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2015 Value Modifier Results

Background

The Physician Feedback Program/Value-Based Payment Modifier (VM) provides comparative performance information to physicians and medical practice groups, as part of Medicare's efforts to improve the quality and efficiency of medical care. By providing meaningful and actionable information to physicians so they can improve the care they deliver, CMS is moving toward physician payment that rewards value rather than volume. In the Fall of 2014, CMS made available to all physician groups and physician solo practitioners physician feedback reports that included information about the quality and cost of care. For physician groups with 100 or more eligible professionals that are subject to the Value-Based Payment Modifier (VM) in 2015, the physician feedback reports include information about their VM adjustment.

The VM is one of many tools CMS is using to shift the basis for Medicare payments from volume to value. On January 26, 2015, Health and Human Services (HHS) Secretary Sylvia M. Burwell announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients. HHS set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018. The VM and Physician Feedback Programs are part of a strategy to achieve these goals.

Section 1848(p) of the Social Security Act (the Act) requires that CMS establish and apply a VM to specific physicians and groups of physicians the Secretary determines appropriate beginning not later than January 1, 2015 and to all physicians and groups of physicians by January 1, 2017. Physicians in group practices of 100 or more eligible professionals who submit claims to Medicare under a single taxpayer identification number (TIN) are subject to the VM in 2015, based on their performance on quality and cost measures in calendar year 2013.

The Act does not specify the amount of physician payment that should be subject to the adjustment for the VM; however, the statute does require the payment modifier be implemented in a budget neutral manner. Budget neutrality means that the projected aggregate amount by which payments will increase for some groups of physicians based on high performance must be equal to the projected aggregate amount by which payments will decrease for others based on low performance or failure to meet the minimum quality reporting requirements for the VM.

For each payment adjustment year, physician groups ranked into one of the three rewarded cost/quality tiers[1] will have their Medicare physician payments increased. Conversely, certain adjustments will be applied to Medicare physician payments to physician groups that are categorized in one of the program's three cost/quality tiers that receive a downward payment adjustment. This categorization is based on data from the performance period, a calendar year (e.g. 2013 for the 2015 payment adjustment year).

[1] The three cost/quality tiers for which a group receives an upward adjustment are: low cost/average quality; average cost/high quality; low cost/high quality. Groups that treat beneficiaries with an average beneficiary risk score in the top 25 percent of all beneficiary risk scores, receive an additional +1.0x VM payment if they are eligible for an upward adjustment based on their cost and quality performance.

Groups Subject to the 2015 Value Modifier

Based on the methodology codified in 42 C.F.R. § 414.1210(c), there are 1,278 groups of 100 or more eligible professionals (as identified by their TINs). Two hundred sixty-eight of the 1,278 TINs are not subject to the VM in 2015 because one or more physicians under the TIN participated in the Shared Savings Program, Pioneer ACO Model, or Comprehensive Primary Care Initiative in 2013.

Of the remaining 1,010 groups subject to the CY 2015 VM whose physicians' payments under the Medicare Physician Fee Schedule will be subject to the VM in the calendar year (CY) 2015 payment adjustment period., 691 groups either self-nominated for the PQRS as a group and reported at least one measure or elected the PQRS Administrative Claims option as a group. Three hundred nineteen groups failed to self-nominate for PQRS as a group and report at least one measure or elect the PQRS Administrative Claims option as a group.

Of the 691 groups that met the minimum reporting requirement as a group, 127 groups elected to have their CY 2015 VM calculated using the quality-tiering methodology; therefore, only these 127 groups will receive an upward, neutral, or downward adjustment in CY 2015 based on their performance on the quality and cost measures in CY 2013.

Twenty-one of the 127 groups will receive a neutral adjustment in CY 2015 because we have insufficient data to calculate either their quality or cost composite. A TIN falls into the "insufficient data to determine" category if there is insufficient data to determine either the cost or the quality composite. There is insufficient data if either 1) the TIN did not have at least one cost or one quality measure with at least 20 cases; or 2) the cost or quality composite is at least one standard deviation away from the peer group mean composite, but the difference is not statistically significant.

Of the 127 groups that elected to have their CY 2015 VM calculated using the quality-tiering methodology, there are 106 groups for which we were able to calculate both quality and cost composites. We use an adjustment factor (denoted below as "x") to provide upward payment adjustments to those groups that perform well under quality-tiering. The adjustment factor is calculated in a way that redistributes downward adjustments (for those groups that did not meet minimum reporting requirements and those that performed poorly under quality-tiering) to the high performing groups. Fourteen groups are in tiers that will result in an upward adjustment of +1.0x; eleven groups are in tiers that will result in a downward adjustment of -0.5 or -1.0 percent; and 81 groups are in tiers that will result in a neutral VM (meaning no adjustment to their payments) in CY 2015. No groups earned the +2.0x adjustment available to groups that were high quality and low cost.

Of the groups that are eligible for an upward adjustment, none of the groups are eligible to receive an additional +1.0x adjustment to their Medicare payments for treating high-risk beneficiaries. Table 1 shows the distribution of the 106 groups that elected quality-tiering into the various quality and cost tiers (excluding the 21 groups for which there was insufficient cost or quality data).

