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Value-Based Payment Modifier: Another Step Toward Value-Driven Healthcare

The 2010 *Patient Protection and Affordable Care Act* (ACA) contains many provisions that emphasize value-based reimbursement for the provision of quality healthcare services. On July 30, 2012, the Centers for Medicare and Medicaid Services (CMS) published a proposed rule for the most recent initiative, the *Physician Value-Based Payment Modifier* (VBPM).[1] The proposed *modifier* would impact physician fee-for-service payment rates based on the quality and cost of care provided to traditional Medicare beneficiaries on or after January 1, 2015, followed by a two-year phase-in process based on performance periods for Calendar Years 2013 and 2014.[2] Beginning in 2017, the VBPM will be applied to most, if not all, physicians reimbursed under the *Medicare Physician Fee Schedule* (MPFS).[3]

Section 3007 of the ACA requires the Secretary of the *U.S. Department of Health and Human Services* (HHS) to develop a method that compares the *quality* of care provided by a physician, or group of physicians, to the *cost* of care provided in order to generate an appropriate *value modifier* for reimbursement.[4] The ACA requires that the *modifier* be fully implemented by January 1, 2017 and be *budget neutral*, whereby payment adjustments for low-performing physicians will fund increased payments to high performing physicians.[5] CMS plans to phase in the VBPM beginning in 2015 with physician groups of 25 or more *eligible health professionals*, which has been defined to include physicians; physician assistants; nurse practitioners; certified nurse-midwives; clinical nurse specialists; certified registered nurse anesthetists; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals; physical or occupational therapists; quality speech-language pathologists; and, qualified audiologists.[6]

Under the proposed rule, physicians will also have some flexibility in choosing how their quality of care is measured and how their payments will be adjusted.[7] CMS used this flexibility to incentivize the use of the *Physician Quality Reporting System* (PQRS), whereby physician groups with non-satisfactory PQRS reports, or those that do not submit the requisite reporting data, will be subject to a downward rate adjustment of 1 percent.[8] For those with satisfactory PQRS reports, groups that elect to be subject to a *Quality Tiering* calculation will experience an upward or downward adjustment based on where they fall within the tiering system.[9] Physician groups that opt for no *Quality Tiering* will not experience any adjustment to their rates.[10] Significantly, physician groups who satisfactorily report for the PQRS in 2013 will effectively be shielded from penalties in 2015 that relate to either the PQRS or the VBPM.[11]

It is estimated that the first phase of the VBPM could apply to as many as 6,000 physician groups.[12] However, physicians who are participating in Medicare *Accountable Care Organizations* (ACOs) or those who are practicing in *Federally Qualified Health Centers* (FQHCs); *Rural Health Clinics* (RHCs); or, *Critical-Access Hospitals* (CAHs) and are reimbursed under *Method II* payment rules are exempt from the *modifier's* initial application in 2015.[13] Additionally, CMS is required to take into account the special circumstances of physicians, or groups, practicing in rural or otherwise underserved areas.[14]

In a 2012 initiative that offers a demonstration of how the VBPM may impact physician reimbursement, 20,000 physicians in four sample states received reports from CMS on the quality of care they provided to patients, as well as the average amount of costs incurred for their patients' treatment.[15] These "*resource use*" reports, which CMS will eventually distribute to physicians across the U.S., allow physicians to compare their performance metrics to that of their peers, as well as predict how their reimbursement rates may be adjusted under the impending VBPM.[16]

Though some in the industry praise the VBPM as progress towards reimbursing physicians based on their demonstrating *value* through achievement of certain quality benchmarks rather than the *volume* of services they provide, other stakeholders caution that comparisons are difficult to make, as specialists see different types of patients whose costs can vary significantly, and physicians see far fewer patients than hospitals, making accurate statistical measurements more difficult to obtain.[17] The American Medical Association (AMA) has expressed significant concerns that these reports and the VBPM could unfairly impact physician reimbursement, citing statistical problems for physicians who care for relatively few Medicare patients and whose performance is significantly impacted by one or two particularly ill patients or patients who experience poor health outcomes as a result of their own noncompliance or co-morbidity factors.[18] Additionally, the VBPM stratifies physicians based on their "*degree of involvement*" with Medicare beneficiaries, thereby

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resulting in some physicians' reimbursement having the potential to be negatively impacted by the poor performance of another physician involved with a patient's care.[19]

In addition to the proposed rule, CMS is seeking comments from the industry regarding how it may best incorporate *quality* and *cost* measures for individual, hospital-based, and community-based settings as a component of the VBPM.[20] CMS has also requested comments on whether it should develop a VBPM option under which hospital-based physicians can elect to have their performance assessed based on their respective hospital's performance.[21] Though the initiative is still in the early stages of its development, the VBPM is expected to be a "*game-changer*" for physician reimbursement, as Medicare is the largest insurer in the U.S., and similar programs by commercial insurers may not be far behind.[22]

1 "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule; Quality Improvement Organization Regulations: Proposed Rules" Centers for Medicare and Medicaid, Federal Register, Vol. 77, No. 146, July 30, 2012.
2 "Physician Value-Based Payment Modifier and the Physician Feedback Program" Centers for Medicare and Medicaid Services, Fact Sheet, July 6, 2012, p.1, 2.
3 "Medicare's Value-Based, Physician Payment Modifier: Improving the Quality and Efficiency of Medical Care" By Kerry B. Kemp to Changes in Health Care Financing and Organization, July 2012, Washington, DC: Robert Wood Johnson Foundation, p. 15; "Three Problems with Medicare's Value-Based Payment Modifier" By Aubrey Westgate, Physicians Practice, April 20, 2012, http://www.physicianspractice.com/blog/content/article/1462168/2062484 (Accessed 8/27/12).
4 "Patient Protection and Affordable Care Act," Public Law 111–148, 124 STAT. 271, (March 23, 2010).
5 Ibid., 124 STAT 373.
6 Federal Register, Vol. 77, No. 146, July 30, 2012, p. 44995.
7 "CMS Proposals for the Physician Value-Based Payment Modifier Under the Medicare Physician Fee Schedule" Centers for Medicare and Medicaid Services, CMS National Provider Call Program (Physician Feedback and Value-Based Modifier Program): Baltimore, Maryland, August 1, 2012.
8 Ibid.
9 Ibid.
10 Ibid.
11 "Get the 4-1-1 on CMS' Proposed Value-based Modifier Payment" American Academy of Family Physicians, August 8, 2012, http://www.aafp.org/online/en/home/publications/news/news-now/practice-professional-issues/20120808valuebasedprop.html (Accessed 8/27/12).
12 Ibid.
13 Ibid.
14 Kerry B. Kemp, July 2012, p. 8.
15 "Medicare to Tie Doctors' Pay to Quality, Cost of Care" By Jordan Rau, Kaiser Health News, April 15, 2012, http://www.kaiserhealthnews.org/stories/2012/april/15/medicare-doctor-pay.aspx (Accessed 8/27/12).
16 Ibid.
17 Ibid.; Aubrey Westgate, April 20, 2012.
18 Aubrey Westgate, April 20, 2012.
19 Ibid.
20 Federal Register, Vol. 77, No. 146, July 30, 2012, p. 44994-95.
21 Ibid., p. 44996.
22 Jordan Rau, April 15, 2012.

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