Provider Network Growth? How to Avoid Unanticipated Medicare VBPM Penalties

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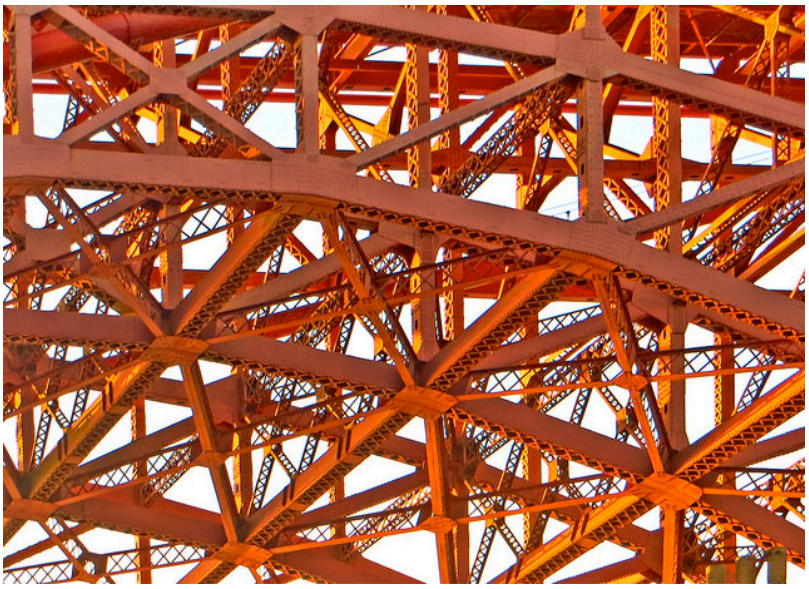

Mergers and acquisitions, joint ventures and affiliations—this is the new face of health care, and the trend shows no signs of slackening. If your group has grown and changed significantly through consolidation, you'd best take a second look at your 2013 Quality and Resource Use Report (QRUR). Chances are, it no longer applies to your organization, putting your at risk for significant penalties under the Value-Based Payment Modifier (VBPM).

The good news is that CMS has released its Mid-Year 2014 QRURs to all providers, regardless of how many providers are billed under your group's Tax Identification Number (TIN). Why bother with a mid-year review? Although these reports don't provide any official tiering information, they offer important insights into how your future VBPM incentives and penalties may be calculated.

Consolidation among providers is happening at a rapid pace, and practices that have maintained their independence for years now see advantages in aligning with larger organizations. As a result, many groups, through consolidation and reorganization, look remarkably different than they did in 2013. But all too many consolidated groups are expending little effort to understand previous feedback they have received from CMS and, in some instances, are not even bothering to download it. CMS has recognized this trend—one of the reasons they developed the Mid-Year QRUR.

CMS stresses that the report is "for informational purposes only," meaning that it is not being used as a basis for incentives or adjustments. In fact, the reports don't even include all of 2014 data; "Mid-Year" has nothing to do with the middle of 2015—it means that the report only goes through the middle of 2014. Regardless of the incomplete annual data, here's why you need to

pay attention:

Groups with More Than 100 Providers at Greatest Risk of Reporting Penalties

Although all services billed under your TIN throughout the calendar year will contribute to your VBPM, Medicare (using its own billing analysis and PECOS) actually locked group sizes for 2014 in mid-October. This is important because VBPM will be calculated for 2016 (based on 2014 services) differently, based on group size.

Specifically, if your organization reports as a Group Practice with 100 or more providers, you must be certain that you're succeeding in PQRS reporting or you could face penalties.

Remember, to calculate group size, CMS does not look at who bills in a given month or your highest head-count during the year—they take the sum total of all providers who have billed throughout the year. So, that practice your group acquired as a great addition to your network has the potential to undercut your VBPM.

Even if you never had more than 100 providers at a given time, *you may still have been nudged up into that category based on who billed in February and who billed in October.* This mid-year QRUR will be the first notice that some of your groups' reporting strategies may not have played out as expected.

Groups Reporting PQRS Individually with 10 or More Providers Also Face VBPM Risks

This reporting threshold can also affect groups who reported as individuals. In 2014, for any group with 10 or more providers, Medicare's 50 percent rule states that at least half must meet PQRS requirements. If this requirement is not fulfilled, the entire group will incur a VBPM penalty (even those who reported PQRS successfully).

Note that this rule is applied by provider count, not by charge. Groups that brought on new practices during the year and report as individuals may have put themselves at risk. For example, a group with 50 providers who successfully reported 30 may feel safe. But if they added a practice with five physicians and six mid-level providers before October 15, their status is less certain. Groups with eight or nine providers who added another provider will find themselves in a similar position. It is important to know that this rule is still in effect in 2015 and will apply to all groups, whether they have two providers or 2,000.

