**Value-Based Modifiers for Medicare**

**The Value-Based Modifier Explained**

This concept is based on participation in Medicare’s quality programs (EHR attestation and PQRS reporting). Medicare has been working towards reimbursement based on quality performance instead of fee-for-service since the inception of the EHR and PQRS programs. However, since 2013, CMS has gathered information on providers to begin this quality reward-based system. Last year, groups of physicians with 100 or more EPs received an upward or downward adjustment on their fee schedule based on their 2013 participation. This year, groups of 10 or more are receiving adjustments based on their 2014 participation. The current plan at CMS is to apply the adjustment beginning in 2017 to solo practitioners or groups with two or more, based on 2015 participation in the quality programs. Attestation for 2015 is very important, as well as participation in the PQRS reporting program. Going forward, 2016 calculations for the value-based modifier will apply to 2018, when CMS is proposing that EPs who haven’t participated at all in any of Medicare’s quality programs face removal from the Medicare system. Right now, for groups of 2-10 and individuals, the goal is to participate and avoid the additional Value Modifier downward adjustment of -2% in 2017.

The value-based modifier system for groups of 10 or more can help groups earn an upward tick in their fee schedule based on their peers and how many in the group participated. (At least 50% of the group must participate.) The group will also be evaluated on cost vs. outcome effectiveness. That calculation will be based on peer groups, total dollars, patient satisfaction, and other factors such as escalating treatments. Because chiropractic costs are relatively low and our patient satisfaction high, this is an area where we can excel. However, it’s unknown just how this may be affected by our high error rate in documentation. There is also greater reward for treating higher-risk beneficiaries, which chiropractors don’t typically see, which means that when we do, diagnosis will become paramount.

**What the Value-Based Modifier Means to You**

The bottom line is that a large multi-disciplinary practice that treats Medicare patients but didn’t participate in any quality program in 2014 will be experiencing negative downward adjustments to their fee schedule this year and the next, and possible exclusion in 2018. Single practitioners will begin to face reductions in 2017 based on 2015 actions. For all practitioners, continuing to avoid participating in Medicare quality programs while trying remain in the Medicare system and treating Medicare beneficiaries will result in possible exclusion in 2018.

The value-based modifier will also be included in the provider profile on the patient-centric Medicare website. Medicare beneficiaries will be continually encouraged to choose providers based on their profile in this website. Exactly what encouragement will be offered to beneficiaries is not currently known.