COMPUTATION OF THE 2017 VALUE MODIFIER

Overview

The Value-Based Payment Modifier (Value Modifier) adjusts Medicare Physician Fee Schedule (PFS) payments to a physician or group of physicians (as identified by their Medicare-enrolled Taxpayer Identification Number [TIN]), based on the quality and cost of care furnished to their Medicare Fee-for-Service (FFS) beneficiaries. This fact sheet summarizes the computation of the 2017 Value Modifier. More detailed information on the computation of the 2017 Value Modifier is available on the 2015 QRUR and 2017 Value Modifier website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html

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 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 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 2017.

Who will be subject to the Value Modifier in 2017?

In calendar year (CY) 2017, the Value Modifier will apply to physician payments under the Medicare PFS for physicians in groups with 2 or more eligible professionals and physician solo practitioners, including those who participated in a Medicare Shared Savings Program Accountable Care Organization (ACO) in 2015. Eligible professionals consist of physicians, practitioners, physical or occupational therapists, qualified speech-language pathologists, and qualified audiologists. Groups and solo practitioners are identified by their Medicare-enrolled TIN. In 2017, the Value Modifier will not be applied to payments for non-physician eligible professionals.

In 2017, the application of the Value Modifier is waived for groups and solo practitioners, as identified by their Medicare-enrolled TIN, if at least one eligible professional who billed for Medicare PFS items and services under the TIN during 2015 participated in the Pioneer ACO Model or the Comprehensive Primary Care initiative in 2015 and none of the TIN's eligible professionals participated in a Shared Savings Program ACO in 2015. CY 2015 is the performance period for the Value Modifier that will be applied in 2017.

How will Value Modifier payment adjustments be applied in 2017?

CMS will divide TINs subject to the 2017 Value Modifier into two categories on the basis of their participation in the PQRS during 2015:

- Category 1 will include TINs subject to the 2017 Value Modifier that met the criteria to avoid the 2017 PQRS payment adjustment as a group or for which at least 50 percent of the eligible professionals in the TIN met the criteria to avoid the 2017 PQRS payment adjustment as individuals; for physician solo practitioners, Category 1 will include TINs that met the criteria to avoid the 2017 PQRS payment adjustment as individuals. TINs with at least one eligible professional participating in a Shared Savings Program ACO in 2015 will be included in Category 1 if their ACO successfully reported quality data to the PQRS through the Group Practice Reporting Option (GPRO) Web Interface as required by the Shared Savings Program to avoid the 2017 PQRS payment adjustment. For TINs in Category 1 (with the exception of those that participated in a Shared Savings Program ACO in 2015), the 2017 Value Modifier will be calculated based on the TIN's quality and cost performance in 2015, using CMS's quality-tiering methodology. For those Category 1 TINs that participated in a Shared Savings Program ACO in 2015, the Value Modifier will be based on the ACO's quality performance in 2015.
- Category 2 will include TINs subject to the 2017 Value Modifier that do not meet the criteria for inclusion in Category 1. For Category 2 TINs, the 2017 Value Modifier will be set at negative two percent (–2.0%) (a downward payment adjustment) for physicians billing under TINs with between 1 and 9 eligible professionals and at negative four percent (–4.0%) (a downward payment adjustment) for physicians billing under TINs with 10 or more eligible professionals. The Value Modifier payment adjustment is applied separately to any PQRS negative payment adjustment the TIN or individual eligible professionals in the TIN may incur.

CMS calculates the 2017 Value Modifier for Category 1 TINs using a quality-tiering approach based on their 2015 performance. The approach can result in an upward, neutral, or downward payment adjustment to physicians billing under the TIN in 2017 based on the TIN's performance on quality and cost measures and the number of eligible professionals in the TIN in 2015. For those Category 1 TINs that participated in a Shared Savings Program ACO in 2015, this approach can result in an upward, neutral, or downward payment adjustment to physicians billing under the TIN in 2017 based on the ACO's performance on quality measures and the number of eligible professionals in the TIN in 2015.

