

## **Value-Based Payment Modifier**

The Patient Protection and Affordable Care Act (ACA) directs the Secretary of Health & Human Services to develop and implement a budget-neutral payment system that will employ a value-based payment modifier to adjust Medicare physician fee schedule payments based on the quality and cost of care physicians deliver to Medicare beneficiaries. The Secretary will phase in the new payment modifier over a two-year period beginning in 2015. For physicians for whom the value modifier will apply in 2015, the Centers for Medicare and Medicaid Services (CMS) will analyze services delivered in calendar year 2013. In 2015 and 2016, CMS will apply the value-based payment modifier to specific physicians and/or groups of physicians that the Secretary determines appropriate. Beginning in 2017, all physicians are expected to be affected.

### **What is the intent of this value-based payment program and how is it structured?**

CMS is developing the value-based payment (VBP) program in an effort to move physician reimbursement towards a system that rewards value rather than volume. 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.

The program contains two primary components – the Quality and Resource Use Reports (QRURs, also referred to as Physician Feedback Reports) and the implementation of the value-based payment modifier (VBPM).

- The QRURs are confidential reports about the quality and costs of care that a physician provided to fee-for-service Medicare patients during the performance period.
- CMS will apply the VBPM to physician payment in all groups of 100 or more eligible professionals (as defined by CMS) starting in 2015 (based on performance and cost data from CY 2013). The VBPM 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. The program includes an opt-in payment adjustment for those who have satisfactorily reported measures under the Physician Quality Reporting System (PQRS). The scoring methodology for the VBPM will assess quality of care furnished compared to cost during the performance period (CY 2013) to calculate an adjustment to payments under the physician fee schedule during the payment adjustment period (2015).

### **Given the complexity of the value-based modifier, can the basics of the program be summed up more simply?**

In 2015, only physician practices of 100 or more eligible professionals will be affected by the modifier. Those practices that participate in PQRS and meet certain criteria will have the opportunity to receive positive adjustments in their payments, while non-PQRS reporters will receive a negative adjustment in their payments. A non-PQRS reporter includes groups that did not self-nominate to participate in the PQRS GPRO and did not report at least one measure.

While the modifier does not take effect until 2015, and only for some practices, it is important that physicians take notice of this provision of law sooner because the modifier in 2015 will be based on physician performance data from calendar year (CY) 2013.

### **Specifically, what physician practices will be affected by the value-based payment modifier in 2016 and 2017?**

At this time, CMS has not finalized which physician practices will be affected by the VBPM in 2016 and 2017. The ACA requires that the VBPM be applied to all physicians by 2017.

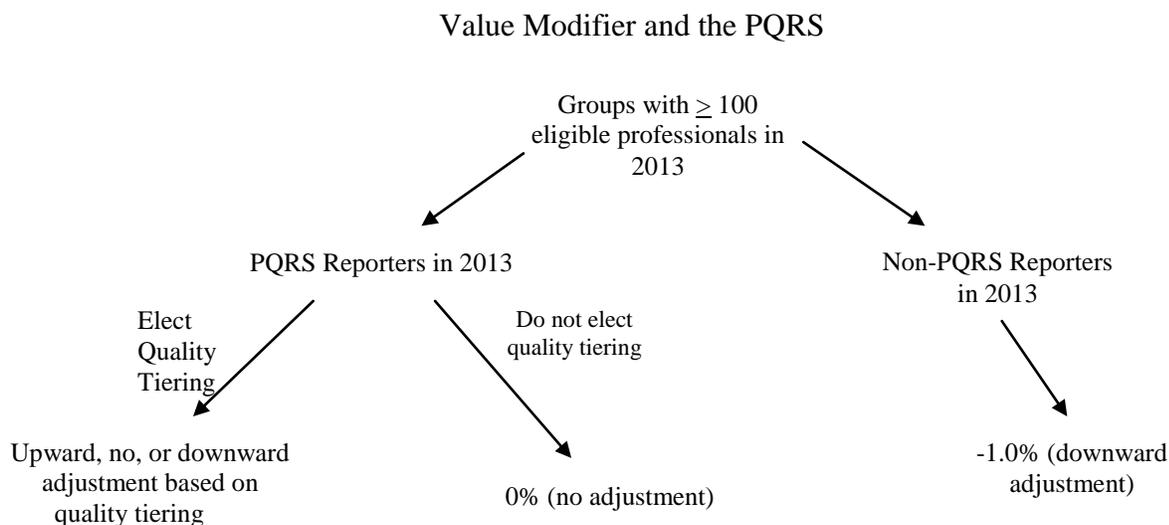
### How will the value-based maybe modifier be applied to physician practices?

In an effort to align programs, CMS is separating all groups of physicians with 100 or more eligible professionals into two categories based on PQRS participation.

The first category of groups of physicians includes those that (a) self-nominated for PQRS as a group and report at least one measure or (b) have elected the PQRS administrative claims option for CY 2013. Groups in this category include those groups that have self-nominated and have met the satisfactory reporting criteria for the PQRS incentive payment. This category's VBPM will be set at 0 percent.

- Within this category, CMS is offering practices an option to calculate the VBPM using a quality-tiering approach. This allows groups of physicians to elect 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).

The second category includes groups of physicians with 100 or more eligible professionals that have not PQRS reported in 2013. This includes groups that did not self-nominate to participate in the PQRS GPRO and did not report at least one measure. This category's VBPM will be set at -1.0 percent in 2015. This downward payment adjustment for the 2015 VBPM will be in addition to the -1.5 percent payment adjustment assessed under the Act for failing to meet the satisfactory reporting criteria under PQRS.



### What is the “quality-tiering” option and how will it affect payments in 2015?

Practices that PQRS report in 2013 and elect quality tiering in 2013 to calculate their VBPM will have the opportunity 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). VBPM scoring

methods focus on how the group of physicians' performance differs from the national benchmark on a measure-by-measure basis.

<b>Quality/cost</b>	<b>Low cost</b>	<b>Average cost</b>	<b>High cost</b>
<b>High quality</b>	+2.0x*	+1.0x*	+0.0%
<b>Medium quality</b>	+1.0x*	+0.0%	-0.5%
<b>Low quality</b>	+0.0%	-0.5%	-1.0%

\* 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 Resources**

- *American College of Physician's "Running A Practice" webpage.*

[http://www.acponline.org/running\\_practice/payment\\_coding/medicare/vbp\\_program.htm](http://www.acponline.org/running_practice/payment_coding/medicare/vbp_program.htm)

- *American College of Physicians "Physician and Practice Timeline": An at-a-glance summary of upcoming important dates related to a variety of regulatory, payment, educational, and delivery system changes and requirements.*

[http://www.acponline.org/running\\_practice/physician\\_practice\\_timeline/](http://www.acponline.org/running_practice/physician_practice_timeline/)