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2017 VALUE-BASED PAYMENT MODIFIER PROGRAM EXPERIENCE REPORT

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I. INTRODUCTION AND KEY FINDINGS

This Experience Report highlights characteristics of the practices subject to the Medicare physician Value-Based Payment Modifier (Value Modifier) in 2017.[1] The Value Modifier is a pay-for-performance program designed to reward physician groups and solo practitioners who provide high quality and cost-effective care, while encouraging improvement for those practices that are determined to have lower performance or did not satisfactorily participate in the Physician Quality Reporting System (PQRS).

The Value Modifier applies upward, downward, or neutral payment adjustments to Medicare Physician Fee Schedule payments to physicians in 2017 based on both a practice's performance on quality and cost measures and its PQRS reporting status during the 2015 performance period. The Value Modifier provides neutral payment adjustments based on performance to the overwhelming majority of physicians in practices that satisfactorily report PQRS measures. It only adjusts payments upward or downward for statistically significant above- or below-average performance on measures of quality and cost of care provided to beneficiaries.

In 2017, the Value Modifier completed the three year phase in to all physicians in practices, as identified by their Medicare enrolled Taxpayer Identification Numbers (TINs), including solo physician practitioners. Also, 2017 is the first year in which the Value Modifier adjusts payments to physicians in practices that participated in a Shared Savings Program Accountable Care Organization (ACO) during the performance period. Physician practices were not subject to the 2017 Value Modifier if one or more eligible professionals (EPs) in the TIN participated in the Pioneer ACO Model or the Comprehensive Primary Care (CPC) initiative in 2015.

For more information on the methodology used to calculate the Value Modifier, please refer to the informational documentation on the Centers for Medicare & Medicaid Services' (CMS') website, located at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html.

Under the 2017 Value Modifier, the majority of physicians billed under TINs that satisfied minimum quality reporting requirements and avoided the automatic downward payment adjustment. CMS anticipates that successful trend to continue under the new Quality Payment Program. The first performance period of the Quality Payment Program is January 1, 2017 through December 31, 2017, and the first payment adjustment year will be 2019.

The Quality Payment Program replaces the PQRS, the Value Modifier Program, and the Medicare Electronic Health Record Incentive Program, reduces quality reporting requirements, and has many flexibilities that allow eligible clinicians to pick their pace for participating in the first year.

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[1] The numbers in this report reflect PQRS and Value Modifier informal review decisions as of January 11, 2017 in addition to subsequent decisions for 17 TINs that were large enough to have a meaningful impact on the calculation of the Value Modifier upward payment adjustment factor (AF). The AF calculations include assumptions about the resolution of the pending informal reviews.

Clinicians will be able to practice as they always have, but they may receive higher Medicare payments based on their performance for participating in the Quality Payment Program. CMS is committed and diligently working with clinicians to support their successful transition into the Quality Payment Program. CMS' goal is to further reduce burdensome requirements and empower patients and clinicians to make decisions about their healthcare.

To prepare for success in the Quality Payment Program, EPs are encouraged to review their PQRS feedback report, review their Annual Quality and Resource Use Report (QRUR), and visit https://qpp.cms.gov/ to learn about the Quality Payment Program.

A. Key findings

1. In 2015, 885,108 physicians billed under the 208,832 TINs that are subject to the 2017 Value Modifier. Of these, 593,278 physicians (67.0 percent) billed under TINs that were classified as Category 1 (i.e., avoided the 2017 PQRS payment adjustment) and 291,830 physicians (33.0 percent) billed under TINs that were classified as Category 2 (i.e., did not avoid the 2017 PQRS payment adjustment; Figure 1).
2. Of the physicians who billed under Category 1 TINs in 2015, 12,176 (2.1 percent) billed under TINs receiving upward payment adjustments in 2017; 26,973 (4.5 percent) billed under TINs receiving downward payment adjustments due to performance; and 554,129 physicians (93.4 percent) billed under TINs receiving neutral payment adjustments, including 11,555 physicians (1.9 percent) who billed under TINs that are held harmless from downward payment adjustments under quality-tiering because 2017 is the first year that TINs of their size are subject to the Value Modifier (Figure 1).
3. For Category 1 TINs, the primary driver of quality-tiering performance was quality, rather than cost (Table 4).
4. A TIN had to have a Quality Composite Score above the 97th percentile to be considered high quality and below the 10th percentile to be considered low quality. A TIN had to have a Cost Composite Score above the 97th percentile to be considered high cost and below the 7th percentile to be considered low cost (Section II.A).
5. Category 1 TINs that were attributed the most clinically complex beneficiaries are more commonly receiving upward payment adjustments than those that were attributed the least complex beneficiaries (3.7 percent compared to 1.6 percent; Table 5).
6. Category 1 TINs receiving upward payment adjustments performed better on nearly every claims-based quality outcome and cost measure than those receiving neutral or downward payment adjustments based on performance. The Per Capita Costs for All Attributed Beneficiaries and 30-day All-Cause Hospital Readmission measures were the two exceptions (Table 6).
7. TINs classified as high quality performed better, on average, on five of the six cost measures and on the Cost Composite Score than TINs classified as average quality or low quality (Table 7).
8. Among physicians in TINs subject to the 2017 Value Modifier, 38.7 percent were in a TIN that reported PQRS data via a Group Practice Reporting Option (GPRO). Among physicians in TINs that reported PQRS data via a GPRO, 97.6 percent were in a TIN

