



# National Advisory Committee On Rural Health and Human Services



## Physician Value-Based Payment Modifier Program Policy Brief December 2011

*Editorial Note: In 2011, the National Advisory Committee on Rural Health and Human Services will focus on the rural implications of key provisions from the Patient Protection and Affordable Care Act through a series of policy briefs with policy recommendations that will be sent to the Secretary of the U.S. Department of Health and Human Services.*

### INTRODUCTION

The Affordable Care Act (ACA) has the potential to dramatically change the health care system. As was the case in the 1980s, when the creation of Medicare's hospital Prospective Payment System (PPS) caused serious damage to the rural health infrastructure, these current structural changes within the ACA could have a different impact on rural providers than on urban providers. The Committee supports the direction of the ACA, including the development of performance measures tied to quality and value-based adjustments to payment structures, but it also believes that it is critically important for the Secretary to accomplish these objectives without impairing access to quality physician care in often burdened and under supported rural areas. The Committee hopes that by providing timely advice it will enable HHS to avoid consequences of new changes in the reimbursement structure.

This policy brief focuses on Section 3007 of the ACA, which establishes a physician value-based payment modifier (VBM) program.<sup>1</sup> The VBM program will provide differential payment to physicians or physician groups based on the quality of care provided compared to the cost of providing care. The Secretary was required to establish the initial measures, dates of implementation, and performance period by January 1, 2012, and directed the Centers for

### Recommendations

1. The Committee recommends that the Secretary make additional efforts to inform rural physicians about the upcoming implementation of the VBM program and establish a system to create dialogue among rural practitioners facing implementation challenges.
2. The Committee recommends that the Secretary require, for a trial period of 1-2 years, that rural physicians report 3-5 common measurements and receive timely reports about their performance. After the reporting system has been established and proficiency has been gained, additional measures could then be added.
3. The Committee recommends that the Secretary make additional assistance available to rural practitioners for the implementation of EHR systems, especially upfront acquisition support and support to secure staff needed to fulfill VBM requirements.
4. The Committee recommends that the Secretary ease the burden of implementation by allowing flexibility in program requirements that place a disproportionate burden on rural practitioners.
5. The Committee recommends that the Secretary account for differences in patient populations in the peer-grouping for physicians in the VBM program.
6. The Committee recommends that the Secretary assure that costs unrelated to the medical decisions of the primary physician be excluded from the cost comparisons made in the VBM program.
7. The Committee recommends that the Secretary use authority granted in Sec. 3007 to exclude rural physicians from the VBM during calendar year 2015 and 2016 to determine the costs, impacts and specific problems of implementing the VBM program in rural areas.
8. The Committee recommends that the Secretary adjust the VBM to recognize the increased cost and decreased administrative support available while providing care in rural areas.

<sup>1</sup> H.R. 3590, 111th Congress: Patient Protection and Affordable Care Act 255-258 (2010) (enacted).

Medicare and Medicaid Services (CMS) to do so. In the 2012 final Medicare Physician Fee Schedule (MPFS) rule, CMS established that it will use existing Physician Quality Reporting System (PQRS) and Electronic Health Record (EHR) Meaningful Use (MU) measures, along with select total per capita cost measures, creating a list of 62 preliminary measures for the VBM program.<sup>2</sup> While these previous systems modify reimbursement based on reporting these measures, the VBM program differs because it is the first to differentiate MPFS payments based on the quality and cost of care physicians provide.

CMS will begin the VBM rule-making process during 2013 for the MPFS effective for calendar year 2014. CMS has established calendar year 2013 as the first performance period. The Secretary has discretion to start the VBM program with a “selected” group of physicians in 2015, with all physicians subject to the VBM in 2017. While many ACA provisions do not specifically address rural concerns, Section 3007 includes language that says the Secretary shall, as appropriate, take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

To aid in the development of this policy brief, the Committee recently met with panels of rural providers in Hattiesburg, Mississippi, and surrounding rural areas. In this policy brief, the Committee identifies specific concerns with the VBM program’s impact on rural healthcare and makes proposals to ensure that access to critically needed care does not diminish. The Committee focuses on: information dissemination; preliminary reduction in measures; VBM’s dependence on EHRs; rural practitioner EHR challenges; rural infrastructure challenges; rural patient population differences; concerns of attribution of higher costs; a no-risk demonstration project; and a rural value-based modifier.

## **DISCUSSION AND RECOMMENDATIONS**

*Dissemination of the VBM program.* After a day of meetings, it was clear many rural providers had not received information on value-based reimbursement programs. Research presented to the Committee showed that out of a sample of 22 rural physicians in Mississippi, not a single one of them knew what the value based modifier program was.<sup>3</sup> Practitioners cannot be expected to prepare for this new program without direct access to information. The Committee believes that lack of information is a key factor slowing preparation for the VBM program. The Committee recommends that the Secretary make additional efforts to inform rural physicians about the upcoming implementation of the VBM program and establish a system to create dialogue among rural practitioners facing implementation challenges.

