Value-Based Physician Reimbursement

Mark Rattray MD
What is value-based reimbursement?

- **Value of care** is a preference-weighted assessment of a particular combination of quality and cost of care performance. [For our purposes, payer preferences are applicable.]

- **Value-based reimbursement** is the incorporation of value assessments in determining care provider reimbursement for services.
Goals

- Explain the reasons and concepts behind value-based reimbursement
- Familiarize you with value measurement terms and methods
- Share what private payers and Medicare are doing
- Help all of you feel more informed and hopefully better prepared. Perhaps inspire a passion within you for this new frontier of medicine
- Provide some summary recommendations
Why value-based reimbursement?

- No consistent correlation between clinical quality and cost
- Known wide variations in quality and cost (at all levels)
- Current system rewards quantity, not value
- Perceived lack of accountability
- Lack of a value focus leads to waste, excess patient risks and costs, and lackluster care coordination
Why value-based reimbursement?

Relationship between quality and Medicare spending, as expressed by overall quality ranking, 2000–2001

Overall quality ranking

1 (Highest)

11

21

31

41

51 (Lowest)

Annual Medicare spending per beneficiary (dollars)

Source: Medicare administrative claims data and Medicare Quality Improvement Organization program data, as analyzed by Baicker and Chandra (2004). The solid line shows that for every $1,000 increase in Medicare spending per beneficiary, a state’s quality ranking dropped by 10 positions. Adapted and republished with permission of Health Affairs from Baicker and Chandra, “Medicare spending, the physician workforce, and beneficiaries’ quality of care” (Web Exclusive), 2004. Permission conveyed through the Copyright Clearance Center, Inc.
Why value-based reimbursement?

Value and Value Measurement
Quality measurement “domains”

- **Process**
  - Often a numerator / denominator measure – for patients for whom a certain test is recommended (denominator), how many received that test (numerator). Example: HbA1c testing for diabetics

- **Outcomes**

- **Access**
  - Availability of needed services; wait times for appointments

- **Structure (and infrastructure)**
  - Current typical measures are EHR, e-prescribing
  - Accrediting organizations often focus on infrastructure

- **Patient experience**
  - CAHPS (Consumer Assessment of Healthcare Providers and Systems) is emerging as the standard. (www.cahps.ahrq.gov)

AHRQ http://www.qualitymeasures.ahrq.gov/browse/by-domain.aspx
Quality measurement

- Early focus was on process measures
  - Measurable, efficiently but imperfectly, by claims data algorithmic analysis
- Current evolution is to broaden to other domains
  - Outcomes
  - Access
  - Structure
  - Patient experience
- These additional domains above require new and more costly measurement mechanisms
  - Electronic Health Records – not a panacea for measurement yet
  - Surveys – require active input from patients, often remote from actual care

AHRQ [http://www.qualitymeasures.ahrq.gov/browse/by-domain.aspx](http://www.qualitymeasures.ahrq.gov/browse/by-domain.aspx)
Quality measurement

- Prediction: Future focus will be on outcomes
- Outcome measures take many forms
  - Mortality
  - Achieving treatment goals – blood pressure control, diabetes control
  - Avoiding adverse effects – readmission, complications, stroke, cardiac events
  - Patient functional status – in many respects, the ultimate outcome measure other than mortality
    - Seems like this measure is what PM&R is all about
    - Opportunity for PM&R to “own” this measure
Quality measurement challenges

- **Data capture** – Often what we would consider the most important measures, such as outcomes, are not currently being captured as electronic data, and manual processes to capture this are expensive and prone to human error.

- **Data completeness** – We may tend to place undue weight on the data we have captured, when that data may relate to only a portion of a physician’s overall practice.

- **Statistical reliability** – Small numbers of observations may not allow sufficient statistical reliability to fairly compare one physician’s performance to another’s.

