The Value Based Payment Modifier
What Doctors of Optometry Need to Know

What is the Value-Based Payment Modifier?

The value-based payment modifier (VBM) provides for incentives or penalties to physicians based upon the quality of care furnished compared to cost during a performance period. The “modifier” is not a coding modifier that needs to be added to claims.

Where did the VBM come from?

For the past decade, leadership within the Centers for Medicare & Medicaid Services (CMS) has indicated that it is the goal of the agency to transform Medicare from a passive payer to an active purchaser of higher quality, more efficient health care. CMS has worked to make this change through a variety of initiatives that encourage a focus on quality, such as the Physician Quality Reporting System (PQRS). The value based payment modifier is another step in this transformation. Specifically, the VBM was mandated through Section 3007 of the Affordable Care Act. The legislation indicated that by 2015, CMS must begin applying a value modifier under the Medicare Physician Fee Schedule (MPFS).

Who Does the VBM Apply to?

Physicians (including optometrists) in group practices of 100 or more eligible professionals (EPs) who submit claims to Medicare under a single tax identification number (TIN) will be subject to the value modifier in 2015, based on their performance in 2013.

Physicians in group practices of 10 or more EPs who participate in Fee-For Service Medicare under a single TIN will be subject to the value modifier in 2016, based on their performance in calendar year 2014.

All physicians who participate in Fee-For-Service Medicare will be affected by the value modifier starting in 2017, based on performance in 2015.

How Does CMS Assess Quality for the purposes of the VBM?

To determine whether an automatic VBM payment reduction will be applied, CMS will first review whether a physician or group practice participated in PQRS. To avoid an automatic VBM payment adjustment, physicians must participate in the Physician Quality Reporting System (PQRS) (www.aoa.org/pqrs)

If you do not participate in PQRS, you will receive a payment penalty based on practice size:

- Groups with between 2 to 9 EPs and physician solo practitioners will receive an automatic negative 2 percent payment PQRS penalty AND a 2 percent VBM payment penalty. (4% total)
• Groups with 10 or more Eps will receive an automatic negative 2 percent PQRS payment penalty **AND** a 4 percent VBM payment penalty. (6% total)

In addition to PQRS reporting, CMS will also evaluate how a physician performs on certain outcomes measures.

**What is “Quality Tiering” for the VBM?**

Quality-tiering is the methodology that is used to evaluate a physician’s performance on quality and cost measures for the VBM. For the CY 2017 VBM (based on 2015 performance), quality-tiering is **mandatory** for physician solo practitioners and physician groups with 2 or more EPs based on their size in CY 2015. Physician and groups that successfully participate in PQRS will be subject to quality-tiering.

**How will quality-tiering impact my practice if I am a solo practitioner?**

Based on performance on quality and cost measures in CY 2015, solo practitioners could receive a VBM adjustment in 2017 that is:

- An upward adjustment of 2 times the Value Modifier adjustment factor, or
- A neutral adjustment (meaning no adjustment)
- Solo practitioners are held harmless from any downward adjustment derived under the quality-tiering methodology.

**How will quality-tiering impact my practice if I have 2-9 physicians in my practice?**

Based on their performance on quality and cost measures in CY 2015, Groups with 2 or more EPs could receive a value modifier adjustment in 2017 that is:

- A maximum upward adjustment of 2 times the Value Modifier adjustment factor, or
- A neutral adjustment (meaning no adjustment) in CY 2017

These groups are held harmless from any **downward** adjustment derived under the quality-tiering methodology.

**How will quality-tiering impact my practice if I have 10 or more physicians in my practice?**

Based on their performance on quality and cost measures in CY 2015, Groups with 10 or more EPs could receive a value modifier adjustment in 2017 that is:

- A maximum upward adjustment of 4 times the Value Modifier adjustment factor, or
- A neutral (meaning no adjustment), or
- A maximum of -4.0% downward Value Modifier adjustment to Medicare PFS physician payments for CY 2017

**How many of my patients will be included in the CMS assessment of my costs and quality of care?**

This will depend on the outcome of the CMS analysis to determine which beneficiaries should be attributed to your practice. Beneficiaries are attributed to you through a two-step process. Under Step 1, beneficiaries are attributed to a practice based on which primary care physician or group of physicians performed the plurality of the patient’s primary care services (as measured by allowed charges). For this process of attribution CMS defines as primary care as practitioners with a specialty in family practice, internal medicine, general practice, geriatric medicine, or nurse practitioners, physician assistants and clinical nurse specialists) If a beneficiary is not assigned to a physician or practice under Step 1, CMS proceeds to Step 2, which would assign beneficiaries to the physician or group practice whose affiliated non-primary care physicians (including ODs) provided the plurality of primary care services (as measured by allowed charges).

