INTRODUCTION
The Affordable Care Act mandates that by 2015 the Centers for Medicare and Medicaid Services (CMS) must begin applying value-based payment modifier (VBPM) under the Medicare Physician Fee Schedule/Fee for Service Medicare.1

The cost composite score will be obtained by adding the total overall costs with the total costs for beneficiaries with specific conditions. The following four quality indicators will be assessed, added together, and given a composite score: clinical care, patient experience, patient safety, care coordination, and efficiency. Two of these composite scores will be added together to result in the value modifier amount. High quality, low cost healthcare is the ultimate goal.2

Research shows that physicians with the least experience have higher cost profiles than do physicians with the most experience.3 Using the new value-based payment modifier for physician reimbursement based on physician cost profiles acquired during residency training programs could result in decreased access to new physicians to provide quality care for patients. Another potential unintended consequence of utilizing the value-based modifier is that it may force new physicians to modify their practice patterns which may result in lower quality care. If new physicians in training programs are concerned with their cost profiles instead of learning to practice medicine, this may result in less familiarity with certain procedures for future physicians.

Many unanswered questions exist. How will new physicians directly out of residency have their cost profiles calculated? How will those cost profiles impact access to care?

PRACTICE PATTERNS
Cost: A research project designed to examine the relationship between publicly available physician characteristics and the cost profiles of 12,116 Massachusetts physicians in 27 different specialties showed that the least experienced physicians have higher costs.
• likely to use newer and more expensive treatment modalities
• lack of experience may translate into more aggressive care
• may treat sicker patients with more complex conditions3

Quality: Systematic Review: The Relationship between Clinical Experience and Quality of Healthcare, concluded the longer a physician has been in practice, the lower the quality of care provided. A total of 52% of the studies resulted in decreased performance with increasing years in practice. Only 2% reported increasing performance with increasing years in practice.4

IMPLICATIONS
The Institute of Medicine states, “If Medicare is able to use the new value-based payment modifier for physician reimbursement based on physician cost profiles acquired during residency training programs, this could result in decreased access to new physicians to provide quality care for patients.”

STAKEHOLDERS
The American Osteopathic Association (AOA) urges CMS to delay the implementation of the Value-Based Payment Modifier system.

American Medical Association (AMA): Value-based modifiers “are not ready for prime time...CMS could and should use the time between now and 2015 to do further testing and refinement of the modifier’s components.” (Executive Vice President and CEO James L. Madara, MD).3

American Academy of Family Physicians (AAFP): “CMS should not rush implementation of the value-based payment modifier and hastily adjudicate physicians’ Medicare payments before CMS’ payment policies are clear.” (Lori Heim, MD)6

American Hospital Association (AHA) feels the effective date of VBPM program needs to be pushed back.7

CONCLUSIONS
The VBPM may penalize new physicians and result in decreased access to new providers and a consequent decrease in access to quality care for patients.

CMS should delay the 2015 implementation of Medicare’s value-based payment modifier allowing sufficient time for CMS to develop written, simplified guidelines for both patients and physicians and post them on the Health Compare Website.

Due to the lack of simplicity and high level of ambiguity, many health care providers are confused about the value-based payment modifier and have not been providing their data to CMS. CMS should work to educate the entire medical community on both the required reporting and the reimbursement formula for health care providers. More education would likely result in more physicians reporting their PQRS data to CMS.

CMS should also calculate cost profiles of new physicians while out in practice after residency, (excluding costs incurred during residency training) in order to calculate more accurate cost profiles.

References

“...There will be losers and winners in any cost profiling effort.”
Ateev Mehrotra, et al