



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N3-01-21
Baltimore, Maryland 21207-0512

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From: Matthew Rader
Thomas Nolan
M. Kent Clemens

Subject: Physician Value-Based Payment Modifier 2016 X-Factor Calculation

Background

Section 3007 of the Affordable Care Act provides for a value-based payment modifier (Value Modifier) to affect Medicare Physician Fee Schedule payments for certain providers (identified by their Medicare Taxpayer Identification Number (TIN)), beginning in calendar year 2015. For the purpose of Office of the Actuary's (OACT's) calculations, providers are grouped into one of eighteen categories, or "tiers," depending on the TIN's composition and how they performed during the performance period associated with the payment year. Tier definitions are shown in the appendix. For each payment year, fixed penalties will be applied to Medicare benefit payments to providers that fall into one of the program's three penalized cost/quality tiers, based on data from the performance year. Conversely, providers ranked into one of the six rewarded cost/quality tiers will have their Medicare benefit payments increased. The bonus percentages are to be budget neutral so that the sum of the projected increased payments will equal the sum of the projected decreased payments.

Request to OACT/Provided Data

OACT was asked to calculate a budget-neutral scalar (x-factor) to apply to the bonus percentages for providers within the rewarded cost/quality tiers for payment year 2016. The x-factor was calculated based on data from performance year 2014 supplied by the Center for Medicare, with adjustments made for estimated physician behavior and an estimated impact of the informal review (IR) process. The performance year data comprised the entire list of provider TINs subject to the Value Modifier for payment year 2016, including the following key data for each TIN:

- Number of physicians.
- Payments for calendar year 2014 incurred Medicare benefits that would be subject to the Value Modifier (including 3 months of payment run out).
- The cost/quality tier under which the TIN is ranked.
- The relative reward or penalty percentage associated with each cost/quality tier.

The determination by CMS of the tier for certain TINs has been appealed by the relevant physician or physician group under the IR process, and CMS has considered and resolved a small

portion of these IRs. TIN level data were provided to OACT for completed IRs and for those still pending.

Review of Provided Data

The provided data was reviewed for reasonability. The 2014 data include 588,167 physician/TIN combinations¹ (compared to 295,589 in 2013) with payments totaling \$30.9 billion (compared to \$12.6 billion). The increase in the number of physician/TIN combinations from 2013 to 2014 is largely due to the inclusion of TINs with 10-99 Eligible Professionals (EPs). The 2015 Value Modifier included TINs with 100 or more EPs, whereas the 2016 Value Modifier includes TINs with 10 or more EPs. When only the TINs with 100 or more EPs in the 2014 data are considered, the result is a physician/TIN combination count of 318,641 with payments totaling \$14.0 billion. The percentage increase in the number of physician/TIN combinations from 2013 to 2014 (taking into account TINs with 100+ EPs) is proportional to the percentage increase in physician payments. Moreover, the payment data provided by the Center for Medicare was compared with data independently obtained from the Integrated Data Repository and both data sets tabulated highly comparable total physician payment dollars at the TIN level as well as in total by tier.

OACT Analysis and Resulting Value Modifier Adjustment Factors

Before any adjustments were applied, the x-factor was approximately 18.38.

Some TINs that are subject to a small penalty (that is, -1 percent or -2 percent) would have scope to increase the volume and/or intensity (V&I) of services delivered to offset a portion of the impact of a payment reduction. We assumed that V&I would increase by 5 percent of the penalty. Thus under this approach, given a reduction of 2 percent, the V&I of physician spending in this TIN is estimated to increase by 0.1 percent to counter the reduction.

Mostly due to a large number of TINs not meeting minimum reporting requirements¹ and therefore receiving an adjustment to 2016 payments of -2 percent, a large amount of payment reductions will be distributed to a relatively small number of TINs in the bonus tiers. The result is that TINs in bonus tiers will receive a considerable positive adjustment. In addition, there are many physicians that bill under multiple TINs. Therefore payments could increase if physicians shift some of their services to the TIN receiving the higher adjustment. We assume that these changes to the practice patterns would increase bonus payments by 15 percent. After these two adjustments were applied, the x-factor was approximately 17.62.

