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2015 Value-Based Payment Modifier Program Experience Report

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I. INTRODUCTION AND KEY FINDINGS

Starting on January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) began applying the Value-Based Payment Modifier (Value Modifier) to physician payments under the Medicare Physician Fee Schedule. The Value Modifier is designed to reward higher quality care delivered at lower cost, as required by Section 3007 of the Affordable Care Act (ACA). Section 3007 of the ACA requires CMS to apply the Value Modifier to specific physicians and groups of physicians as determined by the secretary of the U.S. Department of Health and Human Services beginning no later than January 1, 2015, and to all physicians and groups of physicians paid under the Medicare Physician Fee Schedule beginning no later than January 1, 2017. This report summarizes data on the characteristics and performance of the physician groups subject to the Value Modifier in 2015.

In 2015, the Value Modifier applies to physician payments under the Medicare Physician Fee Schedule for physicians in groups with 100 or more eligible professionals. Eligible professionals consist of physicians, practitioners, physical or occupational therapists, qualified speech-language pathologists, and qualified audiologists. A physician group is identified by its Medicare-enrolled Taxpayer Identification Number (TIN). Calendar year (CY) 2013 was the performance period for the Value Modifier that is being applied in 2015.

Physician groups with 100 or more eligible professionals were subject to the Value Modifier in 2015. Groups of 100 or more eligible professionals were identified using a two-step process. First, CMS generated an initial list of groups that had 100 or more eligible professionals in the Provider Enrollment, Chain, and Ownership System (PECOS) as of October 15, 2013. Second, CMS removed groups from this list if they did not have 100 or more eligible professionals, with at least one physician, who billed fee-for-service (FFS) Medicare under the TIN at any time during 2013. Groups of 100 or more eligible professionals were not subject to the 2015 Value Modifier if one or more physicians participated through the TIN in a Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO), the Pioneer ACO Model, or the Comprehensive Primary Care (CPC) initiative during 2013.

To avoid an automatic -1.0 percent Value Modifier payment adjustment in 2015, physician groups subject to the Value Modifier were required to register for a Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) and either elect the GPRO Web Interface or GPRO registry reporting mechanism and meet the minimum reporting requirement by reporting at least one measure, or elect the CMS-calculated administrative claims option.¹ Groups that did not meet these requirements received an automatic -1.0 percent Value Modifier payment adjustment, meaning that their Medicare Physician Fee Schedule payments were adjusted downward by 1.0 percent in 2015.

For the 2015 Value Modifier, physician groups had the option to elect to have their Value Modifier calculated using quality-tiering, whereby their 2015 Medicare Physician Fee Schedule payments could be adjusted upward or downward or remain unchanged depending on their performance on quality and cost measures in 2013. Groups that registered and met the minimum

¹ Hereafter, we will refer to groups as having met the minimum reporting requirement if they either elected the GPRO Web Interface or registry reporting mechanism and reported at least one measure, or if they elected the CMS-calculated administrative claims option.

reporting requirement, but did not elect quality-tiering, received a neutral payment adjustment (that is, a 0.0 percent Value Modifier payment adjustment).²

Key findings

- Based on the criteria described above, 1,010 physician groups are subject to the Value Modifier in 2015. Of these, 14 groups will have payments adjusted upward based on quality-tiering, 330 groups will have payments adjusted downward—288 for not registering for a PQRS GPRO, 31 for not meeting the minimum reporting requirement, and 11 based on quality-tiering—and 666 groups will have a neutral (meaning no) payment adjustment in 2015. (Figure IV.1)
- 106 of these 1,010 physician groups had their Value Modifier calculated based on their performance on quality and cost measures using quality-tiering. Under quality-tiering, 14 groups will have payments adjusted upward, 11 groups will have payments adjusted downward, and 81 groups will have a neutral payment adjustment in 2015. (Figure IV.1)
- Performance on quality drives upward and downward payment adjustments under quality-tiering more than does performance on cost: of the 14 physician groups that will receive upward payment adjustments, 12 have high quality, but only 2 have low cost; similarly, of the 11 groups that will receive downward adjustments, 10 have low quality, compared with only 4 with high cost. (Table IV.1)
- Of the 904 physician groups whose Value Modifier is not based on quality-tiering,
 - 319 will receive an automatic downward payment adjustment for not registering for a PQRS GPRO or meeting the minimum reporting requirement;
 - 564 will receive a neutral payment adjustment because they registered for a PQRS GPRO and met the minimum reporting requirement but did not elect quality-tiering; and
 - 21 will receive a neutral payment adjustment because they registered, met the minimum reporting requirement, and elected quality-tiering but did not have sufficient data to calculate a Value Modifier based on performance on quality and cost.³ (Figure IV.1)
- On average, physician groups receiving an upward payment adjustment under quality-tiering had fewer admissions for Acute and Chronic Ambulatory Care-Sensitive Conditions (ACSCs), fewer hospital readmissions within 30 days, and lower per capita costs than physician groups receiving a downward payment adjustment under quality-tiering. (Table IV.6)

² Beginning with the 2016 Value Modifier, quality-tiering is mandatory for providers subject to the Value Modifier.

³ To have sufficient data to calculate a Quality or Cost Composite for the Value Modifier, a physician group must have at least 20 eligible cases for at least one measure that is part of the composite. If a physician group's composite score is at least one standard deviation higher or lower than the composite average (computed across all groups with 100 or more eligible professionals), then, in order for the physician group to have sufficient data, the physician group's composite score must also be statistically significantly different from the composite average. If a physician group's composite score is within one standard deviation of the composite average, then the physician group will always be considered average if it has at least 20 eligible cases for at least one measure that is part of the composite.