classified as Category 1. This compares to 47.7 percent for physicians in TINs that reported as individuals (Table 8).[2]

9. The ten physician specialties that had the highest percentage of physicians bill under TINs receiving upward payment adjustments are (1) emergency medicine, (2) nephrology, (3) sports medicine, (4) gastroenterology, (5) hand surgery, (6) interventional pain management, (7) internal medicine, (8) physical medicine and rehabilitation, (9) allergy/immunology, and (10) pain management (Table 9).
10. The ten physician specialties that had the highest percentage of physicians bill under Category 1 TINs receiving downward payment adjustments due to performance are (1) medical oncology, (2) hematology/oncology, (3) gynecological/oncology, (4) radiation oncology, (5) internal medicine, (6) diagnostic radiology, (7) geriatric medicine, (8) hand surgery, (9) cardiac surgery, and (10) thoracic surgery (Table 10).
11. The ten physician specialties that had the highest percentage of physicians bill under TINs receiving downward payment adjustments due to Category 2 status are (1) maxillofacial surgery, (2) optometry, (3) oral surgery (dentists only), (4) chiropractic, (5) psychiatry, (6) general practice, (7) podiatry, (8) plastic and reconstructive surgery, (9) pain management, and (10) interventional pain management (Table 11).

II. BACKGROUND

A. How the Value Modifier is determined

CMS classified TINs as Category 1 or Category 2 based on their participation in the PQRS during the 2015 performance period. Category 1 TINs avoided the PQRS payment adjustment as a group, as a solo practitioner, or by having at least 50 percent of the EPs in the TIN avoid the PQRS payment adjustment as individuals. Category 1 TINs are eligible to receive upward, neutral, or downward payment adjustments based on performance. Category 2 TINs did not avoid the PQRS payment adjustment in one of the ways described above.[3] Physicians in Category 2 TINs that consisted of 1 to 9 EPs are receiving a negative two percent (-2.0%) payment adjustment, while physicians in Category 2 TINs that consisted of 10 or more EPs are receiving a negative four percent (-4.0%) payment adjustment. The 2017 Value Modifier applies separately from and in addition to the 2017 PQRS payment adjustment, if applicable.

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[2] In this report, "TINs that reported as individuals" include TINs that registered for a GPRO and did not avoid the 2017 PQRS payment adjustment as a group, but did have at least 50 percent of the EPs in the TIN avoid the 2017 PQRS payment adjustment as individuals.

[3] TINs that participated in a Shared Savings Program ACO in 2015 are subject to the Value Modifier in 2017, but had different criteria for being classified as Category 1 or Category 2. For more information on how the 2017 Value Modifier applies to TINs that participated in a Shared Savings Program ACO in 2015, including information on the 2016 PQRS special secondary reporting period, please see 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.

Physicians in Category 1 TINs had their Value Modifier payment adjustments calculated using a quality-tiering methodology in which CMS calculated composite scores for quality and cost to assign TINs to low, average, or high quality and cost tiers. To be considered either a high or a low performer on quality or cost, a TIN's composite score had to be at least one standard deviation above or below, and statistically significantly different from, the mean composite score for the peer group. For the application of the 2017 Value Modifier based on these requirements, the composite score cutoffs in percentile terms were as follows:

- For the Quality Composite Score, a TIN had to score above the 97th percentile to be considered high quality and below the 10th percentile to be considered low quality.

- For the Cost Composite Score, a TIN had to score above the 97th percentile to be considered high cost and below the 7th percentile to be considered low cost.

