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Physician Value-Based Payment Modifier

What You Need to Know for 2015

The Affordable Care Act requires that CMS apply a value-based modifier (VBM) to Medicare physician fee schedule payments starting with select physicians in 2015 and all physicians by 2017. The VBM will adjust physician payments based on their performance on a composite of quality and cost measures.

Value-Based Payment Modifier Timeline

Year	Action
2012	CMS provided confidential feedback reports to all successful PQRS participants to demonstrate the type of information that will be used to calculate the VBM
2013	Initial performance period began for large group practices only (≥100 eligible professionals)
2014	Performance period begins for group practices with ≥10 eligible professionals.
2015	• Initial application of the payment modifier for large group practices only (≥100 eligible professionals) based on 2013 performance • Performance period begins for ALL physicians
2016	Application of the payment modifier to group practices with ≥10 eligible professionals based on 2014 performance
2017	Application of the payment modifier to ALL physicians based on 2015 performance

How is Group Practice Defined?

A group is defined as a single Tax Identification Number (TIN) with 2 or more individual EPs, identified by Individual National Provider Identifier (NPI), who have reassigned their billing rights to the TIN. For purposes of determining group size for the VBM, EPs are defined as:

- Physician
- Physician assistant
- Nurse practitioner or clinical nurse specialist
- Certified registered nurse anesthetist
- Certified nurse-midwife
- Clinical social worker
- Clinical psychologist
- Registered dietitian or nutrition professional
- Physical or occupational therapist or a qualified speech-language pathologist
- Qualified audiologist

Determining 2017 Payment Adjustments

Non-PQRS Reporters in 2015

As illustrated below, all group practices and solo practitioners must satisfy Physician Quality Reporting System (PQRS) requirements in 2015 to avoid a penalty under the VBM in 2017.

Failure to do so will result in a 4.0% penalty for group practices with 10 or more eligible professionals (EPs) and a 2.0% penalty for groups with 2-9 EPs and solo practitioners.

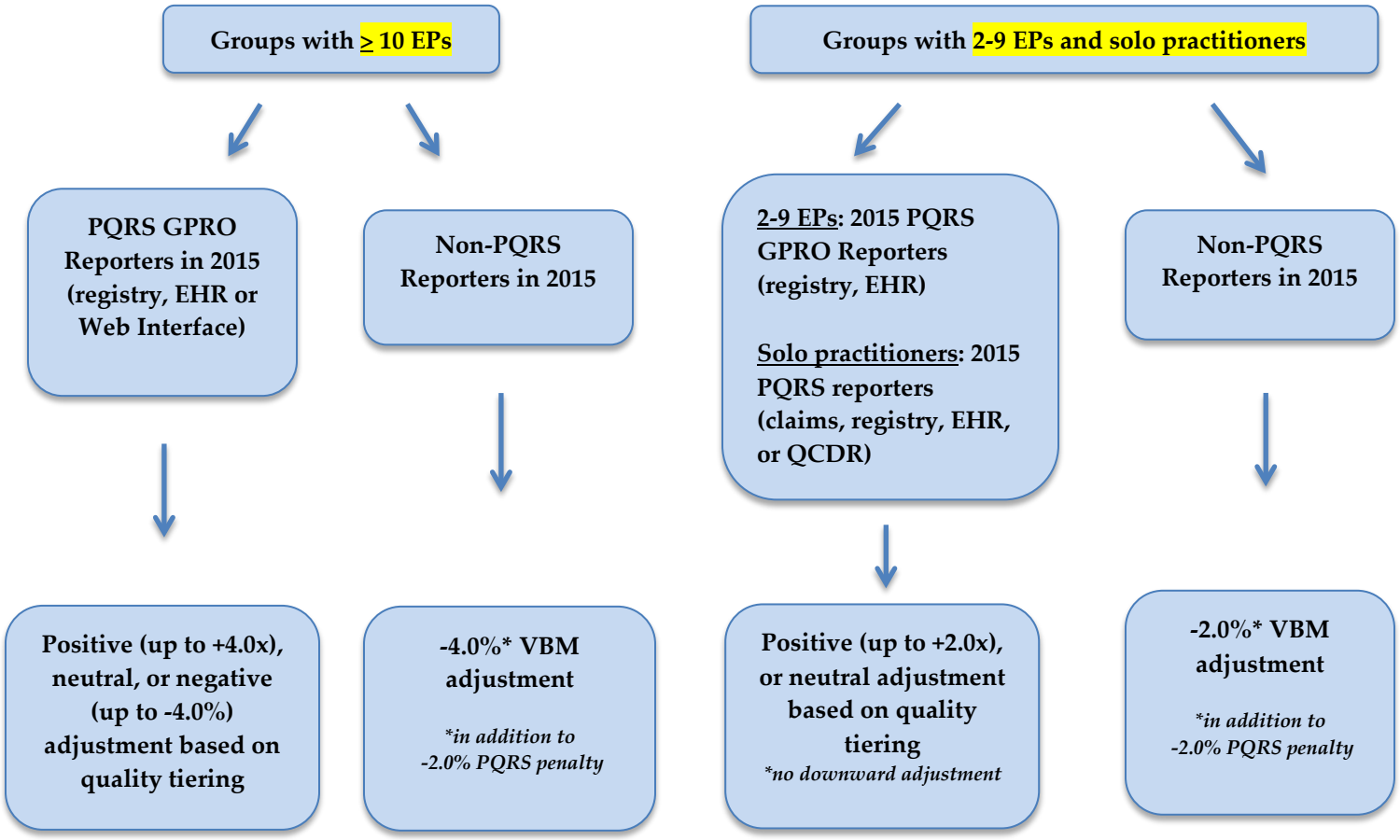
Note that the VBM penalty is separate from the 2.0% penalty that will be applied to EPs in 2017 for failure to satisfy PQRS requirements in 2015 (***see separate PQRS Fact Sheet***). Therefore, some practices may be at risk for as much as a 6.0% penalty in 2017 as a result of these two programs.

