



### ARTICLE I. MEDICARE SHARED SAVINGS PROGRAM INTERACTION WITH THE 2017 VALUE MODIFIER *FREQUENTLY ASKED QUESTIONS*

---

#### ARTICLE II. INTRODUCTION

---

Physicians and other practitioners are subject to a number of Medicare quality reporting requirements and performance initiatives, such as the Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier (Value Modifier). This guide describes the interactions between the Medicare Shared Savings Program (Shared Savings Program) and the Value Modifier. These interactions are explained in a question and answer format, following a brief overview of the Value Modifier and how quality and resource use information, in addition to payment adjustment information, is communicated to groups and solo practitioners in Shared Savings Program Accountable Care Organizations (ACOs).

As established by section 3007 of the Affordable Care Act, the Value Modifier provides for differential payment to groups of physicians and physician solo practitioners under the Medicare Physician Fee Schedule (PFS) based on the quality of care furnished compared to the cost of care during a performance period. The Value Modifier is applied to specific physicians and groups of physicians starting January 1, 2015, and to all physicians and groups of physicians by January 1, 2017.

The Value Modifier will apply to physicians in groups with two or more eligible professionals (EPs) and physician solo practitioners who are participants in a Shared Savings Program ACO beginning January 1, 2017. EPs 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 Taxpayer Identification Number (TIN).

The Value Modifier's impact on ACO participants' physician payments is described in the Quality and Resource Use Reports (QRURs) provided to groups and solo practitioners, including ACO participant TINs. QRURs are confidential feedback reports with information about the resources used and the quality of care furnished to their Medicare fee-for-service (FFS) patients.

#### ARTICLE III. FREQUENTLY ASKED QUESTIONS (FAQS)

---

##### Section 3.01 1. How does the 2017 Value Modifier apply to a TIN that participates in a Shared Savings Program ACO?

Groups of physicians and physician solo practitioners, as identified by their ACO participant TIN, that participated in a Shared Savings Program ACO in 2015 will be subject to the 2017 Value Modifier based on their ACO's quality performance in 2015. In 2017, the Value Modifier



will apply to payments under the Medicare PFS for physicians in groups with two or more EPs and to physician solo practitioners that participated in a Shared Savings Program ACO in 2015.

If the ACO satisfactorily reported quality data via the PQRS Group Practice Reporting Option (GPRO) Web Interface for 2015 and avoided the 2017 PQRS payment adjustment, then the ACO participant TINs that participated in the ACO in 2015 will be included in Category 1 and the 2017 Value Modifier for the ACO participant TINs will be calculated using the Value Modifier's quality-tiering methodology to determine if the ACO participant TINs will receive an upward, neutral or downward Value Modifier adjustment based on the ACO's quality performance. For TINs that participated in a Shared Savings Program ACO in 2015, the Value Modifier Cost Composite will be classified as "Average Cost," and the Value Modifier Quality Composite Score will be calculated based on the quality data submitted by the ACO via the GPRO Web Interface and the ACO's performance on the claims-based 30-day All-Cause Hospital Readmission measure calculated by Medicare for 2015.

If a TIN participated in more than one Shared Savings Program ACO in 2015, then the TIN's Quality Composite Score for the 2017 Value Modifier will be based on the performance of whichever ACO had the highest numerical Quality Composite Score.

For ACO participant TINs, the maximum upward adjustment under quality-tiering for the 2017 Value Modifier is:

- +2.0x for physicians in TINs containing 10 or more EPs for High Quality/Average Cost performance (where "x" represents the upward payment adjustment factor, which is derived from actuarial estimates of projected billings that will determine the precise size of the adjustment for higher performing TINs in a given year).
- +1.0x for physicians in TINs containing between 2 and 9 EPs and physician solo practitioners for High Quality/Average Cost performance.
- All TINs receiving an upward adjustment are eligible for an additional +1.0x adjustment if the ACO in which the TIN participated during 2015 has an assigned beneficiary population in 2015 with an average beneficiary Centers for Medicare & Medicaid Services (CMS) Hierarchical Condition Category (CMS-HCC) risk score in the top 25 percent of all beneficiary risk scores nationwide under the Value Modifier methodology.

