2016 Value Based Payment Modifier Overview for Ophthalmic Practices

The Value Based Payment Modifier (VBPM) provides incentives and levies penalties based on the quality of care and cost of care that eligible professionals provide under the Medicare Physician Fee Schedule (MPFS). **The VBPM penalty is in addition to the penalties associated with PQRS and EHR Meaningful Use. The VBPM is based on participation in PQRS. In some cases, providers may be attributed costs of care they did not provide based on the VBPM cost measure attribution process.**

Who is Affected by the VBPM?

The VBPM is a quality program applied at the group level (identified by Tax Identification Number (TIN)) that is based on cost and quality. The VBPM program is the third quality program affecting groups or individual eligible professionals in addition to the Physician Quality Reporting System (PQRS) and the Electronic Health Records (EHR – Meaningful Use) program.

All providers are subject to the VBPM based on performance in 2016, which affects payments in 2018. The VBPM will be based on successfully reporting PQRS measures for each eligible professional in a group.

How will Providers be Financially Penalized by the VBPM if They Do Not Report PQRS?

In 2018, all eligible professionals, including solo practitioners, who have not successfully reported PQRS measures during the 2016 reporting period, will be assessed a 2% or 4% VBPM reduction, depending on the size of the practice, in all Medicare fee-for-service payments. Groups of 10 or more eligible professionals who do not successfully report PQRS in 2016 will receive a 4% VBPM penalty in CY 2018. Groups of 2-9 eligible professionals or solo practitioners who do not successfully report PQRS in 2016 will receive a penalty of 2% in CY 2018.

This penalty applies to Medicare Part B covered professional services furnished by the eligible professional during 2018.

How can Providers Successfully Avoid the VBPM Penalties?

To avoid VBPM penalties, group practices have multiple choices for how they report in 2016. Any group who participates in the PQRS Group Practice Reporting Option (GPRO) via web interface, CMS qualified registry, or EHR reporting meets the criteria for having reported. Groups must self-nominate for these GPRO PQRS reporting options.

If the group chooses not to report PQRS measures through GPRO web interface, CMS qualified registry or EHR, then CMS will look to see if at least 50% of the eligible professionals in the practice successfully reported for PQRS individually. If they did, they will be assessed as a group based on those eligible professionals that reported.

What Determines the Penalty and Incentive Payments?

Once it is determined that a practice has successfully reported for PQRS, quality tiering will then determine if providers receive a penalty, incentive payment, or no payment change under the VBPM.

What is Quality Tiering?

Quality tiering rewards or penalizes a group based on cost and quality. Quality tiering will determine whether a group of eligible professionals is statistically better, the same, or worse than the national average based on cost and quality. **Quality tiering means that a practice receives a positive, negative, or neutral payment adjustment for 2018 based on 2016 performance.**

Based on cost and quality data from 2016, all solo physician eligible professionals and groups with at least one physician (including optometrists) will face an upward, downward, or no payment adjustment in 2018 based on quality tiering. Prior to 2016, groups of fewer than 10 eligible professionals were only subject to the positive or neutral payment adjustment and did not face a downward payment adjustment. (Solo non-physician eligible professionals or groups of all non-physician eligible professionals will not face a downward adjustment in 2016, as this is the first year the VBPM applies to them).

How are Penalty and Incentive Payments Determined under Quality Tiering?

Groups and solo practitioners will receive two composite scores—quality and cost—based on the group's standardized performance (how far away the group is from the national average).Eligible professionals' specialties will be determined by the Medicare Provider Enrollment, Chain and Ownership System (PECOS).

Quality Measures:

1. Measures reported through PQRS;
2. Outcomes Measures, which include hospital readmissions, composite of acute prevention quality indicators (bacterial pneumonia, urinary tract infection, dehydration), and composite of chronic prevention quality indicators (COPD, heart failure, diabetes); and / or
3. Eligible professionals also have the option of including 2014 Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, or patient experience of care measures.

Cost Measures:

1. Total per capita cost measures for Part A and Part B;
2. Total per capita costs for beneficiaries with 4 chronic conditions: COPD, heart failure, diabetes, and coronary artery disease; and / or
3. Medicare Spending Per Beneficiary Measure, which measures 3 days before and 30 days after an inpatient hospitalization.

CMS will also provide an additional upward adjustment if the average beneficiary risk score for the group is in the top 25% of all beneficiary risk scores. A beneficiary's risk score is a relative measure of expected health for the beneficiary based on health conditions and demographic characteristics.

CMS will use the quality and cost scores to determine the upward or downward adjustments a group or solo practitioner can receive based on quality tiering depending on their practice size.

Attribution Methodology

Attribution for the VBPM cost measures will be determined by a two-step process. First, a beneficiary will be assigned to a Tax Identification Number (TIN) if the beneficiary receives the plurality of primary care services from a primary care provider. For beneficiaries who did not receive any eligible primary care services from a primary care physician during the reporting period, the beneficiary will be assigned to the TIN that provided the plurality of E&M services to the beneficiary.

Therefore, ophthalmologists may be attributed costs of care they did not provide, due to the attribution method used for the VBPM cost measures.

Quality Tiering Adjustments

View the chart below to find out the upward, downward, or neutral adjustments groups will receive based on their quality and cost score. **The 'x' represents the payment adjustment factor, which will be determined at the end of CY 2016 based on the aggregate amount of downward payment adjustments.**

Practices with 10+ providers:

Quality / Cost	Low Cost	Average Cost	High Cost
High Quality	+4x	+2x	+0
Average Quality	+2x	+0	-2%
Low Quality	+0	-2%	-4%

Practices with 1-9 providers will receive an upward, neutral or downward payment adjustment. The maximum upward adjustment is +2x. The maximum downward adjustment is -2%.

Additional Resources

For additional information, you may contact Ashley McGlone at amcglone@ascrs.org or 703-591-2220.