- Of the 106 physician groups that had their Value Modifier based on quality-tiering in 2015,
 - Among the quarter with lowest average beneficiary risk, 22 percent received an upward payment adjustment, 7 percent received a downward payment adjustment, and 70 percent received a neutral payment adjustment.
 - Among the quarter with highest average beneficiary risk, none received an upward payment adjustment, 31 percent received a downward payment adjustment, and 69 percent received a neutral payment adjustment. (Table IV.5)
- Compared with physician groups subject to the Value Modifier that elected the CMS-calculated administrative claims option, groups reporting measures via the GPRO Web Interface or a qualified registry were more likely to elect quality-tiering (Table IV.9) and less likely to receive a downward payment adjustment in 2015. (Table IV.10)
- The five large specialties⁴ with the largest share of physicians in groups with an upward adjustment are gastroenterology, dermatology, endocrinology, obstetrics/gynecology, and physical medicine and rehabilitation; about 5 percent of physicians subject to the Value Modifier in these specialties will receive an upward adjustment in 2015. (Table IV.11)
- The five large specialties with the largest share of physicians in groups with a downward adjustment are optometry, podiatry, psychiatry, urology, and ophthalmology; more than 30 percent of physicians subject to the Value Modifier in these specialties will receive a downward adjustment in 2015. (Table IV.12)

II. HOW IS THE 2015 VALUE MODIFIER DETERMINED?

A. Quality-tiering

To determine the Value Modifier under quality-tiering, CMS calculates composite scores for quality and cost that assign groups to low, average, or high quality and cost categories. Table II.1 shows how these categories relate to the payment adjustment under the Value Modifier. Because the Value Modifier must be budget neutral, CMS uses an adjustment factor to distribute available incentives from downward adjustments to the higher-performing groups—those that are at least average on both quality and cost, and better than average on at least one. The adjustment factor is calculated after the performance period has ended and the Quality and Cost Composites for all physician groups subject to the Value Modifier have been calculated.

⁴ Specialty analyses in this report focus on specialties with more than 1,000 specialists practicing in groups subject to the 2015 Value Modifier.

Table II.1. Quality-tiering categories and adjustment

	Low quality	Average quality	High quality
Low cost	+0.0%	+1.0 x AF (= 4.89%) ^a	+2.0 x AF (= 9.78%) ^a
Average cost	-0.5%	+0.0%	+1.0 x AF (= 4.78%) ^a
High cost	-1.0%	-0.5%	+0.0%

Note: The adjustment factor (AF) for the 2015 Value Modifier is approximately 4.89 percent.

^a Higher-performing groups that satisfactorily reported PQRS quality measures via the GPRO Web Interface or a qualified registry and whose attributed beneficiaries' average risk score was in the top 25 percent of all beneficiary risk scores are eligible for an additional adjustment of +1.0 x AF (= 4.89%).

The amount of the adjustment factor will vary from year to year, based on the projected billings of the higher-performing groups compared with those of groups receiving a downward payment adjustment. The adjustment factor is approximately 4.89 percent for the 2015 Value Modifier, meaning that Medicare Physician Fee Schedule payments to a group categorized as high quality and average cost will be adjusted upward by approximately 4.89 percent in 2015.⁵

The Quality Composite and Cost Composite are each comprised of multiple domains. Quality and cost measures are equally weighted within the domains that make up each composite. The Quality Composite Score is made up of scores from up to six equally-weighted quality domains that align with the National Quality Strategy (NQS): Clinical Process/Effectiveness, Patient and Family Engagement, Population/Public Health, Patient Safety, Care Coordination, and Efficient Use of Health Care Resources.⁶ The Cost Composite Score is made up of costs from up to two equally-weighted cost domains: Per Capita Costs for All Attributed Beneficiaries and Per Capita Costs for Beneficiaries with Specific Conditions. The 2013 Quality and Resource Use Report (QRUR) provides detailed information to physicians and physician groups about their performance on the quality and cost measures used to calculate the 2015 Value Modifier.

III. CHARACTERISTICS OF PHYSICIAN GROUPS SUBJECT TO THE 2015 VALUE MODIFIER

In this section, we describe some of the characteristics of the 1,010 physician groups that are subject to the 2015 Value Modifier as well as the subset of 106 groups whose Value Modifier is based on their 2013 quality and cost performance under quality-tiering.⁷ To provide context, we also describe the characteristics of the 161,033 physician solo practitioners and physician groups

⁵ The adjustment factor for the 2015 Value Modifier was made public on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-Value-Modifier-Results.pdf>. This document also discusses how the 2015 adjustment factor was calculated.

⁶ Only measures with at least 20 eligible cases are included in composite scores. The composite score is an equally-weighted average of the domain scores for the domains with at least one measure with at least 20 eligible cases.

⁷ A total of 268 additional physician groups would have been subject to the Value Modifier had they not had one or more physicians who participated through the group's TIN in a Medicare Shared Savings Program Accountable Care Organization (ACO), the Pioneer ACO Model, or the Comprehensive Primary Care initiative during 2013.

(as identified by their Medicare-enrolled TIN) that received a 2013 QRUR.⁸ Table III.1 summarizes our findings.

Table III.1. Characteristics of physician groups subject to the 2015 Value Modifier

	Physician solo practitioners and physician groups receiving 2013 QRURs	Physician groups subject to 2015 Value Modifier	Physician groups with 2015 Value Modifier based on quality-tiering
Number of TINs	161,033	1,010	106
Average number of EPs	6	300	423
Percentage of TINs that are solo practices	61.7	0.0	0.0
Percentage of TINs with more than 50 percent of EPs with same specialty	86.9	20.6	3.8
Average percentage of EPs that are PCPs	28.7	24.2	28.1
Average percentage of EPs that are physicians	92.6	72.1	73.4
Average percentage of EPs that are non-physicians	7.5	27.9	26.6
Average number of attributed beneficiaries	134	5,174	10,051
Average percentage of beneficiaries attributed on the basis of primary care services provided by PCPs	36.0	73.5	83.9
Average number of primary care services provided by the TIN per attributed beneficiary	3.7	4.8	5.2
Average percentage of primary care service visits provided by the TIN to their attributed beneficiaries	65.8	66.8	68.2
Average CMS-HCC risk score of attributed beneficiaries	1.0	1.2	1.1

Note: Physician solo practitioners and physician groups are identified by their Medicare-enrolled TIN. Beneficiaries are attributed to TINs on the basis of primary care services provided for purposes of computing the administrative claims–based quality and cost measures. The last column (Physician groups with 2015 Value Modifier based on quality-tiering) includes groups that registered, met the minimum reporting requirement, and had sufficient data to calculate both a Quality and Cost Composite.

