DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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Physician Feedback, Quality and Resource Use Reports (QRURs) and Value-Based Modifier Program – Overview & Implementation

Provider Types Affected

This MLN Matters® Special Edition is intended for physicians and non-physician practitioners (Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists), Occupational Therapists, Physical Therapists, Speech-Language Pathologists, and Audiologists submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This Special Edition Article provides an overview of the Physician Feedback and Value-Based Modifier 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.

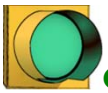
CAUTION – What You Need to Know

Beginning on January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) began applying a Value-Based Payment Modifier (Value Modifier) to physician payments under the Medicare Physician Fee Schedule for physicians in groups with 100 or more Eligible

Professionals (EPs). EPs consist of physicians, practitioners, physical or occupational therapists, qualified speech-language pathologists, and qualified audiologists. A group is defined by its Medicare-enrolled Taxpayer Identification Number (TIN). The Value Modifier Program is being gradually phased in as follows:

- In 2015, the payment adjustments will apply to physicians in groups of 100 or more Eligible Professionals (EPs), based on a 2013 performance period.
- In 2016, the payment adjustments will apply to physicians in groups of 10 or more EPs based on 2014 performance;
- In 2017, the payment adjustments will apply to physician solo practitioners and physicians in groups of 2 or more EPs based on 2015 performance; and
- Beginning 2018, the payment adjustments will also apply to non-physician EPs who are solo practitioners or are in groups of 2 or more EPs. Please note that the performance period for the Value Modifier that will be applied in 2018 will be proposed and finalized in the CY 2016 Medicare Physician Fee Schedule proposed and final rules, respectively.

For more information on future years of the Value Modifier, please visit **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html**.



GO – What You Need to Do

Participate in the Physician Quality Reporting System (PQRS) every year to avoid an automatic downward payment adjustment under the Value Modifier during the associated payment year. The data reported to PQRS for a given calendar year are used to calculate the Value Modifier for the calendar year that follows it by 2 years. For example, PQRS quality data for Calendar Year 2013 were used to calculate the Value Modifier affecting payments in 2015.

PQRS quality data are reported during the first quarter of the year following a given performance year. Physician groups should register to participate in the PQRS Group Practice Reporting Option (GPRO) in the fall of each year, to report data for that year.

Beginning with the 2016 Value Modifier, based on 2014 performance, EPs in a group have the option to participate in PQRS as individuals providing at least 50% of the group report. Use the information provided in your group's Quality and Resource Use Report (QRUR), as described below, to improve your performance on the quality and cost measures that are used to calculate the Value Modifier. Also, make sure that your billing staff is aware of these new payment adjustments.

Download your QRUR to understand how you performed on the cost and quality measures used to calculate the Value Modifier. Information on how to access these reports, which contain valuable information on the quality and cost of care provided to the Medicare beneficiaries you or your group serve is available at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html** on the CMS website.

Background

The Social Security Act requires that CMS establish a Value Modifier that provides for differential payment under the Medicare Physician Fee Schedule (MPFS) based upon the quality of care furnished compared to cost during a performance period. By law, the Value Modifier is to be applied to:

- Specific physicians and groups of physicians that CMS determines appropriate starting January 1, 2015; and
- All physicians and groups of physicians by January 1, 2017.

Accordingly, CMS established the Physician Feedback/Value-Based Payment Modifier Program to provide comparative performance information to individual physicians and groups, as part of Medicare's efforts to improve the quality and efficiency of medical care.

The program (which is specific to Fee-For-Service Medicare—not Medicare Advantage) contains two primary components:

- The Physician Quality and Resource Use Reports (QRURs), and
- The Value-Based Incentive Payment Modifier (Value Modifier).

What is a Quality and Resource Use Report?

CMS has already provided annual QRURs to groups with at least one physician and physicians who are solo practitioners, to provide feedback on the quality of care furnished to Medicare beneficiaries and the cost of that care. Beginning in 2015, CMS will provide QRURs based on 2014 performance to all groups and solo practitioners, including non-physician groups and solo practitioners. Groups and solo practitioners can use the information provided in the QRURs to improve the care they provide to Medicare beneficiaries and to improve performance on quality and cost measures used to calculate the Value Modifier. The QRURs include information about a TINs' performance on PQRS quality measures, 3 claims-based outcome measures, and claims-based cost measures. The reports contain detailed information on care provided both inside a group and outside the group to help improve care coordination and efficiency.