Under quality-tiering, all Category 1 TINs, regardless of size, can earn an upward payment adjustment for demonstrating high quality and/or low 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 high-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 are also eligible for an additional upward payment adjustment of +1.0 times the AF if they treated a disproportionate share of high-risk beneficiaries in 2015 (defined as having an attributed beneficiary population with an average beneficiary CMS-Hierarchical Condition Category [CMS-HCC] risk score in the top 25 percent of all beneficiary CMS-HCC risk scores nationwide). Starting in 2017, TINs that participated in the Shared Savings Program in 2015 may also earn an upward adjustment and are eligible for an additional +1.0 times the AF if the ACO in which the TIN participated during 2015 had an assigned beneficiary population with an average beneficiary CMS-HCC risk score in the top 25 percent of all beneficiary CMS-HCC risk scores nationwide.

Physicians in Category 1 TINs with 1 to 9 eligible professionals could receive an upward or neutral (meaning no adjustment) Value Modifier payment adjustment to their Medicare PFS payments in 2017 based on the TIN's performance in 2015, and will be held harmless from any downward payment adjustment in 2017 (Table 1). Physicians in TINs with 10 or more eligible professionals could receive an upward, neutral, or downward payment adjustment to their Medicare PFS payments in 2017 based on their TIN's performance in 2015 (Table 2).

The 2017 Value Modifier will also apply to payments to physicians billing under TINs that participated in Shared Savings Program ACOs in 2015. Consistent with the application of the Value Modifier to other TINs, if the ACO does not successfully report quality data as required by the Shared Savings Program to avoid the 2017 PQRS payment adjustment, then TINs that participated in the ACO in 2015 will fall in Category 2 for the 2017 Value Modifier and be subject to the automatic downward payment adjustment of negative two percent (-2.0%) (for physicians in TINs with between 1 and 9 eligible professionals) or negative four percent (-4.0%) (for physicians in TINs containing 10 or more eligible professionals).

TINs participating in a Shared Savings Program ACO in 2015 will be classified as Category 1 if their ACO successfully reported quality data via the GPRO Web Interface in 2015 to avoid the 2017 PQRS payment adjustment, with their Value Modifier calculated using a modified approach to quality-tiering. The quality tier categories for such TINs will be based on their ACO's performance on quality measures in 2015. If a TIN participated in more than one ACO in 2015, then the TIN's Quality Composite Score will be based on the performance of the ACO that had the highest numerical Quality Composite Score. In line with non-Shared Savings Program TINs, physicians in Category 1 Shared Savings Program TINs with 1 to 9 eligible professionals can receive an upward or neutral adjustment to their Medicare PFS payments, and physicians in TINs with 10 or more eligible professionals can receive an upward, neutral, or downward payment adjustment to their Medicare PFS payments in 2017. Because the Shared Savings Program uses different cost measures than those used for the Value Modifier, Category 1 Shared Savings Program TINs will be classified as "Average Cost." Please note that in the 2017 Medicare PFS Proposed Rule (81 FR 46408-46409 and 46446-46448), CMS has proposed a special secondary quality reporting period for the 2017 PQRS payment adjustment that will allow eligible professionals who participated in a Shared Savings Program ACO that failed to report quality data for the previously established reporting period for the 2017 PQRS payment

adjustment (that is, January 1, 2015 through December 31, 2015) to subsequently avoid the 2017 PQRS downward adjustment and 2017 Value Modifier automatic downward adjustment. These eligible professionals must report PQRS data separately from the ACO under one of the allowed options for this special secondary reporting period (that is, January 1, 2016 through December 31, 2016). For additional information on how the 2017 Value Modifier will be applied to Shared Savings Program ACO TINs, refer to the document entitled, "Medicare Shared Savings Program Interaction with the 2017 Value Modifier Frequently Asked Questions," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2017-VM-MSSP-FAQs.pdf.

