REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-13

Subject: Hospital-Based Physicians and the Value-Based Payment Modifier (Resolution 813-I-12)

Presented by: Charles F. Willson, MD, Chair

Referred to: Reference Committee J (Dolleen M. Licciardi, MD, Chair)

At the 2012 Interim Meeting, the House of Delegates referred Resolution 813, "Hospital Based Physicians and the Value Based Payment Modifier" which was sponsored by the Society of Hospital Medicine, the Society of Critical Care Medicine and the American College of Emergency Physicians. Resolution 813 asks:

> That our American Medical Association (AMA) conduct a study to identify and evaluate appropriate metrics at the physician and physician group practice level for use by hospital-based specialties within the Value-Based Payment Modifier (VBM) initiative;
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> That during the course of this study, attention is given to a mix of both physician and facility performance metrics not only for the purpose of more accurately capturing hospital-based practice but also for the potential to achieve a greater level of physician-hospital alignment when and if appropriate to reduce costs and improve the quality of patient care; and
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> That our AMA work closely with hospital-based professional societies to construct a program that complies with the Patient Protection and Affordable Care Act VBM mandate and that will validly evaluate hospital-based physicians at the individual and group practice level.

The Board of Trustees assigned this item to the Council on Medical Service for report back to the House of Delegates at the 2013 Interim Meeting. The following report provides an overview of the VBM program and describes AMA advocacy efforts related to the program's development and implementation.

BACKGROUND

The VBM program is being implemented in response to language in the Affordable Care Act of 2010 (ACA) that directed the Centers for Medicare & Medicaid Services (CMS) to establish a system of differential payment based on comparisons of the quality and cost of care furnished. The VBM is a budget-neutral payment modifier that will be phased-in beginning in 2015, according to policies finalized as part of the 2013 Medicare Physician Fee Schedule. CMS is required to apply the VBM to all physicians submitting claims under the Medicare physician fee schedule by 2017.

At the urging of the AMA, CMS raised the size of groups subject to the VBM in 2015 from groups of 25 or more to groups of 100 or more eligible professionals, which include non-MDs who participate in the Physician Quality Reporting System (PQRS). The VBM and PQRS are closely aligned, and for 2015 the level of adjustment under the VBM will be determined primarily by

whether the physician group participated in PQRS in 2013. The minimum requirement for receiving a neutral (i.e., 0.0 percent) adjustment is successful participation in one of three PQRS group reporting methods: the web-interface group reporting option, a registry, or via the PQRS Administrative Claims Option, under which CMS would extract data from claims. Conversely, groups of 100 or more eligible providers that failed to participate in PQRS in 2013 will be subject to a negative adjustment of one percent under the VBM in 2015.

CMS also has created a pathway for groups to voluntarily participate in a quality tiering option in 2015. Groups that successfully participate in PQRS in 2013 can elect to have their VBM calculated using a quality tiering methodology that will determine if group performance is statistically better, the same, or worse than the national mean. Based on a comparison against national cost and quality benchmarks, groups are classified as low, average or high for both cost and quality. The value modifier score is then assigned based on a matrix of these quality and cost scores, with the greatest positive adjustment applied to high-value, low cost providers, and the greatest negative adjustment applied to low-value, high-cost providers.

PROPOSED VBM IMPLEMENTATION POLICIES FOR 2016

CMS included VBM policies for 2016 in the 2014 proposed physician payment schedule rule, which was released in July 2013. Although the rule had not been finalized at the time this report was written, CMS' proposal includes several modifications to the 2015 VBM policies. Specifically, CMS proposes applying the VBM to groups of 10 or more eligible practitioners. Any of the nearly 60% of group practices that CMS says fall into this category would be subject to a penalty if they did not successfully participate in PQRS. In addition, quality tiering would be mandatory for all successful PQRS-participating groups. Under the mandatory quality tiering structure, groups of 10 – 99 eligible practitioners would not be subject to a downward adjustment (unless they fail to meet PQRS reporting requirements), but would be eligible to receive an upward adjustment. Groups of 100 or more eligible practitioners would receive an upward, neutral or downward adjustment based on quality tiering. Potential downward adjustments would increase from -1.0 percent to -2.0 percent.