For ACO participant TINs, the maximum downward adjustment under quality-tiering for the 2017 Value Modifier is:

- Negative two percent (-2.0%) for physicians in TINs containing 10 or more EPs for Low Quality/Average Cost performance.
- Physicians in TINs containing between 2 and 9 EPs and physician solo practitioners are held harmless from downward adjustments for poor performance.



If the Shared Savings Program ACO did not successfully report quality data via the GPRO Web Interface for 2015, then ACO participant TINs will be included in Category 2 and will be subject to the automatic downward adjustment under the 2017 Value Modifier, in addition to the 2017 PQRS payment adjustment. In 2017, the automatic downward Value Modifier adjustment is:

- Negative four percent (-4.0%) for physicians in TINs containing 10 or more EPs.
- Negative two percent (-2.0%) for physicians in TINs containing between 2 and 9 EPs and physician solo practitioners.

Section 3.02 2a. My Shared Savings Program ACO did not successfully report quality data for 2015. Will the EPs that participated in my ACO have another opportunity to submit quality data to CMS to avoid the 2017 PQRS payment adjustment and 2017 Value Modifier automatic downward adjustment?

Yes. CMS has removed the prohibition on eligible professionals who bill under the TIN of an ACO participant in a Shared Savings Program ACO from reporting outside the ACO. This prohibition was removed for purposes of PQRS quality reporting and avoiding the PQRS payment adjustment and the automatic downward adjustment under the Value Modifier. CMS created a one-time PQRS special secondary reporting period for EPs who participated in an ACO that did not successfully report quality data via the GPRO Web Interface for 2015, on behalf of its ACO participant TINs.

Affected EPs may separately report outside the ACO either as individual EPs (using registry, qualified clinical data registry (QCDR), or EHR reporting option) or using one of the group reporting options (registry, QCDR, or EHR) during this PQRS special secondary reporting period if they were participating in an ACO that did not report quality data via the GPRO Web Interface for 2015 on their behalf. Those utilizing a group reporting option do not need to register for it, but must mark the data as group data in their submission. The GPRO Web Interface, CAHPS, and claims reporting are not available options for the PQRS special secondary reporting period. The PQRS special secondary reporting period for the 2017 PQRS payment adjustment will coincide with the 2016 reporting period for the 2018 PQRS payment adjustment and will use the same 2016 data reported by EPs outside the ACO (that is, the January 1, 2016 through December 31, 2016 performance period).



Section 3.03 2b. How will the 2017 Value Modifier apply to EPs that submit quality data during the PQRS special secondary reporting period?

For the 2017 Value Modifier payment adjustment, CMS will assess the individual or group's 2016 data submitted outside the ACO during the PQRS special secondary reporting period against the reporting requirements for the 2018 PQRS payment adjustment to determine if the individual or group practice satisfies PQRS reporting requirements. CMS will use the data reported to the PQRS by the affected EPs under the ACO participant TIN outside of the ACO during the PQRS special secondary reporting period to determine whether the TIN will fall in Category 1 or Category 2 under the 2017 Value Modifier. Groups that meet the criteria to avoid the 2018 PQRS payment adjustment as a group practice participating in the PQRS GPRO (using one of the group registry, QCDR, or EHR reporting options) or have at least 50 percent of the group's EPs meet the criteria to avoid the 2018 PQRS payment adjustment as individuals (using the registry, QCDR, or EHR reporting option), based on data submitted outside the ACO during the PQRS special secondary reporting period, will be included in Category 1 for the 2017 Value Modifier. Solo practitioners who meet the criteria to avoid the 2018 PQRS payment adjustment as individuals using the registry, QCDR, or EHR reporting option, based on data submitted outside the ACO during the PQRS special secondary reporting period, will also be included in Category 1 for the 2017 Value Modifier. Category 2 will include those groups and solo practitioners subject to the 2017 Value Modifier that participated in a Shared Savings Program ACO in 2015 and do not fall within Category 1. Category 2 group and solo practitioner TINs will be subject to the automatic downward payment adjustment under the 2017 Value Modifier.

