Medicare shift to quality over quantity presents challenges

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A new study hints that even large physician practices may have trouble moving to a payment system that rewards quality of health care over quantity of services delivered. The analysis included data from the first

year of a program run by the Centers for Medicare and Medicaid Services (CMS) and known as the Physician Value-Based Payment Modifier program.

Under the Affordable Care Act, CMS in 2012 began reimbursing U.S. hospitals based on the quality of health care they deliver, rather than the quantity. For example, Medicare gives financial bonuses to hospitals that keep readmission rates low, and it does not pay for hospital-acquired conditions, such as bed sores, providing an incentive to prevent them. For CMS to assess quality of care, hospitals must report certain types of data, such as rates of hospital-acquired infections, as indicators of their performance. In 2013, the program expanded to include physician practices that provide health care outside of hospital settings.

Published in the December issue of the journal *Health Affairs*, the study was conducted by researchers at Washington University School of Medicine in St. Louis, the University of Michigan in Ann Arbor, the Harvard T.H. Chan School of Public Health and the U.S. Department of Health and Human Services.

Across the country, 1,010 practices have at least 100 physicians per practice, which was the threshold for being included in the program's first year. Of these, 899 practices treated at least one Medicare beneficiary and were included in the analysis. Of the 899 practices included, 263 (about 30 percent) did not report data to the program as required by CMS and were penalized for failing to do so. For practices failing to report, CMS withheld 1 percent of their 2015 Medicare physician fee schedule billings.

"Almost one-third of practices got a 1 percent payment penalty because they failed to report performance data," said first author Karen E. Joynt Maddox, MD, an assistant professor of medicine at Washington University. "That's a meaningful amount of money. Why take that

financial hit if you don't have to? It suggests that reporting was hard enough that some practices couldn't do it, or elected not to because it was too expensive. This program has the potential to be a big burden.

"We started with the largest practices," Joynt Maddox added. "These are theoretically the most well-resourced and well-equipped practices across the country. And even among these, a large number failed to report. This may reflect the current state of infrastructure in U.S. outpatient practices."

The researchers suggested that CMS should focus on improving this infrastructure by, for example, helping practices obtain electronic data systems that may reduce the time and cost associated with reporting performance data. Such help would be especially important for smaller practices and those that serve racial and ethnic minority groups, practices the study found less likely to report data.

"As this program expands to include all clinicians, I'm concerned there could be unintended consequences, particularly for smaller, under-resourced practices," said Joynt Maddox, also a cardiologist who sees patients at Barnes-Jewish Hospital. "However, CMS recently broadened exemptions so small practices will likely not have to participate initially."

The study also suggests that practices with electronic health records provide higher quality care at lower cost, and as a result, these practices were less likely to receive financial penalties under the program, and more likely to receive bonuses. Electronic record systems are not necessarily the cause of the improved performance, according to the investigators; it could be that higher performing practices tend to invest in technology.

"In theory, having an electronic health record system should make reporting performance data more straightforward," Joynt Maddox said.

"But electronic health record systems are not created equal—some have made it easier than others. And in practices without such systems, a nurse or office manager may be trying to do all the reporting in addition to regular job duties. I think many people are in favor of moving toward a value-based payment system but are also appropriately concerned about how to do it without unfairly harming some physician practices."

More information: Joynt Maddox KE, Epstein AM, Samson LW, Chen LM. Performance and participation of physicians in year one of Medicare's value-based payment modifier program. *Health Affairs*. Dec. 4, 2017.

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