REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-A-11

Subject: Pay for Value
(Resolution 108-A-10)

Presented by: William E. Kobler, MD, Chair

Referred to: Reference Committee A
(Joseph W. Zebley, III, MD, Chair)

At the 2010 Annual Meeting, the House of Delegates referred Resolution 108, which was introduced by the Iowa Delegation and asked that the American Medical Association (AMA) "support development of regional Pay for Value Index incentives that would reward physicians for higher quality and cost-effective care (Pay for Value)."

The Board of Trustees referred Resolution 108-A-10 to the Council on Medical Service for study. This report provides background on the Medicare payment modifier legislated by the 2010 Patient Protection and Affordable Care Act (ACA, PL 111-148) and other value-based payment initiatives, highlights relevant policy, summarizes federal and AMA activity on the geographic adjustments, and presents recommendations.

BACKGROUND

Although still relatively rare, value-based payment models for health care are garnering increasing attention among policymakers. Value can be thought of as the best balance between benefit and cost. Better value can be thought of as improved clinical outcomes, quality, and/or patient satisfaction per dollar spent. The goal of improving value is not necessarily to reduce utilization, but to provide the right care at the right time in accordance with the relative cost and benefit of such care. Scientifically valid research studies on the factors that influence value, cost, efficiency and quality are in the very early stages of development.

Recent legislative and regulatory proposals aim to improve health care quality, not only to achieve better clinical outcomes, but also to make the health delivery system more efficient and increase patient value. Two strategies for meeting these goals include expanding existing initiatives for Medicare "value-based purchasing" and encouraging a more comprehensive overhaul of physician payment including bundled care payments, accountable care organizations (ACOs), shared savings programs and the patient-centered medical home. Council on Medical Service Report 1-A-11, "Physician Payment Reform Update," and Council on Medical Service Report 8-A-11, "Implementing Alternative Health Care Delivery and Physician Payment Models," also before the House of Delegates at this meeting, describe a variety of payment methodologies being tested.

Section 3007 of the ACA mandated that the Centers for Medicare and Medicaid Services (CMS) develop a value-based payment modifier to the Medicare Physician Fee Schedule to be phased in from 2015 to 2017. The budget-neutral value-based modifier will be separate from Geographic Practice Cost Indices (GPCIs) and will pay individual medical professionals based on the quality of care provided to Medicare patients relative to the costs of providing that care.

CMS was also directed to develop a transparent, Medicare-specific "episode grouper" system that could be used to compare resource use and quality among individual physicians in the application of a value-based modifier as well as other payment reforms. In commenting to CMS and others on the episode grouper, the AMA reiterated concerns regarding the accuracy of measurements, appropriateness of risk adjustment methodologies, unresolved data difficulties and attribution problems. In addition, the AMA has repeatedly pointed out that resource measures must include quality as well as efficiency. Accordingly, the AMA is collaborating with Brandeis University and others to develop a transparent, Medicare-specific grouper that could be a first step toward development of a value-based modifier and/or other new payment models.

RESOLUTION 108-A-10

Resolution 108-A-10 asks the AMA to support the development of regional "Pay for Value Index incentives." The resolution highlights two major concerns that persist for rural states, namely the belief that Medicare underpays providers in rural areas and that efficiency, utilization and spending variations differ by region. At the 2010 Annual Meeting, the Reference Committee recommended that Resolution 108-A-10 not be adopted based on testimony which highlighted the fundamental difficulties in scientifically defining and/or measuring value and noted that "quality" is applicable to individual physicians, but cannot be evaluated regionally. While the House of Delegates strongly opposed the proposed regional pay for value incentive, it referred Resolution 108-A-10 to explore concerns regarding geographic differences in Medicare payment, specifically the GPCI system.

Resolution 108-A-10 proposes a "Pay for Value" approach that assumes that there is a connection between the effects of the adjustment factors on the distribution of the health care workforce, quality of care, population health, and the ability to provide efficient, high-value care. However, it is uncertain whether tying payment to geographic location impacts access to and quality of care. The Council notes that the value-based modifier called for in the ACA is not a regional modifier.

Resolution 108-A-10 highlights data from Dartmouth and the Agency for Healthcare Research and Quality that pointed to large regional differences in Medicare expenditures per beneficiary and concluded that higher spending areas do not have better quality care than lower spending areas. While it is widely acknowledged that health care spending patterns vary across the country, the causes and implications of these variations are less clear. Variation in health care spending is not in itself evidence of inefficiency or poor value for the US health care dollar. Some health care cost variation is the result of unique characteristics of local communities or patient populations.

At the 2009 Interim Meeting, Council on Medical Service Report 2, "Geographic Variation in Health Care Cost and Utilization," noted that while the Dartmouth Atlas Project has emerged as a leading source of information regarding geographic variation in health care, some analysts have expressed caution about conclusions drawn from the Atlas findings. The report established policy that encourages further study into the possible causes of geographic variation, with particular attention to risk adjustment methodologies and the effects of demographic factors, differences in access to care, medical liability concerns, and insurance coverage options on demand for and delivery of health care services. It also supports efforts to reduce variation in health care utilization that are based on ensuring appropriate levels of care are provided within the context of specific clinical parameters, rather than solely on aggregated benchmarks (Policy H-155.957, AMA Policy Database).