EP = eligible professional; CMS-HCC = Centers for Medicare & Medicaid Services Hierarchical Condition Categories; PCP = primary care physician; QRUR = Quality and Resource Use Report; TIN = Taxpayer Identification Number

Among all physician solo practitioners and physician groups receiving a 2013 QRUR, 7.5 percent of eligible professionals are non-physicians, on average, whereas non-physician eligible professionals constitute 27.9 percent on average of groups subject to the 2015 Value Modifier. One of the primary drivers behind these differences in eligible professional composition is the size of groups subject to the Value Modifier in 2015. Because physician groups subject to the 2015 Value Modifier must have at least 100 or more eligible professionals, these groups are large, averaging 300 eligible professionals per group. Correspondingly, they are more likely to

⁸ CMS produced a 2013 QRUR for physician solo practitioners and physician groups (as identified by their Medicare-enrolled TIN) for which (1) at least one physician billed FFS Medicare under the TIN in 2013; (2) there was at least one quality or cost measure with at least one eligible case; and (3) no physician in the TIN participated in a Medicare Shared Savings Program ACO, the Pioneer ACO Model, or the Comprehensive Primary Care initiative in 2013.

have a diverse mix of eligible professional types. In contrast, nearly two-thirds of the more than 160,000 2013 QRUR recipients are physician solo practitioners.

Also reflecting their larger size, physician groups subject to the 2015 Value Modifier have many more attributed beneficiaries on average than do the larger set of physician solo practitioners and physician groups receiving a 2013 QRUR: an average of 5,174 beneficiaries are attributed to groups subject to the 2015 Value Modifier compared to 134 beneficiaries attributed to the typical group or solo practitioner receiving a QRUR.⁹ The subset of groups electing quality-tiering are attributed 10,051 beneficiaries on average—nearly twice the average number of beneficiaries among all groups subject to the Value Modifier.

On average, the vast majority (73.5 percent) of beneficiaries attributed to groups subject to the 2015 Value Modifier are attributed on the basis of receiving the plurality of their primary care services from primary care physicians (PCPs) in the group.¹⁰ Note that specialty-only groups would not be attributed a beneficiary that had any primary care service from a PCP.¹¹ In contrast, among all physician groups and physician solo practitioners receiving a QRUR, only 36.0 percent of Medicare beneficiaries were attributed on the basis of receiving the plurality of their primary care services from PCPs.

On average, groups subject to the 2015 Value Modifier provided 4.8 primary care services per beneficiary to their attributed beneficiaries. In comparison, physician groups and physician solo practitioners receiving a QRUR provided 3.7 primary care services per beneficiary to their attributed beneficiaries. Both groups subject to the 2015 Value Modifier and physician groups and physician solo practitioners receiving a QRUR provided about two-thirds of their attributed beneficiaries' primary care services.

On average, groups subject to the 2015 Value Modifier have beneficiaries with relatively high risk scores. Specifically, the average CMS-Hierarchical Condition Categories (CMS-HCC) risk score for beneficiaries attributed to groups subject to the Value Modifier was 1.2.¹² When compared to the average risk score of 1.0 for physician solo practitioners and physician groups

⁹ For purposes of calculating the administrative claims–based quality and cost measures, beneficiaries are attributed to physician solo practitioners and physician groups on the basis of primary care services provided.

¹⁰ PCPs are physicians with one of these specialty designations (CMS specialty codes): family practice (08), general practice (01), geriatric medicine (38), or internal medicine (11). Primary care services include evaluation and management (E&M) services provided in office and other non-inpatient and non-emergency room settings, as well as initial Medicare visits and annual wellness visits. Refer to the Detailed Methodology for the Detailed Methodology for the 2013 QRURs and 2015 Value-Based Payment Modifier document for categorization codes for E&M service categories, available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2013-Detailed-Methodology.pdf>

¹¹ Attribution on the basis of primary care services proceeds in two steps. In the first step, a beneficiary is attributed to a group if the beneficiary receives the plurality of primary care services, as measured by Medicare allowed charges, from the PCPs in the group. If a beneficiary did not receive a primary care service from any PCP, then in the second step a beneficiary is attributed to the group if it (a) received at least one primary care service from a physician of any specialty in the group and (b) received the plurality of the primary care services from non-PCP physicians, nurse practitioners, physician assistants, and clinical nurse specialists in the group.

