COMPUTATION OF THE 2016 VALUE MODIFIER

Overview

The Value-Based Payment Modifier Program adjusts Medicare Physician Fee Schedule (PFS) payments to a physician or group of physicians (as identified by their Taxpayer Identification Number [TIN]), based on the quality and cost of care furnished to their Medicare Fee-for-Service (FFS) beneficiaries.

What is the Value Modifier?

Section 3007 of the 2010 Patient Protection and Affordable Care Act (ACA) directs the Secretary of the U.S. Department of Health and Human Services to establish a budget-neutral Value-Based Payment Modifier (referred to here as the Value Modifier) that provides for differential payment under the Medicare PFS to a physician or group of physicians based upon the quality of care compared to the cost of care furnished to Medicare FFS beneficiaries during a performance period. The Value Modifier is separate from the payment adjustment and incentives under the Physician Quality Reporting System (PQRS). This fact sheet summarizes what the Value Modifier is and how it will be implemented for Medicare PFS payments in 2016. For more detailed information, see the Detailed Methodology for the 2016 Value Modifier and the 2014 Quality and Resource Use Report available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html.

Who will be subject to the Value Modifier?

Beginning January 1, 2015, the Value Modifier was applied to physician payments under the Medicare PFS for physicians in TINs with 100 or more eligible professionals,[1] provided that at least one physician submitted a Medicare claim during 2013 under the TIN. Calendar year (CY) 2013 was the performance period for the Value Modifier that was applied in 2015.

Beginning January 1, 2016, the Value Modifier will be applied to physician payments under the Medicare PFS for physicians in TINs with 10 or more eligible professionals, provided that at least one physician submitted a Medicare claim during 2014 under the TIN. CY 2014 is the performance period for the Value Modifier that will be applied in 2016.

In 2015 and 2016, CMS will not apply the Value Modifier to TINs in which one or more physicians in the TIN participated in the Medicare Shared Savings Program, the Pioneer Accountable Care

[1] Eligible professionals include physicians, practitioners, physical or occupational therapists, qualified speech-language pathologists, and qualified audiologists. For a list of providers designated as eligible professionals by CMS based on their two-digit CMS specialty codes, see the Detailed Methodology for the 2016 Value Modifier and the 2014 Quality and Resource Use Report, available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html

Organization (ACO) Model, or the Comprehensive Primary Care (CPC) initiative during the relevant performance period.

Beginning January 1, 2017, the Value Modifier will be applied to physician payments under the Medicare PFS for physician solo practitioners and physicians in groups with two or more eligible professionals, as identified by their TIN. CY 2015 is the performance period for the Value Modifier that will be applied in 2017. CMS provides specific policies through rulemaking regarding application of the Value Modifier to TINs participating in Medicare Shared Savings Program ACOs, Pioneer ACOs, the CPC initiative, and other similar initiatives.

How will Value Modifier payment adjustments be applied in 2016?

As it did in 2015, CMS will divide TINs subject to the 2016 Value Modifier into two categories on the basis of their registration and participation in the PQRS for the 2014 performance period:

- Category 1 will include TINs that met the criteria as a group to avoid the 2016 PQRS payment adjustment or in which at least 50 percent of eligible professionals in the TIN met the criteria to avoid the 2016 PQRS payment adjustment as individuals. For TINs in Category 1, the 2016 Value Modifier will be calculated based on the TIN's quality and cost performance in 2014, using CMS's quality-tiering methodology.
- Category 2 will include TINs subject to the 2016 Value Modifier that do not meet the criteria for inclusion in Category 1. For Category 2 TINs, the 2016 Value Modifier will be set at –2.0% (a downward payment adjustment). The Value Modifier payment adjustment applies in addition to any PQRS negative payment adjustment the TIN or individual eligible professionals in the TIN may incur.

CMS calculates the 2016 Value Modifier for Category 1 TINs using a quality-tiering approach based on their 2014 performance. Under quality-tiering, all TINs with 10 or more eligible professionals can earn an upward payment adjustment for demonstrating higher quality and/or lower cost, as shown in Tables 1 and 2. Because the Value Modifier each year must be budget-neutral, the size of the upward adjustment will be based on an adjustment factor (AF) calculated to redistribute downward adjustments from low-performing TINs and Category 2 TINs to the higher-performing TINs. The precise size of the AF will vary from year to year based on performance, reporting status, and projected billings. High-performing TINs that treat high-risk beneficiaries are also eligible for an additional upward payment adjustment of +1.0 times the AF.