CMS also proposes replacing the PQRS Administrative Claims reporting option with an option that would allow reporting quality data at the individual level, as long as at least 70 percent of the eligible professionals in the group reported individual measures. In addition, CMS has determined that individual participation in a qualifying clinical registry will satisfy individual PQRS reporting requirements. Also beginning in 2016, groups of 25 or more eligible practitioners will be able to elect to include patient experience of care measures as part of the calculation for the quality of care composite score.

CMS also is proposing changes for 2016 related to the cost of care portion of the VBM calculation. Although the basic methodology remains unchanged, CMS proposes using specialty-adjusted group cost measure benchmarks to better account for physician specialty mix. CMS also proposes adding the Medicare spending per beneficiary (MSPB) measure as an additional measure in the cost of care composite. The MSPB measure is currently included in the Hospital Inpatient Quality Reporting Program and the Hospital Value-Based Purchasing Program, and reflects all Medicare Part A and Part B payments from three days prior to hospital admission through 30 days after discharge.

AMA ADVOCACY EFFORTS

The AMA has strongly advocated for repeal of the VBM and commented extensively on the VBM implementation process. In particular, the AMA has consistently expressed concern about the difficulty in identifying measures for all physicians in all specialties, particularly some hospital-based physicians, physicians in highly specialized subspecialties and physicians who do not typically provide direct patient care. The AMA has advocated for Congressional funding to support the development and evaluation of additional quality and cost measures, and supports the development of PQRS measures based on multi-stakeholder input at all levels, especially from physicians who are the end users of the measures. With respect to the relationship between PQRS reporting and the VBM, the AMA has called on CMS to allow physicians subject to the VBM to report on individual quality measures, rather than the limited number of PQRS group reporting measures that may not be relevant to their specialties. As noted, CMS' proposed VBM policies for 2016 allow groups to avoid VBM penalties if at least 70 percent of eligible practitioners report individual PQRS measures. The AMA has urged CMS to lower the 70 percent threshold so that more groups can avoid PQRS and VBM penalties through reporting at the individual level.

The AMA also has advocated strongly for alternative pathways that will enable greater numbers of physicians to avoid VBM penalties by engaging in clinically relevant quality reporting activities. As a result of AMA advocacy efforts, the American Taxpayer Relief Act of 2012 (ATRA) included a provision that instructed CMS to develop a process that would allow physicians to meet Medicare quality reporting requirements by participating in qualified clinical registries. In the absence of valid and appropriate metrics for certain specialties, registries and similar quality measurement and improvement activities could offer another option for physicians under the VBM program. CMS has proposed that individual participation in a qualified clinical registry be added as a PQRS reporting option in 2014. The AMA has urged CMS to remain flexible regarding its requirements for qualifying clinical data registries and to adopt a phased-in approach that will allow the developers of registries and other such initiatives to further enhance their activities over time.

The AMA has commented on the need to identify appropriate benchmarks and comparison groups for use in calculating the VBM. In particular, the AMA has emphasized the importance of identifying specialists and subspecialists with similar patient mixes to inform peer-to-peer comparisons. CMS has attempted to address this concern in its proposed policy for 2016 that calls for the use of specialty-adjusted cost benchmarks. However, additional refinements are still needed in order to accurately reflect varying risks across patient populations. Although CMS will be using the Hierarchical Condition Category (HCC) model to risk adjust per-capita patient costs, the AMA and others have expressed concern that the HCC does not adequately account for the presence of comorbidities and chronic conditions, or for differences in patient risk due to socioeconomic factors. Experience in the private sector suggests that subspecialty physicians are often identified as high-cost outliers because of a failure to adequately adjust for differences in severity or case mix when compared to other physicians. The problem is likely to be even more acute in Medicare with its limited specialty list which does not distinguish between hospitalists and general internists and between sub-specialties of most specialties.

An AMA-led work group of specialty and state medical society representatives worked with CMS to improve the Quality and Resource Use Reports (QRURs), which were designed to provide physicians with feedback about their practice patterns and how they compare to their peers on certain measures of cost and quality. CMS will use the QRURs to communicate to physicians how their payments will be affected by the VBM. Based on input from the QRUR/VBM work group, CMS intends to provide physicians with additional data, including patient names, which will ensure

