CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF THE ACTUARY

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Subject: Value-Based Payment Modifier 2018 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 sixteen categories (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, downward adjustments will be applied to Medicare benefit payments to certain providers based on data from the performance year.[1] Conversely, providers satisfying certain cost/quality thresholds 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. In 2018, the Value Modifier will apply to physicians, nurse practitioners, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists (collectively referred to as clinicians).

Request to OACT/Provided Data

OACT was asked to calculate a budget-neutral scalar (x-factor) that is used to calculate the bonus percentages for clinicians within the rewarded cost/quality tiers for payment year 2018. The x-factor was calculated based on data from performance year 2016 supplied by the Center for Medicare, with adjustments considered for clinician behavior and for the informal review (IR) process. The performance year (2016) data was used for the entire list of TINs subject to the Value Modifier for payment year 2018, and included the following key data for each TIN:

- Number of clinicians.
- Payments for calendar year 2016 incurred Medicare benefits that would be subject to the Value Modifier (using 3 months of payment run out).
- The cost/quality tier under which the TIN is ranked.
- The relative upward or downward payment adjustment percentage associated with each cost/quality tier.

The determination by CMS of the tier for certain TINs could be appealed by the relevant physician or physician group under the informal review (IR) process. CMS has considered

[1]Providers that will be penalized are TINs that did not avoid the 2018 PQRS payment adjustment as a group or did not have at least 50 percent of the EPs in the TIN avoid the PQRS payment adjustment as individuals.

and resolved a number of these IRs. TIN level data was provided to OACT for completed IRs and for those still pending.

Historical claims data comparing spending of 2016 and 2017 for TINs included in the 2017 Value Modifier payment year was also provided to OACT for use in assessing the behavioral assumptions.

Review of Provided Data

The provided data was reviewed for reasonability. The 2016 data include 932,783 physician/TIN combinations (compared to 921,169 in 2015) with payments totaling $58.0 billion (compared to $57.8 billion). The percentage increase in the number of physician/TIN combinations from 2015 to 2016 is proportional to the percentage increase in physician payments.

OACT Analysis and Resulting Value Modifier Adjustment Factors

Mostly due to a large number of TINs not meeting minimum quality reporting requirements and therefore receiving an adjustment to 2018 payments of either -1 percent or -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. Before any adjustments were applied, the x-factor was approximately 6.7.

Some TINs that are subject to a downward adjustment (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. However, data comparing 2016 and 2017 Medicare claim payments did not support increased V&I for TINs receiving a downward or an upward payment adjustment in 2016. Therefore we assumed that there would be no impact on V&I for TINs receiving an adjustment in 2018.

Each year, individual eligible professionals (EPs) or organizations as a whole are allowed to request a review of their payment adjustment determination through the Informal Review (IR) process. This year, there are approximately 8,000 TINs that have pending IRs. The last two years, a combined total of 8,542 TINs were subject to Physician Quality Reporting System and Value Modifier IRs and 965 changed into a more favorable tier as a result of the IR (i.e. 11.3 percent changed to a more favorable tier). We assumed that 11.3 percent of IRs for the 2018 payment year would move to the more favorable tier. The resulting x-factor from this assumption is about 6.6.

Value Modifier Adjustment Factors

The resulting scalar is 6.6279583429.[2] The Value Modifier bonus factors, grouped by the tier or tiers to which they apply, are shown below:

Tier	Bonus Level	Adjustment Factors
6	+1.0x%	6.6279583429[2]
8		
7	+2.0x%	13.2559166858[2]
9		
10		
11	+3.0x%	19.8838750288[2]

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

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[2]OACT was asked to estimate the adjustment factors to 10 decimal places. While the factors are estimated to be budget neutral, they are not calibrated with this level of precision. The adjustments are roughly 6.6, 13.3 and 19.9.

Appendix:

Aggregate Impact Summary by Cost/Quality Tier

Tier	Cost	Quality	High Risk	EP Range	(In $Millions) Projected 2018 Before Value Modifier Adjustment	Value Modifier Adjustment	Projected 2018 Payments with Adjustment
1	High	Low	-	-	462	0	462
2	Average	Low	-	-	3,046	0	3,046
3	Low	Low	-	-	106	0	106
4	High	High	-	-	21	0	21
5	High	Average	-	-	1,365	0	1,365
6	Average	High	No	-	846	56	902
7	Average	High	Yes	-	404	54	458
8	Low	Average	No	-	50	3	53
9	Low	Average	Yes	-	176	23	200
10	Low	High	No	-	13	2	14
11	Low	High	Yes	-	5	1	6
12	Average	Average	-	-	42,333	0	42,333
13	ACO or other model*				3,896	0	3,896
14	Zero eligible clinicians				6	0	6
15	Failed minimum reporting req.**			1-9	9,018	-90	8,928
16	Failed minimum reporting req.**			10+	2,441	-49	2,392
Total					64,187	0	64,187

* TINs participating in an excluded CMMI model.
** TINs that did not meet minimum reporting requirements.