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). **CMS estimates that the VBPM will affect an additional 900,000 physicians in 2017 based on 2015 reporting.** The VBPM penalty is in addition to the penalties associated with PQRS and EHR Meaningful Use. The VBPM is based on participation in PQRS.

### 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) programs.

All providers will now be subject to the VBPM based on performance in 2015, which affects payments in 2017. **The VBPM will be based in part on successfully reporting PQRS measures for each eligible professional in a group.** Previously, groups of 10 or more eligible professionals were subject to the VBPM in 2016, based on reporting in 2014, and groups of 100 or more eligible professionals were subject to the VBPM in 2015, based on reporting in 2013.

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

In 2017, all eligible professionals, including solo practitioners, who have not successfully reported PQRS measures during the 2015 reporting period, will be assessed a 2% to 4% VBPM reduction, depending on the size of the practice, in all Medicare fee-for-service payments. This applies to Medicare Part B covered professional services furnished by the eligible professional during 2017 or any subsequent year.

This is an increase over the 2% VBPM penalty that applied to groups of 10 or more eligible professionals in 2016 who did not comply with the VBPM in performance year 2014.

### How can Providers Successfully Avoid the VBPM Penalties?

To avoid VBPM penalties and receive positive updates from the VBPM in CY 2017, group practices have multiple choices for how they report in 2015. Any group who participates in the PQRS Group Practice Reporting Option (GPRO) via web interface, CMS qualified registry, or EHR 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 50% of the eligible professionals in the practice reported individually. If they did, then 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 the penalty or incentive payment that providers receive 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 could mean that a practice receives a positive, negative, or neutral payment adjustment for 2017 based on 2015 performance.**

Quality tiering will affect groups of 2-9 eligible professionals and solo practitioners beginning in 2015, however, groups of 2-9 and solo practitioners will not be subject to a downward adjustment in 2017. Groups of 10 or more will be subject to an upward, downward or neutral adjustment.

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). Group cost measures are adjusted by specialty. Eligible professionals’ specialties will be determined by the Medicare Provider Enrollment, Chain and Ownership system (PECOS).

**The quality measures** that will be used for quality tiering include the three outcomes measures below:
- All hospital readmissions
- Composite of acute prevention quality indicators (bacterial pneumonia, urinary tract infection, dehydration)
- Composite of chronic prevention quality indicators (COPD, heart failure, diabetes)

Eligible professionals also have the option of including 2014 Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, or patient experience of care measures.

**The cost measures** that will be used for quality tiering include:
- Total per capita cost measures (Part A and B Medicare charges—or the Medicare Spending Per Beneficiary Measure)
- Total per capita costs for beneficiaries with 4 chronic conditions: COPD, heart failure, diabetes, and coronary artery disease.

The Medicare Spending Per Beneficiary measure will be attributed to the group that provides the plurality of Part B services during a hospitalization. All cost measures are standardized and risk adjusted.

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 score to determine the upward, downward or neutral penalties a group or solo practitioner can receive based on quality tiering depending on their practice size.

Groups of 10 or More Eligible Professionals

Groups of 10 or more eligible professionals who do not successfully report PQRS in 2015, will receive a 4% VBPM reduction in all Medicare fee-for-service payments in CY 2017. Please note, it is likely that many ophthalmology practices will receive a neutral quality tiering score with no upward or downward penalty, based on the fact that many of the quality and cost score elements do not apply to ophthalmologists.

View the chart below to find out the upward, downward, or neutral adjustments groups of 10 or more eligible professionals 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 2015 based on the aggregate amount of downward payment adjustments. For example, if a practice was determined to have average cost and average quality, they would receive no upward or downward adjustment in their Medicare fee-for-service payments for 2017.
<table>
<thead>
<tr>
<th>Quality / Cost</th>
<th>Low Cost</th>
<th>Average Cost</th>
<th>High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Quality</td>
<td>+4x</td>
<td>+2x</td>
<td>+0</td>
</tr>
<tr>
<td>Average Quality</td>
<td>+2x</td>
<td>+0</td>
<td>-2x</td>
</tr>
<tr>
<td>Low Quality</td>
<td>+0</td>
<td>-2x</td>
<td>-4x</td>
</tr>
</tbody>
</table>

**Groups of 2-9 Eligible Professionals and Solo Practitioners**

Groups of 2-9 eligible professionals or solo practitioners who do not successfully report PQRS in 2015 will receive a VBPM penalty of 2% in CY 2017. The maximum upward adjustment for groups of 2-9 or solo practitioners is +2 times the payment adjustment factor. They will not be subject to negative adjustments under quality tiering in 2017, but will either get an upward adjustment or no adjustment.

**Other**

CMS finalized applying the VBPM to non-physician eligible professionals beginning in CY 2018.

**Additional Resources**

For additional information, you can contact Ashley McGlone at amcglone@ascrs.org or 703-383-5724. As additional resources are added to the CMS website, we will provide updates in Washington Watch Weekly.