The Value-Based Modifier

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

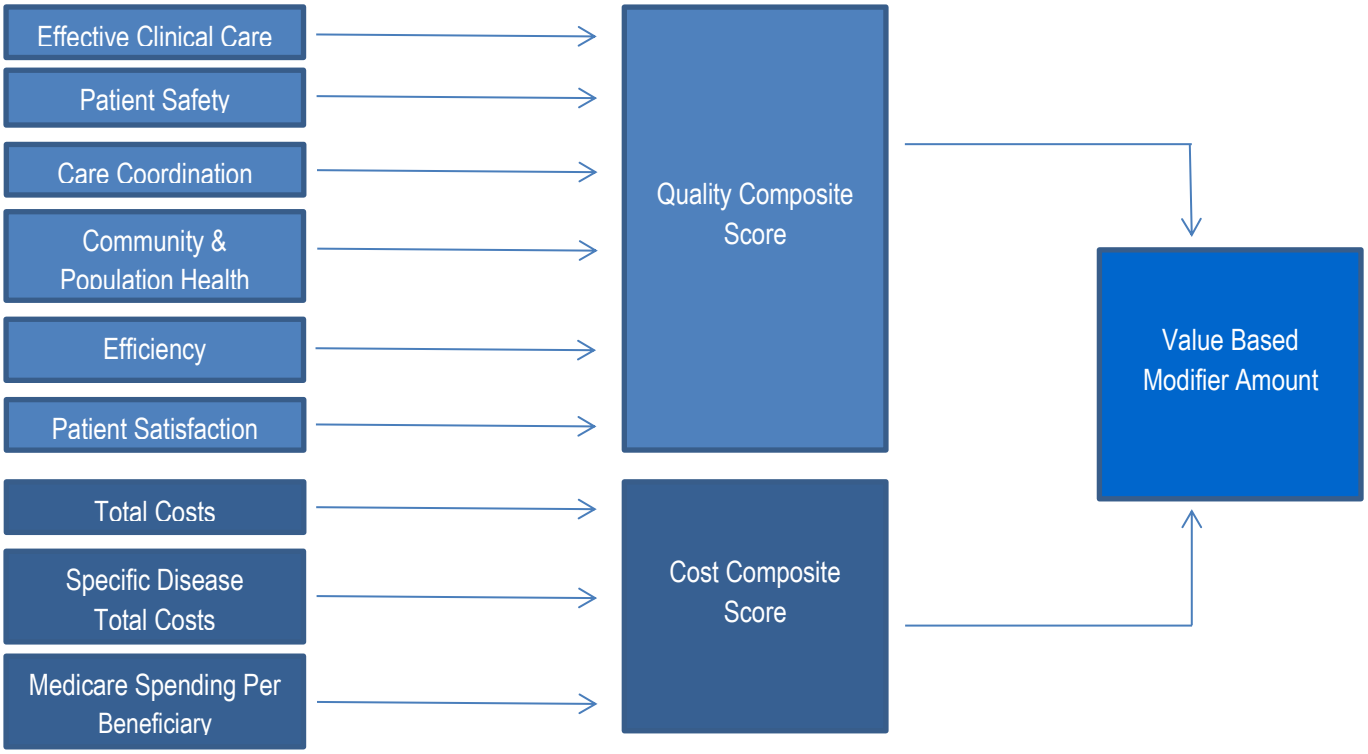
Successfully Navigating the Centers for Medicare & Medicaid Services (CMS) Valued-Based Modifier (VM)

◆ What is VM?

The Affordable Care Act requires that CMS apply a value-based modifier (VM) to Medicare physician fee schedule payments starting with select physicians in 2015 and all physicians by 2017. Unlike the Physician Quality Reporting System (PQRS), which is a pay-for-reporting program that focuses only on quality, the VM is tied to physician performance on a composite of quality and cost measures. Since 2017 VM adjustments are based on 2015 performance and apply to group practices of any size, as well as solo practitioners, it is critical that emergency physicians understand how they may be affected by this program.

◆ Overview of Quality and Cost Composite Scores

The "quality-tiering approach" combines a quality measure composite performance score and a cost measure composite performance score to calculate the VM adjustment. CMS will not include in its calculations measures for which a group or solo practitioner was attributed fewer than 20 cases. In cases where there is insufficient data, CMS will classify the EP's performance as "average" for purposes of quality tiering.



***Note**: The benchmark for each quality measure is based on the **national mean** of each measure's performance rate during the **year prior** to the performance year. The benchmarks for the cost measures are the national mean of performance rates, but adjusted based on the specialty mix of the EPs in the group. All cost measures are also payment standardized to adjust for geographic differences and risk adjusted based on patient characteristics.*

◆ Quality and Resource Use Reports (QRURs)

CMS distributes Quality and Resource Use Reports (QRURs) to all groups and solo practitioners. These, and future reports, are important to review since they provide a preview of how group practices will fare under the Value Modifier. To learn more about the Value Modifier and to access your QRUR, navigate here.

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

◆ Calculation of 2017 VM Using the Quality Tiering Approach

As shown in the tables below, CMS will divide the total scores for all physicians into three tiers based on whether they are above, at, or below the national mean. Since the VM is a budget neutral program, upward adjustments for high performers cannot be calculated until spending on downward adjustments for low performers is determined.

