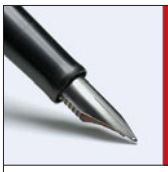


LETTER FROM THE EDITOR-IN-CHIEF

Value-Based Reimbursement Is Premature, But That Won't Stop It

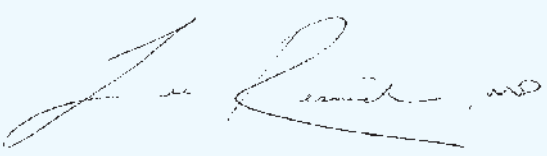
Private payor reimbursement trends nearly always follow Medicare's lead, and at no other time in history has the physician-reimbursement model been so scrutinized. In an attempt to control unwieldly health-care spending, payors are understandably looking to be creative. When they look at the drivers for increased health spending, one thing is clear: Diagnostic testing and imaging services grew far faster since 2000 than any other health-care service. According to MedPAC (the Medicare Payment Advisory Commission), the volume of these services grew from 2000 to 2011 by 91% and 79% respectively, whereas evaluation and management (E/M) services grew by 37%. What's more, tests and imaging services cost more per encounter than E/M services do, thereby influencing overall spending more significantly. Enter value-based payment models.

The idea is to reward what is seen as high-value care and penalize what is seen as low-value care. Comparative effectiveness studies, many of which are funded by federal agencies with ties to Centers for Medicare & Medicaid Services, have been issuing verdicts on tests, procedures, and advanced diagnostics that, when linked to specific diagnoses, demonstrate no benefit. Once the payors had their evidence, all they needed were ways to track and measure quality and medical necessity so that they could begin to impose their new payment model. If you are wondering who came up with the cluster headaches known as ICD-10 (*International Classification of Diseases, 10th Revision, Clinical Modification*) and PQRS (Physician Quality Reporting System), well, now you know. And it's no secret who has been stuck with the bill for their implementation. It's like paying admission to your very own house of torture!

Meanwhile, back in reality, operating expenses for physician practices continue to outpace reimbursement at dramatic rates. If you follow the trends of the Medicare Economic Index (MEI), you know that practice expenses have in fact been climbing 200% faster than reimbursement rates over the last decade. The MEI is a measure of all practice expenses, including compensation for staff, rent, equipment, and technology. More depressing is that inflation increased at a rate of 33% versus the 9% rate increase for fee-for-service (FFS) reimbursement over the same period. Effectively, cost-of-living *and* practice expenses are increasing more than three times as quickly as revenue. Worse, these trends reflect practice income *before* the bulk of electronic medical record integration and *before* the ICD-10 circus came to town. Name two more costly initiatives than these since 2000 . . . go ahead, I dare you.

With margins being what they are in most physician practices, how can we possibly survive this onslaught? Why, see more patients, of course! So we should see patients faster than ever before, which decreases quality, increases errors, and decreases patient satisfaction? Aren't these just the measures being proposed for value-based payments? Now, I am sure someone will be quick to remind me that these new payment systems will allow physicians to actually see fewer patients because value-based reimbursement will be higher . . . right? Well, sort of. The value-based payment formulas are complicated and confusing, but the down arrow here is that physicians are looking at ±2%, on the basis of their performance. In other words, you are cordially invited to increase your effort (aka expense) and decrease your overall efficiency, all in the hopes of getting a 2% payment bump. While this little experiment is being played out, most of your patients continue to get reimbursed under the FFS model. So unless you find ways to treat value-based-payment patients differently than FFS patients, all this effort will actually *decrease* your income.

Urgent care physicians and operators should not fool themselves into thinking that value-based payment models will not be relevant to our industry. Regardless of how this plays out, is it simply not a good idea to add any new payment schemes—with their rules to learn and audits to fear—until we fix the dramatic and growing gap between practice expenses and reimbursement. Continuing to add new models dooms the system to failure. ■



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