- **Attribution** – Who is responsible for a patient’s quality of care? May be straightforward when the patient is cared for by only one physician, but what if many physicians are involved?
Cost of care measurement

- Per capita or Total Cost of Care per patient – usually represented as an annual amount
- Per capita or Total Cost of Care by condition – for example, the total annual cost of care for a diabetic (all costs – not just the care for diabetes)
- Episode of care or condition/procedure-specific cost of care
  - Episode of care (more in next slides)
  - Condition/procedure-specific costs of care – Examples: Costs for asthma care, costs for colonoscopy, costs for knee replacement surgery. All costs are aggregated if they are related to the condition or procedure.
Episodes of care

- Created using algorithmic claims “groupers”
- Groupers
  - Are typically proprietary (e.g., ETGs, MEGs)
  - Map billing codes to over 500 specific conditions
  - Identify start and end of condition
    - Chronic conditions usually have 1 year duration
  - Group claims together to identify condition treatment costs
  - “Attribute” episodes to specific clinicians
    - Typical attribution rule: Episode is assigned to clinician with the “plurality” of E/M codes within an episode
  - Medicare is creating an episode grouper
Example of episode of care measurement

**SPECIALTY: Family Practice**
**RESPONSIBLE CLINICIAN ID: 000003402**

<table>
<thead>
<tr>
<th>EPISODE TREATMENT GROUP DESCRIPTION</th>
<th>MANAGEMENT</th>
<th>SURGERY</th>
<th>ANCILLARY</th>
<th>PHARMACY</th>
<th>FACILITY</th>
<th>TOTAL</th>
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<tbody>
<tr>
<td>Benign hypertension, w/o comorbidity</td>
<td><strong>$3,854</strong></td>
<td>$3</td>
<td><strong>$1,849</strong></td>
<td><strong>$4,029</strong></td>
<td>$488</td>
<td><strong>$10,223</strong></td>
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<td>Cardiovascular disease signs &amp; symptoms</td>
<td><strong>$1,258</strong></td>
<td>$6</td>
<td><strong>$4,180</strong></td>
<td>($120)</td>
<td>$214</td>
<td><strong>$5,539</strong></td>
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<tr>
<td>Minor conduction disorder</td>
<td><strong>$549</strong></td>
<td>$4</td>
<td><strong>$934</strong></td>
<td><strong>$149</strong></td>
<td>$614</td>
<td><strong>$2,251</strong></td>
</tr>
<tr>
<td>Allergic rhinitis</td>
<td><strong>$760</strong></td>
<td>$8</td>
<td>$172</td>
<td><strong>$1,183</strong></td>
<td>$2,124</td>
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</tr>
<tr>
<td>Gastroenterology disease signs &amp; symptoms</td>
<td><strong>$686</strong></td>
<td>$599</td>
<td><strong>$528</strong></td>
<td>($21)</td>
<td><strong>$171</strong></td>
<td><strong>$1,964</strong></td>
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<tr>
<td>Oth minor ortho disorder - neck and back</td>
<td><strong>$1,450</strong></td>
<td>$101</td>
<td>($323)</td>
<td><strong>$402</strong></td>
<td><strong>$1,720</strong></td>
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<tr>
<td>Minor orthopedic trauma - neck and back</td>
<td><strong>$329</strong></td>
<td>$23</td>
<td><strong>$659</strong></td>
<td>($126)</td>
<td><strong>$885</strong></td>
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<tr>
<td>Acute sinusitis</td>
<td>$8</td>
<td>$2</td>
<td>$2</td>
<td><strong>$828</strong></td>
<td><strong>$840</strong></td>
<td></td>
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<tr>
<td>Irritable bowel syndrome</td>
<td><strong>$332</strong></td>
<td>$88</td>
<td><strong>$530</strong></td>
<td>($150)</td>
<td><strong>$23</strong></td>
<td><strong>$823</strong></td>
</tr>
<tr>
<td>Oth minor ortho disorder - foot and ankle</td>
<td><strong>$210</strong></td>
<td>$62</td>
<td><strong>$361</strong></td>
<td>$112</td>
<td><strong>$35</strong></td>
<td><strong>$780</strong></td>
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<tr>
<td>Orthopedic signs and symptoms - unspecified</td>
<td><strong>$244</strong></td>
<td>$30</td>
<td><strong>$181</strong></td>
<td><strong>$172</strong></td>
<td><strong>$627</strong></td>
<td></td>
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<tr>
<td>Minor inflammation of skin &amp; subcutaneous tissue</td>
<td><strong>$315</strong></td>
<td>($1,337)</td>
<td>($970)</td>
<td><strong>$1,475</strong></td>
<td>($517)</td>
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<tr>
<td>Benign neoplasm of the breast, w/o surgery</td>
<td>($103)</td>
<td>($97)</td>
<td>($384)</td>
<td><strong>$22</strong></td>
<td>($562)</td>
<td></td>
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<tr>
<td>Minor infectious disease</td>
<td>($43)</td>
<td>$22</td>
<td><strong>$64</strong></td>
<td>($772)</td>
<td><strong>$134</strong></td>
<td>($594)</td>
</tr>
<tr>
<td>Contraceptive management, with surgery</td>
<td>($57)</td>
<td>($605)</td>
<td>($316)</td>
<td><strong>$8</strong></td>
<td>($970)</td>
<td></td>
</tr>
<tr>
<td>Viral skin infection</td>
<td><strong>$359</strong></td>
<td>($1,827)</td>
<td>($253)</td>
<td><strong>$149</strong></td>
<td>($1,572)</td>
<td></td>
</tr>
<tr>
<td>Routine exam</td>
<td><strong>$513</strong></td>
<td>($235)</td>
<td>($2,271)</td>
<td><strong>$8</strong></td>
<td>($1,993)</td>
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<tr>
<td>Benign neoplasm of the skin</td>
<td><strong>$447</strong></td>
<td>($2,606)</td>
<td>($602)</td>
<td>($58)</td>
<td>($2,818)</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$15,588</strong></td>
<td>($8,428)</td>
<td><strong>$3,306</strong></td>
<td><strong>$7,886</strong></td>
<td><strong>$2,416</strong></td>
<td><strong>$20,768</strong></td>
</tr>
</tbody>
</table>
Cost of care measurement challenges

