Value-Based Payment for Physicians in Medicare: Small Step or Giant Leap?

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In response to extensive evidence of high costs and variable quality of health care, the Patient Protection and Affordable Care Act created the Physician Value-Based Payment Modifier (PVBPM), the first national value-based purchasing program for physicians in fee-for-service Medicare. In 2013, the program required physicians in all practices to report data for the Physician Quality Reporting System—the precursor to the PVBPM—to avoid a payment penalty in 2015. The PVBPM will then use these data to modify Medicare Part B payments for physicians in "large" practices (those with 100 or more eligible professionals) beginning in 2015. Current proposals from the Centers for Medicare & Medicaid Services (CMS) call for the PVBPM to modify Part B payments for physicians in practices with 10 or more eligible professionals starting in 2016 (1) and for all physicians in 2017.

In the first year of the program, large practices eligible for the PVBPM can choose to participate in "value tiering" in which payment could be adjusted by between approximately −1% and 1% of revenue. Payment adjustment will be based on performance for clinical process measures, 30-day hospital readmission rates, acute prevention indicators (hospital admissions for bacterial pneumonia, urinary tract infection, and dehydration), and chronic indicators (hospital admissions and complications related to diabetes, chronic obstructive pulmonary disease, and heart failure). The payment adjustment will also be based on total per capita costs and costs for patients with specific chronic diseases. For large practices that choose not to participate in value tiering, no payment adjustment will be made. Details about how the PVBPM will be expanded to smaller practices have not yet been determined (2).

The concept of shifting from volume- to value-based payment embodied by the PVBPM is a radical change for the Medicare program (3). Here, we discuss the implementation challenges associated with this reform and what they mean for the future of the PVBPM.

Physician Inexperience With Quality Profiling and Value-Based Payment

Physician practices have had some, but not extensive, experience with quality profiling and value-based payment programs. Data from national surveys indicate that approximately one half of practices had been exposed to financial incentives for quality or patient satisfaction by 2008 (4). The percentage of outpatient visits for which quality or patient satisfaction is incentivized is much lower (5). Only around 150 000 physicians and other eligible professionals—approximately 20% of eligible providers—voluntarily participated in the Physician Quality Reporting System in 2010 (6), and performance has yet to be publicly reported. In contrast, most U.S. hospitals publicly reported measures of quality for nearly a decade before Medicare's Hospital Value-Based Purchasing Program began. Practices that lack experience with value-based payment may be resistant to the PVBPM and may not have the infrastructure needed to respond to financial incentives for value (7).

Attributing Patients to Practices

To track quality and cost performance in the PVBPM, the program "attributes" patients exclusively to the practice that provides the most primary care services from primary care physicians. These practices are then responsible for the patients' quality and cost for a given measurement year. Medicare's Shared Savings Program for accountable care organizations also uses this attribution approach. However, without the organizational structure to share accountability across physicians in other care settings, attribution in the PVBPM may result in primary care providers having accountability without clinical oversight.

For example, a practice providing most of a patient's primary care will be responsible for specialist costs incurred from outside of the practice and for the cost of hospital stays and long-term care. Even if primary care providers want to refer their patients to specialists who provide higher-value care, they may not know who those specialists are. Also, given the open networks in Medicare fee-for-service, patients can, and do, receive care from specialists to whom they were not directly referred by their primary care providers. Concern related to patient attribution was one of the primary reasons why the Cost and Resource Use Steering Committee convened by the National Quality Forum recently did not endorse the total per capita cost measure included in the PVBPM.

Potential for Unintended Consequences

If the incentives of the PVBPM become sufficiently large, the structure of the program opens the door for unintended consequences. A poorly performing multispecialty group practice may be incentivized to separate or even eliminate its primary care practice because adjustments to Part B payments affect all physicians in a practice. Some physicians may opt out of Medicare completely or be compelled to consolidate with larger health systems. This consolidation could lead to higher quality and more integrated care but could also increase prices in the private market (8).

These unintended consequences are improbable in the short term given the small magnitude of the financial incentives for performance as currently planned but would become more probable if incentives ramp up over time. In the PVBPM, the CMS faces the classic tradeoff between providing incentives that are strong enough to motivate behavior change and increasing the likelihood of unintended consequences.

Considerations for the Future of the PVBPM

An unfolding congressional deal may consolidate the PVBPM with other incentive programs for physicians as part of a package that seeks to fix the sustainable growth rate (9). Although new legislation may change some of the specifics of how the PVBPM is implemented, the key issues identified in this article will remain relevant as value-based payment incentives are extended to physicians.

The ideal in value-based payment is to create a single set of performance measures that spans care settings for which a single group of providers shares accountability for the health of a population. However, for the foreseeable future, a relatively small proportion of providers will be part of integrated delivery systems or accountable care organizations that could conceivably perform this function (10). The next best option is for the CMS to closely align performance measures across different settings.

For example, in the short term, the PVBPM could incentivize only those measures that are included in hospital incentive programs (such as 30-day readmission and cost per acute episode). This approach would create a stronger interest for hospitals and physician practices to work together even if they are not formally integrated. For other measures, the PVBPM could maintain pay-for-reporting, transitioning toward value-based payment only after sufficient progress is made on the aligned measures.

Many features of the PVBPM are forward-looking: The attribution methodology pushes primary care providers to manage patients across the continuum of care, and the performance measures directly incentivize high-value care. Some challenges faced by the PVBPM—such as physician practices' relative inexperience with large-scale reporting and incentive programs—are likely to be resolved over time. Other challenges—such as the balance of accountability and authority and the mismatch of incentives with other value-based programs—will require engagement with physicians to develop strategies for value improvement and offset unintended consequences.

The PVBPM envisions more accountable, value-based health care. Whether our unaccountable, volume-based health care system can respond is unclear.

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