Because the Value Modifier must be budget neutral, CMS uses an adjustment factor (AF) to distribute downward payment adjustments to the TINs receiving upward payment adjustments. The AF is approximately 15.48 percent for the 2017 Value Modifier.[4] This means that in 2017, Medicare Physician Fee Schedule payments to Category 1 TINs receiving upward payment adjustments as a result of quality-tiering are being adjusted upward by +1.0, +2.0, +3.0, +4.0, or +5.0 times 15.48 percent, depending on each TIN's performance, size, and their attributed beneficiaries' average CMS-Hierarchical Condition Category (HCC) risk score (Tables 1 and 2).

Table 1. 2017 Value Modifier quality-tiering categories and payment adjustments for TINs with 10 or more EPs, with physician counts

	Low quality	Average quality		High quality	
Low cost	0.0% (149)	30.95% (383)	46.43%[a] (2,414)	61.90% (0)	77.38%[a] (69)
Average cost	–2.0% (13,949)	0.0% (433,616)		30.95% (2,508)	46.43%[a] (2,930)
High cost	–4.0% (3,605)	–2.0% (9,419)		0.0% (285)	

Note: The numbers in parentheses represent the number of physicians who billed in 2015 under TINs in each tier.

[a] TINs receiving upward payment adjustments who had the most clinically complex attributed beneficiaries are receiving the additional high-risk bonus adjustment of 15.48 percent (+1.0 x AF).

Table 2. 2017 Value Modifier quality-tiering categories and payment adjustments for TINs with 1 to 9 EPs, with physician counts

	Low quality	Average quality		High quality	
Low cost	0.0% (6)	15.48% (76)	30.95%[a] (90)	30.95% (28)	46.43%[a] (32)
Average cost	0.0%[b] (8,835)	0.0% (108,455)		15.48% (2,542)	30.95%[a] (1,104)
High cost	0.0%[b] (887)	0.0%[b] (1,833)		0.0% (63)	

Note: The numbers in parentheses represent the number of physicians who billed in 2015 under TINs in each tier.

[a] TINs receiving upward payment adjustments who had the most clinically complex attributed beneficiaries are receiving the additional high-risk bonus adjustment of 15.48 percent (+1.0 x AF).

[b] In 2017, Category 1 TINs with 1 to 9 EPs are held harmless from downward payment adjustments under the quality-tiering methodology.

[4] For more information on the methodology used to calculate the AF, please see the document entitled, "Physician Value-Based Payment Modifier 2017 X-Factor Calculation," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2017-VM-OACT-Adjustment-Factor.pdf.

B. Quality and Resource Use Reports

Under the Value Modifier program, CMS disseminates confidential reports, called QRURs, to groups and solo practitioners nationwide. CMS produced 2015 Annual QRURs for groups and solo practitioners with at least one EP who billed Medicare Part B during 2015 regardless of whether they would be subject to the 2017 Value Modifier. In September 2016, 279,404 TINs received a 2015 Annual QRUR that included information about the TIN's 2017 Value Modifier status and payment adjustment. For more information on the contents of the QRUR, please refer to, "How to Understand Your 2015 Annual QRUR," available at the following URL: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-UnderstandingYourAQRUR.pdf.

III. CHARACTERISTICS OF TINS SUBJECT TO THE 2017 VALUE MODIFIER

A. TIN characteristics: EPs and attributed beneficiaries

Table 3 provides information on the TINs that are subject to the 2017 Value Modifier. It describes the characteristics of the EPs that billed under the TINs in each category and the characteristics of the beneficiaries attributed to those TINs.

The number of TINs subject to the Value Modifier increased from 13,813 in 2016 to 208,832 in 2017. This increase was largely due to the expansion of the application of the Value Modifier in 2017 to the 193,429 TINs with fewer than 10 EPs, including solo practitioners. Further, 2017 is the first year in which the Value Modifier applies to physicians in TINs that participated in a Shared Savings Program ACO.

