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Medicare's Physician Value-Based Payment Modifier — Will the Tectonic Shift Create Waves?

Alyna T. Chien, M.D., and Meredith B. Rosenthal, Ph.D.

For at least two decades, the Centers for Medicare and Medicaid Services (CMS) has been transforming itself from a passive payer to an active purchaser of health care, a process that was accelerated by the passage of the 2010 Affordable Care Act (ACA). One ACA provision ushered in a new payment paradigm for physicians — the Physician Value-Based Payment Modifier (PVBM).¹ The PVBM seeks to financially reward physicians who provide health care that is high value — both high in quality and low in cost.² Although the PVBM is being rolled out to physicians in large groups first, the legislation requires that the PVBM be applied to all physicians and groups by January 1, 2017.¹

The PVBM reward formula is a simple, relative system in which performance is assessed in two dimensions (quality and cost), with payments accruing to physicians who have above-average performance along both dimensions. Physicians who perform worse than average or choose not to be involved will be paid less; physicians with average performance will experience no change. The maximum bonus is about 2%

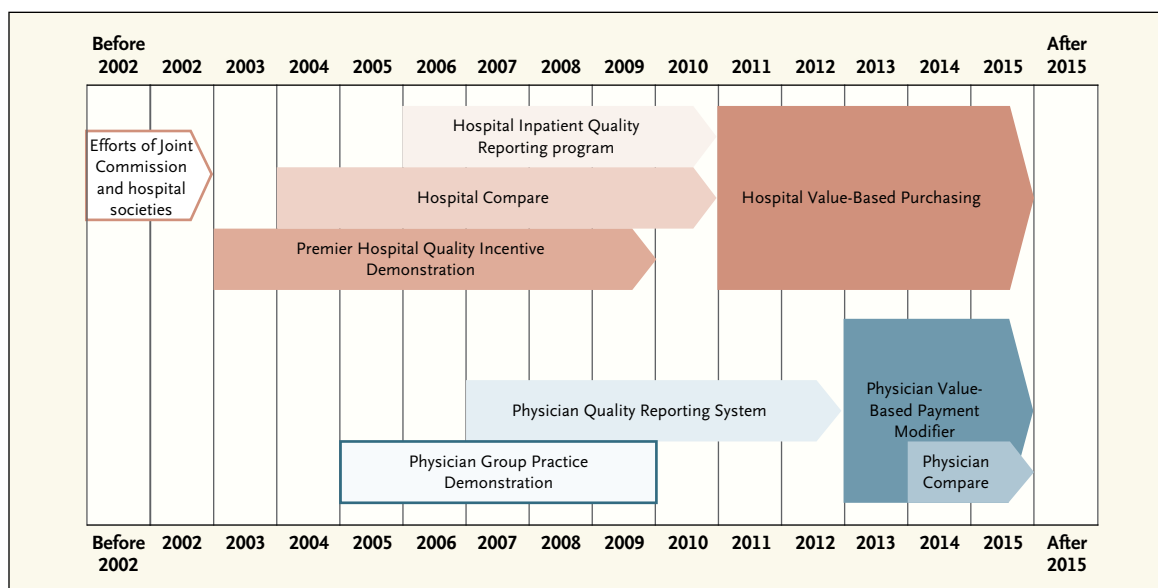
of Medicare fees, and the maximum penalty is approximately 1%. For CMS, scoring physicians relative to one another achieves budget neutrality. For physicians, it eliminates the effects of common shocks to performance, such as an influenza epidemic or vaccine shortage. The key disadvantage of this incentive structure is the inherent uncertainty for physicians about the amount of improvement that will be necessary to receive a bonus or avoid a penalty.

Although the PVBM will eventually affect all the approximately 600,000 physicians who currently bill Medicare, the program will first target the 180,000 physicians working in practices of 100 or more eligible professionals and then expand to include the 220,000 physicians working in practices of 10 or more. This first group of physicians has now declared whether they will participate in the PVBM or accept de facto penalties. Will this tectonic shift in CMS's approach to physician payment set off a new wave of efforts to improve quality and cost performance?

Examination of CMS's path leading up to the PVBM, as compared with the parallel Hospital

Value-Based Purchasing (HVBP) program, offers some insight into the answer to this question (see timeline). In particular, the timeline highlights gaps in physicians' preparedness for value-based purchasing relative to that of hospitals. Three major CMS programs have served as building blocks for HVBP: a quality-reporting program known as Hospital Inpatient Quality Reporting; Hospital Compare, which allows the public to view quality information; and a direct test of pay for performance in hospitals under the Premier Hospital Quality Incentive Demonstration (Premier).

