one that can offer consulting, reporting, and data submission services. These types of firms can help make reporting easy.

**Company background:**

ReportingMD® provides high quality Medical Intelligence™ (MI) products, health information consulting, and custom solutions. We are a qualified registry by the Center for Medicare and Medicaid Services (CMS) for Physician Quality Reporting Systems (PQRS) since 2008 and a data submission vendor for PQRS and Meaningful Use. ReportingMD's TOM application uses ONC certified technology for submitting your eCQM and PQRS data electronically. Our services and solutions allow providers and practices to effectively manage outcomes in support of PQRS, MU, Values Based Payment Modifier

(VBM), ACO, PCMH and Population Health from a programmatic and reporting perspective. We help our clients by aggregating data from multiple sources, including EMRs and Practice Management Systems, analyzing this data, and interpreting the results to assist with navigation of the multiple CMS quality performance programs. Our goal is to partner with healthcare providers to support them in providing high quality clinical outcomes for their patients.