Table 1. Quality-tiering categories and 2017 Value Modifier payment adjustments for physicians in TINs with between 1 and 9 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%

* High-performing TINs treating high-risk beneficiaries (based on mean CMS-HCC risk scores) will receive an additional adjustment of +1.0 times the AF. Because Shared Savings Program ACO TINs are designated as Average Cost, High and Low Cost tiers do not apply to Shared Savings Program TINs. Category 1 Shared Savings Program ACO TINs can be classified as Low Quality/Average Cost, Average Quality/Average Cost, or High Quality/Average Cost.

Table 2. Quality-tiering categories and 2017 Value Modifier payment adjustments for physicians in TINs with 10 or more eligible professionals

	Low Quality	Average Quality	High Quality
Low Cost	0.0%	+2.0 x AF*	+4.0 x AF*
Average Cost	–2.0%	0.0%	+2.0 x AF*
High Cost	–4.0%	–2.0%	0.0%

* High-performing TINs treating high-risk beneficiaries (based on mean CMS-HCC risk scores) will receive an additional adjustment of +1.0 times the AF. Because Shared Savings Program ACO TINs are designated as Average Cost, High and Low Cost tiers do not apply to Shared Savings Program TINs. Category 1 Shared Savings Program ACO TINs can be classified as Low Quality/Average Cost, Average Quality/Average Cost, or High Quality/Average Cost.

Quality and Cost Composite Score calculations

For Category 1 TINs, 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 TINs that participated in a Shared Savings Program ACO in 2015, the Cost Composite Score is classified as Average Cost and the Quality Composite Score used for quality-tiering summarizes the ACO's performance on quality measures across four quality domains: Effective Clinical Care; Community/Population Health; Patient Safety; and Communication and Care Coordination.

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 the minimum required number of eligible cases and a benchmark for the measure is available.[1]

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. Measures are standardized relative to a national benchmark, such that 0 represents the benchmark rate and the standardized score represents the number of standard deviations the measure score is from the benchmark. Specifically, 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

The minimum number of eligible cases for all quality and cost measures is 20, with two exceptions. The Medicare Spending per Beneficiary (MSPB) cost measure requires at least 125 eligible episodes to be included in the Cost Composite Score. The 30-day All-Cause Hospital Readmission measure requires at least 200 eligible cases to be included in the Quality Composite and applies only to TINs with 10 or more eligible professionals; however, the ACO-level 30-day

[1] 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.

All-Cause Hospital Readmission measure calculated for Shared Savings Program TINs is included in the Quality Composite Score regardless of case size.

For the 2017 Value Modifier calculations, the benchmark for each quality measure (except the 30-day All-Cause Hospital Readmission measure) is the case-weighted national mean performance rate during 2014 among all TINs in the measure's peer group. The benchmark for the 30-day All-Cause Hospital Readmission measure is the case-weighted national mean performance rate during 2014 among all TINs and ACOs in the measure's peer group. For each quality measure (except the 30-day All-Cause Hospital Readmission measure), the peer group is defined as all TINs nationwide that had at least 20 eligible cases for the measure. For the 30-day All-Cause Hospital Readmission measure, the peer group is defined as all TINs nationwide with 10 or more eligible professionals that had at least 200 eligible cases and all ACOs in the Shared Savings Program with at least 1 eligible case.

The benchmark for each cost measure is the case-weighted national mean cost during 2015 among all TINs in the measure's peer group. For each cost measure (except the MSPB measure), the peer group is defined as all TINs nationwide that had at least 20 eligible cases for the measure. For the MSPB measure, the peer group is defined as all TINs nationwide that had at least 125 eligible episodes.

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. For additional information on the quality benchmarks used in the calculation of the 2017 Value Modifier, refer to the document entitled, "Benchmarks for Measures Included in the Performance Year 2015 Quality and Resource Use Reports," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/PY2015-Prior-Year-Benchmarks.pdf.

