The Value-Based Payment Modifier: How to Prepare Your Practice

What is it?
The Value-Based Payment Modifier (VBPM), established by the Patient Protection and Affordable Care Act (ACA), is part of the Centers for Medicare & Medicaid Services’ (CMS) effort to move toward physician reimbursement that rewards value over volume in the Medicare program. The VBPM relies on PQRS participation for the purposes of reporting quality; however, CMS also utilizes outcomes and cost measures when determining whether to apply an upward, downward or neutral payment adjustment to an eligible professional (EP)’s or group’s Part B covered professional services under the Medicare Physician Fee Schedule (PFS). These payment adjustments will also be based on how the practice’s quality and cost performance compares to national benchmarks.

The VBPM must be budget neutral, meaning upward payment adjustments for higher quality and lower costs will balance the downward adjustments applied for lower quality and higher costs. These adjustments under the VBPM are made in addition to penalties EPs and groups could potentially receive under PQRS for unsatisfactory reporting or non-participation.

When will it be applied and for who?
CMS is taking a phased-in approach in implementing the VBPM. Groups with 100+ EPs will see the VBPM applied to their 2015 payments based on their performances in 2013. In 2016, groups with 10+ EPs will have their Medicare payments adjusted based on 2014 reporting. Finally, CMS will complete the phase-in by applying the VBPM to all physicians, including those in Medicare Shared Savings Program (MSSP) and Pioneer Accountable Care Organizations (ACOs), in 2017 based on their performance in 2015.

- **2013 performance – potentially modifies 2015 payment for:**
  - Group practices with 100 or more EPs

- **2014 performance – potentially modifies 2016 payment for:**
  - Group practices with 10 or more EPs

- **2015 Performance – potentially modifies 2017 payment for:**
  - **All Medicare Part B fee for service physicians**, including those participating in MSSP-ACOs, the Pioneer ACO Program, the Comprehensive Primary Care Initiative (CPCI) and other Innovation Center Models

How are payments impacted by the VBPM?
CMS applies any penalties or bonuses to the Medicare paid amounts for items and services billed under the PFS at the Tax Identification Number (TIN) level so that beneficiary cost-sharing is not affected. While a practice’s group size is determined by assessing the number of EPs billing under the TIN, any penalties or bonus payments made during the 2015-2017 program years will be issued only to items and services billed by physicians under the TIN.
How does it work?

The illustration below provides a basic overview of how the VBPM will be applied. Further information regarding quality and cost measures can be found on pages 3-5.

**Quality-Tiering**

The quality-tiering analysis under the VBPM provides an upward, neutral or downward payment adjustment based on the group’s performance on quality and cost measures as compared with national benchmark performance data in these areas. For the 2017 VBPM, which is based on 2015 performance, quality-tiering is mandatory in 2017 for all physicians. In 2017, groups with 2-9 EPs and solo practitioners will be held harmless from any downward payment adjustments while groups with 10+ EPs may see up to a -4% payment adjustment.

Upward adjustments, or incentives earned under quality-tiering, will be established by CMS after the performance period has ended. Incentive payments will be based on the aggregate amount of downward payment adjustments determined under budget neutrality requirements.
Quality Measures

CMS calculates the quality composite score based on a TIN’s performance on six equally-weighted quality domains:

1) Clinical Process/Effectiveness
2) Patient and Family Engagement
3) Population/Public Health
4) Patient Safety
5) Care Coordination
6) Efficient Use of Healthcare Resources

From each of these domains, based on how a group reported for PQRS, the VBPM quality composite score will include all 2015 PQRS quality measures and reporting mechanisms available for both individual and GPRO reporting when calculating the 2017 VBPM.

