DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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FACT SHEET

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Changes for the Physician Value-based Payment Modifier in the CY 2015 Medicare Physician Fee Schedule Final Rule

Overview

On Oct. 31, 2014 the Centers for Medicare & Medicaid Services (CMS) issued a final rule that updates payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (PFS) on or after Jan. 1, 2015. The final rule includes policies for implementing the Value-based Payment Modifier (Value Modifier) in the Affordable Care Act that would adjust payments to physicians, groups of physicians, and other eligible professionals based on the quality and cost of care they furnish to beneficiaries enrolled in the traditional Medicare Fee-for-Service (FFS) program. Under the Value Modifier Program, performance on quality and cost measures can translate into payment incentives for providers who provide high quality, efficient care, while providers who underperform may be subject to a downward adjustment.

The Medicare PFS final rule is one of several rules for calendar year that reflect a broader Administration-wide strategy to deliver better care at lower cost by finding better ways to deliver care, pay providers, and use information. Provisions in these rules are helping to move our health-care system to one that values quality over quantity and focuses on reforms such as measuring for better health outcomes, focusing on disease prevention, helping patients return home, helping manage and improve chronic diseases, and fostering a more-efficient and coordinated health care system.

This fact sheet discusses the policies for implementing the Value Modifier. Separate fact sheets, also issued today, discuss the changes to payment policies for services furnished under the PFS, and the changes to these quality reporting programs and other policies included in this rule.

Physician Value Modifier for items and services paid under the PFS

The Affordable Care Act established a Value Modifier that provides for differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule based upon the quality of care furnished to Medicare FFS beneficiaries as well as the cost of that care during a performance period. Further, the statute requires that we begin applying the Value Modifier on January 1, 2015, with respect to items and services furnished by specific physicians and groups of physicians (as determined by the Secretary) and to apply it to all physicians and groups of

physicians beginning not later than January 1, 2017. The statute requires that the Value Modifier must be implemented in a budget neutral manner, generally meaning that upward payment adjustments for high performance must balance the downward payment adjustments applied for poor performance.

In this rule, we finalize additions and refinements to the existing Value Modifier policies. These policies continue our phased-in implementation of the Value Modifier by reinforcing our emphasis on quality measurement, alignment with the Physician Quality Reporting System (PQRS), physician choice, and shared accountability.

Group size and application of the Value Modifier to non-physician EPs

CMS will begin applying the Value Modifier in calendar year (CY) 2017 to all physicians, including those in groups with two or more eligible professionals (EPs) and to physicians who are solo practitioners. This policy completes the phase-in of the Value Modifier to all physicians and groups of physicians as required by the statute.

CMS estimates that its policies to apply the Value Modifier to physicians in all groups with two or more EPs and to all solo practitioners who are physicians in CY 2017 will affect approximately 900,000 physicians.

The statute provides discretion to apply the Value Modifier beginning in CY 2017 to EPs who are not physicians. We proposed to apply the Value Modifier beginning in CY 2017 to nonphysician EPs in groups with two or more EPs and to non-physician EPs who are solo practitioners. In order to provide nonphysician EPs with more time to prepare for the Value Modifier, we are finalizing a policy to apply the Value Modifier to nonphysician EPs beginning in CY 2018.

Value Modifier payment adjustments

CMS proposed to increase the maximum downward adjustment under the Value Modifier from -2.0 percent in the CY 2016 payment adjustment period to -4.0 percent for the CY 2017 payment adjustment period for all groups and solo practitioners. In this rule, CMS revised the policy and will increase the maximum amount of payment at risk from -2.0 percent to -4.0 percent only for groups with ten or more EPs. That is, for CY 2017 payments, a -4.0 percent Value Modifier adjustment will apply to groups of ten or more EPs subject to the Value Modifier that do not meet the quality reporting requirements for the Physician Quality Reporting System (PQRS).

In addition, we will increase the maximum downward adjustment under the quality-tiering methodology for groups with ten or more EPs to -4.0 percent for groups of ten or more EPs classified as low quality/high cost and set the adjustment at -2.0 percent for groups classified as either low quality/average cost or average quality/high cost. CMS will also increase the maximum upward adjustment under the quality-tiering methodology in the CY 2017 payment adjustment period to +4.0x ('x' represents the upward payment adjustment factor) for groups of ten or more EPs classified as high quality/low cost and set the adjustment to +2.0x for groups of ten or more EPs classified as either average quality/low cost or high quality/average cost.