If eligible professionals who are part of a TIN that participated in a Shared Savings Program ACO that did not satisfactorily report quality data via the GPRO Web Interface on their behalf in 2015 decide to use the PQRS special secondary reporting period, it is important to note that such TINs should expect to be initially classified as Category 2 and receive an automatic downward adjustment under the 2017 Value Modifier for items and services furnished in 2017 until CMS is able to determine whether the TIN has met the criteria to avoid the 2018 PQRS payment adjustment as described above via the PQRS special secondary reporting period. CMS will process the data submitted for 2016, determine whether the group or solo practitioner will be classified as Category 1 or Category 2 for the 2017 Value Modifier, and notify the TIN if there is a change in the TIN's 2017 Value Modifier status. If CMS determines that the group or solo practitioner will be classified as Category 1, then the TIN will receive an "Average Quality/Average Cost" designation. CMS will then update the TIN's status so that physicians billing under the TIN will stop receiving an automatic downward adjustment under the Value Modifier for items and services furnished in 2017 and reprocess all claims that were previously paid. Since TINs taking advantage of this PQRS special secondary reporting period will have missed the deadline for submitting an informal review request for the 2017 Value Modifier, the informal review submission periods for these TINs will occur during the 60 days following the release of the QRURs for the 2018 Value Modifier.



If a Shared Savings Program ACO satisfactorily reported quality data via the GPRO Web Interface for 2015 on behalf of its EPs and avoided the 2017 PQRS payment adjustment, then CMS will not use the data reported to the PQRS by the EPs under the participant TIN outside of the ACO during the PQRS special secondary reporting period.

### Section 3.04 3. What is the ACO Participant List and how is it used in the Value Modifier?

Upon approval to participate in the Shared Savings Program, ACOs must certify a list of ACO participant TINs that have signed participation agreements with the ACO. Prior to the start of every performance year, each ACO must certify its ACO Participant List as final and accurate, accounting for changes made to its ACO Participant List (e.g., to add new ACO participants, modify existing ACO participants, and/or delete ACO participants). This list determines the ACO participant TINs that will be assessed for the Value Modifier using the approach described in Q1, Q2a, and Q2b above. The Value Modifier will be applied to all physicians that bill under the ACO participant TIN during the 2017 payment adjustment period.

### Section 3.05 4. Does the Value Modifier Program use the same benchmarks for quality measures as the Shared Savings Program?

No, the benchmarks for quality measures are not the same for the Value Modifier and the Shared Savings Program. The Value Modifier uses a national case-weighted mean to evaluate performance on each quality and cost measure used in the Quality and Cost Composite calculations. The Value Modifier quality benchmarks are based on data available in the year prior to the performance period (for example, 2014 quality data are used to calculate quality benchmarks for the 2015 performance period used for the 2017 Value Modifier). Under the Shared Savings Program, quality benchmarks are established using all available Medicare FFS data for up to three years and a sliding scale is generally used to score an ACO's performance.

The benchmarks for quality measures that will be used for the 2017 Value Modifier are available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html>.

### Section 3.06 5. I am a physician submitting claims to CMS through multiple Medicare-enrolled TINs, one of which is participating in an ACO under the Shared Savings Program. Are claims and quality data submitted



under all of these TINs used to calculate my Value Modifier payment adjustment?

The Value Modifier is calculated and applied at the TIN level for each group of physicians or physician solo practitioner.

- For each TIN that did not participate in a Shared Savings Program ACO in 2015, its 2017 Value Modifier is calculated based on the TIN's performance on quality and cost measures during 2015.
- For each 2015 Shared Savings Program ACO participant TIN, its 2017 Value Modifier is calculated based on the ACO's quality performance during 2015, as described in Q1 above. If the ACO did not satisfactorily report quality data via the GPRO Web Interface for 2015, then the EPs under the participant TIN will have another opportunity to submit quality data to CMS during the PQRS special secondary reporting period, as described in Q2a above.