Outcomes Measures

Utilizing claims data as well as measures data reported via PQRS reporting mechanisms, CMS will automatically calculate performance on these three outcomes measures as part of the VBPM quality-tiering analysis:

1) Composite of Acute Prevention Quality Indicators
   A composite of rates of potentially preventable hospital admissions for dehydration, urinary tract infections and bacterial pneumonia.
2) **Composite of Chronic Prevention Quality Indicators**


3) **All cause readmission**

The rate of provider visits within 30 days of discharge from an acute care hospital per 1,000 discharges among eligible beneficiaries assigned. CMS will exclude this measure from the quality domain for a group or solo practitioner who has fewer than 200 cases during the relevant performance period.

Performance on outcomes are risk-adjusted to account for patient characteristics that may lead to higher costs and lower quality of care.

**Cost Measures**

CMS will calculate the following cost measures as part of the VBPM quality-tiering analysis:

1) **Total per capita costs**

Total per capita costs include payments under both Part A and Part B, but do not include Medicare payments under Part D. CMS will use a 60-day claims run-out to calculate the total per capita costs for the measures. The cost score compares how a TIN performs relative to the mean performance on a measure-by-measure basis within each cost domain.

2) **Total per capita costs for beneficiaries with the following four chronic conditions:**

   - Chronic Obstructive Pulmonary Disease (COPD)
   - Heart Failure
   - Coronary Artery Disease
   - Diabetes

3) **Medicare spending per beneficiary measure (MSPB)**

An MSPB episode spans from three days prior to an index admission at a subsection (d) hospital through 30 days post discharge, with some exclusions. Costs for each episode are risk-adjusted for age and severity of illness and the included payments are standardized to account for geographic variation. CMS calculates the MSPB amount as the measures performance rate. An MSPB episode will be attributed to the group subject to the VBPM whose EPs submitted the plurality of claims (as measured by allowable charges) under the group’s TIN for all Medicare Part B services rendered during an inpatient hospitalization that is an index admission for the MSPB measure during the applicable performance period (2015 for the purposes of the 2017 VBPM).

CMS will risk adjust and standardize all VBPM cost measures. A detailed description of CMS’ risk adjustment and standardization methodologies is available [here](#).

Additional information on VBPM cost measurement methodologies is available [here](#).
Patient Attribution

Patient attribution is based on the plurality of primary care services a physician or non-physician practitioner provides to a beneficiary. Medicare beneficiaries are attributed to a physician’s or non-physician practitioner’s (NPP’s) group if the physician or NPP furnished a plurality of the beneficiary’s primary care services. Beneficiaries are first attributed based on primary care services furnished by primary care physicians and NPPs. If a beneficiary is not assigned in the first step, CMS will attribute the beneficiary to a group practice or physician that provided the plurality of primary care services, regardless of specialty.

Minimum number of cases

CMS will use a minimum case size of 20 in order for a quality or cost measure to be included in the quality of care or cost composite. To the extent that a group of physicians fails to meet the minimum number of cases for a particular measure, the measure would not be counted and the remaining measures in the domain would be given equal weight. To the extent that CMS cannot develop a quality of care composite or cost composite, it would not calculate a VBPM for quality-tiering purposes and the group’s payment would not be affected.

Risk Adjustment

Per capita cost measures are risk-adjusted to account for differences in patient medical costs and to more accurately allow physicians and groups to compare themselves to their peers. CMS utilizes a prospective two-model approach when determining its risk adjustment of per capita cost measures. The CMS HCC risk adjustment model is used to first determine beneficiary-level risk scores, which are then used to determine the risk adjustment factors applied to each TIN through the QRUR risk-adjustment model. This process is used to ultimately determine the expected costs of care compared to non-risk-adjusted per capita costs and across all groups and physicians as compared to the mean beneficiary cost.

Specialty Adjustment

CMS uses “specialty benchmarking” in an attempt to more accurately account for a group practice’s specialty composition so that quality-tiering produces fair peer group comparisons. Specifically, prior to computing a standardized score for each cost measure, the agency adjusts the standardized score calculation by applying a “specialty adjustment” to account for the group’s specialty composition. CMS identifies an EP’s specialty based on what is listed on the largest share of the EP’s Medicare Part B claims, using the EP’s specialty listed in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). CMS adjusts the standardized score methodology using three steps, which are detailed on page 18 of MGMA’s 2014 Final Medicare Physician Fee Schedule Analysis.

