

## **Value Based Payment Program**

As Finalized in the Medicare 2014 Physician Fee Schedule

**What is the Value Based Payment (VBP) Program?** The VBP program is intended to provide comparative performance information to physicians as part of Medicare's efforts to improve the quality and efficiency of medical care. This is hoped to be achieved by providing meaningful and actionable information to physicians so they can improve the care they furnish, and by moving toward physician reimbursement that rewards value rather than volume. The program contains two primary components – the Quality and Resource Use Reports (QRURs, also referred to as Physician Feedback Reports) and the value based payment (VBP) modifier. This value-based purchasing initiative was included in the Affordable Care Act (ACA). The ACA directs CMS to provide information to physicians and medical practice groups about the resource use and quality of care they provide to their Medicare patients, including quantification and comparisons of patterns of resource use/cost among physicians and medical practice groups. The ACA mandates that by 2015, CMS begin applying a VBP modifier under the physician fee schedule. In addition, this program must be implemented in a budget neutral manner. In the 2014 final rule, CMS continues to phase in the VBP program as required by the ACA to apply to all physicians and groups of physicians by January 1, 2017.

**Quality Resource Use Reports (QRURs):** In 2012, CMS started sending out QRURs to groups of 25 or more eligible professionals (EPs) in a select number of states. In the fall of 2013, CMS expanded this group nationally and sent CY 2012 QRURs to all groups of 25 or more EPs. These reports included information regarding how the group of physicians might fare under the VBP modifier and gave groups a “first look” at how the VBP could affect their payment in the future under this program. In addition, the QRURs provided groups of 100 or more EPs with quality-tiering information on 2012 data that they could use to decide whether or not to elect to be assessed under the quality-tiering approach in 2015 (based on 2013 performance). CMS continues to hold training sessions to educate physicians and staff on how to interpret and understand the QRURs. CMS intends to disseminate reports containing CY 2013 data in the late summer of 2014 to all physicians. These reports will contain performance on the quality and cost measures used for the VBP program and additional information to help physicians coordinate care and improve the quality of care furnished.

**Value Based Payment (VBP) Modifier as finalized in the 2014 Medicare Physician Fee Schedule:** CMS will apply the value-modifier to physician payment in all groups of 10 or more eligible professionals (EPs) starting in 2016. The VBP modifier will be applied to the Medicare paid amounts for the items and services billed under the physician fee schedule at the tax identification number (TIN) level and will be applied only to the items and services billed by eligible professionals who are physicians under the TIN. The VBP program aligns with the Physician Quality Reporting System and includes a payment adjustment based on PQRS reporting. The scoring methodology for the VBP modifier will assess quality of care furnished compared to cost during the performance period (CY 2014) to calculate an adjustment to payments under the physician fee schedule during the payment adjustment period (CY 2016). CMS will assess the size of the group of physicians based on a query of PECOS within 10 days of the close of the PQRS self-nomination/registration process during the relevant performance year (PQRS registration ends September 30, 2014).