There are over 1,000 TINs for which pending IRs could result in a tier change. The IR data provided to OACT included the starting tier and final tier for only 158 TINs with completed IRs. Making reasonable tier assumptions for the TINs with pending IRs was further complicated by differing filing methods, as IRs could be submitted as a group at the TIN level or at the EP level. Favorable IRs submitted at the TIN level would likely have more of an effect than a favorable IR submitted by a single EP, but the degree is uncertain.

Since an IR decision would affect only the quality component of the TIN's tier, and all other tier components were known, ranges of possible tiers were determined for each TIN with a pending IR. The quality score for TINs belonging to tier 18 is unknown; accordingly, it was assumed that

¹TINs that did not meet minimum reporting requirements are TINs that did not avoid the 2016 PQRS payment adjustment as a group or did not have at least 50 percent of the EPs in the TIN avoid the 2016 PQRS payment adjustment as individuals.

these TINs could either remain in tier 18 or receive a low, average, or high quality score as a result of the pending IRs. To predict the probability of ending at each tier within the range, the tier distribution of the roughly 16,000 TINs with their final tier known was used. After this third adjustment, the x-factor was approximately 15.92.

Value Modifier Adjustment Factors

The resulting scalar is 15.9213483255. The Value Modifier bonus factors, grouped by the tier or tiers to which they apply, are shown below:

Tier	Bonus Level	Adjustment Factors
8	+1.0x%	15.9213483255
10		
7	+2.0x%	31.8426966511
9		
12		
11	+3.0x%	47.7640449766

The projected impacts of these adjustments by tier are shown in the appendix.

The data from the completed IRs were not credible enough to make reasonable assumptions about the IRs still pending, and over 1,000 TINs have pending IRs that could result in a tier change after the x-factor is calculated. As a result, there is a significant level of uncertainty associated with the pending IR assumption that could lead to large deviations from budget neutrality. Impacts of the Value Modifier using the x-factor above against other IR scenarios were projected:

- If TINs experienced no tier movement as a result of the pending IRs, Value Modifier would be projected to save \$8.6 million.
- If all TINs moved to the most advantageous tier, Value Modifier would be projected to cost \$674.8 million.

While the second scenario seems far less likely, it appears that there is a higher probability of a large cost than a large savings.

Matthew Rader, ASA
Actuary

M. Kent Clemens, FSA
Actuary

Thomas Nolan, ASA
Actuary

Appendix:

Aggregate Impact Summary by Cost/Quality Tier

Tier	Cost	Quality	Additional Upward Adjustment for Treating High Risk Beneficiaries	Number of EPs	Projected 2016 Payments with no adjustment	Value Modifier Adjustment	Projected 2016 Payments with adjustment
1	Average	Low	No	100+	\$182,018,204	-\$1,820,182	\$180,198,022
2	Average	Low	No	10-99	\$523,146,043	\$0	\$523,146,043
3	High	Average	No	100+	\$221,406,939	-\$2,214,069	\$219,192,870
4	High	Average	No	10-99	\$354,260,799	\$0	\$354,260,799
5	High	Low	No	100+	\$52,393,646	-\$1,047,873	\$51,345,773
6	High	Low	No	10-99	\$43,239,006	\$0	\$43,239,006
7	Average	High	Yes	10+	\$46,135,009	\$14,690,631	\$60,825,640
8	Average	High	No	10+	\$88,880,910	\$14,151,039	\$103,031,950
9	Low	Average	Yes	10+	\$118,663,770	\$37,785,744	\$156,449,515
10	Low	Average	No	10+	\$80,557,148	\$12,825,784	\$93,382,932
11	Low	High	Yes	10+	\$0	\$0	\$0
12	Low	High	No	10+	\$0	\$0	\$0
13	Average	Average	No	10+	\$19,114,862,192	\$0	\$19,114,862,192
14	High	High	No	10+	\$2,623,616	\$0	\$2,623,616
15	Low	Low	No	10+	\$17,443,515	\$0	\$17,443,515
16	*		No	10+	\$7,213,549,678	\$0	\$7,213,549,678
17	**		No	10+	\$0	\$0	\$0
18	***		No	10+	\$3,718,553,722	-\$74,371,075	\$3,644,182,648
Total					\$31,777,734,198	\$0	\$31,777,734,198

* TINs in which at least one physician participated in the Shared Savings Program, Pioneer ACO Model, or Comprehensive Primary Care Initiative in 2014 and are not subject to the 2016 Value Modifier.

** TINs with zero physicians.

*** TINs that did not meet minimum reporting requirements.