Physicians in Category 1 TINs with 10 to 99 eligible professionals could receive an upward or neutral (meaning no adjustment) adjustment and will be held harmless from any downward payment adjustment in 2016 (Table 1). However, physicians in TINs with 100 or more eligible professionals can receive an upward, neutral, or downward payment adjustment in 2016 based on the TINs' performance on quality and cost measures in 2014 (Table 2).

Table 1. Quality-tiering categories and 2016 payment adjustment for TINs with 10 to 99 eligible professionals

	Low quality	Average quality	High quality
Low cost	0.0%	+1.0 x AF*	+2.0 x AF*
Average cost	0.0%	0.0%	+1.0 x AF*
High cost	0.0%	0.0%	0.0%

* Higher-performing TINs treating high-risk beneficiaries (based on mean CMS-HCC risk scores) will receive an additional adjustment of +1.0 x AF.

Table 2. Quality-tiering categories and 2016 payment adjustment for TINs with 100 or more eligible professionals

	Low quality	Average quality	High quality
Low cost	0.0%	+1.0 x AF*	+2.0 x AF*
Average cost	–1.0%	0.0%	+1.0 x AF*
High cost	–2.0%	–1.0%	0.0%

* Higher-performing TINs treating high-risk beneficiaries (based on mean CMS Hierarchical Condition Category [HCC] risk scores) will receive an additional adjustment of +1.0 x AF.

Quality and Cost Composite Score calculations

The Quality and Cost Composite Scores used for quality-tiering summarize each TIN's performance on quality measures across six quality domains and on cost measures across two cost domains, as shown in Table 3. For information on the measures included in each domain, please see the Detailed Methodology for the 2016 Value Modifier and the 2014 Quality and Resource Use Report available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html.

Table 3. Measure domains in the Quality and Cost Composite Scores

Quality domains	Cost domains
1. Effective Clinical Care 2. Person and Caregiver-Centered Experience and Outcomes 3. Community/Population Health 4. Patient Safety 5. Communication and Care Coordination 6. Efficiency and Cost Reduction	1. Per Capita Costs for All Attributed Beneficiaries 2. Per Capita Costs for Beneficiaries with Specific Conditions

How is measure performance calculated?

The calculation of composite scores begins by standardizing performance on individual quality and cost measures for which the TIN has at least 20 eligible cases and a comparative benchmark is available.[2] Standardizing measure performance transforms measures with disparate scales to a common scale, which enables different measures to be compared and combined with one another into a composite. Measure-level performance is standardized by subtracting the benchmark for the measure from the TIN's performance rate and dividing by the case-weighted standard deviation of the measure.

For 2016 Value Modifier calculations, the benchmark for each quality measure is the case-weighted mean performance rate for the measure in the year prior to the performance year (in this case, 2013), where the mean is calculated for the peer group for that measure. The benchmark for cost measures is the case-weighted mean performance rate for the measure in the performance year (2014), where the mean is calculated for the peer group for that measure. For each quality measure, the peer group for the measure is composed of all TINs nationwide that had at least 20 eligible cases for the measure during the year prior to the performance year. For each cost measure, the peer group for the measure is composed of all TINs nationwide that had at least 20 eligible cases for the measure during the performance year. For case weights, the performance of each TIN in the peer group receives a weight equal to the number of eligible cases the TIN had for the specific measure. Additional information on the benchmarks for the 2014 Quality and Resource Use Reports (QRURs) is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.

How are domain scores calculated?

Domain scores are calculated as the equally-weighted mean of the TIN's standardized measure scores within the domain. Domain scores only include measures for which the TIN has at least 20 cases and benchmarks are available. A domain score is not calculated for TINs that do not have any measures in the domain with at least 20 eligible cases.

How are composite scores calculated?

