Medicare is increasingly becoming a purchaser of services according to their value and not simply an insurer that pays bills. Some providers may provide excellent care at a relatively low cost, and some may provide mediocre care at a high cost. Currently, Medicare pays both the same. This does not help the patient, the dedicated physician, or the payer.

The concept of value considers both the quality of care and the cost of care. It is increasingly being promoted to both pay the most for the best service and to teach providers how to improve their service. Medicare has been required by legislation to establish a range of payments under the Medicare Physician Fee Schedule and to base them on both the quality and cost of service provided during a performance year.

This combination of quality and cost is referred to as the value-based modifier (VBM) and must, by statute, be applied to groups of 100 or more physicians starting in January 2015, to groups of 10 or more in January 2016, and to all physicians in January 2017. The overall amount of payment under the plan must remain budget neutral, so individuals and groups will be winners and losers, depending on how they perform.

The Basics

The VBM will be based on components of quality of care and cost of care. Quality of care will be determined by the Physician Quality Reporting System (PQRS). PQRS data take time to be analyzed, so data from 2 years prior will be used for VBM purposes; 2015 VBM payments will be based on 2013 PQRS data.

Medicare is urging even solo practitioners to participate in PQRS now, so they will be prepared for the impact of the VBM for payments coming in 2017. Although the initial amount “at risk” is relatively small, as currently proposed, Medicare intends to increase this amount, as well as the differential pay for high- and low-quality care, as soon as logistics and experience with the model allows.

The VBM will not apply to rural health clinics, federally qualified health centers, and critical access hospitals. For 2015 and 2016, the VBM will not apply to physician groups in Medicare shared savings accountable care organizations, the Pioneer Accountable Care Organization model, or other Comprehensive Primary Care Initiative.

Group members will be defined as anyone who can bill Medicare under the same Taxpayer Identification Number.

Physicians, nurse practitioners, therapists, dieticians, and clinical social workers will all be in one group if they all bill under the same “TIN.” For example, a group of 30 doctors with 70 other support staff who could bill Medicare would qualify as a group and be subject to the 2015 physician value-based payment modifier policies. The VBM, however, applies only to the items and services billed by the physicians.

Quality, Cost, and the VBM

The Centers for Medicare & Medicaid Services will base the quality of care component of the VBM on PQRS data. For groups not submitting 2013 PQRS data, there will be an initial 1% and 1.5% decrease in payments for the 2015 VBM and PQRS payment systems, respectively. These penalties will probably increase in later years to 5%. Groups that use PQRS and elect not to participate in the VBM in 2015 will receive a 0% increase in payments (this number may become negative in future years). For groups of 10 or fewer practitioners, there will be incentive payments and no penalties in 2016.

The exact effect on payment varies by the method of reporting data, which is too complicated to review here. For groups that use the PQRS system and participate in “quality tiering” under the VBM system, their payments may go up or down or remain the same, depending on how they compare to their peers.

Quality of care will be calculated in accord with six national health care priorities—clinical care, patient experience, population/community health, patient safety, care coordination, and efficiency—each with equal weight in determining the final score. If a group doesn’t report enough PQRS quality measures to fill all six domains, then the ones with data would be equally weighted. A minimum of three domains must be represented.

The final VBM will also be affected by the cost of care delivered. Initially, CMS will calculate and compare total per capita cost and the per capita costs of four chronic diseases: chronic obstructive lung disease, heart failure, coronary artery disease, and diabetes. Costs include those through Medicare Parts A and B, but not D. Attribution of cost (“who charged what”) will be similar to that in accountable care organizations: Whoever made the plurality of primary care visits is ascribed all costs. For the chronic-care nursing home patient, this will almost always be the attending primary care physician, but for the postacute-care patient, it could be the SNFist, the primary care doctor, or even a specialist.

Scoring Quality Tiering

Quality of care and cost of care will be analyzed for every group to ensure reliability and validity of data, and the results will be compared with benchmark data gathered from other groups and from standardized national data. This will allow ranking of groups as low, average, and high in both quality and cost—the so-called quality tiering. A matrix will then be constructed to combine the two into a final payment.

Providers giving high quality with low cost will receive the best payment, and those with the highest cost and the lowest quality will receive the greatest penalty. Low-cost–low quality and high cost–high quality providers will receive a 0% adjustment. An additional upward payment adjustment will be given to providers treating high-risk beneficiaries.

Physician groups will receive feedback reports (Quality and Resource Use Reports) detailing the methodologies and results. These will begin in this fall (based on 2012 data) for physicians in groups of 25 or more and may help them determine how they wish to participate in this system. When and how reports will be given to smaller groups has not been determined.

The Postacute and Long-Term Care Factor

The situation for the PA/LTC physician is more complex than that for the office-based physician. There are unique circumstances for the combined office–PA/LTC practitioner and the dedicated PA/LTC practitioner. The VBM system was designed for the outpatient setting, and PA/LTC practitioners would be best served by a CMS re-evaluation of the system after it analyzes initial results. The practitioner who attends to patients outside of PA/LTC can use the PQRS system if the measures are not long-term care-specific. Finally, the validity of using the four selected chronic diseases for cost comparisons in the chronic nursing home setting is suspect. PA/LTC practices vary considerably, and benchmarking a skilled-nursing and a long-term–dementia practice against each other for quality of care and cost purposes will lead to inequities.

The practitioner who attends exclusively or primarily to PA/LTC patients will have more difficulty than those who have an office practice as their primary reporting site. The electronic health record systems for PA/LTC are few in number and generally not as advanced as their office-based cousins. Many have been adapted from office systems and are not very friendly to collecting the needed PA/LTC data for PQRS purposes.

PQRS data selected for office patients may not suit the PA/LTC patient. Although somewhat complex and beyond the scope of this article, the method of collecting and submitting the required data can be cumbersome and may be best served in PA/LTC by a CMS-endorsed registry. Such a registry would be a valuable tool in the VBM system, accountable care organizations, and even facility-based systems. Currently, AMDA has a workgroup dealing with this and other issues related to electronic health record use and reimbursement.

There are several other issues for PA/LTC that the current VBM system, as currently proposed, does not deal with well. For example, if a SNFist does the plurality of a skilled nursing patient’s physician visits within a year, that doctor becomes responsible for all costs encountered both before and after the nursing home stay—while having little, if any, influence on most of them.

Also, the very complexity of PA/LTC patients can make the PA/LTC provider a higher cost physician. Alternatively, the chronic care patient undergoing palliative care could be a low-cost patient, but a poor performer, under the VBM system, if the measures are not long-term care-specific. Finally, the validity of using the four selected chronic diseases for cost comparisons in the chronic nursing home setting is suspect. PA/LTC practices vary considerably, and benchmarking a skilled-nursing and a long-term–dementia practice against each other for quality of care and cost purposes will lead to inequities.

Dr. Crecelius is a private practitioner, multifacility medical director for Delmar Gardens Nursing Homes in St. Louis, and assistant clinical professor of internal medicine and geriatrics at Washington University School of Medicine. Currently chair of AMDA’s Public Policy Committee and alternate advisor to the AMA RVS Update Committee, he is a past president of the association. You can comment on this and other columns at www.caringfortheages.com, under “Views.”