Value-Based Physician Reimbursement: Challenges and Opportunities for Physical Medicine and Rehabilitation

Mark Rattray, MD

INTRODUCTION

Momentum is increasing to base physician reimbursement not just on the provision of a service but also on other factors, such as quality and safety measures, provision of recommended care, and avoidance of wasteful care. Purchasers of care refer to this as value-based purchasing. Physicians should think of this as value-based reimbursement (VBR). If you have yet to see revenue implications from this approach to payment reform, chances are high that you will within the next 5 years. It is important for physicians to understand the current and emerging future state of these activities. Although physical medicine and rehabilitation (PM&R) is not a specialty that has been impacted heavily by these programs to date, payers will seek to differentiate value within the specialty. Those challenges may be offset by new opportunities for the specialty that the new system would provide. For example, it is quite likely that patient functional status will be included as a common value parameter for many conditions. PM&R's subject matter expertise and services could be leveraged in the design and implementation of functional status measurement for value-based assessments.

BACKGROUND

For many years employer and governmental purchasers have advocated for the measurement of the effectiveness, efficiency, and quality of care to guide purchasing decisions and evolve reimbursement mechanisms that support VBR. Employer purchasers of health care, directly or via their contracted health plans, have deployed various approaches to attempt to quantify value and preferentially purchase high-value care. Some have rewarded greater performance through pay-for-performance initiatives. Large national health plans have identified subsets of their contracted physicians who appear to provide care at lower costs with above-average quality performance. This preferred subset might receive performance bonuses and increased patient volumes from the plans. Those physicians not in preferred status may be ineligible for bonuses and in some instances are excluded entirely from some employer benefit plans or require greater co-pays for plan members to see them.

Congress, urged by the Medicare Payment Advisory Commission and the Government Accountability Office, has increasingly directed that the Centers for Medicare and Medicaid Services deploy elements of value-based purchasing for Medicare services. For some years hospitals have witnessed the potential for greater reimbursement based on the performance on selected measures of quality performance. Recently Medicare announced rules under which it will not pay hospitals at all for conditions or complications that should not occur during hospitalization [1]. The Centers for Medicare and Medicaid Services has been phasing in elements of physician practice measurement through its voluntary quality reporting system known as Physician Quality Reporting Initiative [2].

The Obama administration's health-reform agenda is highly reliant on concepts of a value-based system. It seeks a greater quality system that wastes less and encourages efficient and effective care. This system will further accelerate value measurement and VBR efforts.

M.R. Care Variance, LLC; School of Medicine, University of Washington, Edmonds, WA 98026. Address correspondence to: M.R.; e-mail: mrattray@carevariance.com
Disclosure: nothing to disclose

Disclosure Key can be found on the Table of Contents and at www.pmrjournal.org

Submitted for publication June 3, 2009; accepted June 3.

PM&R
1934-1482/09/$36.00
Printed in U.S.A.

Vol. 1, 706-708, August 2009
DOI: 10.1016/j.pmrj.2009.06.004

VALUE MEASUREMENT

Value is by definition in the eye of the beholder. (The emerging "official" definition of value in health care can be found at http://www.aqaalliance.org/files/PrinciplesofEfficiencyMeasurementApril2006.doc. Excerpt: "Value of care is a measure of specified stakeholder's [such as an individual patient's, consumer organization's, payor's, provider's, government's, or society's] preference-weighted assessment of a particular combination of quality and cost of care performance."). Although efforts are underway to better define value from a patient/consumer perspective, the private and governmental purchaser value perspective has driven much of the debate and momentum. Purchasers view value as benefits received (often referred to as quality) for expenditures. Quality is seen as multidimensional, incorporating process quality and outcomes to the extent data exist and can be captured. Process quality measurement has been with us for some time, although PM&R as a specialty has not been a high priority for such measures. The greatest focus has been on primary care disease-prevention activities and increasingly on high-volume and high-cost specialties in which practitioners treat highly prevalent and costly diseases. Although the purchaser stakeholder perspective remains dominant, most recognize the need to include elements of the patient perspective in value assessments used for VBR.

The science of value measurement in health care is receiving new attention because previous attempts at value measurement at times have overreached the available science. There is a general consensus that we need to more comprehensively define health-care value. We need well-defined, consensus-developed objective measures, measurement, and reporting of value. To keep this from being cost-prohibitive we need to rely heavily on electronic data capture supported with public domain and transparent analysis and reporting methods. Value measurement logically supports value improvement. In many respects what is going on is the accelerated installation of continuous quality improvement in health care. Continuous quality improvement has served many industries well and in health care may well improve the quality and affordability of the care that our system delivers.

The process of measuring value starts with identifying elements (or measures) of care that are perceived to be of value and might be able to be quantified. Many items on our wish list of measures currently lack the necessary data capture infrastructure for measurement to occur. The push is on to build out this infrastructure where possible. To date most physician value performance assessments have focused on process quality and cost/resource expenditures. Process quality measures are measures that typically define a population of patients that should receive a particular health-care service. Examples would be patients within a certain age range that saw a primary care physician that should have received a specific vaccine. These patients form the denominator of the measure. The number of patients who received the vaccine forms the numerator. The number of those who received the service divided by the number that should have received the service may be referred to as the quality measure performance rate.