Each overall composite score is calculated, first, as the equally-weighted mean of the TIN's domain performance scores, if the TIN has a score for at least one domain included in the composite. An overall composite score is not calculated for TINs that do not have at least one domain score included in the composite. For both Quality and Cost Composite Scores, each TIN's mean domain score is then standardized to generate a distribution of mean domain scores centered at 0 and with a standard deviation of 1 by subtracting the peer group's mean domain score from the TIN's mean domain score and dividing the result by the peer group's mean domain score standard deviation. The standardized mean Quality

[2] Measures for which no benchmark is available are not included in Value Modifier calculations, but measure results are included in the QRURs for informational purposes.

Domain Score is the TIN's Quality Composite Score, and the standardized mean Cost Domain Score is the TIN's Cost Composite Score.

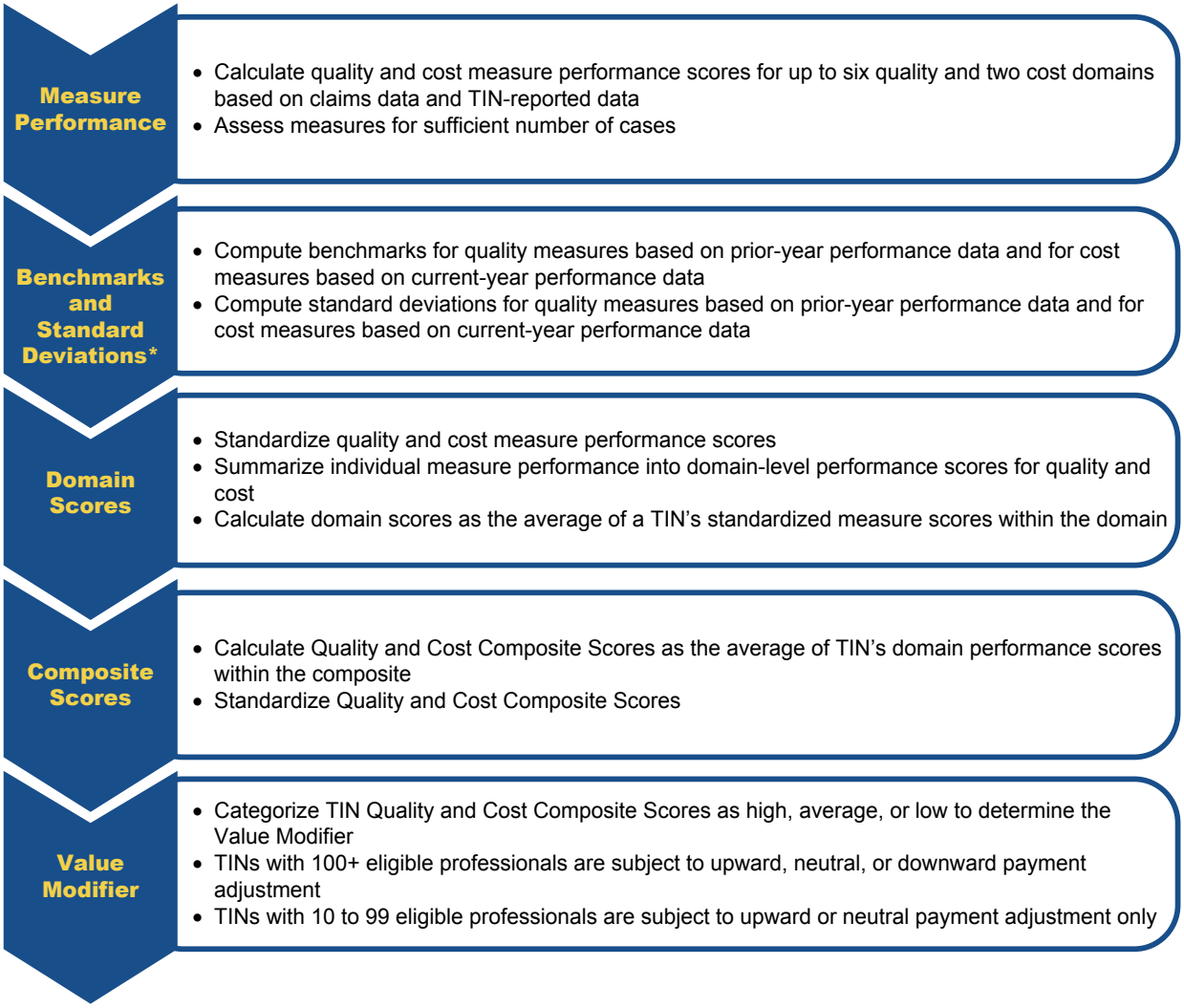
At the composite score calculation level, the peer group for TINs with 10 or more eligible professionals is all TINs with 10 or more eligible professionals that are subject to the Value Modifier and for which a mean domain score can be computed. This enables TINs subject to the Value Modifier (based on group size of ten or more eligible professionals) to be compared at the composite level to other groups subject to the Value Modifier. The peer group for TINs with fewer than ten eligible professionals is all TINs with one or more eligible professionals and at least one physician (excluding TINs that participated in the Medicare Shared Savings Program, Pioneer ACO Model or the CPC initiative in 2014) and for which a mean domain score can be computed.

