



National Hospice and Palliative Care Organization  
**Palliative Care Resource Series**

**PQRS AND THE VALUE BASED  
PAYMENT MODIFIER**

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## INTRODUCTION

Section 1848(p) of the Affordable Care Act requires CMS to establish a value based payment modifier (VBPM) and apply it to certain physicians and physician group practices by Jan. 1, 2015, and to all physicians — including solo practitioners — by Jan. 1, 2017. The VBPM impacts all Part B physicians and significantly raises the stakes for physicians to participate in and comply with the Physician Quality Reporting System (PQRS) and Meaningful Use. Over time, non-physician practitioners (nurse practitioners and physician assistants, for example) will also be impacted by the VBPM.

Let's take a look at how we got here.

## A LONG TIME COMING

For those of us who have been involved in health care reimbursement for at least a decade, the Value Based Payment Modifier can be recognized as having been in the works for quite some time. Testifying before the House Ways and Means Subcommittee on Health on September 29, 2005 then CMS Administrator Mark B. McClellan, M.D., Ph.D. stated that CMS believed an important component of delivering high quality care is the ability to measure and evaluate quality, and that CMS was committed to the development of reporting and payment systems that will support and reward quality.

The same year, as part of its overall quality improvement efforts, CMS launched the Physician Voluntary Reporting Program (PVRP). The PVRP would initiate the process by which physicians submitting claims to Medicare Part B, who chose to participate, would begin reporting quality data and be able to receive feedback on their performance. Missing from this initiative was any financial incentive for physicians reporting. Not surprisingly, PVRP was short-lived.

Next up for physicians in 2005 was the Oncology Demonstration Program. CMS established three categories of HCPS 'G' codes that physicians used to report symptoms of nausea and vomiting, fatigue, and pain associated with chemotherapy. Practices reporting data on all three factors qualified for an additional payment of \$130, per encounter for chemotherapy administration. This Demonstration was revised in 2006 and continued for a second year. Interestingly in today's environment, there was one common thread that seemed to run through the different programs' attempts to measure quality: efforts and questions regarding physician use of electronic medical records.

These and some lesser-known demonstration projects might have provided real clinical information that physicians could use in treating their patients, but analysis and anecdotal evidence supported that physicians would report on clinical quality measures if there were reimbursement to cover the costs of the requested tracking and reporting. According to at least one study, the practice administrator primarily made this determination.

In more recent years, CMS rolled out the e-prescribing, PQRI (now the Physician Quality Reporting System, or PQRS), and EHR incentive programs. Physicians who integrated e-prescribing and PQRI (Physician Quality Reporting Initiative) into their practices early on were rewarded with up to a combined incentive payment of 4 percent of their total Medicare Part B allowed charges. For some early adopters, these programs added nicely to practice revenue. I recall a five-physician practice that was delighted to receive two checks of slightly over \$70,000, each, for reporting both e-prescribing and PQRI when each had a potential 2 percent incentive. For whatever the reason, palliative care physicians and nurse practitioners did not seem to know about these programs while there were incentive monies available.

## FAST FORWARD TO 2015

The PQRS was always a “carrot and stick” program; it started off paying incentives and, over time, was to result in payment penalties for Part B providers who did not report. As letters from CMS noting Medicare Part B payment reductions for palliative care providers based on lack of PQRS reporting in 2013 were received early in 2015, the reality of PQRS’s impact on all Part B providers could not be avoided. And, now this included palliative care organizations. Understand that PQRS has always been available for all Part B providers to participate in. In the simplest of terms, each provider chooses quality measures to report to CMS from a predefined, approved list. How this is done can vary from organization to organization as well as physician or non-physician practitioner to physician/NPP within an organization. There has always been a degree of flexibility in the method of reporting; this remains today, although the bar has been raised relative to the number of measures that an individual or group practice must report. From a Medicare billing and reimbursement perspective, a palliative care program is a physician practice. And if your palliative care program has 2 or more providers (even 1 physician and 1 nurse practitioner), CMS considers you a group practice. This is one of the concepts so important for palliative care providers to understand: you bill Medicare Part B, consequently Part B program requirements apply to your organization and individual providers. And, when it comes to PQRS, there are no exceptions.