Therefore, if a physician bills under multiple TINs in 2017, different Value Modifier payment adjustments could be applied to the physician depending on which TIN he/she is billing under.

It is important to note that a physician's performance does not track or carry between TINs from the performance period to the payment adjustment period. In other words, a physician who bills under TIN A in 2015 and then bills under TIN B in 2017 will have his/her 2017 Medicare PFS payments adjusted based on the Value Modifier applied to TIN B.

Section 3.07 6. How is the 2017 Value Modifier applied to a TIN that joins or leaves a Shared Savings Program ACO during 2017?

ACO participant TINs' 2017 Value Modifier will be calculated under the rules described in Q1 above based on the ACO's quality performance if the TIN was a Shared Savings Program ACO participant in 2015. If the ACO did not successfully report quality data via the GPRO Web Interface for 2015, then the EPs under the ACO participant TIN will have another opportunity to submit quality data to CMS during the PQRS special secondary reporting period, as described in Q2a above. The same Value Modifier will be applied to the TIN during 2017 regardless of whether it leaves the ACO, joins another ACO, or if the ACO is no longer participating in the Shared Savings Program during 2017.

If a TIN did not participate in a Shared Savings Program ACO in 2015, then its 2017 Value Modifier will be calculated based on the TIN's performance on quality and cost measures during 2015, even if it subsequently joins an ACO during 2016 or 2017.



Section 3.08 7. How will the 2018 Value Modifier be applied to a TIN that participates in a Shared Savings Program ACO in 2016?

In 2018, the Value Modifier will apply to all physicians, nurse practitioners, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists who are solo practitioners or in groups with two or more EPs based on performance in 2016. In determining the application of the 2018 Value Modifier to ACO participants:

- If the ACO successfully reports quality data via the PQRS GPRO Web Interface for 2016 and avoids the 2018 PQRS payment adjustment, then ACO participant groups and solo practitioners will be included in Category 1 for the 2018 Value Modifier. Their Cost Composite will be classified as “Average Cost”, and the Quality Composite score will be calculated based on their ACO’s quality performance on the GPRO Web Interface measures, the 30-day All-Cause Hospital Readmission measure, and the Consumer Assessment of Healthcare Providers & Systems (CAHPS) for ACOs survey for 2016. Any data reported to the PQRS by the EPs under the participant TIN outside of the ACO for 2016 will not be used to determine the ACO participant TIN’s 2018 Value Modifier.
- If the ACO does not successfully report quality data via the GPRO Web Interface for 2016 on behalf of its EPs to avoid the 2018 PQRS payment adjustment, then CMS will use the data reported to the PQRS by the EPs under the participant TIN either as a group (using one of the group registry, QCDR, or EHR reporting options) or as individuals (using the registry, QCDR, or EHR reporting option) outside of the ACO to determine whether the TIN would fall in Category 1 or Category 2 under the 2018 Value Modifier. CMS will assess the individual EP’s or group’s 2016 data submitted outside the ACO. Groups that meet the criteria to avoid the 2018 PQRS payment adjustment as a group practice participating in the PQRS GPRO or have at least 50 percent of the group’s EPs meet the criteria to avoid the 2018 PQRS payment adjustment as individuals, based on data submitted outside the ACO will be included in Category 1 for the 2018 Value Modifier. Solo practitioners who meet the criteria to avoid the 2018 PQRS payment adjustment as individuals, based on data submitted outside the ACO will be included in Category 1 for the 2018 Value Modifier. For these Category 1 ACO participant TINs, the Value Modifier Quality Composite will be classified as “Average Quality” and the Value Modifier Cost Composite will be classified as “Average Cost”; thus resulting in a neutral payment adjustment under the Value Modifier in 2018. Category 2 will include those ACO participant TINs that do not fall within Category 1. These ACO participant TINs will be subject to an automatic downward payment adjustment under the 2018 Value Modifier.

