PA/LTC Physicians Disadvantaged by the Value-Based Modifier

By Rod Baird

Public Policy

Not long ago, my wife and I attended a production of “The Book Club Play” by Karen Zacarias. Much like the characters in the play, I rely on a small group of long-term care private practice leaders who meet two to three times a year to discuss topics such as regulations, audit issues, marketing, recruitment, and performance metrics. We have built a level of trust over time, and the organizational information that we share has become more detailed and revealing.

More recently, we have been sorting out implications of the value-based modifier program (VBM). This is one of the many legislated reforms contained in the Patient Protection and Affordable Care Act (health reform). The law directs the Department of Health and Human Services Secretary to develop a budget-neutral program that “shall establish a payment modifier that provides for differential payment to a physician or a group of physicians . . . based upon the quality of care furnished as compared to cost.”

The act mandates that the Centers for Medicare & Medicaid Services create a similar scheme for the PA/LTC institutional provider community by 2017.

How Medical Groups Fare

VBM affected groups larger than 99 physicians in 2013, affects groups of 10 or more in 2014, and will affect every group of 2 or more by 2015. VBM measures two performance dimensions: quality and cost. Each dimension has three performance levels: low, medium, and high.

Any medical group that submitted claims to Medicare Part B on behalf of 25 or more providers during 2012 can preview CMS’s assessment of its group’s Medicare fee-for-service claims to Medicare Part B on behalf of the beneficiary, and risk-adjusted costs were approximately $41,000 per person. The national benchmark cost is $10,337. Again, keep in mind that this national benchmark involves younger, healthier patients.

The quality performance score of the groups ranged from -1.59 to +0.30. Three of the groups were below average, with their tiers determined by use of the administrative claims-reporting option for GPRO.

The fourth group, with a positive score, is part of a Pioneer Accountable Care Organization. There is an interesting explanation for this. Under the 2012 group practice reporting options, accountable care organizations could select the patient sample to use in reporting its member physicians’ quality performance, so the organization could eliminate frail elders from their sample. That option existed only during the first years of the Pioneer accountable care option program. I expect its 2013 scores to drop, once the option to choose patients disappears. Why? Appropriate care for the PA/LTC population frequently is at odds with a prevention-oriented model used in ambulatory settings.

What Next?

AMDA’s leadership is working to help ensure that PA/LTC practices are rated fairly and benchmarked against others who are providing similar services to similar patient populations. In fact, AMDA’s strategic plan—released last year—included developing quality measures specific to PA/LTC quality improvement as a key goal. The association has reviewed these data and presented a strategy to CMS. Otherwise, unless CMS changes its benchmark data, it will be essentially impossible for PA/LTC-focused medical groups to avoid a “high cost” assignment. Despite our best proactive efforts on this, I suspect that a solution will take some while. In the meantime, we must deal with a flawed system and do what we can to promote the real meaning of our dismal-looking numbers.

Toward this end, we need to employ a strategy to be recognized as “high quality.” There doesn’t appear to be any opportunity to demonstrate quality via the use of administrative claims, as the elements subject to measurement are beyond the provider’s control. So we will have to find other ways to document and promote quality. Again, this will take time.

Like the characters in the play, I have learned that reaching out to my colleagues is the best way to navigate challenges and find answers. I will continue to speak with other physicians in my area and work with AMDA on its efforts to develop and promote PA/LTC quality performance measures.

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Between High Cost, Low Quality

When I saw that my group ranked poorly on CMS’s quality-cost rating, there was no doubt in my mind that my “book club” peers would have similarly dismal rankings. Because their patient population is sicker, has more comorbidities, uses more medications, and has a higher utilization rate, PA/LTC physicians probably will be lower on the matrix, and their groups will be penalized with lower payments and public shaming. This is an unavoidable consequence of serving a frail, elderly population.

After a few phone calls and some coaching on how to access CMS’s obscure system, my colleagues had copies of their reports. You can see the results from a representative sample of four long-term care physician groups in the online version of this column at www.caringfortheages.com. As expected, there was no way the LTC groups could measure up when compared with ambulatory groups.

Based on a review of the four LTC groups’ Quality and Resource Use Report results, it’s clear that 100% of the groups were classified as “high cost.” All four groups were at the very top of the “cost” hierarchy. Their risk-adjusted costs were tightly clustered (three at 96% and one at 97%). Their average costs were approximately $41,000 per beneficiary, and risk-adjusted costs were approximately $20,000 per person. The national benchmark cost is $10,337. Again, keep in mind that this national benchmark involves younger, healthier patients.

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