Table 3. Characteristics of TINs subject to the 2017 Value Modifier

	All TINs subject to 2017 Value Modifier	TINs with 10 or more EPs subject to 2017 Value Modifier	TINs with 1 to 9 EPs subject to 2017 Value Modifier
Number of TINs	208,832	15,403	193,429
Number of physicians	885,108	582,287	302,821
TIN characteristics: EPs			
Average number of EPs	5.6	53.6	1.8
Percentage of TINs that are solo practices	65.6%	0.0%	70.8%
Predominantly single specialty: Percentage of TINs with more than 50 percent of EPs with same specialty	88.3%	55.6%	90.9%
Predominantly primary care providers (PCPs): Percentage of TINs with more than 50 percent of EPs who are PCPs	25.3%	29.6%	25.0%
Average percentage of EPs who are physicians	92.9%	70.0%	94.8%
TIN characteristics: Attributed beneficiaries[a]			
Average number of attributed beneficiaries	120.0	910.9	57.0
Average percentage of beneficiaries attributed on the basis of primary care services provided by PCPs (Step 1)	42.2%	64.0%	40.4%
Average TIN-level CMS-HCC score	1.16	1.39	1.13

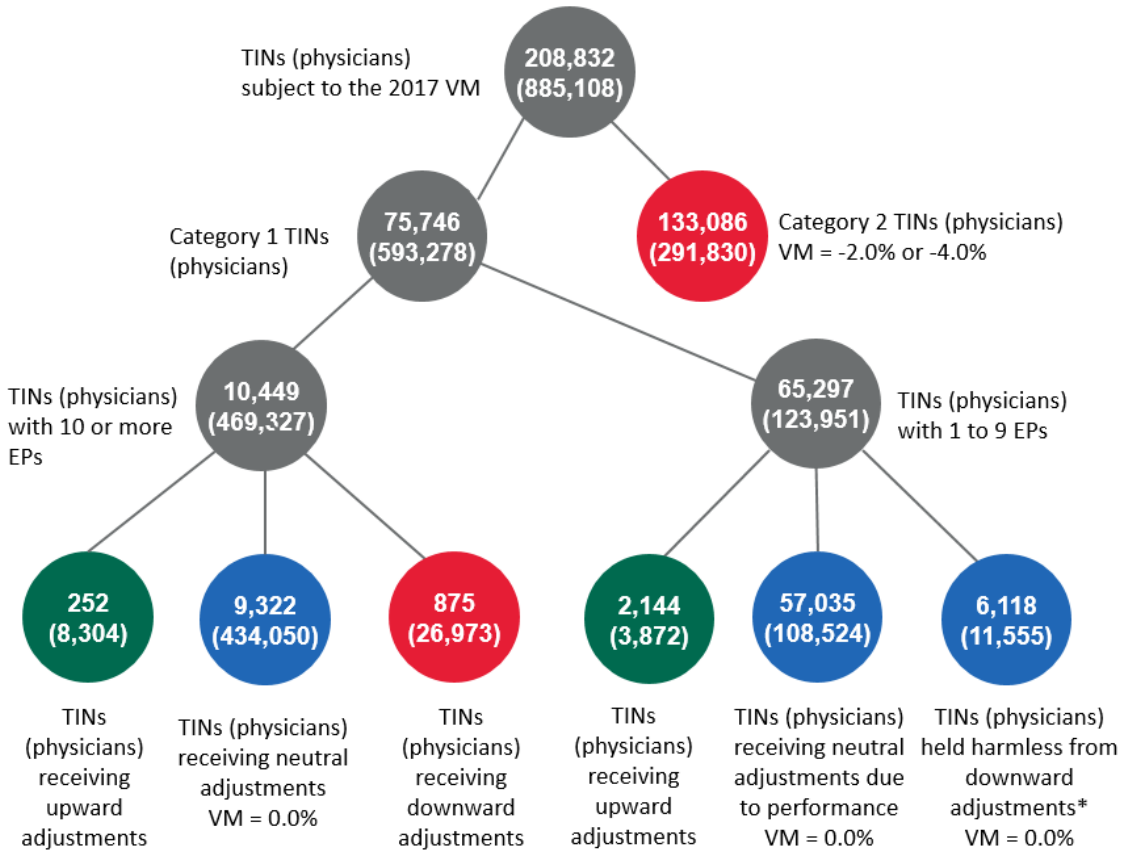
[a] The term, attributed beneficiaries, refers to beneficiaries attributed to a TIN for the per capita cost measures and claims-based quality outcome measures; a different attribution method is used for the PQRS and MSPB measures.

IV. THE 2017 VALUE MODIFIER: QUALITY-TIERING AND PERFORMANCE

Figure 1 shows the number of TINs subject to the 2017 Value Modifier that were classified as Category 1 and Category 2, and the results of quality-tiering for Category 1 TINs of different sizes. It also shows how many physicians billed under TINs in each classification in 2015.