For example, if a physician, nurse practitioner, physician assistant, LCSW, etc., submits one Medicare Part B claim in 2015, regardless of the place of service, PQRS applies to that provider. Failure to report PQRS in 2015 will result in payment penalties being applied in 2017. The only question is how large the penalty will be, and that depends on the size of your “group,” and whether the individual provider is a physician or non-physician practitioner. I would urge you to keep in mind that a small program in 2015 could take off and be much larger in 2017, or one provider who rarely sees palliative patients may have his/her role change dramatically in a year or two. Consequently, it is not wise to think, “Oh, it’s not worth the effort to report PQRS.” as your situation may change.

The Physician Quality Reporting System is part of an overall effort to move toward a value-based purchasing (VBP) system that aims to reward the value of care provided, rather than the quantity of services. To this end, PQRS quality measures are intended to define, standardize and drive improvement in the quality of health care. A payment adjustment, applicable to professionals who do not satisfy the criteria for reporting quality data under PQRS, is intended to encourage professionals to adopt evidence-based, outcomes-driven healthcare delivery practices.

According to a recent CMS report<sup>1</sup>, participation in PQRS has grown dramatically since its 2007 inception. Some highlights from this report include the following metrics:

- A total of \$218,930,348 in PQRS incentive payments were earned in the 2013 program year, which reflects successful participation of 494,619 eligible professionals within 48,313 practices. For 2013, the earned incentive was equal to 0.5 percent of total estimated Medicare Part B Physician Fee Schedule allowed charges for the covered professional services furnished during 2013.
- Total incentive payments for the 2013 PQRS program year increased by 31 percent compared to 2012 (\$166,925,037).
- The number of eligible professionals who qualified for an incentive for PQRS in 2013 increased by 35 percent from 2012 (N=367,240), including eligible professionals who were part of a group practice that were incentive eligible under the GPRO or through successfully meeting the requirements of the CPC Initiative or successful participation through a Medicare ACO under the Shared Savings Program or the Pioneer ACO Model.
- The number of practices that received an incentive for the 2013 program year increased by 65 percent from 2012 (N=29,254).
- The average incentive was \$443 per eligible professional and \$4,531 per practice; the average incentive decreased slightly from 2012.

As noted, PQRS has evolved into a penalty only program, and the penalties are rising each year. In addition, PQRS is a component of the Value Based Payment Modifier program (discussed below), and because of this, any provider who does not successfully report PQRS in 2015 will also be hit by a VBPM reduction in 2017 of at least 2% in addition to the 2% PQRS payment penalty.

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<sup>1</sup> 2013 Physician Quality Reporting System and eRx Reporting Experience and Trends

## WHAT THE VBPM IS (AND WHAT IT ISN'T)

The VBPM is *not* a 2-digit modifier to further explain a CPT® or HCPCS code. Rather, it embodies the concept of using incentives to modify physician behavior, with the hope that this may have a positive impact on both the quality of care provided and the costs associated with that care. Physicians who work in an MRA (Medicare Risk Adjustment) or ACO (Accountable Care Organization) environment are already familiar with these concepts. From a coding perspective, the VBPM requires sound knowledge and application of diagnosis (ICD) codes (more on this, later).

CMS stated in the 2013 Physician Fee Schedule final rule that the value based payment modifier

“has the potential to help transform Medicare from a passive payer to an active purchaser of higher quality, more efficient and more effective healthcare by providing upward payment adjustments under the PFS to high performing physicians and downward adjustments for low performing physicians.”

By implementing this initiative, CMS is seeking to reward high quality care and quality improvements, and promote more efficient and effective care through the use of evidence-based measures, and reduce duplication and fragmented care.

## VBPM IMPOSES A COST FOR FAILURE TO REPORT

The current fee schedule payment method does not contain any incentives for physicians to focus on the quality of care, the relative value of each service they furnish, nor the cumulative costs of services or items they provider and order, and the services that their patients receive from other providers. The VBPM goals are to improve quality and lower the per-capita growth in expenditures. These are important components in revamping how care and services are paid for. The VBPM will apply only to PFS (physician fee schedule) services billed on an assignment basis and not to non-assigned claims, to avoid any impact on beneficiary cost-sharing.

The VBPM will be implemented in a budget-neutral manner, with payments increasing for some physicians but decreasing for others. In fact, the amount of money available for incentive payments will be limited to the amounts adjusted for high cost, low quality care. To help ensure the data is meaningful, CMS does not include any information where fewer than 20 beneficiaries are involved, and, from a cost perspective the dollars are risk adjusted. This initiative gives different weights to patients whose care a physician directs, versus those patients for whom the doctor may only contribute some care. All of this is an attempt to balance the data between costs a doctor can control and those the doctor cannot control.