GEOGRAPHIC PRACTICE COST INDICES (GPCI)

The Medicare Physician Payment Schedule uses GPCI adjustments to fine-tune payments to account for regional differences in the cost of work, practice expense and professional liability insurance inputs in 89 different payment areas. During testimony on Resolution 108-A-10, there was widespread agreement that fundamental flaws are associated with determining GPCIs and estimating the costs of practice inputs (e.g., physician office rent data). Long-standing AMA policy aggressively promotes the compilation of accurate data on all components of physician practice costs and the changes in such costs over time, as the basis for informed and effective advocacy concerning physician payment under Medicare (H-400.966[1]).

In addition, Policies H-400.988 and H-400.984 advocate for the use of valid and reliable data related to physician practice costs. Policy H-400.988 states that geographic variations under a Medicare payment schedule should reflect only valid and demonstrable differences in physician practice costs, especially liability premiums, with further adjustments as needed to remedy demonstrable access problems in specific geographic areas. Policy H-400.984 states the AMA will work to ensure that the most current, valid and reliable data are collected and applied in calculating accurate GPCIs and in determining geographic payment areas for use in the new Medicare physician payment system, with data collected from rural practice sites for this purpose.

Resolution 108-A-10 states that "CMS has for 18 years never used a survey to measure actual physician expenses for GPCI determination but, instead, uses proxies which have never been shown to be scientifically valid, verifiable, and accurate." In 2010, CMS asked the Institutes of Medicine (IOM) to conduct two critical studies on unjustified geographic variation in spending and the promotion of high-value health care. The first report, tentatively expected in May 2011, will evaluate the accuracy of the geographic adjustment factors used for Medicare payment. The second report, expected in spring 2012, will evaluate the effects of the adjustment factors on the distribution of the health care workforce, quality of care, population health and the ability to provide efficient, high-value care.

Resolution 108-A-10 also mentions the latest AMA practice expense survey. In 2007 and 2008, the AMA and 70 national health care organizations jointly sponsored a broad survey of specialty and non-physician practitioners using 2006 data. The AMA Physician Practice Information (PPI) survey did not collect price information on practice inputs and the AMA did not provide CMS with any data to differentiate rent within the general office expense category with respect to the practice expense GPCIs. The AMA met with the IOM in 2010 and clarified that the PPI survey data did not differentiate rent within the general office expense data. The survey found that respondents from large metro areas and from the North East had lower median total expenses than those from other areas. These physicians also tended to use fewer resources as measured by their hours worked and the number of non-physician staff, which may have offset the higher staff wages and office rents that physicians in large metro areas would be expected to pay. Resource use should vary by physician specialty and setting, and these factors were significant in explaining variation in total expense. After controlling for these factors, expenses did not differ significantly by either metro location or Census region.

The AMA emphasized that the work of the IOM Technical Advisory Panel should include a review of GPCIs and that it should also carefully review comments received on July 13, 2010 regarding the Notice of Proposed Rulemaking. Most importantly, the AMA stressed that it is critical that physicians have input into future revisions to methodology and sources of data that are objective, consistent, transparent and relevant.

DISCUSSION

There are limited data available on measures of outcomes, quality, efficiency and risk-adjustment. Accordingly, the Council believes that AMA support of payment methodologies that redistribute Medicare payments among providers based on such measures would be premature. Consistent with Policy H-165.383, the Council recommends new AMA policy that would support payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable and accurate.

The Council acknowledges that GPCI adjustments are an extremely contentious issue for many reasons. Some physicians believe geographic adjustment factors are the best tool available to ensure that they receive fair payment for treatment of Medicare patients. Others believe that geographic adjustments do not result in fair pay for everyone and could potentially cause a decrease in access to care or poorer health outcomes for patients. The two IOM studies on adjustment factors that were previously described should inform the debate on such issues. Until the IOM studies are completed, the Council believes that physician participation in future revisions of GPCI methodology is critical and that AMA should continue to emphasize the use of valid and reliable data on actual physician office rents. Accordingly, the Council supports reaffirming Policies H-400.988 and H-400.984, which advocate for the use of valid and reliable data related to physician practice costs.

RECOMMENDATIONS

The Council recommends that the following recommendations be adopted in lieu of Resolution 108-A-10 and that the remainder of the report be filed:

1. That our American Medical Association support payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data. (New HOD Policy)

2. That our AMA amend Policy H-400.988 to read as follows: "…geographic variations under a Medicare payment schedule should reflect only valid and demonstrable differences in physician practice costs, especially liability premiums, with other non-geographic practice cost index (GPCI)-based adjustments as needed to remedy demonstrable access problems in specific geographic areas."(Amend HOD Policy)

3. That our AMA amend Policy H-400.984 to read as follows: "Our AMA will work to ensure that the most current, valid and reliable data are collected and applied in calculating accurate geographic practice cost indices and in determining geographic payment areas for use in the new Medicare physician payment system." (Amend HOD Policy)

Fiscal Note: Staff cost estimated at less than $500 to implement.

References are available from the AMA Division of Socioeconomic Policy Development.