- Per capita or Total Cost of Care
  - Capture of all costs (may miss patient purchased care)
  - Total cost of care usually used for primary care physicians
  - When comparing physicians based on a patient’s total costs
    - How much control did the physician have over those costs?
      - Different contracted rates with hospitals and other care providers
      - Other physicians’ decisions may have significant impact on those costs
      - Patient benefit plans and care decisions may impact costs
  - Lack of standardized methodology between payers
Cost of care measurement challenges

- **Episodes of care**
  - Claims-based and therefore dependent on capturing claims, adequate and consistent diagnosis codes
  - Proprietary episode groupers (ETGs, MEGs, etc.) are complex and perceived as “black boxes”
  - Attribution of costs to specific providers – what if more than one physician is involved in the management of an episode of care?
  - Statistical reliability – When there are more than 500 episode types, many episode types will have very few instances for comparison
  - Peer group used for comparison

- **Condition/procedure-specific costs of care**
  - Virtually no standardization between payers
  - Otherwise challenges are similar to episodes of care
Combining quality and cost of care measurements

- To compare physician performance, quality results may be rolled up into a “quality composite or index”, cost results into a “cost composite or index”, and the two combined into a “value composite or index”

- Creation of each index requires a differential weighting of the underlying measures. For example, the various quality measures much each carry a specific weight when combined into a quality index, same with cost measures, and finally the quality index must be weighted relative to the cost index. Such weighting will vary between payers.
Value-Based Reimbursement
How are payers using value measurement?