How are Value Modifier adjustment categories determined?

For Category 1 TINs, CMS uses the Quality and Cost Composite Scores to determine whether TINs receive an upward, neutral, or downward payment adjustment and the magnitude of the adjustment through quality-tiering. To be considered either a high or a low performer in quality, a TIN's Quality Composite Score must be at least one standard deviation above or below the mean quality composite score for the peer group and must be statistically significantly different from the mean quality composite score for the peer group. Similarly, to be considered either a high or a low performer in cost, a TIN's Cost Composite Score must be at least one standard deviation above or below the mean cost composite score for the peer group and must be statistically significantly different from the mean cost composite score for the peer group. If the TIN's Quality or Cost Composite Score is within one standard deviation of the mean composite score for the peer group or is not statistically significantly different, then the TIN's performance is designated as average.

Figure 1 summarizes the process for determining each TIN's Value Modifier.

Figure 1. Methodology for Determining the 2016 Value Modifier for Category 1 TINs



*The performance rates of TINs with fewer than 20 eligible cases for a given cost or quality measure are excluded from the calculation of the benchmark for the measure

Calculating a Value Modifier Payment Adjustment: An example

Below is a hypothetical example of how the 2016 Value Modifier payment adjustment would be calculated for a TIN with 100 or more eligible professionals that does not treat high-risk beneficiaries (based on mean CMS-HCC risk scores).

Table 4 illustrates the calculation of a Cost Composite Score. The Cost Composite consists of two equally-weighted domains: (1) Per Capita Costs for All Attributed Beneficiaries and (2) Per Capita Costs

for Beneficiaries with Specific Conditions. The former domain includes two measures: Per Capita Costs for All Attributed Beneficiaries and Medicare Spending per Beneficiary (MSPB). The latter domain includes four condition-specific measures that summarize per capita costs for beneficiaries with the following chronic conditions: diabetes, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), and heart failure.

As described above, we begin by computing standardized scores for each of the six measures within the Cost Composite. These are calculated by subtracting the measure's benchmark cost for the peer group (column C in Table 4) from the TIN's risk-adjusted per capita cost (column B) and dividing by the peer group's benchmark cost standard deviation (column D). The result is the standardized score for the individual cost measure (column E). For example, in Table 4, the TIN's Per Capita Costs for All Attributed Beneficiaries (row 1) is $17,795, the benchmark is $10,370, and the standard deviation is $1,864. Therefore, the standardized score for this measure is ($17,795 – $10,370) / $1,864 = 3.98. This rate is also the domain score (row 3) because it is the only measure in this domain for which there are at least 20 eligible cases (this TIN had no eligible cases for the MSPB measure [row 2]).

The second domain score for Per Capita Costs for Beneficiaries with Specific Conditions is the mean of the standardized scores for the diabetes (row 4) and heart failure (row 7) measures. Note that the COPD and CAD measures (rows 5 and 6, respectively) are not included (column F) because there are fewer than 20 eligible cases for each measure (column A). Therefore, the domain score is (4.64 + 0.72) / 2 = 2.68 (row 8).