A total of 885,108 physicians billed under TINs subject to the 2017 Value Modifier. Of these, 593,278 physicians (67.0 percent) billed under TINs that were classified as Category 1 and 291,830 physicians (33.0 percent) billed under TINs that were classified as Category 2. Of the physicians who billed under Category 1 TINs in 2015, 12,176 (2.1 percent) billed under TINs receiving upward payment adjustments in 2017; 26,973 (4.5 percent) billed under TINs receiving downward payment adjustments due to performance; and 554,129 physicians (93.4 percent) billed under TINs receiving neutral payment adjustments, including 11,555 physicians (1.9 percent) who billed under TINs that are held harmless from downward payment adjustments under quality-tiering because 2017 is the first year that TINs of their size are subject to the Value Modifier.

Figure 1. TINs and physicians subject to the 2017 Value Modifier



Note: The numbers in parentheses in this chart indicate the number of physicians who, in 2015, billed under one of the TINs in the associated bubble. "VM" in this chart stands for 2017 Value Modifier payment adjustment amount.

* TINs in this category had below-average performance, but are held harmless from downward payment adjustments because 2017 is the first year that TINs of this size are subject to the Value Modifier.

A. Quality-tiering results for the 2017 Value Modifier

Table 4 shows the quality and cost tier distribution of Category 1 TINs. The primary driver behind performance was quality, as TINs' quality tiers deviated from average more frequently than their cost tiers. Among 2,396 TINs with above-average performance,[5] 2,283 TINs (95.3 percent) had high quality and only 135 TINs (5.6 percent) had low cost. Of the 6,993 TINs with below-average performance, 5,819 TINs (83.2 percent) had low quality and 1,786 TINs (25.5 percent) had high cost.

Table 4. Distribution of all Category 1 TINs, by quality and cost tiers (N = 75,746 TINs)

	Low quality	Average quality	High quality	Total
Low cost	0.0% (8)	0.1% (113)	0.0% (22)	0.2% (143)
Average cost	6.9% (5,207)	87.6% (66,319)	3.0% (2,261)	97.4% (73,787)
High cost	0.8% (612)	1.6% (1,174)	0.0% (30)	2.4% (1,816)
Total	7.7% (5,827)	89.3% (67,606)	3.1% (2,313)	100.0% (75,746)

Notes: This table displays the quality and cost tiers of the 75,746 Category 1 TINs subject to the 2017 Value Modifier. It excludes Category 2 TINs for which the Value Modifier was not determined through quality-tiering. Some percentages do not sum to the total due to rounding. Values in parentheses represent the number of TINs.

B. The 2017 Value Modifier by TIN characteristics

In the following sections, we examine the relationship between TIN characteristics and Value Modifier outcomes, such as payment adjustment, Category 1 or Category 2 classification, and quality and cost tier.

[5] Having above-average performance means having one of the following combinations of quality and cost tiers: high quality and average cost, average quality and low cost, or high quality and low cost. Having below-average performance means having one of the following combinations of quality and cost tiers: low quality and average cost, low quality and high cost, or average quality and high cost.

1. TIN payment adjustment categories by average beneficiary risk score

CMS used CMS-HCC risk scores to risk-adjust the per capita cost measures in the QRUR, and to determine which TINs receiving upward payment adjustments are eligible for an additional high-risk bonus adjustment. Table 5 stratifies Category 1 TINs into quartiles based on their attributed beneficiaries' average CMS-HCC risk score and their 2017 payment adjustment. It shows that Category 1 TINs that were attributed the most clinically complex beneficiaries are more commonly receiving upward payment adjustments than those that were attributed the least complex beneficiaries (3.7 percent compared to 1.6 percent). However, these TINs are also more commonly receiving downward payment adjustments than TINs in any other quartile (2.8 percent of TINs in the highest quartile compared to 1.1 percent of TINs in the third quartile, 0.8 percent of TINs in the second quartile, and 0.4 percent of TINs in the lowest quartile). Of the TINs attributed the most clinically complex beneficiaries, 12.8 percent are being held harmless from downward payment adjustments due to TIN size.

Table 5. Distribution of Category 1 TINs across payment adjustment categories, by average beneficiary CMS-HCC score (N = 75,746 TINs)

	Average CMS-HCC score			
	Lowest quartile (0.12–0.72 CMS-HCC score)	Second quartile (0.72–1.02 CMS-HCC score)	Third quartile (1.02–1.41 CMS-HCC score)	Highest quartile (1.41–11.70 CMS-HCC score)
Percentage (number) of TINs receiving upward payment adjustment	1.6% (443)	4.6% (647)	4.0% (675)	3.7% (631)
Percentage (number) of TINs receiving neutral payment adjustment due to performance	90.5% (25,148)	88.4% (12,567)	89.1% (15,038)	80.7% (13,604)
Percentage (number) of TINs held harmless from downward payment adjustment (TINs with 1 to 9 EPs only)	7.5% (2,095)	6.2% (881)	5.9% (988)	12.8% (2,154)
Percentage (number) of TINs receiving downward payment adjustment (TINs with 10 or more EPs only)	0.4% (109)	0.8% (114)	1.1% (186)	2.8% (466)
Total	100.0% (27,795)	100.0% (14,209)	100.0% (16,887)	100.0% (16,855)