Value is often simplistically thought of as benefits (often referred to as quality) divided by cost. In any value equation the amount of resources consumed is an important variable. Cost often serves as the unit of resource expenditures, but analysis of the quantity and types of actual services delivered is also important in value analyses. Cost is usually depicted on a per-capita basis, for example, costs per patient per month or year, often including the number and costs of office visits, laboratory tests, imaging studies, and hospitalizations. Increasingly an episode of care approach is advocated for reporting on resource use/costs. Rather than just looking at per capita results, episodes of care analyses seek to quantify resource expenditure at a condition level. Physicians are then compared with physicians in their specialty for their average episode costs for specific conditions. Proprietary episode software identifies more than 500 conditions for episode analyses. Under a grant from the Robert Wood Johnson Foundation [3], the American Board of Medical Specialties is developing nonproprietary episodes of care, starting with 20 of the most common, most resource-intense conditions.

The episode of care construct can be applied to value measurement beyond resource use. Condition-specific quality measures, many of which may already exist, can be included in the construction of condition-specific episodes of care. With the incorporation of quality measures with resource use, episodes of care show promise as a unit of value.

WHAT MIGHT VBR LOOK LIKE?

Expect a phased, incremental plan for physician VBR to emerge out of the national health-care reform efforts. Massachusetts, facing large increasing costs for their universal coverage program and seeking to avoid tax hikes, recently indicated that it will move more quickly to VBR as a potential solution [4], and the lessons learned could hasten other regional and national timelines.

The creation and testing of public domain condition-specific (episode of care) assessments of resource use are ongoing. are underway to identify current quality measures in use for possible inclusion in episode-based measurement. Most see the need for additional measures of quality and an expanded data capture and processing infrastructure to enable more sophisticated value measurement. Most of the early value measurement systems have relied entirely on claims data. Increased and improved data linkages with physicians, other care providers, and *patients* have the potential to enable better characterizations of value.

Many physicians can expect to see, as many have already, an evolution of "value report cards" from purchasers or payers that contain assessments on quality measures and resource consumption applicable to their patients. Typically these reports would contain per capita and episode-based information. The weighting of the various quality measures, as well as the relative weighting of quality and cost would be established by the measuring entity, ideally with appropriate

stakeholder input and consensus. The resulting value calculations could then be applied to bonuses or to sliding scale reimbursements for this physician's services for episodes of this type.

It is likely that physicians will see more global measurement across all episode types they treat. In such a case a composite value could be calculated and applied more globally across all the services the physician provides. One could imagine an incremental approach to implementation of VBR such that an increasing percentage of a physician's reimbursement is value based.

Many argue that holding physicians accountable for the value of acute complex or complicated chronic disease care oversimplifies the complexities of providing the "right care" for such conditions. Care provided by the prehospital care system, hospitals, and other care providers may be outside a physician's direct control and yet weigh heavily in value assessments. This issue has led to the proposal that value accountability for some complex acute and chronic conditions will be assumed by or assigned to "accountable care organizations" comprising local hospitals and the physicians who work within and around them [5].

Work is ongoing as to how best to designate value accountability for care spanning multiple providers of care. If these accountable entities become responsible for value and become the payee for complex acute or chronic condition episodes, physicians may be increasingly looking for reimbursement from these entities rather than directly from government or health plans. It is anticipated that integrated delivery systems will accept care value responsibility—some already have [6]. Physicians not tightly linked to a delivery system may wish to evaluate their affiliation options in anticipation of the adoption of the accountable care organization model for episodes that frequently require multiple care providers.

CONCLUSION

The momentum for VBR has several implications for PM&R. All specialties are being asked for relevant and meaningful value measures. Multiple organizations are actively generating additional quality measures to broaden measurement across all specialties, and to more comprehensively measure the care activities of each specialty. This poses challenges to PM&R, such as assisting in the creation of relevant measures, implementing data capture systems, communicating to and informing members of the specialty as to measures and measurement activities, and driving measurable improvement.

Second, the evolving measurement of quality is likely to include patient-generated assessments, predominately patient satisfaction and functional status. Given that PM&R has a core mission of improving or stabilizing patient functional status, the specialty might logically be looked to as an expert in this area. As demands increase for incorporation of functional status as a component of the value equation, the specialty is well positioned to assist in the development and deployment of functional status assessment and measurement across many conditions, not just those conditions typically within the purview of the specialty.

REFERENCES

1. CMS. Medicare and Medicaid move aggressively to encourage greater patient safety in hospitals and reduce never events. Available at: http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3219&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=false&cboOrder=date. Accessed June 10, 2009.
2. CMS. Physician Quality Reporting Initiative. Available at: http://www.cms.hhs.gov/pqri/. Accessed June 10, 2009.
3. Robert Wood Johnson Foundation. Charting the Course to High-Value Health Care. March 2009. Available at: http://www.rwjf.org/files/research/hvhcissuebrief.pdf. Accessed June 10, 2009.
4. New York Times. March 15, 2009. Available at: http://www.nytimes.com/2009/03/16/health/policy/16mass.html?_r=1&scp=1&sq=massachusetts%20doctors&st=cse. Accessed June 10, 2009.
5. Fisher ES, Staiger DO, Bynum JPW, Gottlieb DJ. Creating accountable care organizations: The extended hospital medical staff. Health Affairs 2007;26:w44-w57.
6. Paulus RA, Davis K, Steele GD. Continuous innovation in health care: Implications of the Geisinger experience. Health Affairs 2008;27:1235-1245.