ICLOPS Case Study: VBPM Consultation Lifts Specialty Group's Quality Tier and Medicare Revenues

written by Dave Halpert | October 14, 2015

Medicare's Value-Based Health Care programs aren't just about penalties. You can also earn a reward. Case in point—an ICLOPS orthopedic client recently asked The Big Question: Are there really incentives to be earned through Medicare's Value-Based Care? With the release on September 9 of the Annual Quality and Resource Use Reports (QRURs), the answer is a resounding "Yes."

At its core, the Value-Based Payment Modifier (VBPM) is a simple proposition: Those who are able to demonstrate higher quality care at a lower cost than other groups are rewarded, while those who can't are penalized. The rewards come from the pool of penalty revenues in Medicare's budget-neutral program. Many components go into the VBPM calculation:

- Performance in the measures you reported for PQRS
- Performance in Medicare's claims-based outcomes measures
- Per Capita Costs for All Beneficiaries
- Per Capita Costs for Beneficiaries with Chronic Conditions
- Medicare Spending Per Beneficiary

To compound the challenge and the complexity of VBPM methodology, remember that each of these components is scored comparatively, making it more difficult for groups to determine whether they are leading the pack, or need to catch up. But challenging does not equal impossible.

Here's how one provider group was able to break from the pack by demonstrating high quality

while controlling costs—and to reap significant incentive rewards.

The Goal: Positive Tiering for a Large (100+ Provider) Orthopedic Group Practice

The group's 100+ providers practice in several locations and cover the breadth of orthopedic care, encompassing sports medicine, surgery, imaging, as well as physical and occupational therapy.

This group's QRUR revealed that they had the potential to be positively tiered, based on their ability to demonstrate high quality care without a corresponding increase in patients' costs. These actions established the best starting point for ensuring a positive result, because the group did the following:

Started early in the year to fulfill PQRS reporting requirements;
Collaborated to accurately and comprehensively report on thousands of patients without sacrificing productivity.
Reviewed measure performance on an ongoing basis, taking steps to adjust and improve;
Made informed selections of PQRS measures prior to submission;
Focused on continuity of care

Following our recommendations, the group first ensured that they fulfilled PQRS requirements—with good reason. For a group of this size, failing to report PQRS successfully would mean two penalties, totaling a hefty 4 percent of 2016 Medicare revenues:

A 2 percent penalty for failing to report for PQRS
A 2 percent penalty, levied automatically, for VBPM

To make sure that at least 9 measures over 3 National Quality Strategy Domains were reported, the group began with a broader approach, collecting information on 15 measures. They developed and implemented an end-to-end system for collecting measure responses, utilizing front desk, administrative and technology staff, in addition to the physicians. The group recognized that, given their patient volume, the only way to collect this information was to work together, and that everybody could play a role, particularly in measures that can be collected during registration (e.g. tobacco use).

But a few extra tactics were needed to ensure that they passed the mark. ICLOPS worked with the group to boost the calculations for the VBPM beyond the CMS Mean. Here are our key recommendations, and how they paid dividends for the group:

1. Align providers in separate locations via Group Practice Reporting Option.

The group utilized the Group Practice Reporting Option (GPRO), via Qualified Registry. By reporting as a group, rather than as a collection of individuals, they were able to reduce the administrative burden.

While the group used ICLOPS Registry functionality to drill down to the provider and patient levels and identify where improvement could occur, the fact that they started from a summary level made it much easier to track progress and identify areas for improvement.

2. Evaluate and report only those measures that most accurately and positively represent the group.

ICLOPS provided guidance on how the group's VBPM was calculated and which measures were best suited to improving their standing, as well as the nuances of each individual measure. Looking at previous results and trends, we were able to help the group visualize performance compared to the rest of the country. High performance, alone, doesn't necessarily guarantee that a measure is right for submission.

For example, we advised this orthopedics group not to submit measure #154 for Falls Risk Assessment. The group frequently reported this measure to indicate that patients were not at risk, meaning that they were considered performance exclusions. As a result, however, a small number of instances unfairly skewed the group's performance rate in a negative direction. That result could never be considered a true measure of performance or care, and it misrepresented the group.

By using other measures instead, the group was able to maintain control of their Quality Composite. In particular, we assisted with data retrieval for Pain Assessment, Medication Verification, BMI and Blood Pressure to complete all four measures. By submitting these measures instead of the others, the group was able to improve their quality tiering composite while still ensuring that all PQRS requirements were fulfilled.

In addition to these recommendations, ICLOPS worked with this group throughout the year to hone existing measure performance and to continuously evaluate the effects of previous selections, as well as account for the most recently released information from CMS. These updates, coupled with ongoing review and validation, paid dividends at the point of submission.

3. Demonstrate continuity of care and efficiency.

ICLOPS educated the group about how Medicare is tabulating costs and how that methodology applied to their practice. In particular, we focused on how cost composites are not necessarily based on the care provided by the practice; rather, they follow the attributed beneficiary.

Armed with this knowledge, the group actively engaged in processes to ensure that a primary care provider also saw their patients. In this way, the costs associated with managing chronic health issues unrelated to orthopedics would not be attributed to their practice.

The group was able to dovetail its PQRS efforts to influence this process. Several cross-cutting measures in the Community and Population Health NQS Domains allow providers to meet performance even if the patient's results were not optimal. For example, measure #128 (related to BMI) and measure #317 (related to blood pressure) track whether patients were screened and, if results are not in a pre-defined range, whether follow-up action was taken. In these measures, referring the patient back to a primary care provider (if the encounter is occurring in a specialty setting) is an acceptable response.

The result? While the final adjustment factor won't be determined until CMS completes the informal review process in November, the group will receive at least 0.5 percent for its PQRS bonus plus 1 percent multiplied by the adjustment factor. The group was able to improve simultaneously on two fronts: improve performance and ensure continuity of care. The 2014 QRUR showed strong performance in PQRS measures, as well as excellent results on claims-based outcomes measures focusing on Ambulatory Care Sensitive Condition (ACSC) Admissions.

Download your free copy of our new eBook, *ICLOPS Value-Based Payment Modifier Primer: How NOT to Forfeit Your Medicare Revenues.*

Founded in 2002, ICLOPS has pioneered data registry solutions for improving patient health. Our industry experts provide comprehensive Value-Based Payment Modifier Solutions that help you both report and improve your performance. ICLOPS is a CMS Qualified Clinical Data Registry.

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