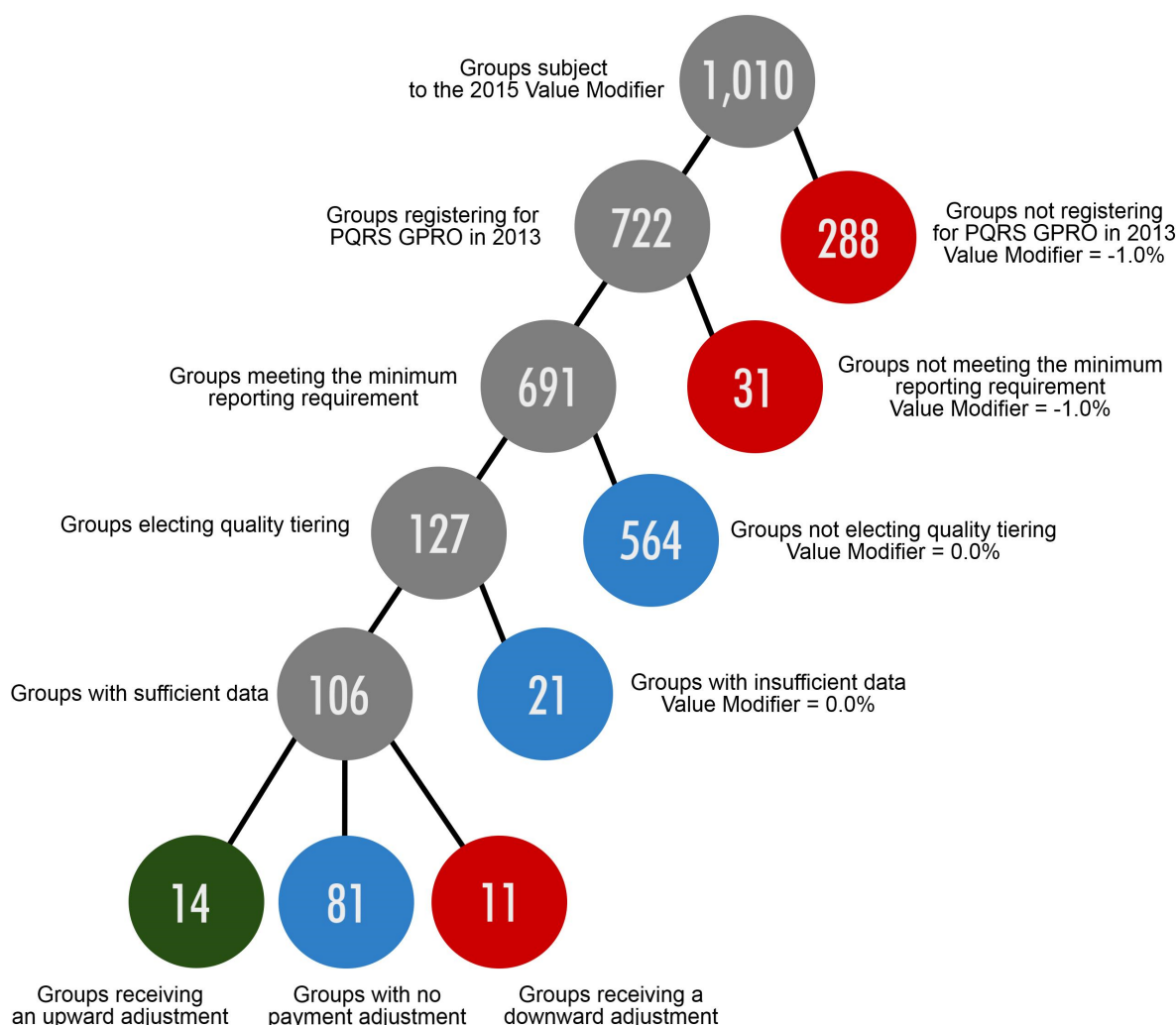
¹² Risk scores predict beneficiaries' health care expenditures relative to the average beneficiary. For example, a beneficiary with a risk score of 1.02 is expected to have expenditures that are 2 percent higher than average.

receiving a 2013 QRUR, this indicates that the average beneficiary attributed to a group subject to the Value Modifier is expected to incur expenditures for Medicare-covered services that are 20 percent higher than the expected expenditures for the average beneficiary.

IV. THE 2015 VALUE MODIFIER, QUALITY-TIERING, AND PERFORMANCE

Figure IV.1 is a flow chart illustrating how many groups were subject to the 2015 Value Modifier, the steps at which a Value Modifier was calculated, and how many groups ultimately received a Value Modifier of -1.0 percent, 0.0 percent, or an upward adjustment.

Figure IV.1. Physician groups subject to the 2015 Value Modifier



PQRS = Physician Quality Reporting System

As illustrated in the figure, 1,010 groups were subject to the 2015 Value Modifier. Of these, 722 registered for a PQRS GPRO in 2013. The 288 groups that did not register for a PQRS GPRO received a Value Modifier of -1.0 percent. Of the 722 groups that registered, 691 met the minimum reporting requirement. The 31 groups that did not meet the minimum reporting

requirement received a Value Modifier of -1.0 percent. Of the 691 that registered for a PQRS GPRO and met the minimum reporting requirement, 127 elected quality-tiering. The 564 groups that did not elect quality-tiering received a Value Modifier of 0.0 percent. Of the 127 groups electing quality-tiering, 106 groups had sufficient data to calculate the Value Modifier.¹³ The 21 groups with insufficient data received a Value Modifier of 0.0 percent. Of the 106 groups with sufficient data, 14 received an upward adjustment, 81 received no payment adjustment, and 11 received a downward adjustment in 2015.

A. Quality-tiering results for the 2015 Value Modifier

In Table IV.1, we present the distribution of the physician groups across tiers. Of the 106 groups that elected quality-tiering and had sufficient data, 11 (10.4 percent) received a downward payment adjustment, 14 (13.2 percent) received an upward payment adjustment, and 81 (76.4 percent) received a neutral payment adjustment.¹⁴ Although most physician groups are classified as average for both quality and cost, performance on quality drove differences in payment adjustments under quality-tiering more than performance on cost did. Of the 11 groups receiving a downward adjustment, 10 had low quality, whereas only 4 had high cost (3 had both low quality and high cost). Of the 14 groups receiving an upward adjustment, 12 had high quality, but only 2 had low cost.

Table IV.1. Distribution of quality and cost tiers of groups for which the Value Modifier was determined by quality-tiering (N=106 groups)

	Low quality	Average quality	High quality
Low cost	0.0% (0)	1.9% (2)	0.0% (0)
Average cost	6.6% (7)	76.4% (81)	11.3% (12)
High cost	2.8% (3)	0.9% (1)	0.0% (0)

Note: The number of groups represented by each cell is in parentheses. Percentages might not add to 100.0 percent because of rounding.