physicians are better able to verify and take action on the information provided in the report. Policy D-450.964, which was adopted at the 2012 Interim Meeting, calls for the AMA to continue to work with CMS to improve the relevance and usability of the QRURs, and to advocate, educate and seek to delay implementation of the VBM program. The AMA's comments on the VBM policies included in the 2014 proposed physician payment schedule rule urged CMS to delay the proposed expansion of the program, which would more than double the number of physicians subject to the modifier in 2016. The AMA once again restated its concern that it will never be possible to develop a methodology that can accurately judge performance at the individual physician level for all specialties. Regarding the specific modifications included in the proposed rule, the AMA detailed its opposition to expanding the modifier to groups of less than 50 eligible practitioners, increasing the VBM penalty from one percent to two percent, and mandating participation in the tiering option. The AMA also reiterated its concerns regarding the need to adjust cost data to account for differences in specialty mix. Although the proposed rule attempts to address this issue, a large percentage of physicians in certain specialties that treat patients with multiple or costly conditions are still likely to be designated as "high cost" on the total aggregate cost measure. The inclusion of the MSPB as an additional measure in the cost of care composite is problematic because the measure has not been tested in the physician setting, and, absent a more reliable adjustment for specialty mix, it is possible that certain physicians would be routinely penalized by the use of this measure.

The AMA also addressed several issues related to the PQRS program that have an impact on the VBM. The AMA emphasized the importance of expanding PQRS reporting options that could help physicians avoid penalties, and urged CMS to phase in any increased reporting requirements more slowly. The AMA is particularly concerned that increasing reporting requirements would place an even greater burden on specialties that continue to struggle with identifying meaningful clinical quality measures to report. Consistent with these concerns, the AMA urged CMS to maintain the PQRS Administrative Claims reporting option for the purposes of avoiding VBM and PQRS penalties. The AMA also encouraged CMS to undertake a study to better evaluate the current PQRS measure portfolio, which would help identify priority areas where CMS, medical specialties and measure developers should focus their resources for quality measure development, testing and implementation.

The AMA's detailed comments on the 2014 proposed physician payment schedule rule are available at http://www.ama-assn.org/resources/doc/washington/2014-physician-fee-schedule-comment-letter-06sept2013.pdf.

DISCUSSION

Although the ACA requires that the VBM be applied to all physicians by 2017, it is notable that major private sector payers that use value-based payments do so for only a limited number of specialties. The AMA continues to urge repeal of the VBM and express concern that it is unlikely that CMS will be able to construct a modifier that will be valid for all specialties at the individual physician level. In the meantime, the AMA is working with CMS to identify additional ways to allow physicians to participate meaningfully in quality reporting initiatives that are the basis for VBM adjustments.

Resolution 813-I-12 specifically addresses the metrics that will be used to assign the VBM to physician payments, and highlights the lack of performance measures that are applicable to hospital-based physicians. CMS attempted to address this concern by including a provision in the 2014 proposed physician payment schedule rule that would integrate measures currently used in the

hospital inpatient quality reporting program into PQRS. The AMA's comments to CMS expressed support for this concept, and urged CMS to work closely with affected specialties in implementing this proposal. The proposed rule also sought comment on whether CMS should allow individual physicians to have their hospital's performance scores attributed to them. The AMA defers to individual specialty societies regarding whether this approach would be appropriate for their members.

In the absence of clinically relevant measures and benchmarks, many specialties are likely to be at a disadvantage with respect to VBM implementation. However, the Council does not believe that it is appropriate for the AMA to be developing metrics for individual specialties as called for in Resolution 813-I-12. Although the AMA has been involved in measure development through the AMA-convened Physician Consortium on Performance Improvement (PCPI), PCPI's current priority areas include reviewing and maintaining existing measure sets, and addressing measure gaps that are likely to have the broadest impact, such as those that expand across multiple settings and patient populations.

The Council believes that the most effective way for the AMA to influence the future of the VBM is to continue in its role as a convener of stakeholders interested in working with CMS to address broad-based methodological issues that affect all physicians. The AMA has been successful in encouraging CMS to expand the options available to physicians under the VBM program, and can provide a supporting role for individual specialties as they pursue specialty-specific enhancements and modifications to the program.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 813-I-12 and the remainder of the report be filed.

1. That our American Medical Association (AMA) continue to advocate that the Value-Based Payment Modifier (VBM) program be repealed or significantly modified. (New HOD Policy)

2. That our AMA encourage national medical specialty societies to pursue the development of relevant performance measures that demonstrate improved quality and lower costs, and work with the Centers for Medicare & Medicaid Services to have those measures incorporated into the Value-Based Payment Modifier program and other quality measurement and improvement programs. (New HOD Policy)

Fiscal Note: Less than $500 to implement.