If a group practice does not register to participate in the PQRS Group Practice Reporting Option (GPRO), but ***at least 50%*** of EPs in the group satisfy PQRS reporting requirements ***as individuals***, CMS will hold the group and its individuals harmless from PQRS-related penalties, but subject them to the quality-tiering approach described below.

PQRS Reporters in 2015

All EPs who satisfy PQRS will be subject to a performance-based payment adjustment, known as the "quality-tiering approach." Larger groups may receive upward, neutral or downward performance-based adjustments (up to -4%). Smaller groups and solo practitioners would be held harmless from downward performance-based payment adjustments, but can receive neutral or upward performance-based adjustments.

Application of the 2017 Value-Based Payment Modifier



Calculating Quality and Cost Performance under the Quality-Tiering Approach

The "quality-tiering approach" combines a quality measure composite performance score and a cost measure composite performance score to calculate the VBM adjustment.

To calculate the ***quality composite score***, CMS will consider performance on the following measures:

- Any **PQRS measures** reported by the group or individual
- 3 outcome measures that CMS will automatically calculate based on claims. CMS attributes beneficiaries to the practice that provided the plurality of primary care services to that beneficiary:
    - **All-cause readmissions**
    - **Acute preventive quality indicator composite** (bacterial pneumonia, UTI, dehydration)
    - **Chronic preventive quality indicator composite** (COPD, HF, DM)

The benchmark for each quality measure is based on the **national** mean of each measure's performance rate during the year **prior** to the performance year.

To calculate the ***cost composite score,*** CMS will consider performance on the following measures:

- **Total per Capita Costs for All Beneficiaries**: Evaluates all Medicare Part A and B costs associated with any beneficiary over a year. Beneficiaries are attributed to the group that provided the plurality of primary care services to that individual.
- **Total per Capita Costs for Select Conditions**: Evaluates a Part A and B costs for patients with specific conditions (HF, CAD, COPD, DM). Beneficiaries are attributed to the group that provided the plurality of primary care services to that individual.
- **Medicare Spending per Beneficiary**: Evaluates Part A and B costs spanning 3 days prior to and 30 days after an inpatient hospitalization. Beneficiaries are attributed to the group that provided the plurality of Part B services during the inpatient stay.

The benchmarks for the cost measures are the national mean of performance rates, but adjusted based on the specialty mix of the EPs in the group. All cost measures are also payment standardized to adjust for geographic differences and risk adjusted based on patient characteristics. If CMS attributes fewer than 20 cases to a group or solo practitioner for any of the cost measures, the EP's cost composite will be classified as "average" (see below).

Since the VBM is a budget neutral program, spending on upward adjustments for high performers cannot exceed spending on downward adjustments for low performers. As shown in the table below, CMS will divide the total scores for all physicians into three tiers based on whether their score is above, not different from, or below the national mean. Those who are high quality/low cost will receive the greatest upward adjustment and those that are low quality/high cost will receive the greatest downward adjustment. Once the performance period has ended and the aggregate amount of downward adjustments for 2017 is known, CMS will

apply an adjustment factor ("x") to determine upward payments. To ensure that the VBM does not discourage practices from providing care to more complex or sick patients, CMS also will apply an additional upward payment adjustment for groups treating high-risk beneficiaries.

Calculation of the 2017 Value Modifier Using the Quality-Tiering Approach

Groups with > 10 EPs			
Cost/Quality	Low Quality	Ave 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 with 2-9 EPs and solo practitioners			
Cost/Quality	Low Quality	Ave 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%

** Eligible for an additional +1.0x if average beneficiary risk score is in the top 25% of all beneficiary risk scores*

Quality and Resource Use Reports

The Quality and Resource Use Reports (QRURs) are annual reports that CMS provides to group practices with the following information:

- Comparative information about the quality and cost of care furnished to their Medicare FFS patients
- Beneficiary-specific information to help coordinate and improve the quality and efficiency of care furnished
- Information on how the group would fare under the VBM

In the late summer of 2014, CMS distributed 2013 QRURs to *all* groups and solo practitioners. In the late summer of 2015, CMS will disseminate QRURs based on 2014 data to all groups and solo practitioners. These reports will show how TINs would fare under the policies finalized for the 2016 VBM.

It is important to review your QRURs since they will serve as a preview of the VBM methodologies CMS will apply to your practice in the coming years. You should use this opportunity to:

- Verify the accuracy of EPs billing under your group's TIN
- Determine how your group would fare under the VBM (see "Performance Highlights")

- Examine the number of patients attributed to your group and the basis for their attribution
- Evaluate how your group's performance compares to other groups and which attributed beneficiaries are driving your group's cost and quality measures

QRURs are available via the following link: https://portal.cms.gov

How to Get Started with the Value-Based Payment Modifier

The VBM does not require any additional action other than satisfying PQRS reporting requirements as either a group practice or solo practitioner.

Additional Information

For more information on the VBM and QRURs, please visit:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html