Value Based Payment Modifier

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

Successfully Navigating the Centers for Medicare & Medicaid Services (CMS) Value Based Payment Modifier (VM)

What is the Value Based Payment Modifier (VM)?

The VM program is intended to assess both quality of care furnished, and the cost of that care, under the Medicare Physician Fee Schedule (MPFS) and pay physicians differentially based on specific program components. To gradually implement the program, the Centers for Medicare & Medicaid Services (CMS) applied the payment modifier to groups of 100 or more eligible professionals (EPs) in 2013, then to groups of 10 or more EPs in 2014. In CY2015, CMS is expanding this to program, to include solo practitioners and groups of 2 or more.

How is VM Implemented?

Implementation of the VM is based on Physician Quality Reporting System (PQRS) participation. This means that physicians and practices not participating in PQRS may start to see their payments reduced. Any payment adjustment (negative, neutral, or positive) will be applied in CY2017, two years after the PQRS performance year. For information on a fast, convenient, and cost effective online registry to help you collect and report quality measure data to CMS for the PQRS incentive program, see the PQRS*wizard*.

What Changes are Occurring in 2015 that will be Applied in 2017?

For a brief overview of how the VM Payment Adjustments and Quality-Tiering components of the program may affect you, please see below:

For PQRS reporters	For Non-PQRS reporters
Groups with 2-9 EPs and solo practitioners:	*Groups with 2-9 EPs and solo practitioners:*
Upward or neutral VM adjustment (+0.0% to +2% of MPFS)	Automatic -2.0% of MPFS downward adjustment
Groups with 10+ EPs:	*Groups with 10+ EPs:*
Upward, neutral, or downward VM adjustment (-4.0% to +4.0% of MPFS)	Automatic -4.0% of MPFS downward adjustment

How are my Quality and Cost Scores Calculated?

Each group receives two composite scores (quality and cost), based on the group's standardized performance (e.g. how far away from the national mean). Quality scores are comprised of clinical care, patient experience, patient safety, care coordination, efficiency and population / community health. Cost scores are comprised of total per capita costs (plus Medicare Spending Per Beneficiary) and total per capita costs for beneficiaries with specific conditions. Group cost measures are adjusted for specialty composition. This approach identifies statistically significant outliers in order to assign outlier groups to their respective quality and cost tiers.

	Low Quality		Average Quality		High Quality	
Group Size	**2-6 EPs & Solo**	**10+ EPs**	**2-6 EPs & Solo**	**10+ EPs**	**2-6 EPs & Solo**	**10+ EPs**
Low Cost	+0.0%	+0.0%	+1.0x*	+2.0x*	+2.0x*	+4.0x*
Average Cost	-0.0%	-2.0%	+0.0%	+0.0%	+1.0x*	+2.0x*
High Cost	-0.0%	-4.0%	-2.0%	-2.0%	+0.0%	+0.0%

Please Note: Groups and solo practitioners receiving an upward adjustment are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25% of all beneficiary risk scores nationwide.

How are Patients Attributed to my Group for Purposes of Cost Calculation?

Step 1: Identify all beneficiaries who have had at least one primary care service rendered by a group physician.

Step 2: Assign beneficiaries who have had a plurality of primary care services (allowed charges) rendered by primary care physicians.

Step 3: For beneficiaries that remain unassigned, assign beneficiaries who have received a plurality of primary care services (allowed charges) rendered by any EP.

Exclusions: Patients that are part year beneficiaries (including those new to Medicare), died during the year, or had one or more months of Medicare Advantage are excluded from the attribution for calculating costs.

What Role do the Physician Feedback (QRURs) Reports Play in This?

The QRUR reports distributed by CMS to physicians play a crucial role in informing providers and groups impacted by the VM on areas that present opportunities for improvement as it relates to their quality and cost measures. CMS is working to provide reports to all physicians and groups in the Spring and Fall of 2015.

Visit the Academy's website for more detailed information!

http://www.entnet.org/content/value-based-payment-modifier