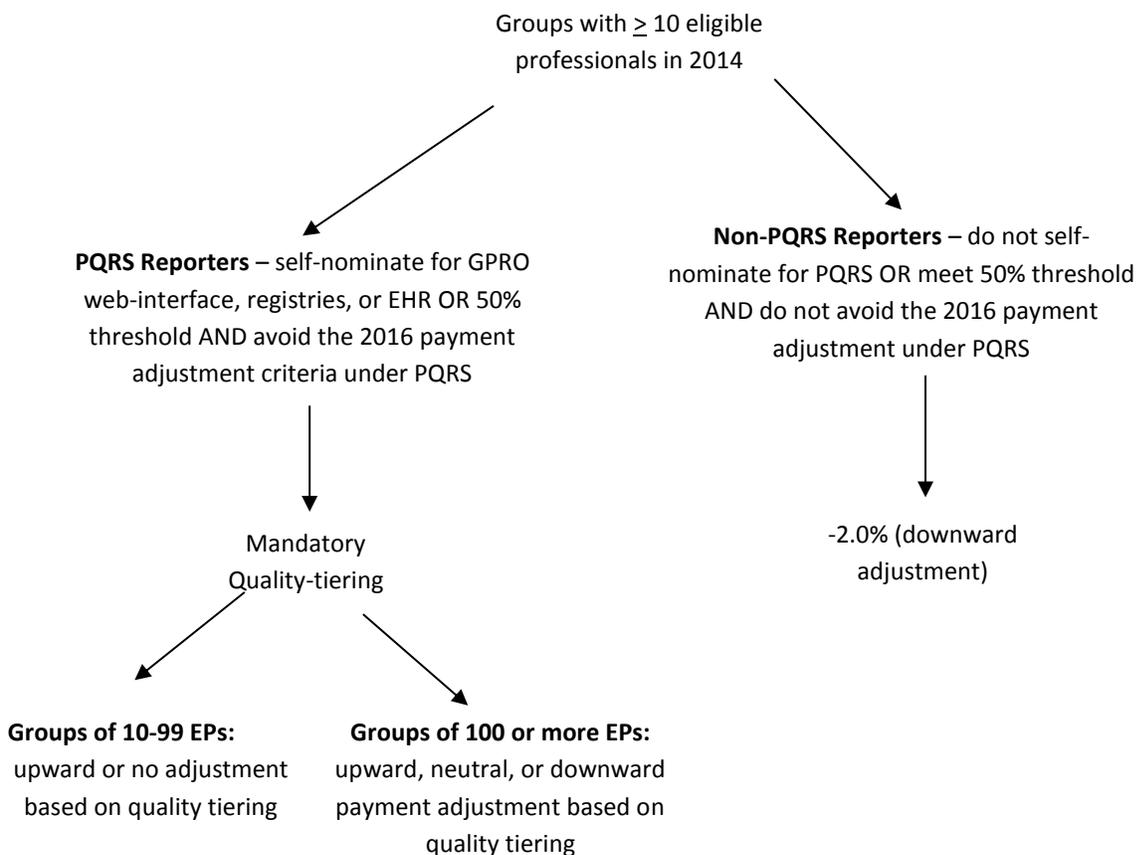
CMS will separate all groups of physicians with 10 or more eligible professionals into two categories based on PQRS reporting.

- The first category of group practices will include those that self-nominated for PQRS and meet the criteria to avoid the 2016 PQRS payment adjustment as a group. If a group does not seek to

report quality measures as a group, CMS will calculate a group quality score if at least 50 percent of the EPs within the group report measures individually. Groups in this first category will avoid the -2.0 percent payment adjustment under the VBP modifier. CMS will apply quality-tiering to all group practices of 10 or more EPs:

- Groups of 100 or more EPs will be subject to an upward, neutral, or downward adjustment based on quality-tiering. This will allow groups of physicians to earn an upward payment adjustment for high performance (high quality/low cost tier) and be at risk for a downward payment adjustment for poor performance (low quality/ high cost tier).
- Groups of 10 – 99 EPs will be subject to an upward or neutral adjustment based on quality-tiering. These groups will be “held harmless” from the downward payment adjustment since this is their first year in the VBP program.
- The second category includes groups of physicians with 10 or more eligible professionals that have not self-nominated for PQRS or do not meet the 50% threshold and did not avoid the 2016 payment adjustment under PQRS. This category’s VBP modifier will be set at -2.0 percent. This downward payment adjustment for the 2016 VBP will be in addition to the -2.0 percent payment adjustment assessed for failing to meet the satisfactory reporting criteria under the 2016 PQRS reporting requirements.