In addition, many practitioners at certain rural care facilities will not qualify for the VBM program. The Committee notes that providers practicing in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) are paid outside of the MPFS and, therefore, will not be able to take part in the VBM program. There are currently more than 3,800 RHCs and more than 7,000 FQHC service sites, with a significant percentage of FQHC service sites are located in or serving rural populations.<sup>4</sup> This means that a significant portion of the rural primary care workforce will not be subject to the VBM. This has also been the case for other key quality-focused Medicare physician initiatives, including the PQRS and E-prescribing, as Congress continues to draft these provisions looking only at those providers who bill under the MPFS. The Committee believes HHS and other policy makers should consider how and when to bring RHC and FQHC providers into the larger quality framework emerging in Medicare.

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<sup>2</sup> Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2012, 42772 Centers for Medicare and Medicaid Services § Section 4 (2011).

<sup>3</sup> Oden, Greg, Chief Medical Officer, Pioneer Health Service. Remarks at Meeting of the National Advisory Committee on Rural Health and Human Services. September 2011. Hattiesburg, MO.

<sup>4</sup> "Rural Health Clinic (RHC) Resources." *Rural Assistance Center - Rural Health and Rural Human Services Information*. Web. 22 Dec. 2011. <[http://www.raconline.org/info\\_guides/clinics/rhc.php](http://www.raconline.org/info_guides/clinics/rhc.php)>.

Preliminary reduction in measures. The Committee views the greatest challenge of the first few years of the VBM program as the development of the infrastructure and processes to report the measures. This will be an even greater challenge in rural communities because of the lack of existing infrastructure compared to large urban health centers. Imposing 60+ measures on rural practitioners at the start of the program, before the establishment of a working reporting system, will, in the view of the Committee, overburden rural physicians. The implementation could be made more manageable by first focusing on establishing the reporting process for this new VBM program, initially requiring only 3-5 measures to be reported. These preliminary measures should be easily obtained from routine office visits and could include hemoglobin A1C, blood pressure, flu, and preventive service measures. In addition, the Committee believes that feedback to the physician on his or her performance should be timely and not exceed a year after the measured care was given. The Committee recommends that the Secretary require, for a trial period of 1-2 years, that rural physicians report 3-5 common measurements and receive timely reports about their performance. After the reporting system has been established and proficiency has been gained, additional measures could then be added.

VBM's dependence on EHR. The success of a quality-incentive program is directly dependent on participants' access to a robust system to report on quality and cost measures. However, healthcare systems in rural areas lag behind the rest of the country in the implementation and use of EHR.<sup>5</sup> Although reluctance to change is an issue, there are significant structural problems in rural areas that cannot be ignored. Small practices generally lack flexible administrative capital and personnel who can be dedicated to implementation of EHR systems.<sup>6</sup> Many rural providers are already working at capacity taking care of the needs of their communities and do not have the ability to reduce workload to institute and maintain new software programs. In addition, a period of lost productivity typically accompanies implementation of an EHR, further threatening the viability of small providers already operating on thin margins. The Committee learned in Hattiesburg that a number of the EHR systems already in place are not capable of supporting the demands for data required in the VBM program. The lack of sufficient HIT support in rural communities and in solo and small group practices is responsible for some problems surrounding implementation, including limited EHR options. The Committee is also concerned that excess demand for these services has led to a situation in which rural providers are losing available HIT staff to better financed urban areas. Regional Extension Centers (RECs) could be directed to offer more assistance to rural practices. In particular, RECs can help with the health IT professional shortage and RECs could be better incentivized and evaluated for all their work with rural practices. In addition, the Committee has heard that EHR incentive payments are not sufficient in rural areas because of the retrospective nature of the payments and more restrictive administrative capital in rural areas. The Committee recommends that the Secretary make additional assistance available to rural practitioners for the implementation of EHR systems, especially upfront acquisition support and support to secure staff needed to fulfill VBM requirements.

Rural Practitioner EHR Challenges. Small rural practices are often exclusively paper driven and lack the capital and expertise needed to make the change to EHR.<sup>7</sup> As the Committee heard from rural physicians during its site visit to Collins, Mississippi, much of the burden of selecting, installing, and operating new EHR systems falls on rural practitioners themselves because their hospital or clinic lacks the needed staff and financial resources for a dedicated EHR coordinator. There are a significant number of older physicians working in busy, isolated practices who are eligible to retire and for whom there are

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<sup>5</sup> Mills, T.R., Vavroch, J., Bahensky, J.A., and Ward, M.M. "Electronic Medical Record Systems in Critical Access Hospitals: Leadership Perspectives on Anticipated and Realized Benefits." *Perspectives in Health Information Management*. Ahima Foundation, Spring 2010. Web. 22 Dec. 2011. <<http://perspectives.ahima.org/>>

<sup>6</sup> Rosenblatt R.A., Andrilla H.A., Curtin T., and Hart L.G. "Shortages of medical personnel at community health centers: implications for planned expansion." *JAMA* 2006;295:1042-9.