Groups with 2-9 EPs and Solo Practitioners			
Cost/Quality	**Low Quality**	**Average Quality**	**High Quality**
Low Cost	+0.0%	+1.0x*	+2.0x*
Average Cost	+0.0%	+0.0%	+1.0x*
High Cost	+0.0%	+0.0%	+0.0%

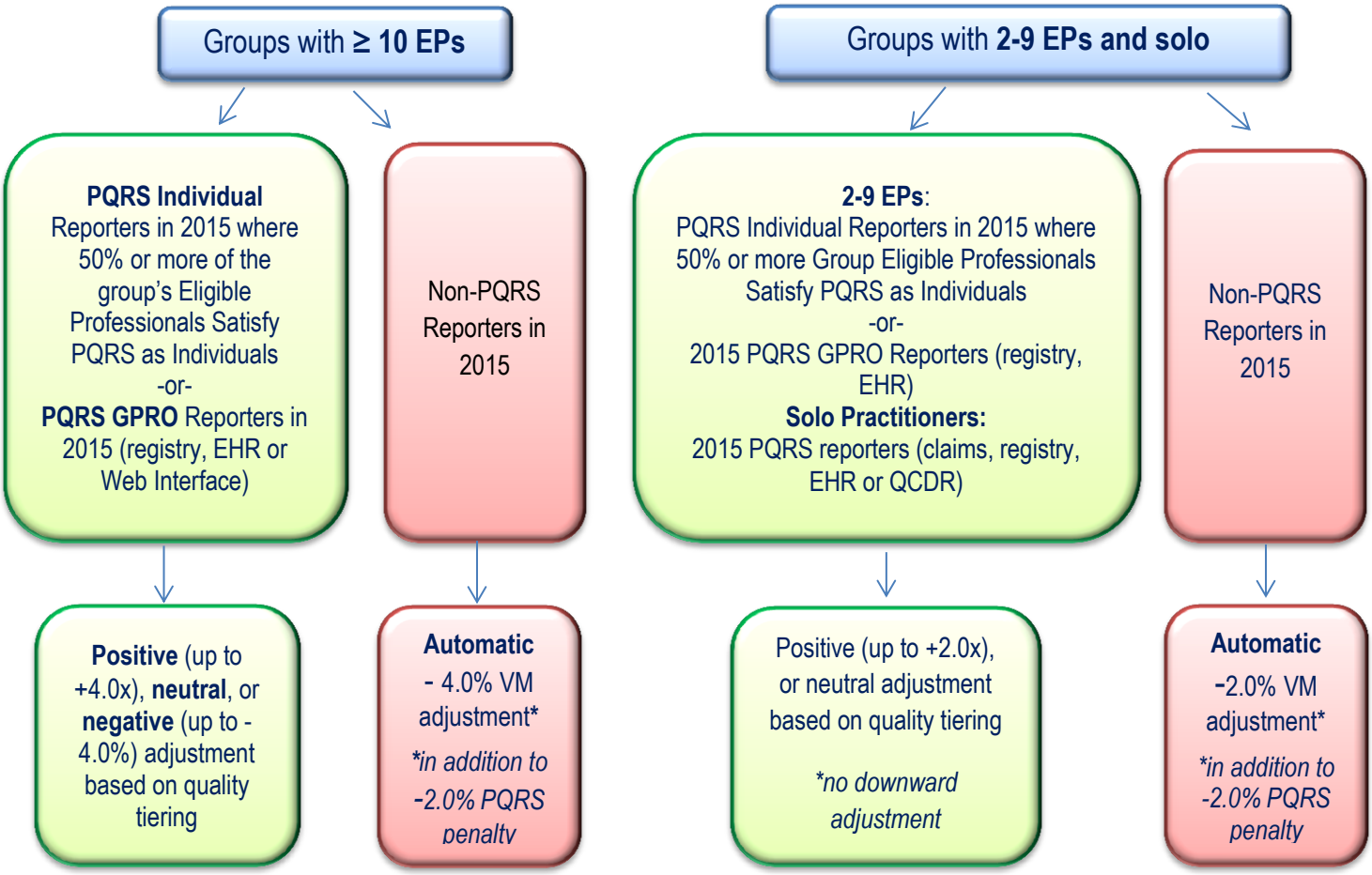
Groups with ≥ 10 EPs			
Cost/Quality	**Low Quality**	**Average Quality**	**High Quality**
Low Cost	+0.0%	+2.0x*	+4.0x*
Average Cost	-2.0%	+0.0%	+2.0x*
High Cost	-4.0%	-2.0%	+0.0%

**Eligible for an additional +1.0x if average beneficiary risk score is in the top 25% of all beneficiary risk scores.*

◆ Application of the 2017 Value-Based Payment Modifier

As illustrated below, all group practices and solo practitioners ***must satisfy PQRS requirements in 2015*** to avoid a *separate* penalty under the VM in 2017.

Note that if a group practice does not register to participate in the PQRS GPRO in 2015, but at least 50% of eligible professionals (EPs) in the group satisfy PQRS reporting requirements as individuals, CMS will hold the group and its individuals harmless from penalties imposed on non-PQRS reporters, but will subject the group to the "quality-tiering" approach described below.



For more specific information regarding the Value Modifier, the PQRS, and how emergency physicians will be affected by these programs, please visit: http://www.acep.org/quality/pqrs