DEPARTMENT OF HEALTH & HUMAN SERVICES
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FACTSHEET

2018 Value Modifier Results

Practices Receive Upward or Neutral Adjustments to their Medicare Payments in 2018 based on Performance on Quality and Cost Measures

CMS is committed to transforming the healthcare delivery system – and the Medicare program – by putting a strong focus on patient-centered care and allowing healthcare providers to direct their time and resources to patients and improve outcomes. Currently, clinicians receive payment adjustments based on the quality and cost of care they provide their patients. This program – the Value Modifier – ends in 2018.

The Quality Payment Program, established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), is a quality payment incentive program for physicians and other eligible clinicians, which rewards value and outcomes in one of two ways: through the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). MIPS replaces and streamlines the Value Modifier along with several other quality incentive payment programs.

Today, CMS announced the results of the final 2018 Value Modifier. The results show that over 20,000 clinicians will receive between 6.6% to 19.9% more on their Medicare physician fee schedule payments as a result of their high performance on quality and cost measures in 2016. To learn more about QPP, please visit https://qpp.cms.gov/.

The Value Modifier provides payment adjustments to eligible clinicians (physicians, nurse practitioners, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists) based on quality and cost measure performance and reporting. Clinicians who met the minimum quality reporting requirements (i.e., they satisfactorily reported quality data as a group or had at least 50% of their eligible professionals satisfactorily report quality data individually) receive positive or neutral payment adjustments based on performance. Downward payment adjustments are applied only to clinicians in practices that did not meet these minimum quality reporting requirements. Practices that reported quality data and would have received downward adjustments due to performance based on Value Modifier policies in previous years were held harmless as a result of policy changes included in the 2018 Medicare Physician Fee Schedule Final Rule. In 2018, the overwhelming majority of clinicians received neutral payment adjustments.

For clinicians and groups with a positive payment adjustment, the Value Modifier payment adjustment factor is used to calculate the amount of the upward payment adjustment. The payment adjustment factor is calculated by CMS' Office of the Actuary (OACT) and is based on the projected aggregate amount of downward payment adjustments. The 2018 payment adjustment factor is 6.6%. This factor is then multiplied by either 1, 2, or 3, as shown in the table below, to determine the amount of the payment adjustment for certain clinicians. OACT makes assumptions about the outcome of pending informal reviews when calculating the payment adjustment factor. In 2017 and 2016, the final payment adjustment factors were 15.5% and 15.9% respectively. Further details about OACT's calculations may be found in the document titled, "Value-Based Payment Modifier 2018 X-Factor Calculation," located on the 2018 Value Modifier web page.

In 2016, almost three-fourths of clinicians subject to the Value Modifier billed under a practice that will receive a neutral or upward 2018 payment adjustment based on their meeting minimum quality reporting requirements or statistically significant above average performance on quality and/or cost measures. The remaining one-fourth of clinicians billed under a practice that did not meet minimum quality reporting requirements and will therefore receive a downward payment adjustment in 2018. This is a 7 percentage point decrease from 2017 in the number of clinicians receiving a downward adjustment. This decrease occurred despite the expansion of the Value Modifier to additional clinician types, although as noted above, practices that would have received downward adjustments in 2018 based on performance were held harmless. The following table shows the breakdown of upward, neutral, and downward payment adjustments by number and percentage of practices and clinicians.

	2018				**2017**	**2016**	**2015**
Value Modifier Payment Adjustment Status	**Total Practices**		**Total Clinicians**		**Total Physicians**		
	#	%	#	**%**	%	%	%
All upward payment adjustments (1.0x, 2.0x, 3.0x in 2018)	3,478	1.7%	20,481	1.8%	1.4%	0.9%	3.2%
Neutral payment adjustment due to performance	74,024	35.7%	746,556	64.8%	61.3%	65.3%	72.1%
Neutral payment adjustment due to holding harmless from performance	8,007	3.9%	87,841	7.6%	1.3%	3.8%	N/A
Downward adjustment due to performance	N/A	N/A	N/A	N/A	3.0%	2.2%	1.1%
Downward adjustment due to failing quality reporting	121,642	58.7%	296,475	25.8%	33.0%	27.8%	23.6%
Total Value Modifier Practices & Clinicians	207,151	100.0%	1,151,353	100.0%	100.0%	100.0%	100.0%

The table below shows a breakdown of the number of clinicians subject to the 2018 Value Modifier in practices that met minimum quality reporting requirements in each quality-tier, and the associated Value Modifier amount.

	Low Quality	**Average Quality**	**High Quality**
Low Cost	0.0% (2,526)	+1.0x = +6.63% (1,231) +2.0x* = +13.26% (4,252)	+2.0x = +13.26% (220) +3.0x* = +19.88% (53)
Average Cost	0.0%** (60,634)	0.0% (743,774)	+1.0x = +6.63% (10,460) +2.0x* = +13.26% (4,265)
High Cost	0.0%** (7,537)	0.0%** (19,670)	0.0% (256)

*Clinicians subject to the Value Modifier that bill under these practices are eligible for an additional +1.0x adjustment to their Medicare payments for treating high-complexity beneficiaries.
** In 2018, practices that met minimum quality reporting requirements will not receive downward adjustments due to performance.