### Section 3.09 8. Did ACO participant TINs receive a 2015 Mid-Year QRUR and a 2015 Annual QRUR?

Yes. In April 2016, CMS made the 2015 Mid-Year QRURs available to groups and solo practitioners nationwide, including TINs that participated in a Shared Savings Program ACO in 2015. These reports provided groups and solo practitioners TIN-level performance information on the claims-based quality outcome and cost measures based on a performance period from July 1, 2014 through June 30, 2015. These reports were provided for informational purposes only and did not affect the TINs' Medicare PFS payments.

In September 2016, CMS made the 2015 Annual QRURs available to groups and solo practitioners nationwide, including TINs that participated in a Shared Savings Program ACO in 2015. For ACO participant TINs, the Annual QRURs show their 2017 Value Modifier payment adjustment. The Annual QRURs also show ACO-level performance information on the 30-day All-Cause Hospital Readmission measure and the GPRO Web Interface measures submitted by the ACO that are used to determine the Quality Composite Score. The QRURs also provide TIN-level performance information on the cost measures, which is provided for informational purposes for Shared Savings Program ACO participants.

Additional information about the 2015 Mid-Year and 2015 Annual QRURs is available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html>.

### Section 3.10 9. How can TINs access their QRURs?

Authorized representatives of groups and solo practitioners can access their QRURs on the CMS Enterprise Portal at <https://portal.cms.gov> using an Enterprise Identity Management System (EIDM) account with the correct role. Instructions for obtaining an EIDM account to access a QRUR are available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html>. For questions about setting up an EIDM account, contact the QualityNet Help Desk (refer to Q12).

### Section 3.11 10. Will ACOs have access to their participant TINs' QRURs?

The 2015 Mid-Year and Annual QRURs are provided to ACO participant TINs. ACOs will not have access to the TINs' QRURs unless they have coordinated a process with each ACO participant TIN and ACO Security Official. For example, if an ACO participant TIN wants to give access to its QRUR to the ACO, then the ACO Security Official must first submit a request for a Group Representative role with the ACO participant TIN via the EIDM. Then, the ACO participant TIN's Security Official must approve the request in order to give the ACO Security Official access to its QRUR. However, ACOs that are a single TIN entity will be able to access



their TIN's QRUR if they have the correct EIDM roles.

Instructions for obtaining an EIDM account to access a QRUR, including how to coordinate access to multiple QRURs, are available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html>.

### Section 3.12 11. Is there a 2017 Value Modifier informal review process?

Yes. If your TIN is subject to the 2017 Value Modifier and you disagree with the Value Modifier calculation indicated in your TIN's 2015 Annual QRUR, then an authorized representative of your TIN can submit a request for an informal review through the CMS Enterprise Portal at <https://portal.cms.gov>. More information about the 2017 Value Modifier and 2015 Annual QRUR Informal Review process, including the deadline for submitting an informal review request, is available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html>.

Since ACO participant TINs taking advantage of the PQRS special secondary reporting period for the 2017 PQRS payment adjustment will have missed the deadline for submitting an informal review request for the 2017 Value Modifier, the informal review submission periods for these TINs will occur during the 60 days following the release of the 2016 Annual QRURs for the 2018 Value Modifier.

### Section 3.13 12. Where can I find additional resources?

Information about the 2015 QRURs and 2017 Value Modifier is available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2015-QRUR.html>.

General information about the Value Modifier is available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>.

For questions about the Value Modifier and QRURs, please contact the Physician Value Help Desk: Monday – Friday: 8:00 am – 8:00 pm ET; Phone: 1-888-734-6433 (select option 3); Email: [pvhelpdesk@cms.hhs.gov](mailto:pvhelpdesk@cms.hhs.gov).

For questions about the PQRS program and obtaining an EIDM account, please contact the QualityNet Help Desk: Monday – Friday: 8:00 am – 8:00 pm ET; Phone: (866) 288-8912 (TTY 1-877-715-6222); Email: [qnetssupport@hcqis.org](mailto:qnetssupport@hcqis.org).

For questions about the Shared Savings Program, please email: [SharedSavingsProgram@cms.hhs.gov](mailto:SharedSavingsProgram@cms.hhs.gov).