Table 1: Distribution Using 2013 Data of Quality and Cost Tiers for 106 Physician Groups with 100 or More Eligible Professionals that Elected Quality-Tiering and had Sufficient Data to Calculate a Cost and Quality Composite

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0% (0)	+1.0x = 4.89%[2] (2)	+2.0x = 9.78%[2] (0)
Average Cost	-0.5% (7)	+0.0% (81)	+1.0x = 4.89%[2] (12)
High Cost	-1.0% (3)	-0.5% (1)	+0.0% (0)

Calculation of the Value Modifier Adjustment Factor

The upward payment adjustment factor ("x") is determined after the close of the performance period and is based on the aggregate amount of downward payment adjustments. Any funds derived from the application of the downward adjustments under quality-tiering and the downward adjustment for groups who fail to meet the minimum reporting requirements would be available to all groups of physicians eligible for an upward payment adjustment.

The resulting adjustment or "x" factor is **4.89%**. We estimated the total payment decreases based on the CY 2013 claims paid to groups receiving the downward payment adjustments. The CY 2013 payment amounts were trended forward to estimate 2015 payments to physician groups. Table 2 and Table 3 below show the number of groups subject to the downward, neutral and upward adjustments and the projected 2015 adjustment amounts that were used to calculate the upward payment adjustment or "x" factor.

[2] This number has been rounded. The actual upward adjustment for 1.0x will use additional level of precision and is: 4.8887679%

Table 2: Groups Receiving Neutral (No Adjustment) or Upward VM Payment Adjustments in 2015

2013 Performance Period				2015 Payment Adjustment Period		
Category	**Cost**	**Quality**	**# of TINs**	**Total Projected Physician Payments before VM**	**VM Adjustment**	**Projected Adjustment Amount**
Category 1[3] elected quality-tiering	Avg	High	12	**$224,053,894**	**+1.0x = 4.89%**	**$10,953,475**
	Low	Avg	2	**$8,680,771**	**+1.0x = 4.89%**	**$424,383**
	Avg	Avg	81	**$997,772,747**	**0%**	**$0**
	Insufficient Data to determine[4]		21		**0%**	**$0**
Category 1[3] did not elect quality-tiering	-	-	564	**$8,338,054,230**	**0%**	**$0**
Not Subject to the Value Modifier[5]	-	-	268		**0%**	**$0**
Total	-	-	**680**	**$9,568,561,642**	-	**$11,377,858**

Table 3: Groups Receiving Negative VM Payment Adjustment in 2015

2013 Performance Period				2015 Payment Adjustment Period		
Category	**Cost**	**Quality**	**# of TINs**	**Total Projected Physician Payments before VM**	**VM Adjustment**	**Projected Adjustment Amount**
Category 2[6]	-	-	319	**$1,095,376,847**	**-1%**	**-$10,953,768**
Category 1[3], elected quality tiering	Avg	Low	7	**$49,201,914**	**-0.5%**	**-$246,010**
	High	Avg	1	**$4,264,203**	**-0.5%**	**-$21,321**
	High	Low	3	**$15,675,856**	**-1%**	**-$156,759**
Total	-	-	**330**	**$1,164,518,820**	-	**-$11,377,858**

[3] Category 1 includes groups that either (a) self-nominated for the PQRS as a group and reported at least one measure or (b) elected the PQRS Administrative Claims option as a group.

[4] A TIN falls into the "insufficient data to determine" category if there is insufficient data to determine either the cost or the quality composite. There is insufficient data if either 1) the TIN did not have at least one cost or one quality measure with at least 20 cases; or 2) the cost or quality composite is at least one standard deviation away from the peer group mean composite, but the difference is not statistically significant.

[5] TINs in which at least one physician participated in the Shared Savings Program, Pioneer ACO Model, or Comprehensive Primary Care (CPC) Initiative in 2013 are not subject to the 2015 Value Modifier.

[6] Category 2 includes groups that did not self-nominate for the PQRS as a group and report at least one measure or did not elect the PQRS Administrative Claims option as a group.

2015 Performance if all Groups of 100 or More Eligible Professionals Were Subject to Quality-Tiering

For the 2015 Value Modifier, groups of 100 or more eligible professionals were given the option of electing quality-tiering. The Value Modifier is being phased in, and beginning with the 2016 Value Modifier, quality-tiering will be mandatory for all groups and solo practitioners when they become subject to the Value Modifier (although small groups and solo practitioners will initially be held harmless from downward adjustments under the quality tiering methodology during the first year in which it applies to them). For informational purposes, Table 4 shows how all groups of 100 or more eligible professionals would have performed under mandatory quality-tiering. This includes groups that elected quality-tiering and those that did not. If all groups of 100 or more eligible professionals were subject to quality-tiering in 2015, 31 groups would receive an upward adjustment and 65 would receive a downward adjustment based on their quality and cost performance.

Table 4: Performance of groups of 100+ EPs if all groups were subject to quality-tiering

Category	Cost	Quality	# of TINs	VM Adjustment[7]
Category 1[3] and able to calculate a cost composite and a quality composite	Low	High	0	+2.0X
	Low	Average	9	+1.0X
	Average	High	22	+1.0X
	Low	Low	2	0%
	High	High	1	0%
	Average	Average	450	0%
	Average	Low	35	-0.5%
	High	Average	10	-0.5%
	High	Low	20	-1.0%
Insufficient data to determine[4]	-	-	142	0%
Category 2[6]	-	-	319	-1.0%
Not Subject to the Value Modifier[5]	-	-	268	0%

[7] This column represents the VM adjustment that would apply if the TIN had selected quality-tiering.