- Private payers
  - Early efforts
    - Pay for performance
    - Narrow networks
    - Tiered networks
  - Evolving efforts
    - Bundled care services (with/without warranties)
      - Must meet quality requirements; agree to fixed prices
    - Accountable Care Organizations
Early private payer efforts

- **Challenges**
  - Rush to market for competitive advantage
  - Initial focus on cost not quality / value
  - Lack of transparency – “Black boxes”
  - Statistical reliability weak
  - Poor physician engagement due to historical lack of credibility

- **Legacy**
  - Spawned the Ambulatory Care Quality Alliance
  - Quality / Value focus emerged
  - Increased physician specialty society engagement
  - Focus moved from individual physicians to systems of care
  - Lessons learned influenced Medicare efforts
Evolving private payer efforts

- **Bundled care services**
  - Pioneered by large employers
  - Focused initially on elective orthopedic and cardiac procedures
  - May involve employee travel out of area to “centers of excellence”
  - Employee financial incentives
  - Often involves 90 day warranties

- **Accountable Care Organizations**
Medicare value-based efforts

- **Physician Compare website**
  - Currently only demographic information
  - Will evolve to have quality and cost performance info
- **Physician Quality Reporting System (PQRS)**
  - Upcoming penalties for not reporting
- **Physician Value-Based Payment Modifier**
  - Adjustment made to payments based on quality and cost
- **Accountable Care Organizations**
Physician Compare web site

Physician Compare Provider Profile

JOHN WILLIAMS
Internist

Add To My Favorites

Office Locations
Group Practice Locations

Locations Within Your Searched Area

View map of area locations

21616 76TH W AVE 208
EDMONDS, WA 98026

Map & Directions
(425) 776-2499

Additional Information

Education:
- Graduated: 1981
- School: OREGON HEALTH SCIENCES UNIVERSITY SCHOOL OF MEDICINE

Gender:
- Male
Medicare PQRS reporting

- Physicians self-report certain quality measures
- Reporting methods
  - On claims forms using specific “G” codes
  - Via web based tool
  - Via certain claims registries products
  - Via certified EHR vendor products
- Incentives for reporting, non-reporting
  - 2013, 2014: +.5%
  - 2015: -1.5%
  - 2016: -.2.0%
AAPM&R quality reporting resources

Performance Measures Resources

Performance measurement is the quantitative assessment of health care processes and outcomes for which a health care practitioner, health care organization, or health care system may be accountable. As the landscape of the health care system continues to evolve, health care professionals are being forced to examine how they evaluate their performance. With increased pressure to reduce costs and improve quality of care for patients, many physicians still struggle with how to achieve this. To meet the needs of the changing environment, your Academy is actively working to develop and provide evidence based clinical tools and resources that will enhance the quality of care provided by physiatrists.

If there are any questions or comments about the Performance Measures section, please contact the Academy National Office at (847) 737-6000.

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Suggested PM&R PQRS measures

36 - Stroke and Stroke Rehabilitation: Rehabilitation Services Ordered
48 - Urinary Incontinence: Assessment of Presence or Absence of Urinary 
Incontinence in Women Aged 65 Years +
109 - Osteoarthritis (OA): Function and Pain Assessment
130 - Documentation of Current Medications in the Medical Record
131 - Pain Assessment and Follow-Up
134 - Preventive Care and Screening: Screening for Clinical Depression and 
Follow-Up Plan
154/155 - Falls: Risk Assessment & Plan of Care
163 - Diabetes Mellitus: Foot Exam
182 - Functional Outcome Assessment
244 - Hypertension: Blood Pressure Management
Medicare Value-Based Payment Modifier

- “Physicians in groups of 100 or more eligible professionals who submit claims to Medicare under a single tax identification number will be subject to the value modifier in 2015, based on their performance in calendar year 2013.”

- “All physicians who participate in Fee-For-Service Medicare will be impacted by CMS’ emphasis on reporting quality data through PQRS and by 2017 will be affected by the value modifier.”

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html
Medicare Value-Based Payment Modifier

- In calendar year 2013, medical practice groups of 100 or more eligible professionals (all of whom file Medicare Fee-For-Service claims under the physician fee schedule using a single tax identification number) **must register and participate in PQRS as a group in order to avoid a negative one percent payment adjustment (in 2015) under the value modifier.**

- CMS will provide reports (in 2013) solely to groups in which twenty-five or more eligible professional submit claims under a single tax identification number (TIN). The 2012 QRURs will allow groups of 100 or more eligible professionals to make an informed decision about the method they will elect for reporting quality measures in 2013 and whether or not to choose the quality tiering option for determining their 2013 value modifier.