Note: The CMS-HCC score quartiles are based on the distribution of TIN-level average CMS-HCC scores for all TINs subject to the Value Modifier. However, the TIN counts shown in this table include only Category 1 TINs. Thus, the number of TINs appearing in each quartile is not the same.

The 75,746 Category 1 TINs were assigned to these quartiles based on the average CMS-HCC score for beneficiaries that were either attributed for the per capita cost measures and claims-based quality outcome measures or had attributed MSPB episodes.

2. Payment adjustment–level performance

Table 6 shows average measure scores for Category 1 TINs by payment adjustment category. Category 1 TINs receiving upward payment adjustments performed better on nearly every claims-based quality outcome and cost measure than TINs receiving neutral or downward payment adjustments. Conversely, TINs that had below-average performance had lower scores on every claims-based quality outcome and cost measure than TINs that are receiving upward or neutral payment adjustments due to performance. Also, with the exception of the MSPB measure, TINs receiving downward payment adjustments had worse scores on all claims-based quality outcome and cost measures than TINs receiving neutral payment adjustments due to TIN size.

Table 6. Select performance measures for Category 1 TINs, by payment adjustment category (N = 75,746 TINs)

	Upward payment adjustment	Neutral payment adjustment due to performance	Held harmless from downward payment adjustment (TINs with 1 to 9 EPs only)	Downward payment adjustment (TINs with 10 or more EPs only)
Number of TINs	2,396	66,357	6,118	875
Number of physicians	12,176	542,574	11,555	26,973
Select measures included in the 2017 Value Modifier				
Average Acute ACSC Composite rate[a]	4.4	5.2	10.2	17.1
Average Chronic ACSC Composite rate[a]	36.9	40.6	53.8	70.9
Average 30-day All-Cause Hospital Readmission rate[b]	15.2	15.2	15.9	16.0
Average per capita costs				
All attributed beneficiaries	$10,640	$9,975	$13,085	$19,775
Diabetes	$16,045	$16,340	$21,572	$29,484
COPD	$26,649	$28,962	$40,158	$45,333
CAD	$17,842	$18,593	$24,876	$34,368
Heart failure	$27,802	$29,653	$41,315	$50,027
Average MSPB	$20,302	$20,442	$21,312	$20,856
Other measures reported in 2015 Annual QRUR, but not included in the 2017 Value Modifier				
Average percentage of attributed beneficiaries who received emergency services not included in a hospital admission	28.2%	29.1%	35.0%	47.7%

Note: Higher scores indicate worse performance for all measures shown in this table.

[a] Hospital admissions per 1,000 beneficiaries.

[b] Per 100 index admissions.

3. Composite-level performance

Table 7 shows the average performance of Category 1 TINs on the Quality and Cost Composite Scores, quality and cost domains, and selected quality and cost measures, stratified by

quality tier. The Quality Composite Score was based on (1) PQRS measures reported by the TIN or by individual EPs within the TIN and (2) three claims-based quality outcome measures calculated from Medicare Fee-for-Service claims submitted for Medicare beneficiaries attributed to the TIN. A TIN could also have elected to have Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS survey measures included in their Quality Composite Score.

TINs classified as high quality had better scores in all six quality domains, on average, than TINs classified as average or low quality. TINs classified as high quality also performed better on five of the six cost measures and on the Cost Composite Score than TINs classified as average or low quality.

