CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF THE ACTUARY

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

Date: February 6, 2017

From: Matthew Rader
Thomas Nolan
M. Kent Clemens

Subject: Physician Value-Based Payment Modifier 2017 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 twenty-five 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, penalties will be applied to Medicare benefit payments to certain providers based on data from the performance year.[1] Conversely, providers ranked into 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 2017. The x-factor was calculated based on data from performance year 2015 supplied by the Center for Medicare, with adjustments considered for physician behavior and for the informal review (IR) process. The performance year (2015) data was used for the entire list of provider TINs subject to the Value Modifier for payment year 2017, and included the following key data for each TIN:

- Number of physicians.
- Payments for calendar year 2015 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 reward or penalty 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 include TINs that did not avoid the 2017 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 TINs that fall into one of the penalized cost/quality tiers.

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 2015 and 2016 for TINs included in the 2016 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 2015 data include 921,169 physician/TIN combinations (compared to 588,167 in 2014) with payments totaling $57.8 billion (compared to $30.9 billion). The increase in the number of physician/TIN combinations from 2014 to 2015 is largely due to the inclusion of TINs with less than 10 Eligible Professionals (EPs). The 2016 Value Modifier included TINs with 10 or more EPs, whereas the 2017 Value Modifier includes TINs of all sizes. When only the TINs with 10 or more EPs in the 2015 data are considered, the result is a physician/TIN combination count of 625,005 with payments totaling $33.1 billion. The percentage increase in the number of physician/TIN combinations from 2014 to 2015 (taking into account TINs with 10+ 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 CMS's 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

Mostly due to a large number of TINs not meeting minimum reporting requirements and therefore receiving an adjustment to 2017 payments of either −2 percent or -4 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 20.1.

Some TINs that are subject to a small penalty (that is, −2 percent or −4 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. Data comparing 2015 and 2016 physician claim payments support increased V&I for TINs receiving a penalty in 2016. In addition, it also appears that TINs receiving a penalty in 2016 had greater attrition rates in physicians than TINs receiving no penalty. We assumed the combined effect of increased V&I and fewer physicians would have an aggregate V&I impact of 30 percent for TINs receiving a penalty. Thus a 4 percent penalty would result in a 1.2 percent increase in physician spending to partially offset the penalty. This assumption resulted in an x-factor of approximately 15.8.

Data comparing 2015 and 2016 physician claim payments do not support increased V&I for TINs receiving a bonus in 2016. Therefore we assumed that there would be no impact on V&I for TINs receiving a bonus.

173 TINs belong to Accountable Care Organizations (ACOs) in which the ACO failed to report quality data for 2015 placing the TINs in either tiers 24 or 25, which are penalty tiers. If these

ACOs satisfactorily report PQRS quality data in a special secondary reporting period, the TINs can avoid the penalty and move to tier 19. We have assumed that all of these TINs will report the quality data and avoid the penalty. The resulting x-factor from this assumption is about 15.6.

Each year, individual eligible professionals (EPs) or organizations as a whole are allowed to request a review of their payment adjustment determination through the IR process. This year, there are approximately 4,300 TINs that have pending IRs. Last year, a combined total of 1,803 TINs were subject to PQRS and Value Modifier IRs and 122 changed into a more favorable tier as a result of the IR (i.e. 6.6 percent changed to a more favorable tier). We assumed that 6.6 percent of IRs for the 2017 payment year would move to the more favorable tier. The resulting x-factor from this assumption is about 15.5.

Value Modifier Adjustment Factors

The resulting scalar is 15.4756527356.[2] The Value Modifier bonus factors, grouped by the tier or tiers to which they apply, are shown below:

Tier	Bonus Level	Adjustment Factors
10	+1.0x%	15.4756527356
14		
8	+2.0x%	30.95130547123
9		
12		
13		
18		
7	+3.0x%	46.4269582069
11		
17		
16	+4.0x%	61.9026109426
15	+5.0x%	77.3782636782

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

Matthew Rader, ASA
Actuary

M. Kent Clemens, FSA
Actuary

Thomas Nolan, ASA
Actuary

[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.

Appendix:

Aggregate Impact Summary by Cost/Quality Tier

Tier	Cost	Quality	High Risk	EP Range	(In $Millions)		
					Projected 2017 Before VM Adjustment	Value Modifier Adjustment	Projected 2017 Payments with adjustment
1	Average	Low	No	10+	950	-15	935
2	Average	Low	No	1-9	1,205	0	1,205
3	High	Average	No	10+	618	-10	608
4	High	Average	No	1-9	362	0	362
5	High	Low	No	10+	215	-7	208
6	High	Low	No	1-9	142	0	142
7	Average	High	Yes	10+	146	68	214
8	Average	High	No	10+	157	48	205
9	Average	High	Yes	1-9	177	55	232
10	Average	High	No	1-9	309	48	356
11	Low	Average	Yes	10+	126	58	184
12	Low	Average	No	10+	32	10	42
13	Low	Average	Yes	1-9	20	6	26
14	Low	Average	No	1-9	12	2	14
15	Low	High	Yes	10+	3	2	5
16	Low	High	No	10+	0	0	0
17	Low	High	Yes	1-9	6	3	9
18	Low	High	No	1-9	1	0	1
19	Average	Average	No	1+	38,398	0	38,398
20	High	High	No	1+	18	0	18
21	Low	Low	No	1+	3	0	3
22	ACO or other model*				1,907	0	1,907
23	Zero Physicians				0	0	0
24	Failed minimum reporting req.**			10+	3,432	-104	3,329
25	Failed minimum reporting req.**			1-9	10,633	-166	10,467
Total					58,871	0	58,871

* TINs in which at least one EP participated in the Pioneer ACO Model or Comprehensive Primary Care Initiative in 2015 and are not subject to the 2017 Value Modifier.

** TINs that did not meet minimum reporting requirements.