VBP Modifier 2016 program year (based on 2014 performance)



### Quality Tiering Methodology

- VBP modifier scoring methods focus on how the group of physicians' performance differs from the benchmark on a measure-by-measure basis. For each quality and cost measure CMS will divide the difference between a group of physicians' performance rate and the national benchmark by the measure's standard deviation. The benchmarks are the national means of the quality or cost measure. CMS will unify the calculation of the benchmark by weighting the performance rate of each physician and group of physicians submitting data on the quality measure by the number of beneficiaries used to calculate the performance rate.
- The "Quality of Care Composite" will be constructed by classifying each group's quality measures into one of the six National Quality Strategy domains, weighing each measure equally within each domain, and weighing the domains equally to form the quality composite.
  - Six National Quality Strategy domains:
    - Make care safer by reducing harm caused in the delivery of care (patient safety)
    - Ensure that care engages each person and family as partners (patient experience)
    - Promote effective communication and coordination of care (care coordination)
    - Promote the most effective prevention and treatment practices for leading causes of mortality (clinical care)
    - Work with communities to promote wide use of best practice to enable healthy living (population/community health)
    - Make quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models (efficiency)
- The "Cost Composite" will be constructed by classifying each group's per capita cost measures into two domains – all patients and all patients with four specific chronic conditions, weighing each measure equally within each domain, and weighing the domains equally to form the cost composite. All cost measures are payment standardized and risk adjusted. In addition, as finalized in the 2014 rule CMS will adjust cost measures based on specialty mix of the EPs in the group.
  - In addition, in the 2014 rule CMS finalized that they will use the Medicare Spending per Beneficiary (MSPB) measure in the total per capita costs domain for all patients. The MSPB measure (3 days prior and 30 days after an inpatient hospitalization) attributes hospitalization to the group of physicians providing the plurality of Part B services during the inpatient hospitalization. The MSPB measure will be added to the total per capita costs for all attributed beneficiaries domain and equally weighted with the total per capita cost measure.
- CMS will classify the quality of care composites scores into high, average, and low quality of care categories based on whether they are statistically above, the same as, or below the mean quality composite score. Similarly, CMS will identify those groups of physicians that have cost composite scores that are statistically different from the mean cost composite scores of all groups. These groups will be classified into high, average, and low cost categories. In order to assess meaningful differences, scores must be at least one standard deviation from the mean to be classified as high or low performers/cost. In addition, in order to assess precision, a group of physicians' score must be statistically different from the mean at the 5.0 percent level of significance for performance/cost. CMS will compare quality and cost to determine the VBPM according to the amounts in the following table:

Quality/cost	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Medium quality	+1.0x*	+0.0%	-1.0%
Low quality	+0.0%	-1.0%	-2.0%

\* Eligible for an additional +1.0x if reporting clinical data for quality measures and average beneficiary risk score is in the top 25 percent of all beneficiary risk scores.

- Since the total sum of downward adjustments is unknown at this time, CMS cannot determine specific upward payment amount percentage. Rather, as shown in the table above, CMS will give groups that provide high quality and low cost care the highest upward adjustment. The value of “x” will depend on the total sum of negative adjustments in a given year. In addition, to ensure that the value modifier encourages physicians to care for the severely ill and beneficiaries with complicated cases, CMS will provide an additional upward payment adjustment for groups of physicians furnishing services to high-risk beneficiaries.

#### **Additional Information**

- CMS will not apply the VBPM for 2015 and 2016 to groups of physicians that are participating in the Shared Savings Program or the testing of the Pioneer ACO model. CMS does not wish to unintentionally disturb their investments in implementing these programs. In addition, CMS will not apply the VBPM in 2015 or 2016 to groups of physicians that are participating in other Innovation Center initiatives, such as the CPCI or other CMS programs which also involve shared savings and participants making substantial investments to report quality measures and to furnish higher quality, more efficient and effective healthcare.
- CMS finalized that CY 2015 will be used as the performance year for the CY 2017 payment adjustment period. As required by the ACA, the VBP modifier must apply to all physicians by 2017.
- Groups of physicians with 25 or more EPs can elect to include the patient experience of care measures collected through the PQRS CAHPS survey for CY 2014 in their VBP modifier for CY 2016.