With each of the two domain scores calculated (rows 3 and 8, column E), the mean cost domain score for the TIN may now be computed as (3.98 + 2.68) / 2 = 3.33 (row 9). The TIN's peer group for the Cost Composite Score is all TINs with 10 or more eligible professionals that are subject to the Value Modifier and for which a mean domain score can be computed. The final step in calculating the TIN's Cost Composite Score is to standardize its mean cost domain score by subtracting the peer group mean of the mean cost domain score (0.16, row 10, column C) from the TIN's mean cost domain score (3.33, row 9) and dividing by the standard deviation of mean cost domain scores within the peer group (2.96, row 10, column D), yielding a standardized Cost Composite Score of 1.07 (row 11). A Cost Composite Score of 1.07 means that the TIN's Cost Composite Score is 1.07 standard deviations higher than the mean Cost Composite Score for the TIN's peer group, reflecting the TIN's higher risk-adjusted costs across the individual performance measures. To be considered either a high or low performer relative to its peers on the Cost Composite Score, a TIN's Cost Composite Score must be at least one standard deviation above or below the mean cost composite score for the peer group and must be statistically significantly different from the mean cost composite score for the peer group. In this example, the TIN's Cost Composite Score of 1.07 is not statistically significantly different from the mean,[3] in which case the TIN's cost performance would be designated as average.

The computation of the Quality Composite Score is analogous to the calculation of the Cost Composite Score, differing only in the specific measures and domains that constitute the composite. For

[3] Computations related to statistical significance testing are not shown.

this example, let's assume the TIN's Quality Composite Score is 1.67, and that 1.67 is statistically significantly different from the mean. As a result, this TIN's quality performance would be designated as high quality. For more detailed information on the calculations of Quality and Cost Composite Scores, see the Detailed Methodology for the 2016 Value Modifier and the 2014 Quality and Resource Use Report available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html.

Given that the TIN was categorized as high quality and average cost, physicians billing under the TIN would receive an upward Medicare PFS payment adjustment of +1.0 times the AF in 2016.

Table 4. Example Cost Composite Score Computation

		TIN's number of eligible cases (A)	TIN's risk-adjusted per capita cost (B)	Benchmark (mean) (C)	Standard deviation (D)	Standardized score (E)	Included in domain score (F)
(1)	Per Capita Costs for All Attributed Beneficiaries	207	$17,795	$10,370	$1,864	3.98	Yes
(2)	MSPB	0	—	$8,975	$1,234	—	No
(3)	Domain Score: Per Capita Costs for All Attributed Beneficiaries (from Row 1)					3.98	
(4)	Per Capita Costs for Beneficiaries with Diabetes	84	$28,153	$14,946	$2,848	4.64	Yes
(5)	Per Capita Costs for Beneficiaries with COPD	18	$26,240	$24,270	$4,934	0.40	No
(6)	Per Capita Costs for Beneficiaries with CAD	4	$22,140	$17,333	$3,384	1.42	No
(7)	Per Capita Costs for Beneficiaries with Heart Failure	54	$30,157	$26,190	$5,537	0.72	Yes
(8)	Domain Score: Per Capita Costs for Beneficiaries with Specific Conditions					2.68	
(9)	Mean Cost Domain Score					3.33	
(10)	Peer Group Mean & S.D. of Mean Cost Domain Score (TINs with 10+ eligible professionals)			0.16	2.96		
(11)	Standardized Cost Composite Score					1.07	

Where can TINs find their 2016 Value Modifier and their Quality and Cost Composite Scores?

In September 2015, CMS made available the 2014 Annual Quality and Resource Use Reports (QRURs) to every group practice and solo practitioner nationwide. Groups and solo practitioners are identified in the QRURs by their TIN. Authorized representatives of TINs can access the 2014 Annual QRURs at https://portal.cms.gov using an Enterprise Identity Data Management (EIDM) account with the correct role. For more information on how to access the 2014 Annual QRURs, please visit the How to Obtain a QRUR website.

The quality and cost data contained in the 2014 Annual QRURs are used to calculate the 2016 Value Modifier. For TINs with 10 or more eligible professionals that are subject to the 2016 Value Modifier, the 2014 Annual QRURs show how payments to physicians in the TIN will be affected by the Value Modifier in 2016, including any upward, neutral, or downward payment adjustment. For TINs with less than 10 eligible professionals, the QRURs are for informational purposes only and their Medicare payments will not be affected by the Value Modifier in 2016. Educational documents on the QRURs are available on the 2014 QRUR website.