**What are the quality measures I will be assessed on for the purposes of the VBM?**

To determine a practice’s quality, CMS will evaluate performance based on certain outcomes measures. Specifically: two composite rates of potentially preventable hospital admissions and the all-cause hospital readmission measure. CMS will not evaluate performance on the all cause hospital readmission measure if a group or solo practitioner has fewer than 200 cases for the measure during the performance period.

**What are the cost measures I will be assessed on for the purposes of the VBM?**

To determine whether a practice’s costs are low, average or high, CMS will calculate the total per capita costs and the total per capita costs for beneficiaries with four chronic conditions: COPD, Heart Failure, Coronary Artery Disease, Diabetes. CMS will also look at Medicare spending per beneficiary. These costs will be compared with other physicians. A group or solo practitioner will receive a cost composite score that is classified as “average” under the quality-tiering methodology if the group or solo practitioner does not have at least one cost measure with at least 20 cases.

**I understand that if you see patients that CMS considers more complex or difficult to treat, it’s possible to obtain an additional bonus. Is that accurate?**

That is accurate. Groups and solo practitioners that are eligible for a payment increase may also qualify to receive an additional payment increase of one times the Value Modifier adjustment factor, if the group or solo practitioner’s average beneficiary risk score is in the top 25 percent of all beneficiary risk scores.
Is the VBM a specific percentage?

No. The ACA did not specify the amount of physician payment that should be subject to the adjustment for the VBM. The statute does require the payment modifier be implemented in a budget neutral manner. This means that the positive payment incentives that are provided will be based on the amount of money collected from negative payment adjustments.

How does CMS calculate the VBM?

CMS will first aggregate the downward payment adjustments for those that did not participate in PQRS and also those who received poor scores related to cost and quality of care. Using the total downward payment adjustment amount, CMS will then develop the upward payment adjustment factor (x). These calculations will be done after the performance period has ended.

What is the VBM for 2015 based on 2013 performance?

For 2015, the VBM “x” factor is 4.89% Included below is a chart that illustrates the impact of the VBM amount based on cost and quality analysis.

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>+0.0% (0)</td>
<td>+1.0x = 4.89%²</td>
<td>+2.0x = 9.78%²</td>
</tr>
<tr>
<td>Average Cost</td>
<td>-0.5% (7)</td>
<td>+0.0% (81)</td>
<td>+1.0x = 4.89%²</td>
</tr>
<tr>
<td>High Cost</td>
<td>-1.0% (3)</td>
<td>-0.5% (1)</td>
<td>+0.0% (0)</td>
</tr>
</tbody>
</table>

How will I know how the VBM will impact my practice? Will I not know until payment increases or reductions are applied?

CMS provides Quality Resource and Use Reports (QRURs) to give physicians insight into how the VBM will impact their practice. The QRURs provide information about a physician’s quality and cost performance rates for the VBM. These reports provide information that will help physicians understand how the VBM will impact their practice. In September 2014 CMS made available QRURs to all groups and solo practitioners who met two criteria:

- at least one physician billed under the TIN in 2013, and
- the TIN had at least one eligible case for at least one of the quality or cost measures included in the QRUR.

Does the new SGR legislation impact the VBM?

Yes. The legislation sunsets application of the VBM to physicians after 2018. However, the VBM will continue in a different format after that time for the new Merit-Based Incentive Payment System (MIPS). MIPS provides variable, performance based incentive payments beginning in 2019. Incentives are based on quality, resource use, clinical practice improvement activities, and meaningful use of EHRs. While the VBM program will sunset there will be a continued focus on quality and resource use.

**Remember:** Participation in PQRS is critical for avoiding payment penalties under the Value Modifier Program.

**How Does 2015 PQRS Participation Affect the VM in 2017?**

- **Yes:** Do you plan to report for PQRS in 2015?
  - **Yes:** Are you a solo EP or part of a group?
    - **Solo:** Are you a physician?
      - **Yes:** Physician will avoid 2017 PQRS payment adjustment. 
      - **No:** EP will avoid 2017 PQRS payment adjustment. 
      - VM does not apply to non-physician EPs in 2017.
    - **Group:** Does the group plan to report PQRS as a group?
      - **Yes:** Does group meet 50% threshold?
        - **Yes:** All EPs in group report PQRS to avoid 2017 PQRS payment adjustment. For the 50% threshold option, at least 50% of the EPs must report to avoid the 2017 PQRS payment adjustment.
        - **No:** Physicians in Groups of 2-9 EPs and solo practitioners: Subject to upward or neutral VM adjustment.
        - **Yes:** Physicians in Groups of 10+ EPs: Subject to upward, neutral or downward VM adjustment.
      - **No:** All EPs (solo and in groups of 2+ EPs) will be subject to the 2017 PQRS payment adjustment of -2.0%
- **No:** Participation by solo EPs is mandatory.