Even though quality-tiering was optional for the 2015 Value Modifier, it will not be optional in subsequent years. In Table IV.2, we display the distribution across quality and cost tiers of the physician groups of 100 or more eligible professionals that registered for a PQRS GPRO and met

¹³ To have sufficient data to calculate a Quality or Cost Composite for the Value Modifier, a physician group must have at least 20 eligible cases for at least one measure that is part of the composite. If a physician group's composite score is at least one standard deviation higher or lower than the composite average (computed across all groups with 100 or more eligible professionals), then, in order for the physician group to have sufficient data, the physician group's composite score must also be statistically significantly different from the composite average. If a physician group's composite score is within one standard deviation of the composite average, then the physician group will always be considered average if it has at least 20 eligible cases for at least one measure that is part of the composite.

¹⁴ Combining the information in Tables II.1 and IV.1, the physician groups receiving a downward payment adjustment consist of seven groups with low quality, average cost scores (payment adjustment of -0.5 percent); three groups with low quality, high cost scores (payment adjustment of -1.0 percent); and one group with average quality, high cost scores (payment adjustment of -0.5 percent). The groups receiving an upward payment adjustment consist of 12 groups with high quality, average cost scores (payment adjustment of 1.0 x AF) and two groups with average quality, low cost scores (payment adjustment of 1.0 x AF). No groups were eligible for the high-risk bonus adjustment, available to high-performing groups that satisfactorily reported PQRS quality measures via the GPRO Web Interface or a qualified registry and whose attributed beneficiaries' average risk score was in the top 25 percent of all beneficiary risk scores.

the minimum reporting requirement. This table illustrates what the distribution of payment adjustments would have been under the hypothetical scenario that all groups subject to the 2015 Value Modifier were also subject to quality-tiering. Both a Quality and Cost Composite could be calculated for 549 of these 691 groups. Most of these groups were classified in the average-cost and average-quality tier (82.0 percent). If all of these groups had been assessed under quality-tiering, 5.6 percent would have received an upward payment adjustment, 82.5 percent would have had a neutral payment adjustment, and 11.8 percent would have received a downward payment adjustment.

Table IV.2. Distribution of quality and cost tiers for all groups subject to the 2015 Value Modifier with both a Quality and Cost Composite Score (N=549 groups)

	Low quality	Average quality	High quality	Total
Low cost	0.4% (2)	1.6% (9)	0.0% (0)	2.0% (11)
Average cost	6.4% (35)	82.0% (450)	4.0% (22)	92.3% (507)
High cost	3.6% (20)	1.8% (10)	0.2% (1)	5.6% (31)
Total	10.4% (57)	85.4% (469)	4.2% (23)	100% (549)

Notes: This table displays the quality and cost categories of 549 groups (out of 1,010 groups that were subject to the 2015 Value Modifier) that registered for a PQRS GPRO, met the minimum reporting requirement, and have both Quality and Cost Composite Scores. This table illustrates how all groups subject to the 2015 Value Modifier would have performed if quality-tiering were mandatory. It includes groups for which the Value Modifier was not actually based on performance under quality-tiering. Percentages might not add to 100.0 percent because of rounding.

As with the quality-tiered physician groups in Table IV.1, under the hypothetical scenario that all groups subject to the 2015 Value Modifier were also subject to quality-tiering, lower performing groups that would have received a downward adjustment are more likely to have low quality (10.0 percent of all groups) than high cost (5.4 percent); and higher performing groups that would have received an upward adjustment are more likely to have high quality (4.2 percent) than low cost (1.6 percent).

B. Performance under the 2015 Value Modifier

In the following sections, we examine characteristics of groups to identify commonalities or differences by payment adjustment category and performance on the Quality and Cost Composites. In the first subsection, we consider the characteristics of the 106 groups that were quality-tiered, by payment adjustment category. In the second subsection, we examine relationships between group characteristics and performance on the Quality and Cost Composites among the 106 groups.

1. Characteristics by payment adjustment level

Among the 106 groups electing quality-tiering, groups receiving an upward payment adjustment were more likely to be larger than groups receiving a downward or neutral payment adjustment. On average, groups receiving an upward payment adjustment also had more physicians (493) compared to groups receiving a downward (231) or neutral (290) payment adjustment. On average, groups receiving an upward payment adjustment had more attributed beneficiaries (11,867) than groups receiving a downward (2,788) or neutral (9,691) payment adjustment (Table IV.3). Examining this another way, among groups in the top quartile for size by attributed beneficiaries, 6 (23 percent) received an upward payment adjustment, 20 (77

percent) received a neutral payment adjustment, and 0 received a downward payment adjustment. Among groups in the bottom quartile, 3 (11 percent) received an upward payment adjustment, 16 (59 percent) received a neutral payment adjustment, and 8 (30 percent) received a downward payment adjustment (Table IV.4).

Table IV.3. Characteristics of groups electing quality-tiering, by payment adjustment category (N=106 groups)

	Upward payment adjustment	Neutral payment adjustment	Downward payment adjustment
Number (percentage) of groups	14 (13.2)	81 (76.4)	11 (10.4)
Average number of physicians	493	290	231
Average number of attributed beneficiaries	11,867	9,691	2,788
Percentage of attributed beneficiaries with specific conditions			
Diabetes	24	27	31
COPD	8	10	13
CAD	26	26	29
Heart failure	10	12	18
Average of group-level CMS-HCC score	1.02	1.11	1.38

Note: The group-level hierarchical condition categories (HCC) score is the average Centers for Medicare & Medicaid Services-HCC score calculated among its attributed beneficiaries.