In terms of active involvement in quality measurement, CMS had achieved and maintained participation levels of over 90% among the roughly 3500 hospitals participating in the Hospital Inpatient Quality Reporting program for 9 years preceding the start of HVBP. By comparison, after 6 years, only one third of physicians participate in the comparable Physician Quality Reporting System. Whereas the Hospital Compare website had been presenting information on hospital quality for 9 years before the beginning of HVBP, CMS is not scheduled to debut



Medicare's Quality-Incentive Programs Leading up to Hospital Value-Based Purchasing, as Compared with Those before the Launch of the Physician Value-Based Payment Modifier.

Adapted from a figure by Lia Lankford.

physician-quality information on Physician Compare until 2014 (i.e., after the PVBM goes into effect). CMS has also benefitted from 6 years of experience with the hospital Premier program but has not conducted an equivalent pay-for-performance pilot for physicians. CMS's most analogous physician experience stems from its Physician Group Practice Demonstration, but since that demonstration involved 10 extremely large and sophisticated practices taking on financial risk for their patient populations, the experience is much more generalizable to accountable care organizations than to the physicians being targeted by the PVBM.

The lack of experience with physician-level measurement and reporting has important implications for the PVBM. First, far greater numbers of physicians will need to become engaged in reporting of quality and cost perfor-

mance. This challenge should not be underestimated: there are nearly 150 times as many physicians who bill Medicare as there are hospitals, the physician population includes physicians of all types (primary medical, surgical, and subspecialists), and many of these physicians work in a wide array of smaller practices that are still acquiring the basic infrastructure (e.g., health information technology) or organizational affiliations (e.g., independent practice associations) needed to measure and improve the quality and cost of care.

Second, the stock of measures being used in the PVBM may be too focused on the primary care sector to engage the interest or participation of hospital-based and subspecialty providers. Moreover, the science of measuring the performance of individual physicians and small practices is inadequately devel-

oped. For example, how will one be able to assess individual and small-group physician performance when, even for common conditions, existing measures require a volume of patients beyond that seen by a typical physician or small-group practice?²³ If condition-specific quality measures are not applicable to individual-physician-focused programs because of insufficient volume, then it may be important for methodology experts to shift development attention toward "all-condition" measures (e.g., patients' functional status) that can apply to all patients irrespective of their clinical conditions.

Third, physician-performance measurement requires tackling the contentious issue of quality and cost attribution methods. To date, attribution methods have been somewhat simplistic, with hospitals being held accountable only for the quality and cost of

care that occurs while a patient is hospitalized. The PVBM expands the accounting domain to all sectors of the health care system, which is a far more complex proposition. All parties will need to recognize the interrelatedness

to generate a measurable effect on performance.

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of hospital and ambulatory care and of primary care and subspecialty services, and they will need to tackle thorny issues related to sharing or parsing clinical responsibility for patients when several different physicians, multiple practices, and one or more hospitals can be involved in a typical patient's care.

Finally, although stakeholders may be somewhat familiar with the incentive-design elements within the PVBM, evidence is lacking about the costs and benefits of alternative approaches to incentive design for physicians. Going forward, it will be increasingly important to test whether absolute or relative targets are preferable,⁴ whether it is better to provide incentives to organizations (which provide the infrastructure for measuring quality and cost) or to physicians (who make clinical decisions),⁵ how quality and cost performance should be balanced in the reward formula, and how large an incentive is required

will need to participate in remedial and advanced work. Ideally, a diverse group of physicians and their respective professional societies will need to determine how to share accountability for patients and lead consensus-building efforts pertaining to the clinical focus of measurement and improvement endeavors. Leading measurement entities — the Agency for Healthcare Research and Quality, the National Quality Forum, the National Committee for Quality Assurance — will need to create new tools and methods that recognize the challenges of physician-level performance profiling. CMS should leverage its resources (e.g., Quality Improvement Organizations) to facilitate learning opportunities for a wide array of practice types and settings, test alternative incentive designs, and make data submission and reporting as efficient as possible.

Given the challenges entailed by a much-needed tectonic shift

toward value-oriented physician payment, it made sense for the ACA to require CMS to introduce an incentive program with familiar design elements, quality measures, and attribution methods. But the PVBM cannot be effective until a broader base of physicians is fully engaged, potentially controversial issues related to accountability and attribution are addressed, and stakeholders gain the necessary experience in improving care quality and cost in real-world settings.

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From the Division of General Pediatrics, Boston Children's Hospital (A.T.C.), Harvard Medical School (A.T.C.), and the Department of Health Policy and Management, Harvard School of Public Health (M.B.R.) — all in Boston.

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