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 benchmarks are available and for which the TIN has the required minimum number of eligible cases. No domain score is calculated if the TIN does not have the required minimum number of eligible cases for at least one measure with a benchmark in that domain.

How are composite scores calculated?

First, each Quality and Cost Composite Score is calculated 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 domain score is the TIN's Quality Composite Score, and the standardized mean cost domain score is the TIN's Cost Composite Score.

For all TINs subject to the 2017 Value Modifier, the peer group for the Quality Composite Score includes all TINs subject to the 2017 Value Modifier for which a Quality Composite Score could be calculated. For all TINs subject to the Value Modifier, the peer group for the Cost Composite Score includes all TINs subject to the 2017 Value Modifier for which a Cost Composite Score could be calculated, with the exception of TINs that participated in a Shared Savings Program ACO in 2015. This enables TINs subject to the Value Modifier (based on group size of one or more eligible professionals) to be compared at the composite level to other groups subject to the Value Modifier.

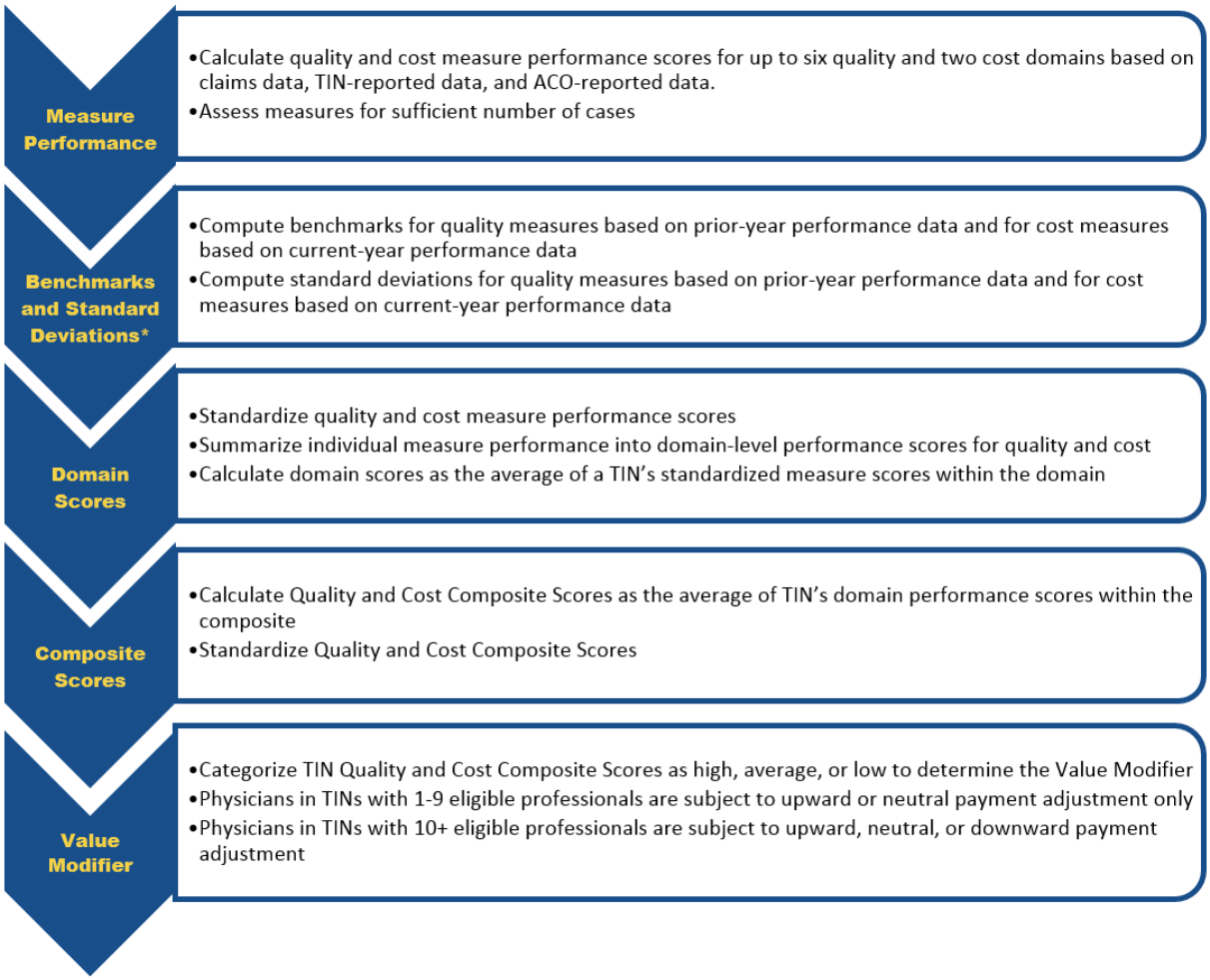
For additional information on the calculation of Quality and Cost Composite Scores, please see the responses to FAQ numbers 4 and 5 in Section C of the document entitled, "Questions and Answers About the 2015 Quality and Resource Use Reports and 2017 Value-Based Payment Modifier," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-FAQs-QRUR.pdf.