CAD = coronary artery disease; COPD = chronic obstructive pulmonary disease

Groups receiving an upward payment adjustment also were more likely than others electing quality-tiering to treat lower-risk beneficiaries than groups receiving a downward payment adjustment.¹⁵ The average CMS-HCC risk score among groups receiving an upward payment adjustment was 1.02 versus 1.38 for groups receiving a downward payment adjustment (Table IV.3). Among groups in the highest quartile for average beneficiary risk, 0 received an upward payment adjustment, 18 (69 percent) received a neutral payment adjustment, and 8 (31 percent) received a downward payment adjustment. In contrast, among groups in the lowest quartile, 6 (22 percent) received an upward payment adjustment, 19 (70 percent) received a neutral payment adjustment, and 2 (7 percent) received a downward adjustment (Table IV.5).

¹⁵ Note that all cost measures included in the Value Modifier are risk-adjusted using CMS-HCC risk scores to account for differences in beneficiary-level risk factors that can affect medical costs regardless of the care provided.

Table IV.4. Distribution of groups across performance categories, by group size (N=106 groups)

	Group size based on number of attributed beneficiaries			
	Lowest quartile	Second quartile	Third quartile	Top quartile
Upward Payment Adjustment	3 (11.1%)	2 (7.7%)	3 (11.1%)	6 (23.1%)
Neutral Payment Adjustment	16 (59.3%)	23 (88.5%)	22 (81.5%)	20 (76.9%)
Downward Payment Adjustment	8 (29.6%)	1 (3.9%)	2 (7.4%)	0 (0.0%)

Note: The 106 groups electing quality-tiering were divided into four quartiles, based on their number of attributed beneficiaries.

Table IV.5. Distribution of groups across performance categories, by average beneficiary risk (N=106 groups)

	Average CMS-HCC risk score			
	Lowest quartile	Second quartile	Third quartile	Top quartile
Upward Payment Adjustment	6 (22.2%)	5 (19.2%)	3 (11.1%)	0 (0.0%)
Neutral Payment Adjustment	19 (70.4%)	21 (80.8%)	23 (85.2%)	18 (69.2%)
Downward Payment Adjustment	2 (7.4%)	0 (0.0%)	1 (3.7%)	8 (30.8%)

Note: The 106 groups electing quality-tiering were divided into four quartiles, based on their attributed beneficiaries' average CMS-HCC risk score.

CMS-HCC = Centers for Medicare & Medicaid Services-hierarchical condition categories

Moreover, for each of the four chronic conditions pertaining to condition-specific cost—diabetes, COPD, CAD, and heart failure—we looked at the percentage of attributed beneficiaries with the condition. Groups receiving an upward payment adjustment had a lower percentage of beneficiaries with each of these conditions than groups receiving a neutral payment adjustment or a downward payment adjustment.

2. Payment adjustment–level performance

By construction, physician groups receiving an upward payment adjustment were more likely to have higher quality and/or lower costs compared to groups receiving a neutral or downward payment adjustment, and their performance on three administrative claims–based outcome measures and five per capita cost measures reflected this. Groups receiving an upward payment adjustment had fewer admissions on average for Acute and Chronic ACSCs compared to groups receiving a downward payment adjustment (Table IV.6). Such groups also had fewer hospital readmissions within 30 days (14.3 percent versus 16.7 percent, respectively). Their average risk-adjusted total per capita cost was also lower, at \$9,228 compared to \$12,555 for groups receiving a downward adjustment. The share of attributed beneficiaries with emergency services not resulting in a hospital admission—a metric reported in the QRUR, but not included in calculating the Value Modifier—was also lower for groups receiving an upward payment adjustment compared to those receiving a downward payment adjustment (29.6 percent compared to 46.0 percent, respectively).

The difference in performance rates between groups that receive a downward payment adjustment and groups that receive a neutral payment adjustment is larger than the difference in performance rates between groups that receive an upward payment adjustment and groups that receive a neutral payment adjustment. For example, the difference in the average Acute ACSC Composite rate between groups receiving an upward payment adjustment and groups receiving a neutral payment adjustment is 1.4 admissions per 1,000 beneficiaries. However, the corresponding difference between groups receiving a downward payment adjustment and groups receiving a neutral payment adjustment is much greater, at 5.1 admissions per 1,000 beneficiaries.

Table IV.6. Performance measures and other statistics of groups electing quality-tiering, by payment adjustment category (N=106 groups)

	Upward payment adjustment	Neutral payment adjustment	Downward payment adjustment
Measures included in Value Modifier			
Average Acute ACSC Composite rate ^a	4.7	6.1	11.2
Average Chronic ACSC Composite rate ^a	42.2	50.4	65.7
Average 30-day All-Cause Hospital Readmission rate	14.3%	15.3%	16.7%
Per capita cost measures (dollars)			
Overall	9,228	9,630	12,555
Diabetes	13,313	13,845	18,086
COPD	22,008	22,115	27,776
CAD	15,334	16,212	20,396
Heart failure	23,688	23,918	29,250
Other statistics reported in QRUR			
Percent of beneficiaries with emergency services that did not result in a hospital admission	29.6	34.0	46.0

^a Per 1,000 beneficiaries.

ACSC = ambulatory care-sensitive conditions; CAD = coronary artery disease; CMS-HCC = Centers for Medicare & Medicaid Services-hierarchical condition categories; COPD = chronic obstructive pulmonary disease; QRUR = Quality and Resource Use Report

3. Composite-level performance

Table IV.7 shows the average performance of quality-tiered groups in each quality category along a number of dimensions, including average Quality and Cost Scores, average quality domain scores, and average performance measure scores for four selected measures: the three administrative claims–based quality outcome measures and Per Capita Costs for All Attributed Beneficiaries. Domain scores are the average of the standardized scores of measures within the domain. Measures are standardized to indicate performance relative to the peer group mean (benchmark), measured in standard deviations. A negative domain score indicates performance that is worse than the average for all groups for which the domain score could be calculated. Similarly, a positive domain score indicates better than average performance for the domain. Domain scores between –1.0 and 1.0 indicate performance within one standard deviation of average performance, whereas scores outside this range indicate performance that is more than one standard deviation from average.