Payment at risk is -4.0 percent, with potential upward adjustment of up to +4.0x ('x' represents the upward payment adjustment factor). The upward adjustment factor will be contingent on the total calculated downward adjustment, as this latter element will determine the pot of money available for incentive payments under VBPM. To begin filling that pot, *solo physicians and those in small group practices who do not report PQRS in 2015 are scheduled to incur an automatic -4.0 percent of all MPFS allowed charges in 2017 due to the Value Modifier.*

Clearly, PQRS takes on increasing importance in calendar year 2015.

## QRURS CAN TELL YOU WHERE YOU STAND, NOW

To avoid physicians being taken by surprise by the impact of the VBPM, the 2013 Quality and Resource Use Reports (QRURs) were made available to solo physicians and group practices. These reports contain quality and cost performance data for calendar year 2013. For physicians in groups of 100 or more physicians, the data in these reports will be applied to the physicians' payments for services paid under the Medicare Physician Fee Schedule in 2015. At the end of April 2015, CMS released more recent QRUR reports which contain data through about mid-year 2014.

All physicians should take advantage of the opportunity to review the QRURs. These can be accessed at <https://portal.cms.gov>, using the User ID and password for the doctor or practice's IACS (Individuals Authorized Access to the CMS Computer Services) account. If needed, physicians can contact the QualityNet Help Desk for Assistance at either **1-866-288-8912** or via [qnetsupport@hcqis.org](mailto:qnetsupport@hcqis.org) from 7:00 AM to 7:00 PM CT, Monday through Friday.

Each QRUR contains the quality and cost information that will be used to determine where a physician, or physician group, falls on the "quality versus cost" continuum. The information has been drawn primarily from claims data and the information reported via PQRS. With that in mind, CMS is on record as stating, "We strongly encourage physicians to participate in the PQRS program and the EHR Incentive Program sooner rather than later and to choose to report quality of care measures that best reflect their practice and patient population."

## CONCLUSIONS

Reporting PQRS cannot be avoided. To do so jeopardizes the financial health of your palliative care program. Remember that there are no exceptions to reporting PQRS measures, no minimum number of Part B claims, and no exemption for hospital-based palliative consulting practices.

While not discussed here, if more than 10% of your palliative care Medicare Part B billings are for services not in a hospital inpatient setting, the EHR incentive program and Meaningful Use applies to that provider as well.

The QRURs are fascinating to read. Think about this measure: How many patients received a systemic steroid within seven days after being diagnosed with an exacerbation of COPD? Now that there is Medicare Part D claims data, CMS can easily determine what medications a beneficiary has taken. A doctor's claim starts the clock ticking for the "seven days" noted in this item (date of service), and the ICD-9-CM (or, as of Oct. 1, 2015 the ICD-10-CM) code on the first claim submitted tells Medicare when the diagnosis of an acute episode of COPD was first made (first treatment day). This is one of many similar examples found in a QRUR. As a coder, I recognized the importance of moving to ICD-10 more clearly after reviewing the information provided in these reports. And, knowing that CMS was risk adjusting the doctors' scores emphasizes how critical our diagnosis coding has become.

After seeing what's in a QRUR, it becomes clear that accurate and complete coding is more important than ever. Be aware that the VBPM payment adjustment is separate from the PQRS payment adjustment, or payment adjustments from other Medicare sponsored programs. These program adjustments are cumulative. Think about some of the potential additional penalties: -2 percent for not reporting PQRS in 2015, and up to -3 percent for not meeting Meaningful Use in 2015. Other payment adjustments may change, but it's clear a physician could be down as much as -9 -percent or more in 2017, based on 2015 performance year calculations.

Much of this information is being published as CMS educates beneficiaries to compare physicians of the same specialty. Currently, beneficiaries can use the Physician Compare website to find a doctor; soon, they'll have access to some of the quality metrics being reported in PQRS and the QRURs. Transparency in government just got personal!

### Sources:

- [www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Value-BasedPaymentModifier.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Value-BasedPaymentModifier.html)
- CMS-1524-FC
- [www.medicare.gov/physiciancompare](http://www.medicare.gov/physiciancompare)

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