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 High Quality or Low 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 High Cost or Low 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 2017 Value Modifier for Category 1 TINs



*The performance rates of TINs with fewer than the required minimum number of 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 2017 Value Modifier payment adjustment would be calculated for a TIN with 10 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 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. The TIN's Medicare Spending per Beneficiary (row 2) is $10,244, the benchmark is $8,975, and the standard deviation is $1,234. Therefore, the standardized score for this measure is ($10,244 - $8,975) / $1,234 = 1.03. The domain score for the Per Capita Costs for All Beneficiaries Domain (row 3) is then the average of the two measure scores: (3.98 + 1.03) / 2 = 2.51.

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 (2.51 + 2.68) / 2 = 2.60 (row 9). The TIN's peer group for the Cost Composite Score is all TINs with one 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's mean of the mean cost domain score (0.16, row 10, column C) from the TIN's mean cost domain score (2.60, 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 0.82 (row 11). A Cost Composite Score of 0.82 means that the TIN's Cost Composite Score is 0.82 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 0.82 is not at least one standard deviation above the mean Cost Composite Score for the peer group and is not statistically significantly different from the mean;[2] therefore the TIN's cost performance would be designated as average.

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

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 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.

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 +2.0 times the AF in 2017.

Table 4. Example Cost Composite Score Computation

		TIN's number of eligible cases (A)	TIN's risk-adjusted 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	132	$10,244	$8,975	$1,234	1.03	Yes
(3)	Domain Score: Per Capita Costs for All Attributed Beneficiaries (from Rows 1 – 2)					2.51	
(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 (from Rows 4 – 7)					2.68	
(9)	Mean Cost Domain Score					2.60	
(10)	Peer Group Mean & S.D. of Mean Cost Domain Score (TINs with 1+ eligible professionals)			0.16	2.96		
(11)	Standardized Cost Composite Score					0.82	

Where can TINs find their 2017 Value Modifier and their Quality and Cost Composite Scores?

In September 2016, CMS made available the 2015 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. The 2015 Annual QRURs show how TINs performed in 2015 on the quality and cost measures used to calculate the 2017 Value Modifier. For physicians in TINs that are subject to the 2017 Value Modifier, the QRUR shows how the Value Modifier will apply to payments under the Medicare Physician Fee Schedule for physicians who bill under the TIN in 2017.

Authorized representatives of TINs can access the 2015 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 2015 Annual QRURs, please visit the How to Obtain a QRUR website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html.

Additional information about the 2017 Value Modifier and 2015 Annual QRURs is available on the 2015 QRUR and 2017 Value Modifier website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html.