Determining group practice size

CMS determines group practice size at the TIN level, using data from PECOS as well as Medicare claims data. Within 10 days of June 30, CMS will query PECOS to calculate the number of EPs who reassign their Medicare billing privileges to the practice’s TIN. EPs include not only physicians, but other non-physician providers such as nurse practitioners, physician assistants and certain therapists. A complete list of EPs is available here. EPs are removed from the group size determination if, based on a Medicare claims analysis, they do not submit claims under the group’s TIN during the performance year.
Quality and Resource Use Reports (QRURs)

Under the ACA, CMS is required to provide physicians and group practices with confidential reports that contain data on the quality of care the physician or group practice provided to its attributed Medicare fee-for-service beneficiaries and the costs associated with this care. These reports illustrate how a group practice performs relative to its peers and include quality measures, cost data and outcomes metrics CMS will use to determine an EP’s or group’s VBPM.

In 2014, CMS released the 2013 QRURs to nearly all solo practitioners and groups of physicians, which contain quality and cost data based on their CY 2013 performance. For groups with 100+ EPs, the 2013 QRUR is especially important as it provides information on how the VBPM will affect their Medicare reimbursement in 2015. However, all solo practitioners and groups with less than 100 EPs are encouraged to download and review their 2013 QRUR, as it provides an opportunity to learn about the methodologies used to calculate the VBPM and preview how they may fare in future years.

Currently, the agency is only providing these reports on a calendar year basis; however, CMS is considering releasing these reports more frequently in the future. The agency expects to make 2014 QRURs available to all individual physicians and groups of physicians in late summer 2015. For more information on QRURs and how to access them, visit MGMA’s QRUR Resource Center.

What do I need to do to start preparing my practice for the VBPM?

1. Identify when your practice and its physicians will be impacted by the VBPM.

2. Participate in PQRS. Participation is required, as the VBPM relies on PQRS measures reported by physicians for quality performance analysis. This also means that those providers who are impacted by the VBPM and do not participate as required in PQRS will see a double penalty— one reduction for non-PQRS participation as well as an additional reduction under the VBPM for not participating in quality reporting. PQRS and the VBPM are inter-related, but distinct programs and criteria must be satisfied in each separate program.

3. Access your practice’s QRUR. Authorized representatives of groups can access their QRURs through the CMS portal using an Individual Authorized Access to CMS Computer Services (IACS) account. These reports contain quality and resource use (cost) information for physicians and provide a preview of how a group practice would fare under the VBPM policies. Learn more about how to access and interpret these reports here.

*Note: Program criteria change annually; be sure to reference each VBPM performance year’s policies for complete program details.

MGMA Resources

- Access the MGMA VBPM Resource Center for more information, including timely program updates and resources to assist you in understanding program requirements.
- Visit MGMA’s QRUR Resource Center to learn how to access your report.
- The MGMA PQRS-Value Modifier Survival Guide assists practices in understanding the VBPM’s interaction with PQRS.
- If interested in reviewing 2016 VBPM program details, which is based on 2014 performance, download MGMA's member-benefit webinar on-demand.

Reminder! Be sure to subscribe to MGMA's Washington Connection e-newsletter to receive the latest news on the VBPM and other regulatory and health legislation issues affecting medical group practices. This e-newsletter is sent weekly by our Government Affairs team straight from the nation's capital. Subscribe here!

CMS Resources
- Medicare Physician Value-Based Payment Modifier webpage.
- CMS Summary of 2015 VBPM policies. CMS has not yet released a summary of 2016 VBPM policies.

Disclaimer: This document represents the key PQRS and VBPM program requirements practices should consider when participating in these programs. It is based on questions and concerns frequently raised by our members and is not intended to be a complete instruction on achieving success. Please visit the CMS PQRS and VBPM websites to review additional information.