Preparing a budget is challenging enough on its own; unforeseen cuts can be especially detrimental. By examining the Mid-Year QRUR, you have an opportunity to prepare yourself for what may have otherwise been an unexpected penalty or, better yet, to confirm that your

projected revenues are accurate.

Provider Mix Can Shift the Balance of Patient Attribution and Associated Costs

Medicare's patient attribution methodology has already caused its share of confusion. CMS is the only authority that can determine which clinician provided the "plurality of primary care services," as it requires an end-of-year claims analysis. Groups who made significant changes to their provider makeup may be in for a surprise when they see how patients were attributed.

In particular, groups that have added primary care providers are going to find many more attributed patients than they had previously. When looking at who provided the most primary care services, Medicare first looks for a primary care provider (in 2014, it was a primary care physician—in 2015, it is any provider). Being on the hook for these patients means that your group is now responsible for all of those patients' costs, whether provided by someone in your group or not, as Medicare calculates costs on a Medicare Spending Per Beneficiary (MSPB) basis.

Those groups that have added specialists are also going to see a shift in cost assignment, although the effects are different. If patients are being attributed to your specialists, that means those patients are not being appropriately managed and may wind up contributing negatively to your group's cost and quality metrics. Your quality composite utilizes patient attribution in addition to your PQRS measures; the composite is based on claims-based quality metrics (like re-admissions) for your entire patient denominator—your attributed patients.

The Mid-Year QRUR provides information about your attributed patients (e.g. are they being attributed based on primary care or specialists providing primary care) and whether your patients are receiving the majority of their care from your practice or others. The report also includes important information on the breakdown, by type, of your costs. Seeing both how your patient population is attributed and the nature of their utilization can enable you to determine how you can improve and where you may be responsible (in Medicare's eyes) for closing gaps in care.

Mid-Year QRURs Give Preview of Tiering with Specialty Adjustments

For the first time, Medicare is looking at tiering as it relates to specialty, rather than solely at the raw numbers. So, an orthopedic surgeon may still be "dinged" when an attributed patient is admitted for COPD, but now that surgeon will be judged against *other orthopedic surgeons'* COPD patients.

The rubric remains the same (meaning that Medicare is still focused on spending per

beneficiary and most closely examining the same four chronic conditions), but there is now some semblance of accounting for specialty. These reports are your sneak peek at how you will be graded, once your specialty adjustment kicks in.

Account for Risk Adjustment When Budgeting for VBPM

Mid-Year QRURs also provide insight into how CMS will risk-adjust your population. As we have described, when calculating your VBPM, CMS will analyze all claims related to your attributed patients, looking for costs and outcomes (such as re-admissions). However, it is important to know that CMS will apply a risk-adjustment when calculating your scores. For example, with risk-adjustment, 50 re-admissions may be scored as only 40 to account for patients who are sicker than average. The easiest way to understand this is to compare providers who treat underserved populations versus those who treat younger populations and those who live in more affluent areas.

In this context, knowing how Medicare views one of your patients' admissions or what one dollar spent on your patient equals in "Medicare dollars" is crucial. You may think that you have more challenging patients than the general population, but trust us—as a Registry with clients across the country, one of the most frequent comments we hear is how each client's patients are sicker than anyone else's. You are not alone if you've wondered whether your more challenging patients are going to affect your practice in the P4P environment. Being able to quantify your patients' risk status is critical in understanding how you will be affected by VBPM.

Identify Strategies to Maximize Revenues and Avoid VBPM Penalties

Whether your group is looking to partner with other groups or not, mid-year QRURs offer insight into where your group would stand in terms of VBPM if the clock stopped on July 1, 2014. While certainly not real-time, the information here gives valuable clues about what questions to ask and which direction to take. When your attributed patients are admitted, are they going to your local facility, or elsewhere? If they are seeking treatment at another location, is there a reason? Are your patients getting more outpatient treatment than the CMS average? There may be issues that go beyond those related to PQRS process measures.

There's another reason you should review this mid-year QRUR. The informal VBPM review process, which allows providers to request that CMS give their group a second look before applying penalties, closes at the end of February. Groups who receive CMS penalty letters notifying them in fall 2015 of the coming payment adjustment will only be able to request this review until February 2016 (as of now). Forewarned is forearmed.

Make no mistake—organizations will be penalized in 2016 and 2017 for the VBPM. If nothing else, this report substantially detracts from the "we didn't know" argument that Medicare is

anticipating. You can't plead ignorance. As soon as possible, you should familiarize yourself with the Mid-Year QRUR. Whether this report helps you proactively or reactively, it can give you significant strategic insights —but only if you take the time to download it and review it with an experienced partner.

Download your free copy of the ICLOPS *Insider's Guide to PQRS 2015 Reporting: How to Succeed in the Value-Based Health Care Environment*.

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