

### SPECIALTY ADJUSTMENT

#### Overview

The Value-Based Payment Modifier (Value Modifier) Program evaluates the performance of solo practitioners and groups, as identified by their Medicare Taxpayer Identification Number (TIN), on the quality and cost of care they provide to their Medicare Fee-for-Service beneficiaries. The Centers for Medicare & Medicaid Services (CMS) disseminates this information to TINs in confidential Quality and Resource Use Reports (QRURs). For each TIN subject to the Value Modifier, CMS also uses these data to calculate a Value Modifier that adjusts the TIN's physicians' Medicare Physician Fee Schedule payments upward, downward, or not at all, based on the TIN's performance.

This Fact Sheet summarizes what specialty adjustment is and how it is implemented to calculate a TIN's cost performance for the 2017 Value Modifier. Beginning with the 2014 QRURs and the 2016 Value Modifier, CMS adjusts all cost measures for each TIN's specialty mix to facilitate comparisons in health care costs across disparate TINs. More information on the specialty adjustment of specific cost measures is available in the Measure Information Forms available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html>.

#### How does specialty adjustment work?

CMS recognizes that costs vary across specialties and across TINs with varying specialty mixes. To support the goal of comparing TINs more accurately with their peers, CMS applies specialty adjustment separately to the Per Capita Costs for All Attributed Beneficiaries, Per Capita Costs for Beneficiaries with Specific Conditions, and the Medicare Spending per Beneficiary measures. Specialty adjustment is accomplished by determining the risk-adjusted cost that would be expected for a solo practitioner, given the practitioner's specialty, or TIN, given the TIN's specialty mix, and comparing this expected value to the actual risk-adjusted cost.

Specialty-adjusted costs for a TIN with a disproportionate number of high-cost specialists will be lower than the TIN's non-specialty-adjusted costs, because the high-cost specialists will generate expected costs that exceed the average cost across all TINs; similarly, specialty-adjusted costs will be higher than non-specialty-adjusted costs for TINs that have a disproportionate number of low-cost specialists.

Specialty adjustment is different from risk adjustment. For the cost measures included in the QRUR and Value Modifier calculations, risk adjustment is performed at the beneficiary level. When measures are risk adjusted, it means that TINs that usually take care of more clinically complex beneficiaries will not be judged to have worse performance than other TINs solely because their beneficiaries were sicker. Specialty adjustment, performed at the TIN level,

complements risk adjustment by comparing a TIN’s risk-adjusted costs to the risk-adjusted costs of TINs with the same specialties. Additional information on risk adjustment is included in the Risk Adjustment Fact Sheet available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html>.

## Identifying physician specialty and calculating specialty adjustment

Eligible professional specialties are identified based on the CMS specialty code listed most frequently on Medicare Part B claims for services rendered by the professional during the performance year.<sup>1</sup> In the case of a tie, the specialty listed on the most recent claim is selected.

Once a single specialty is identified for each eligible professional, CMS adjusts the cost measures to account for each solo practitioner’s specialty and each TIN’s specialty composition using three steps:

Step 1: Calculate a national average per capita cost for each specialty. This *national specialty-specific expected cost* is the weighted average of each TIN’s payment-standardized and risk-adjusted costs. The weights reflect the number of beneficiaries attributed to each TIN, as well as the number and share of practitioners of the relevant specialty in each TIN.

Step 2: Estimate the average cost for a TIN of a particular specialty mix based on the national average costs for every specialty represented in the TIN. This is referred to as the *specialty-adjusted expected cost*.

Step 3: Compare the *specialty-adjusted expected cost* for each TIN to its actual payment-standardized and risk-adjusted cost. This *specialty-adjusted expected cost* is then compared against the cost benchmark—the national average of all TINs regardless of size—to determine the TIN’s cost performance for the 2017 Value Modifier.

## Example of specialty adjustment

This example illustrates specialty adjustment with two TINs (TIN 1 and TIN 2) and two specialties (A and B), with the following characteristics:

TIN	Risk-Adjusted Per Capita Cost	Number of Attributed Beneficiaries	Number of Eligible Professionals in TIN		Share of Eligible Professionals in TIN		Share of Part B Payments		National Average Per Capita Cost
			Specialty A	Specialty B	Specialty A	Specialty B	Specialty A	Specialty B	
TIN 1	\$12,000	1,500	10	30	25%	75%	35%	65%	\$9,714
TIN 2	\$8,000	2,000	21	39	35%	65%	60%	40%	\$9,714

<sup>1</sup> Eligible professionals include physicians, practitioners, physical or occupational therapists, qualified speech-language therapists, 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 2017 Value Modifier and the 2015 Quality and Resource Use Report, available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html>

**Step 1:** To compute the national specialty-specific expected cost for a specialty across all TINs, we first calculate the numerator, which is the product of each TIN's observed risk-adjusted per capita cost multiplied by the TIN's weight for the relevant specialty, summed across all TINs. Each TIN's weight is the number of attributed beneficiaries in the TIN multiplied by that specialty's share of the TIN's eligible professionals, multiplied by the number of eligible professionals of that specialty in the TIN. This sum is divided by the denominator, which is the sum of all TINs' weights that were used in the numerator.

For this example, the national specialty-specific expected cost for Specialty A is

$$\frac{(\$12,000 \times [1,500 \times 25\% \times 10] + \$8,000 \times [2,000 \times 35\% \times 21])}{([1,500 \times 25\% \times 10] + [2,000 \times 35\% \times 21])} = \$8,813.$$

Similarly, the national specialty specific expected cost for Specialty B is

$$\frac{(\$12,000 \times [1,500 \times 75\% \times 30] + \$8,000 \times [2,000 \times 65\% \times 39])}{([1,500 \times 75\% \times 30] + [2,000 \times 65\% \times 39])} = \$9,599.$$

**Step 2:** To calculate the specialty-adjusted expected cost for each TIN, we multiply the above national specialty-specific expected costs by each TIN's proportion of specialty-specific Part B payments. For each TIN, we compute the product of the TIN's proportion of specialty-specific Part B payments and specialty-specific expected costs, summed across all the TIN's specialty types.

For this example, the specialty-adjusted expected cost for TIN 1 is

$$(35\% \times \$8,813) + (65\% \times \$9,599) = \$9,324.$$

Similarly, the specialty-adjusted expected cost for TIN 2 is

$$(60\% \times \$8,813) + (40\% \times \$9,599) = \$9,127.$$

**Step 3:** Divide the per capita cost by the specialty-adjusted expected cost and multiply this ratio by the national average per capita cost to convert this ratio to a dollar amount. Assuming the national average per capita cost is \$9,714, compute the specialty-adjusted per capita cost for each TIN.

For this example, the specialty-adjusted per capita cost for TIN 1 is

$$\left( \frac{\$12,000}{\$9,324} \right) \times \$9,714 = \$12,502.$$

Similarly, the specialty-adjusted cost for TIN 2 is

$$\left( \frac{\$8,000}{\$9,127} \right) \times \$9,714 = \$8,515.$$