In CY 2017, CMS will apply a maximum downward adjustment of -2.0 percent for groups with two to nine EPs and solo practitioners, if the group or solo practitioner does not meet the quality reporting requirements for the PQRS. The maximum upward adjustment for groups of two to nine EPs and solo practitioners will be +2.0x ('x' represents the upward payment adjustment factor) if classified as high quality/low cost. Groups of two to nine EPs and solo practitioners classified as either average quality/low cost or high quality/average cost will receive a +1.0x upward adjustment. Groups of two to nine EPs and solo practitioners will be held harmless from downward adjustments under the quality-tiering methodology for the CY 2017 payment adjustment period.

Setting the Value Modifier adjustment based on PQRS participation

CMS previously established CY 2015 as the performance period for the CY 2017 payment adjustment period for the Value Modifier. Similar to the approach established for the CY 2016 Value Modifier and in a continued effort to align the Value Modifier with PQRS, CMS will classify groups and solo practitioners subject to the CY 2017 Value Modifier using a two-category approach that is based on whether and how groups and solo practitioners participate in the PQRS in 2015. Category 1 will include those groups with two or more EPs that meet the criteria for satisfactory reporting of data on PQRS quality measures via the PQRS Group Practice Reporting Option (GPRO) (through use of the web-interface, electronic health record (EHR), or registry reporting mechanism) for the CY 2017 PQRS payment adjustment. Category 1 also includes groups that do not register to participate in the PQRS GPRO in CY 2015, but have at least 50 percent of the group's EPs either meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals (through the use of claims, EHR, or registry reporting mechanism) or satisfactorily participate in a PQRS-qualified clinical data registry for the CY 2017 PQRS payment adjustment. Lastly, we will include in Category 1 those solo practitioners that meet the criteria for satisfactory reporting of PQRS quality measure data as individuals or satisfactorily participate in a PQRS-qualified clinical data registry for the CY 2017 PQRS payment adjustment.

Category 2 will include those groups and solo practitioners that are subject to the CY 2017 Value Modifier and do not fall within Category 1. As discussed above, for CY 2017, CMS will apply a -4.0 percent Value Modifier downward payment adjustment to groups with ten or more EPs that fall in Category 2. CMS will apply a -2.0 percent Value Modifier downward payment adjustment to groups with two to nine EPs and solo practitioners that fall in Category 2.

In addition, CMS will apply the quality-tiering methodology, which is used for evaluating performance on quality and cost measures for the Value Modifier, to all groups and solo practitioners in Category 1 for the CY 2017 Value Modifier. However, groups with two to nine EPs and solo practitioners will receive only upward or neutral adjustments as determined under the quality-tiering methodology, and groups with ten or more EPs will receive upward, neutral or downward payment adjustments as determined under the quality-tiering methodology. In other words, groups with between two and nine EPs and solo practitioners that are in Category 1 will be held harmless from any downward adjustments derived from the quality-tiering methodology for the CY 2017 Value Modifier. This approach will reward groups and solo practitioners that provide high-quality/low-cost care, reduce program complexity, and fully engage groups and solo practitioners into the Value Modifier in CY 2017.

For CY 2017, the Value Modifier quality composite score will be based on PQRS quality measures that are reported through all available PQRS reporting mechanisms, as well as three additional claims-based measures that CMS will calculate. In addition, we finalized our proposal that groups with two or more EPs would be able to elect to have the patient experience of care measures collected through the CAHPS for PQRS survey in CY 2015 included in their quality of care composite for the Value Modifier for CY 2017. The cost composite for the CY 2017 VM will be calculated using the same cost measures that were finalized in the 2014 PFS for use in the CY 2016 Value Modifier – five total per capita cost measures and the Medicare Spending per Beneficiary (MSPB) measure.

Policies to apply the Value Modifier to groups and solo practitioners that participate in the Shared Savings Program, the Pioneer ACO Model, the Comprehensive Primary Care Initiative, or other similar Innovation Center models or CMS initiatives

Beginning with the CY 2017 payment adjustment period, we proposed to apply the Value Modifier to physicians and nonphysician EPs that participate in an Accountable Care Organization (ACO) under the Medicare Shared Savings Program (Shared Savings Program) during the payment adjustment period. Beginning in the CY 2017 payment adjustment period, we will apply the Value Modifier to physicians in groups with two or more EPs and to physicians who are solo practitioners who are participating in an ACO under the Shared Savings Program with some modification. Consistent with our final policy for nonphysician EPs who are not participants in a Shared Savings Program ACO, we are finalizing a policy to apply the Value Modifier to nonphysician EPs in Shared Savings Program ACOs beginning in CY 2018. We are also finalizing our proposal to use the PQRS GPRO web-interface measures in determining the quality of care composite for groups and solo practitioners participating in ACOs under the Shared Savings Program in CY 2017. CMS will also use the all cause hospital readmissions measure as calculated for ACOs under the Shared Savings Program for inclusion in the quality composite for the Value Modifier for these groups and solo practitioners. We are also finalizing a policy that Shared Savings Program ACO participants would be subject to an automatic downward adjustment under the Value Modifier, if the ACO failed to successfully report PQRS quality measures. In contrast to our proposal, we are finalizing a policy that we will use the performance period status in order to determine whether an eligible professional was a participant in a Medicare Shared Savings Program ACO, a Pioneer ACO, or the Comprehensive Primary Care Initiative.

