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POLICY FORUM
Will the Medicare Value Modifier Get Us Closer to Rewarding Quality Care?
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It is widely acknowledged that physician payment under Medicare's current fee-for-service mechanism (Resource-Based Relative-Value Scale [RBRVS]) is dysfunctional, paying excessively for procedures and insufficiently for cognitive services and coordination of care [1]. The consequences of this payment model range from excessive costs of care to distortions in medical student career choices that contribute to shortages of primary care physicians in the workforce [1, 2]. Despite its shortcomings, RBVRS serves as the basis of payment not only for Medicare but for most commercial payers.

As the Affordable Care Act was being written, policymakers began to realize that health system reform would require fundamental change in how physicians are paid, moving towards a more value-based payment system [3]. "Paying for value rather than volume" has become the policy mantra of discussions about physician payment. Models of payment reform range from refinements in fee-for-service to risk-adjusted global payment for comprehensive care [4, 5].The Center for Medicare and Medicaid Innovation was established by the Center for Medicare Medicaid Services (CMS) to encourage and field test new payment models [6].

Recognizing that transformational payment reform may be years away, yet eager to begin moving expeditiously towards payment for value, Congress included in the Affordable Care Act a section reforming traditional Medicare fee-for-service by attaching a payment modifier to the fee schedule. The proposal adjusts physician payment up by as much as 2 percent or down by as much as 1 percent, starting in 2015, based on performance measured by cost and quality standards starting in 2013 [7]. It provides an additional 1 percent bonus for achieving goals in the care of high-risk patients. Initially, only practices with 25 or more practitioners would be subject to the modifier, with expansions to include all physicians by 2017.

As with payment reform in general, physicians and physician organizations have responded with ambivalence and concern, some asking for delay, a narrower application, and more physician education by the Center for Medicare Medicaid Services [8, 9]. Key questions include details about quality measurement and the validity of the quality measures selected [10]. The proposal also contains potential pitfalls for small practices, putting them at risk financially for actions they cannot control, such as patient behavior.

These proposals and the topic of physician payment in general raise questions about the ethics of payment incentives. Before considering the ethics, it is worthwhile to examine physician behavior to see if financial incentives actually matter. The public expects physicians, as highly educated professionals dedicated by oath to the health of their patients, to be the least affected by payment incentives because of the imperative to "do the right thing" regardless of financial consequences. However, economists, as students of human behavior, view physicians, like all human beings, as strongly influenced by financial incentives. After all, they argue, payment is a potent form of behavioral reward for work done, and using financial incentives is a good way to change human behavior.

An examination of physician behavior finds evidence supporting both views. For example, recent surveys of medical student attitudes found financial reward to be less of a consideration in career choice than other factors [11, 12]; more students are now choosing careers in primary care despite little immediate improvement in its financial rewards [13]. On the other hand, for over a decade actual residency applications have disproportionately gone down "the ROAD" (radiology, ophthalmology, anesthesia, and dermatology) [2], suggesting that high pay per unit of work does influence choice in many instances. The RBRVS's mechanism for restraining growth in health expenditures (the sustainable growth rate or SGR) [14] has been ineffective, suggesting that physicians do indeed respond to fee for service by providing more services, just like everyone else being paid according to volume of work they perform.

The picture that emerges from epidemiologic study of physician economic behavior is a mixed one. Researchers find wide variation in per capita health care costs by hospital region as documented in the Dartmouth Atlas [15].The only explanation for the marked differences Atul Gawande could find in health care costs for Medicare beneficiaries in McAllen and El Paso, Texas, (whose populations are very similar demographically and medically) was the amount of services provided; health outcomes were no different [16], indicating that the additional services did not improve patient health. Some march to the drummer of maximizing income, others march to a different drummer. From the intensity of responses by some professional societies to Medicare's coding modifier proposal [9], it appears that economic incentives matter a whole lot to many of their members.

There is nothing inherently wrong or unethical with financial incentives; one need not be a saint and ignore them. The ethical problem comes into play when financial incentives distort behavior, tempting us to inappropriately maximize income. Maximizing income is not per se unethical either; it can be a matter of economic survival, as in practices that provide mostly underpaid yet essential evaluation and management services (the term assigned by CMS and private insurers to patient history taking, diagnosis, treatment planning, and associated activities, usually referred to as "E/M" services or "cognitive work").

The ethical goal is not to eliminate financial incentives—they are inherent in every payment system, not just fee-for-service. Rather, the task is to better align them with societally desired health outcomes and the interests of our patients. The problem with RBRVS is that its incentives are misaligned (volume-based, excessive payment for procedures), leading to the world's highest per capita health care costs and mediocre health outcomes [17]. We get what we pay for.

Although the immediate impetus for payment reform is cost containment, the goals of our health care system are best expressed by the Triple Aim adopted by CMS under Donald Berwick's leadership: "better health, better health care, at lower cost" [18]. We designers of physician payment reform have focused our efforts on improving the value of care (defined as quality ÷cost), in which cost is only one part of the equation.

How might one harness the power of financial incentives to accomplish value-based payment? Do the CMS-proposed value modifiers seem likely to support the desired goal of moving from "volume to value"? Allow me to share with you some considerations relevant to reform of physician payment in support of the Triple Aim. First we must ensure access to care. Fee for service does this very well, but in essence too well—as noted, the sustainable growth rate in RBRVS has failed to check provision of excessive services. Alternatives? Let us consider paying by practice panel size—the larger the panel, the greater the practice's income. That would ensure access, but might compromise visit availability and quality of care if one's panel gets too big. It might also encourage "cherry-picking" of patients to minimize the care burden of one's panel. However, if we risk-adjust the payment for each patient in the panel, we can obviate cherry-picking and better match practice financial resources with patient needs. Also, let's monitor patient access to be sure visits are readily available and measure care quality to ensure quality does not suffer from too many patients to care for. In this manner, panel size should self- correct, especially if we provide financial rewards for exceptional access and quality.

What emerges from such considerations is a model of risk-adjusted comprehensive payment for comprehensive care with bonuses for quality and patient experience. This has been proposed both for primary care's patient-centered medical home [5] and for accountable care organizations [19]. Cost is contained by paying on a risk-adjusted, predetermined per-capita basis (often referred to as "capitation," a term shunned due to its negative connotations from an early, failed version of global payment). As noted, monitoring and rewarding quality and patient experience counters gaming. Such payment models might not serve for all medical care delivery—some fee-for service might be appropriate for discrete procedural services—but setting and living within a global budget does inhibit delivery of low-value services.

The CMS proposal represents a baby step in the direction of changing the reward system. It attempts to do so while maintaining RBRVS's fee-for-service system. One might question the wisdom of doing so, given the current payment system's

dysfunctionality. What's needed is a concerted effort to move more expeditiously towards fundamental physician payment reform that will better promote achievement of the Triple Aim.

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