<sup>7</sup> Mills, T.R. et al.

currently no replacements.<sup>8</sup> An inflexible and sudden requirement for VBM and EHR implementation may cause many of these physicians to retire in order to avoid the expense and frustration of such a large and rapid system change. In addition, the Committee has seen how younger physicians, facing the challenge of implementing EHR in small practices, have joined medical groups or sold their practices to hospitals instead. This consolidation of hospitals and physicians holds both promise of greater efficiency and potential challenges for rural areas. As the Committee heard from physicians in Collins, a pattern of consolidation could reduce the commitment to the health of rural areas and the continuity of care provided by small practices located in the community. *The Committee recommends that the Secretary ease the burden of implementation by allowing flexibility in program requirements that place a disproportionate burden on rural practitioners.*

Rural patient population differences. The additional challenges faced by the rural population demonstrate another disparity with urban centers. Research shows greater prevalence of health issues such as obesity, smoking, unmanaged diabetes and heart disease in rural areas.<sup>9</sup> Rural physicians in the rural Gulf Coast of Mississippi who spoke to the Committee say their practices are already stretched and that they have significantly more restricted resources to take on additional patient care responsibilities imbedded in possible new measures. These physicians are concerned that, if directly compared to urban centers with greater resources, they will be unfairly penalized. *The Committee recommends that the Secretary account for differences in patient populations in the peer-grouping for physicians in the VBM program.*

Concerns of attribution of higher costs. In rural practices, there are common circumstances in patient care that cause additional costs which are outside the control of the primary care physician. If these costs are attributed to the physician, they would adversely affect his or her cost measurements. Many of these costs can come from larger tertiary facilities, where care decisions can be made without the direct input of rural primary care physicians. For example, many post-acute care decisions on “what appropriate care is” are made by the tertiary care hospital without consultation of the primary care physician. In addition, the costs of air ambulances and other medical transportation can be extraordinary in rural areas and these costs have little to do with the medical decisions made by a rural physician. *The Committee recommends that the Secretary assure that costs unrelated to the medical decisions of the primary physician be excluded from the cost comparisons made in the VBM program.*

Assessing the extent of the problem through a no-risk introductory period. As the Committee’s aim is to avoid adverse consequences in the establishment of this new payment system, the Committee believes that this could be most effectively achieved with an effort to determine the scope of rural implementation issues during a modified introductory period. *The Committee recommends that the Secretary use authority granted in Sec. 3007 to exclude rural physicians from the VBM during calendar year 2015 and 2016 to determine the costs, impacts and specific problems of implementing the VBM program in rural areas.*

Rural value-based modifier. The Committee believes strongly that there is a difference in the challenges faced by rural communities and those faced by urban communities in implementing the VBM program. As the Committee heard firsthand in rural Mississippi, rural providers do not have the same robust infrastructure and access to resources. The patients in rural areas are disadvantaged with lower levels of access to care, as well as poorer health status and less access to transportation. Long-term sustainability

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<sup>8</sup> Doescher M.P., Fordyce M.A., and Skillman S.M. *Policy brief: the aging of the primary care physician workforce: are rural locations vulnerable?* Seattle, WA: WWAMI Rural Health Research Center, University of Washington; June 2009. <[http://depts.washington.edu/uwrhrc/uploads/Aging\\_MDs\\_PB.pdf](http://depts.washington.edu/uwrhrc/uploads/Aging_MDs_PB.pdf)>

<sup>9</sup> Eberhardt M.S. and Pamuk E.R. "The Importance of Place of Residence: Examining Health in Rural and Nonrural Areas." *American Journal of Public Health* 94.10 (2004): 1682-686.

of VBM requirements may require hiring additional personnel that may already be in place in urban centers. The Committee recognizes that Part B payments already are adjusted for a variety of factors, some of which relate to rural physicians. In establishing the structure of the VBM, the Secretary should provide recognition of the increased cost and decreased administrative support available while providing care in rural areas. This could be accomplished by splitting cost savings pools differently with rural physicians. Because of the challenges laid out throughout this policy brief, the Committee believes the VBM payments will need to continue this special recognition to effectively manage these disadvantages. The Committee recommends that the Secretary adjust the VBM to recognize the increased cost and decreased administrative support available while providing care in rural areas.

## **CONCLUSION**

There is a clear difference between adequately staffed medical practices that are given incentives to reallocate resources to improve quality of care and medical practices that are already stretched thin and which are then required to undertake significant new administrative burdens. Small, rural practices often fall into this latter case. By following the recommendations in this policy briefing and adjusting the VBM to recognize disproportionate burdens upon rural practitioners, access to essential rural health services could be secured, while pursuing meaningful increases in the value of care these rural practices provide.