Table 7. Average performance of Category 1 TINs, by quality tier (N = 75,746 TINs)

Performance metric	All Category 1 TINs	Low quality	Average quality	High quality
Number of TINs	75,746	5,827	67,606	2,313
Number of physicians	593,278	27,431	556,286	9,561
Quality Composite Score	**0.1**	**-1.5**	**0.3**	**1.1**
Effective Clinical Care	0.0	-1.4	0.1	1.2
Person- and Caregiver-Centered Experience and Outcomes	-0.3	-2.3	0.0	0.5
Community/Population Health	0.2	-0.9	0.3	1.1
Patient Safety	0.1	-1.4	0.3	0.7
Communication and Care Coordination	0.2	-1.8	0.3	1.0
Acute ACSC Composite rate[a,c]	5.8	9.8	5.5	4.3
Chronic ACSC Composite rate[a,c]	42.1	53.5	41.3	37.6
30-day All-Cause Hospital Readmission rate[b,c]	15.3	15.8	15.2	15.2
Efficiency and Cost Reduction	0.0	-0.4	0.0	1.8
Cost Composite Score[c]	**-0.3**	**0.5**	**-0.3**	**-0.5**
Average Per Capita Costs				
All attributed beneficiaries[c]	$11,122	$12,710	$10,956	$11,453
Diabetes[c]	$18,080	$20,890	$17,842	$17,507
COPD[c]	$30,912	$37,543	$30,447	$27,955
CAD[c]	$20,292	$23,583	$20,020	$19,372
Heart failure[c]	$31,946	$39,078	$31,412	$29,303
Average MSPB[c]	$20,509	$20,883	$20,481	$20,479

Notes: The measure scores shown in this table are unstandardized performance scores. Domain scores are the equally weighted average of standardized measure scores in the domain. The composite scores are the equally weighted average of non-missing domain scores. Scores shown in this table are based only on non-missing values.

[a] Hospital admissions per 1,000 beneficiaries.

[b] Per 100 index admissions.

[c] Higher scores indicate worse performance.

4. Distribution of TINs by reporting mechanism

Table 8 shows the percentage of TINs classified as Category 1, stratified by reporting mechanism. GPRO TINs were classified as Category 1 far more frequently (96.0 percent) than TINs that reported as individuals (31.2 percent). For every reporting mechanism, the percentage of physicians who billed under Category 1 TINs was higher than the percentage of TINs that were classified as Category 1. For example, while 36.3 percent of TINs were classified as Category 1 across all reporting mechanisms, 67.0 percent of physicians billed under TINs that were classified as Category 1. This indicates that, for all reporting mechanisms, TINs classified as Category 1 were larger, on average, than TINs classified as Category 2.

Table 8. Distribution of TINs subject to the Value Modifier, by reporting mechanism (N = 208,832 TINs)

TIN type	Number of TINs (physicians) subject to the Value Modifier	Number and percentage of TINs (physicians) classified as Category 1	
All TINs (physicians)	208,832 (885,108)	75,746 (593,278)	36.3% (67.0%)
TINs (physicians) that reported via GPRO Web Interface, registry, or EHR	**16,222 (342,172)**	**15,573 (334,039)**	**96.0% (97.6%)**
Web Interface (non-Shared Savings Program)	288 (73,061)	278 (72,225)	96.5% (98.9%)
Web Interface (Shared Savings Program)[a]	12,673 (150,787)	12,500 (149,498)	98.6% (99.1%)
Qualified registry	2,355 (86,233)	2,076 (82,333)	88.2% (95.48%)
EHR	906 (32,091)	719 (29,983)	79.4% (93.4%)
TINs (physicians in TINs) reporting as individuals	**192,610 (542,936)**	**60,173 (259,239)**	**31.2% (47.7%)**

[a] There were 397 ACOs with at least one TIN subject to the 2017 Value Modifier. Of those, 389 (98.0 percent) successfully reported PQRS measures via Web Interface in 2015.

5. Payment adjustment by physician specialty

Table 9 shows the specialties that had the largest share of physicians bill under TINs receiving upward payment adjustments. Specialists in (1) emergency medicine, (2) nephrology, (3) sports medicine, (4) gastroenterology, (5) hand surgery, (6) interventional pain management, (7) internal medicine, (8) physical medicine and rehabilitation, (9) allergy/immunology, and (10) pain management billed under TINs receiving upward payment adjustments most commonly. Furthermore, of the 2,396 TINs receiving upward adjustments, the percentage with a physician in each of these specialties varies. Only 0.3 percent of these TINs included at least one physician specializing in sports medicine while 32.2 percent included at least one internal medicine physician.