Beginning with the CY 2017 payment adjustment period, we proposed to apply the Value Modifier to physicians and nonphysician EPs in groups with two or more EPs and to physicians and nonphysician EPs who are solo practitioners that participate in the Pioneer ACO Model, the Comprehensive Primary Care Initiative, or other similar Innovation Center models or CMS initiatives during the relevant performance period. As stated above for participants in the Shared Savings Program, for CY 2017, we are finalizing a policy to apply the Value Modifier to physicians in groups with two or more EPs and to solo practitioners who are physicians who participate in these models. In response to comments received on our proposals, we are finalizing a policy to apply average cost and average quality to these groups and solo practitioners in CY 2017. Additionally, the Innovation Center is considering a waiver to the Value Modifier for

groups and solo practitioners that participate in these models. Please refer to the final rule for additional details on our final policies, which have changed from the proposed rule.

Methodological refinements to address NQF issues regarding the total per capita cost measures

Two of the major issues that the National Quality Forum (NQF) Cost and Resource Use Committee raised in its review of the total per capita cost measure will be addressed beginning with the CY 2017 Value Modifier. First, CMS is modifying the beneficiary attribution methodology used for the Value Modifier to allow for more consideration of primary care services furnished by nonphysician eligible professionals while maintaining general consistency with the assignment methodology used for the Shared Savings Program. These changes will apply to the five per capita cost measures and the three claims-based quality measures. Second, CMS will include certain part-year beneficiaries in the five total per capita cost measures for the Value Modifier.

Expanded informal inquiry process

CMS will expand the informal inquiry process for the Value Modifier starting with the CY 2015 payment adjustment period. The agency will establish a brief period for a group or solo practitioner to request correction of a perceived error made by CMS in the determination of its Value Modifier payment adjustment. These errors could include errors made by CMS in assessing the eligibility of a group or solo practitioner for the Value Modifier based on its participation in a Shared Savings Program ACO, computing standardized scores, computing domain scores, computing composite scores, and/or computing additional outcome or cost measures. For the CY 2015 payment adjustment period, CMS will recalculate the groups cost composite if we find an error was made. At this time we are not operationally able to recalculate a quality composite but we will classify a group as "average quality" in the event we determine that we have made an error in the calculation of the quality composite. CMS is currently working to develop and operationalize the necessary infrastructure to support a process for correcting errors related to quality measure data in the future. Specific deadlines for the informal inquiry process are provided in the final rule for CY 2015 and subsequent years.

Physician Feedback Program

For the last three years, we have provided annual Quality and Resource Use Reports (QRURs) to groups of physicians to provide feedback on the quality and cost of care furnished to Medicare beneficiaries. We will continue to use the annual QRURs to explain how the Value Modifier would affect payment under the PFS. On September 30, 2014, we disseminated QRURs based on CY 2013 data to groups of physicians of all sizes and to solo practitioners, These QRURs contain performance information on the quality and cost measures used to calculate the quality and cost composites of the Value Modifier and showed how TINs would fare under the policies finalized for the CY 2015 Value Modifier. For groups of physicians with 100 or more EPs, the CY 2013 QRUR also showed how a group's payments will be affected by the CY 2015 Value Modifier, including any upward, neutral or downward payment adjustment if the group elected the quality-tiering option. The QRURs also include additional information about the TIN's performance on the Medicare Spending per Beneficiary (MSPB) measure, individually-reported PQRS measures, and the specialty-adjusted cost measures. In the late summer of 2015, we intend to disseminate QRURs based on CY 2014 data to all groups and solo practitioners, and the reports will show how TINs would fare under the policies finalized for the CY 2016 Value

Modifier. We encourage groups to access their CY 2013 QRURs in order to help them understand their current performance levels and how to use the information provided in the QRURs to improve the quality of care provided to their beneficiaries and cost efficiency. The reports are available via the following link: https://portal.cms.gov.

The final rule can be viewed at https://www.federalregister.gov/public-inspection. Please be mindful this link will change once the rule is published on Nov. 13, 2014 in the Federal Register.

For more information on the Value Modifier and Physician Feedback Program, visit: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html

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