Table IV.7. Average performance of groups by quality tier (N=106 groups)

Performance metric	Quality tier		
	Low	Average	High
Quality Composite Score	-1.2	0.3	1.0
Clinical Process/Effectiveness domain score	-2.0	0.3	1.1
Patient and Family Engagement domain score			
Population/Public Health domain score	-1.4	0.2	0.6
Patient Safety domain score	-0.4	0.4	1.3
Care Coordination domain score	-0.4	0.4	0.8
Acute ACSC Composite rate ^a	11.4	6.0	5.0
Chronic ACSC Composite rate ^a	65.9	50.1	44.1
30-day All-Cause Hospital Readmission rate	16.8%	15.3%	14.1%
Efficient Use of Health Care Resources domain score			
Cost Composite Score	1.2	-0.3	-0.2
Per Capita Costs for All Attributed Beneficiaries (dollars)	12,107	9,634	9,750
Per Capita Costs for Beneficiaries with Specific Conditions (dollars)			
Diabetes	17,644	13,828	14,059
COPD	26,454	22,210	22,897
CAD	19,572	16,216	16,199
Heart failure	28,135	23,910	25,082

Note: Measures are standardized to indicate performance relative to the peer group mean (benchmark), measured in standard deviations. Domain scores are the (equally-weighted) average of standardized measure scores in the domain. The average composite scores are the (equally-weighted) average of nonmissing domain scores. Acute and Chronic ACSC Composite measures are expressed as rates per 1,000 beneficiaries. The 30-day All-Cause Hospital Readmission measure is expressed as the rate of acute care hospital readmissions per 100 index admissions. Higher Cost Composite Scores indicate worse performance.

^a Per 1,000 beneficiaries.

ACSC = ambulatory care-sensitive conditions; CAD = coronary artery disease; COPD = chronic obstructive pulmonary disease

Groups categorized as high quality overall scored consistently better across all domains, on average, than groups categorized as average or low quality. These groups also scored better on all three administrative claims-based quality outcome measures included in the Care Coordination domain. Groups categorized as high quality overall also had lower cost (on average, Per Capita Costs for All Attributed Beneficiaries of \$9,750) than groups categorized as low quality (on average, Per Capita Costs for All Attributed Beneficiaries of \$12,107).

Table IV.8 displays the average performance of quality-tiered groups in each cost category. Groups classified as low cost performed better in all quality domains than groups classified as high cost. Low cost groups performed slightly worse than average cost groups on the Clinical Process/Effectiveness and Patient Safety domains while performing slightly better on the Care Coordination domain.

Table IV.8. Average performance of groups by cost tier (N=106 groups)

Performance metric	Cost tier		
	Low	Average	High
Quality Composite Score	0.2	0.3	-0.7
Clinical Process/Effectiveness domain score	-0.4	0.2	-0.7
Patient and Family Engagement domain score			
Population/Public Health domain score		0.2	
Patient Safety domain score	0.2	0.6	-0.4
Care Coordination domain score	0.9	0.4	-0.7
Acute ACSC Composite rate ^a	2.6	6.2	15.0
Chronic ACSC Composite rate ^a	31.2	50.5	70.8
30-day All-Cause Hospital Readmission rate	15.9%	15.3%	16.9%
Efficient Use of Health Care Resources domain score			
Cost Composite Score	-2.4	-0.3	4.2
Per Capita Costs for All Attributed Beneficiaries (dollars)	6,095	9,644	17,699
Per Capita Costs for Beneficiaries with Specific Conditions (dollars)			
Diabetes	8,839	13,926	24,126
COPD	16,671	22,248	36,718
CAD	10,145	16,158	29,027
Heart failure	15,325	23,920	42,025

Notes: Measures are standardized to indicate performance relative to the peer group mean (benchmark), measured in standard deviations. Domain scores are the (equally-weighted) average of standardized measure scores in the domain. The average composite scores are the (equally-weighted) average of nonmissing domain scores. Acute and Chronic ACSC Composite measures are expressed as rates per 1,000 beneficiaries. The 30-day All-Cause Hospital Readmission measure is expressed as the rate of acute care hospital readmissions per 100 index admissions. Higher Cost Composite Scores indicate worse performance.

^a Per 1,000 beneficiaries.

ACSC = ambulatory care-sensitive conditions; CAD = coronary artery disease; COPD = chronic obstructive pulmonary disease

4. Performance by physician group type

Groups electing to report PQRS measures via the GPRO Web Interface or a qualified registry were more likely to elect quality-tiering than groups that elected the CMS-calculated administrative claims option who were subject to the 2015 Value Modifier (Table IV.9). Of the 258 groups that registered for the GPRO Web Interface or a registry, 227 (88.0 percent) met the minimum reporting requirement, and 64 (24.8 percent) elected quality-tiering. Of the remaining 752 groups subject to the 2015 Value Modifier, 464 (61.7 percent) registered and elected the CMS-calculated administrative claims option as a group, with 63 (8.4 percent) electing quality-tiering.

Table IV.9. Groups subject to the Value Modifier by group type (N=1,010)

Group type	Number of groups subject to the Value Modifier	Number and percent of groups that registered for PQRS GPRO		Number and percent of groups that met minimum reporting requirement		Number and percent of groups that elected quality-tiering	
All groups	1,010	722	71.5%	691	68.4%	127	12.6%
Groups that elected GPRO Web Interface or a registry	258	258	100.0%	227	88.0%	64	24.8%
Groups that elected the administrative claims option	464	464	100.0%	464	100.0%	63 ^a	13.6%
Other groups subject to the Value Modifier	288	0	0.0%	0	0.0%	0	0.0%

Notes: All percentages are relative to the first column (number of groups subject to the Value Modifier).

^a Of the 63 groups electing the administrative claims option and electing quality-tiering, 21 did not have sufficient data to calculate a Quality and/or Cost Composite Score. All groups electing the GPRO Web Interface or registry reporting option had sufficient data.