- **From July through October 15, the self-nomination process will allow groups of 100 or more eligible providers to voluntarily choose to participate in quality tiering under the value modifier.** Quality tiering will determine if group performance is statistically better, the same, or worse than the national mean. Quality tiering could result in a positive or negative 2015 payment adjustment for a relatively small number of groups with cost and quality performance indicators that vary substantially from the mean. The majority of groups would have no adjustment as a result of choosing quality tiering—only the outliers.
Medicare Value-Based Payment Modifier

**How the Value Modifier is Assessed**

- **Groups of physicians with eligible professionals**: 100

  - **Satisfactory PQRS Reporters** (using GPRO web-interface, claims, registries, EHRs, or administrative claims)
    - Elect Quality Tiering calculation → Upward or downward adjustment based on quality tiering
  
  - **Non-satisfactory PQRS Reporters** (including groups not participating in any PQRS reporting mechanism)
    - 0.0% (no adjustment)
    - -1.5% adjustment for not reporting
    - -1.0% (additional downward adjustment)
Medicare PVBM quality measures

- PQRS measures
- 30 day Post Discharge Visit
- All Cause Readmission
- Composite of Acute Prevention Quality Indicators
  - Bacterial Pneumonia
  - Urinary Tract Infection (UTI)
  - Dehydration
- Composite of Chronic Prevention Quality Indicators
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Heart failure
- Diabetes Composite
  - Uncontrolled Diabetes
  - Short term Diabetes Complications
  - Long term Diabetes Complications
  - Lower extremity amputation for diabetes
Medicare PVBM cost measures

- Total per capita costs
- Total per capita costs for patients with specific conditions
  - Chronic obstructive pulmonary disease
  - Heart failure
  - Coronary artery disease
  - Diabetes
- Proposed attribution method
  - Plurality of charges with minimum of two E/M services
Medicare PVBM scoring

Value Modifier Scoring

Combine each quality measure into a quality composite and each cost measure into a cost composite using the following domains:

Clinical care
Patient experience
Patient safety
Care coordination
Efficiency

Quality of Care Composite Score

VALUE MODIFIER AMOUNT

Cost Composite Score

Total overall costs
Total costs for beneficiaries with specific conditions
PVBM payment adjustments

- For those groups that elect “quality tiering”
- “Physicians who score in these categories who treat high-risk beneficiaries could receive an additional one percentage point in bonus”

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Low cost</th>
<th>Average cost</th>
<th>High cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High quality</td>
<td>2.0%*</td>
<td>1.0%*</td>
<td>0.0%</td>
</tr>
<tr>
<td>Average quality</td>
<td>1.0%*</td>
<td>0.0%</td>
<td>-0.5%</td>
</tr>
<tr>
<td>Low quality</td>
<td>0.0%</td>
<td>-0.5%</td>
<td>-1.0%</td>
</tr>
</tbody>
</table>
Goals (revisited)

- Explain the reasons and concepts behind value-based reimbursement
- Familiarize you with value measurement terms and methods
- Share what private payers and Medicare are doing
- Help all of you feel more informed and hopefully better prepared. Perhaps inspire a passion within you for this new frontier of medicine
- Provide some summary recommendations
Recommendations

- If you are part of a group of over 100* physicians make sure your organization is aware of Medicare’s Value-Based Modifier program and is preparing for it.
- If you are part of a group of more than 25* physicians, make sure someone reviews and considers the Medicare Quality and Resource Use Report (QRUR) if received.
- Participate in the Medicare PQRS program to avoid revenue penalties.
- Become and remain aware of how your practices/organizations are responding to payers’ bundling and accountable care organization initiatives.

*Billing under the same Tax ID#
Recommendations (cont.)

- Become and remain aware of how your organization’s bundling and ACO participation will incorporate and budget for PM&R services
- Request and review existing payer quality and cost comparative information for your practice
- Develop a value improvement culture in your practice. Implement value improvement initiatives
- Consider a participatory / leadership role in value measurement and improvement
- Advocate for functional status measurement in value assessments. “Own this space”