For more information about QRURs, see **https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/QRUR_Presentation.pdf.**

What is the Value-based Payment Modifier (Value Modifier)?

The Value Modifier can be upward, downward, or neutral (meaning no adjustment), and it applies to the Medicare paid amount of physician payments under the Medicare Physician Fee Schedule.

Beginning on January 1, 2015, CMS is applying the Value Modifier to Medicare Physician Fee Schedule Payments made to physicians in group practices with 100 or more EPs billing under a single TIN. In 2015, groups of 100 or more EPs that met the minimum PQRS reporting requirement had the option to elect whether they wished to have their Value Modifier calculated based on quality performance. For those groups who elected this "quality tiering

approach," CMS determined each group's Value Modifier adjustment for 2015 based on their performance on PQRS measures and claims-based outcome and cost measures in 2013.

The Value Modifier payment adjustment for CY 2015 ranges from a downward adjustment of negative 1 percent (for low quality/high cost care) to an upward adjustment of positive 2.X (for low cost/high quality care). The "X" in the upward adjustment represents an adjustment factor that is used to redistribute payment reductions (taken from groups that do not successfully report and those that perform poorly on quality and cost measures) to those groups that perform well.

In future years, the quality tiering approach will be mandatory, but in 2016 and 2017, group sizes that are new to the Value Modifier will only be eligible for upward or neutral adjustments under quality tiering. Policies for the 2018 Value Modifier will be made in the 2018 Physician Fee Schedule rule. As the Value Modifier's application to smaller group sizes and groups of non-physician EPs is gradually phased in, the maximum available incentives and maximum downward adjustments are gradually increased.

More information on the Value Modifier is available at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html** on the CMS website.

What Payments are Affected by the Value-Modifier?

In 2015 CMS applies the Value Modifier adjustment at the TIN level to the items and services billed by physicians in the group, not to other eligible professionals that also may bill under the TIN. A 'Physician' is defined for the Value Modifier Program as: a Doctor of Medicine; Doctor of Osteopathy; Doctor of Podiatric Medicine; Doctor of Optometry; Doctor of Dental Surgery; Doctor of Dental Medicine; or Doctor of Chiropractic.

Beginning with 2018 payments, the Value Modifier will apply to non-physician EP's payments as well. These include Non-Physician Practitioners (e.g., Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists), Occupational Therapists, Physical Therapists, Speech-Language Pathologists, and Audiologists. The Value Modifier is applied to the Medicare paid amounts for the items and services billed under the MPFS so that beneficiary cost-sharing is not affected.

Application of the Value Modifier at the TIN level means that if a physician changes groups from TIN A in the performance period (CY 2013) to TIN B in the payment adjustment period (CY 2015), then CMS would apply TIN B's Value Modifier to the physician's payments for items and services provided during 2015 and billed under TIN B.

What If I Think There is an Error in My Value Modifier?

If a physician group believes that CMS has made an error in the calculation of the group's Value Modifier, then the group may request a correction through our informal review process. For the 2016 Value Modifier and beyond, informal review must be requested no later than 60 days after receipt of the QRUR. If, upon review, CMS determines that we have made an error in the calculation of the quality composite and we are unable to recalculate it, then we will

classify the TIN as "average quality." For the 2016 Value Modifier and beyond, if we are able to receive and utilize corrected quality data, then we will recalculate the quality composite. If we determine we made an error in the calculation of the cost composite then we will re-compute the cost composite to correct the error.

Who Can I Contact for Further Information?

Physician Value Help Desk (for Value Modifier questions)

Monday – Friday: 8:00 am – 8:00 pm EST

Phone: 888-734-6433, press option 3

QualityNet Help Desk (for PQRS questions: 866-288-8912 (TTY 877-715-6222)

7:00 a.m.–7:00 p.m. CST M-F or qnetsupport@hcqis.org

You will be asked to provide basic information such as name, practice, address, phone, and e-mail address.

Additional Information

More information about the full implementation of the CMS Physician Feedback/Value-Based Payment Modifier Program is available at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html** on the CMS website.

A summary of the 2015 Physician Value-based payment modifier policies can be found at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/CY2015ValueModifierPolicies.pdf** on the CMS website.

You can review the timeline (2012-2017) for the Physician Feedback/Value-Based Payment Modifier Program at **https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Timeline.html** on the CMS website.

More information about the Value Modifier program is available at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html** on the CMS website.

You can find out more about the PQRS program at **http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html** on the CMS website.