GPRO = Group Practice Reporting Option

Table IV.10 displays the performance of quality-tiered physician groups by group type, distinguishing groups by specialty mix and whether the group reported PQRS data via the GPRO Web Interface or registry or elected the CMS-calculated administrative claims option. A larger proportion of groups reporting via the GPRO Web Interface or registry received upward adjustments (14.1 percent), compared to groups electing the CMS-calculated administrative claims option (11.9 percent), and a smaller proportion received downward adjustments (7.8 versus 14.3 percent).

Table IV.10. Performance of groups by group type (N=106 groups)

Group type	Number of groups	Upward payment adjustment		Neutral payment adjustment		Downward payment adjustment	
All groups	106	14	13.2%	81	76.4%	11	10.4%
Groups electing the GPRO Web Interface or registry	64	9	14.1%	50	78.1%	5	7.8%
Groups electing the administrative claims option	42	5	11.9%	31	73.8%	6	14.3%
Groups with up to 50% eligible professionals in same specialty	102	13	12.7%	80	78.4%	9	8.8%
Groups with more than 50% eligible professionals in same specialty	4	1	25.0%	1	25.0%	2	50.0%
Groups with up to 50% PCPs	98	12	12.2%	75	76.5%	11	11.2%
Groups with more than 50% PCPs	8	2	25.0%	6	75.0%	0	0.0%

GPRO = Group Practice Reporting Option; PCP = primary care physician

5. Performance by physician specialty

Physicians of 62 different specialties practice in the 1,010 physician groups subject to the Value Modifier. To identify which of the more common specialties are associated with upward

or downward payment adjustments, we analyzed the 34 specialties with more than 1,000 physicians practicing in the 1,010 groups subject to the Value Modifier.¹⁶

As shown in Table IV.11, the five large specialties with the largest share of physicians in groups with an upward payment adjustment are (in descending order) gastroenterology, dermatology, endocrinology, obstetrics/gynecology, and physical medicine and rehabilitation. These specialists are in the 14 groups that, besides registering for a PQRS GPRO and meeting the minimum reporting requirement, had elected quality-tiering and scored among the higher-performing groups (at least average performance on quality and cost measures and better than average performance on quality, cost, or both). Among all gastroenterologists practicing in the 1,010 groups subject to the Value Modifier, 5.5 percent practiced in groups that will receive an upward payment adjustment.

Table IV.11. Specialties with largest share in groups receiving an upward payment adjustment

Specialty description	Number of specialists in groups subject to the value modifier	Percent in group with upward payment adjustment due to performance
Gastroenterology	4,178	5.5
Dermatology	2,539	5.4
Endocrinology	2,520	5.0
Obstetrics/Gynecology	10,823	4.9
Physical Medicine and Rehabilitation	2,066	4.8
Neurology	5,882	4.2
Podiatry	1,406	4.0
Radiation Oncology	1,691	3.9
Infectious Disease	2,608	3.8
Vascular Surgery	1,188	3.8

Note: Specialist counts reflect unique physician-group combinations, rather than unique physicians. Thus, physicians billing under the TIN of multiple groups are counted multiple times. The “Percent in Group with Upward Payment Adjustment Due to Performance” is, for a given specialty, the number of physicians billing under the 14 TINs receiving an upward payment adjustment, as a percentage of all physicians of that specialty billing under the 1,010 TINs subject to the 2015 Value Modifier.

Among the ten large specialties listed in Table IV.12, the percentage of specialists in groups receiving a downward payment adjustment (relative to those in the 1,010 groups subject to the Value Modifier) ranges from 52.6 percent for optometrists to 27.7 percent for critical care (intensivists). The five large specialties with the largest share of physicians in groups with a downward adjustment are optometry, podiatry, psychiatry, urology, and ophthalmology. A specialist’s group could have a downward payment adjustment for one of three reasons: (1) the group did not register for the GPRO Web Interface, registry, or administrative claims option, (2) the group registered, but did not meet the minimum reporting requirement, or (3) the group elected quality-tiering and performed poorly on quality and/or cost measures. For all specialties listed in Table IV.12, failure to register is the most common reason that these specialists’ groups received a downward payment adjustment.

¹⁶ The physician counts in this section reflect unique physician-group combinations. Therefore, any physician billing under the TINs of multiple groups is counted multiple times in this analysis.

Table IV.12. Specialties with largest share in groups receiving a downward payment adjustment

Specialty description	Number of specialists in groups subject to the Value Modifier	Percent in groups with downward payment adjustment	Percent in groups that did not register	Percent in groups that did not meet minimum reporting requirement	Percent in groups with downward payment adjustment due to performance
Optometry	1,762	52.6	51.8	0.6	0.3
Podiatry	1,406	40.4	35.4	2.1	2.9
Psychiatry	7,729	40.3	36.6	2.1	1.5
Urology	3,132	30.9	25.4	4.8	0.7
Ophthalmology	3,803	30.1	27.0	1.9	1.1
Internal Medicine	41,284	28.9	25.2	2.3	1.4
Pediatric Medicine	5,737	28.6	26.3	1.7	0.6
Emergency Medicine	19,084	28.3	25.9	1.7	0.7
Family Practice	27,787	28.0	25.3	2.3	0.5
Critical Care (Intensivists)	1,727	27.7	22.2	3.2	2.3

Note: Specialist counts reflect unique physician-group combinations, rather than unique physicians. Thus, physicians billing under the TIN of multiple groups are counted multiple times. Each of the last four columns displays, by specialty, the number of physicians billing under a TIN described by the column header, as a percentage of all physicians of that specialty billing under the 1,010 TINs subject to the 2015 Value Modifier. 330 groups received a downward payment adjustment: 288 groups did not register, 31 groups did not meet the minimum reporting requirement, and 11 groups received a downward adjustment due to performance under quality-tiering.