Table 9. Specialties most commonly in Category 1 TINs receiving upward payment adjustments

Specialty description	Number of physicians in TINs subject to the Value Modifier	Percentage of physicians in TINs receiving upward payment adjustments due to performance	Among TINs receiving upward payment adjustments, percentage with at least one physician in specialty (N =2,396 TINs)
All Specialties	878,693	1.4%	n/a
Emergency medicine	66,636	5.5%	5.4%
Nephrology	9,615	2.5%	3.9%
Sports medicine	1,035	2.2%	0.3%
Gastroenterology	14,850	2.0%	6.1%
Hand surgery	1,498	1.9%	0.5%
Interventional pain management	2,069	1.9%	1.3%
Internal medicine	125,579	1.8%	32.2%
Physical medicine and rehabilitation	9,276	1.7%	4.0%
Allergy/immunology	3,874	1.7%	1.6%
Pain management	2,471	1.6%	1.2%

Notes: This analysis includes only specialties with at least 1,000 physicians that billed under TINs subject to the 2017 Value Modifier. Physicians are identified by National Provider Identification number (NPI). Physician counts reflect unique NPI–TIN combinations, rather than unique physicians. Thus, physicians who billed under multiple TINs are counted multiple times in this analysis.

n/a indicates the field is not applicable.

Table 10 shows the specialties that had the largest share of physicians bill under TINs receiving downward payment adjustments due to performance. Physicians in (1) medical oncology, (2) hematology/oncology, (3) gynecological/oncology, (4) radiation oncology, (5) internal medicine, (6) diagnostic radiology, (7) geriatric medicine, (8) hand surgery, (9) cardiac surgery, and (10) thoracic surgery billed under TINs receiving downward payment adjustments due to performance most commonly. Over half (51.1 percent) of the 875 TINs receiving downward payment adjustments due to performance had at least one internal medicine physician billing under the TIN.

Table 10. Specialties most commonly in Category 1 TINs receiving downward payment adjustments due to performance

Specialty description	Number of physicians in TINs subject to the Value Modifier	Percentage of physicians in TINs receiving downward payment adjustments due to performance	Among TINs receiving downward payment adjustments due to performance, percentage with at least one physician in specialty (N = 875 TINs)
All specialties	878,693	3.0%	n/a
Medical oncology	3,373	10.4%	6.9%
Hematology/oncology	9,487	6.5%	12.2%
Gynecological/oncology	1,193	5.7%	2.2%
Radiation oncology	5,804	5.4%	5.9%
Internal medicine	125,579	5.2%	51.1%
Diagnostic radiology	50,270	4.5%	13.8%
Geriatric medicine	2,249	4.5%	7.7%
Hand surgery	1,498	4.0%	3.2%
Cardiac surgery	1,880	3.8%	2.6%
Thoracic surgery	2,569	3.8%	5.3%

Notes: This analysis includes only specialties with at least 1,000 physicians that billed under TINs subject to the 2017 Value Modifier. Physicians are identified by NPI. Physician counts reflect unique NPI–TIN combinations, rather than unique physicians. Thus, physicians who billed under multiple TINs are counted multiple times in this analysis.

n/a indicates the field is not applicable.

Table 11 shows the specialties that had the largest share of physicians bill under TINs receiving downward payment adjustments due to Category 2 status. Physicians in (1) maxillofacial surgery, (2) optometry, (3) oral surgery (dentists only), (4) chiropractic, (5) psychiatry, (6) general practice, (7) podiatry, (8) plastic and reconstructive surgery, (9) pain management, and (10) interventional pain management billed under TINs receiving downward payment adjustments due to Category 2 status most commonly. Of all Category 2 TINs, 21.1 percent included at least one chiropractic specialist and 12.3 percent included an optometrist.

Table 11. Specialties most commonly in TINs receiving downward payment adjustments due to Category 2 status

Specialty description	Number of physicians in TINs subject to the Value Modifier	Percentage of physicians in TINs receiving downward payment adjustments due to Category 2 status	Among Category 2 TINs, percentage with at least one physician in specialty (N = 133,086 TINs)
All Specialties	878,693	33.0%	n/a
Maxillofacial surgery	1,236	81.1%	0.4%
Optometry	35,231	78.8%	12.3%
Oral surgery (dentists only)	2,114	75.1%	0.8%
Chiropractic	43,730	74.1%	21.1%
Psychiatry	33,116	63.4%	7.2%
General practice	7,853	61.8%	3.1%
Podiatry	18,013	60.1%	5.8%
Plastic and reconstructive surgery	5,433	46.6%	1.5%
Pain management	2,471	43.0%	0.6%
Interventional pain management	2,069	42.5%	0.5%

Notes: This analysis includes only specialties with at least 1,000 physicians who billed under TINs subject to the 2017 Value Modifier. Physicians are identified by NPI. Physician counts reflect unique NPI–TIN combinations, rather than unique physicians. Thus, physicians who billed under multiple TINs are counted multiple times in this analysis.

n/a indicates the field is not applicable.