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To: Health Care Plan Learning and Action Network (HCPLAN)

From: AMGA

Re: HCPLAN Performance Measurement White Paper: Comments

On behalf of AMGA we appreciate the opportunity to comment on the HCPLAN's "Performance Measurement" white paper. AMGA, founded in 1950, represents more than 450 multi-specialty medical groups and integrated delivery systems representing about 177,000 physicians who care for one-in-three Americans. Our member medical groups are interested in performance measurement for numerous reasons. AMGA members have a strong desire to improve the quality and effectiveness care delivery, or in achieving the triple aim of improving the experience of care, improving the health of populations, and reducing spending or the per capita costs of health care.

AMGA has one overarching comment in response to the draft white paper.

The draft performance measurement report notes notes "value" at least fifteen times. For example on page five, "This paper is grounded in the notion that payers, providers, purchasers, and patients should be collectively accountable for ensuring that the health care system delivers the highest possible value for patients and consumers." On page six, "The PBP Work Group conceives of measurement systems," the report states, "as being comprised of three components, each of which is needed to reward providers who deliver high-value health care: 1) measure sets; 2) methods for evaluating performance on measures . . . ; and 3) methods for using." On page seven, the report states, "Payers have an important interest in performance measurement because it is foundational to new payment models, such as PBP models, that enable a shift away from incentives that reward volume rather than value in health care."

The HCPLAN draft reflects its companion CMS document, the MACRA-authorized and recently finalized plan to develop Medicare quality measures. Titled, "CMS Quality Measurement Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMS)," this document also notes value numerous times.¹ For example, the report states, "The MDP describes . . . the roles of quality measures in the transition to a value-based health care." "CMS will strive," the report states further, "to ensure the availability of carefully evaluated and tested clinical quality measures . . . a critical objective in the transition from paying for volume to rewarding value." The Institute of Medicine's (IOM) 2015 report, "Vital Signs, Core Metrics for Health and Health Care Progress," takes the same approach.²

Like CMS and the IOM, the HCPLAN document defines quality as, or a proxy for, value. They, however, are not the same. Quality, or more specifically an outcome, is a value component. Value is the sum of a performance

or outcome numerator measured over a spending denominator, or as Micheal Porter stated in a recent [New England Journal of Medicine](#) essay, "outcomes achieved relative to the costs."³ "Performance measurement" absent calculating value or value improvement is why, for example, MedPAC stated in its June 2014 report to Congress, "Medicare's current quality measurement approach has gone off the tracks"⁴ True quality measurement is not an input or sum total of inputs, for example the sum total of process measures, or even the outcome itself, but again outcomes measured relative to spending or costs.

Measuring and rewarding quality independent of correlating to spending can and does produce perverse effects. These obviously need to be avoided. For example, in a May [Health Affairs](#)' article researchers found CMS paid 231 hospitals participating in the 2015 Medicare Hospital Value-Based Purchasing (HVBP) program a financial bonus for spending efficiency despite the fact their quality scores were "significantly worse" than medium-and high quality hospitals that also received bonuses.⁵ Not surprisingly, this meant there was little correlation between quality performance and spending. Similar results have been found in the Medicare Shared Savings or ACO program. In 2014, the most recent year for which data is available, CMS paid bonuses or shared savings to 86 MSSP ACOs despite the fact these ACOs had a mean quality score that was worse than the worst financially performing 67 ACOs, or those that exceeded their negative Minimum Loss Ratio.⁶ Despite better quality none of these 67 ACOs received a financial bonus. Other, related research has shown similar results. For example, RANDS's Cheryl Damberg has shown hospital CAHPS scores have little relationship to efficiency.⁷

There are numerous opportunities to incorporate value in the HCPLAN performance measurement discussion. Here are a few. The white paper makes mention of the International Consortium for Health Outcomes Measurement (ICHOM). ICHOM outcome measures could be used in conjunction with spending or reimbursement data to calculate value or to "measure" "performance" improvement. More specifically, MACRA funds \$15 million annually between 2015 and 2019 to identify gaps in measures. The HCPLAN could recommend ICHOM measures under the call for measures in the MACRA proposed rule. As the HVBP researchers and others have suggested, HCPLAN could recommend minimum quality and spending thresholds. For example, California's Integrated Healthcare Association's (IHA) value-based pay for performance program imposes both quality and cost thresholds.⁸ If either or preferably both thresholds are not met a performance measurement score would be decreased. Better still, and as noted above, quality and spending are combined to determine a single "value" performance measurement score. For example, bundled payment arrangements lend themselves to value-base performance measurement scoring since they are intentionally designed to drive outcomes over spending or reimbursement.

The foremost goal of performance measurement ought to be organizing around measuring and achieving value or value improvement. Absent this we face, and are already facing, Michael Porter's 2010 admonishment, "cost reduction without regard to outcomes achieved is dangerous and self-defeating." This leads to, he said, false savings or "ill advised cost containment" that results in "micromanagement of physician practices which imposes significant costs of its own."⁹ MedPAC made the same argument in explaining its "off the rails" comment. The commission stated, current quality measurement left providers with "fewer resources" to "improve the outcomes of care, such as reducing avoidably hospital admissions."¹⁰ The HVBP and ACO program rewards illustrate "ill advised" and evidence of "significant costs" can be found in the estimated \$15.4 billion physician practices spent in 2014 to report quality measures.¹¹ In his comments at Health Affairs' May 12th value-based payment meeting, Commonwealth's David Blumenthal recognized the importance of choosing and prioritizing measures that drive value. To do this he emphasized the need to be intentional such that pursuing the goal of improved value is necessary to gain the confidence and cooperation of providers, payers and other key health reform stakeholders.¹² Unless or until performance measurement actually measures performance, physicians of all stripes will find quality measurement, collection and reporting largely onerous and futile. If Medicare and commercial payers alike intend to migrate healthcare payments from volume to quality and value, they need to begin to define quality as outcomes relative to spending.

Notes

1. See: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Final-MDP.pdf>.
2. The IOM report is at: <http://www.nationalacademies.org/hmd/Reports/2015/Vital-Signs-Core-Metrics.aspx>.
3. Michael E. Porter, "Standardizing Patient Outcomes Measurement," The New England Journal of Medicine (February 11, 2016): 504-506. At: <http://www.nejm.org/doi/full/10.1056/NEJMp1511701>. See also, Michael E. Porter, "What Is Value In Health Care?" The New England Journal of Medicine (December 23, 2010): 2477-2481. At: <http://www.nejm.org/doi/full/10.1056/NEJMp1011024>.
4. MedPAC, "Report to Congress: Medicare and the Health Care Delivery System," (June 2014): 41. At: http://www.medpac.gov/documents/reports/jun14_entirereport.pdf?sfvrsn=0.
5. Anup Das, et al. "Adding a Spending Metric to Medicare's Value-Based Purchasing Program Rewarded Low-Quality Hospitals," Health Affairs (May 2016): 898-906.
6. MSSP 2014 results are at: <https://data.cms.gov/Public-Use-Files/2014-Shared-Savings-Program-SSP-Accountable-Care-O/888h-akbg>.
7. Cheryl Damberg, "Charting a Path Forward: Opportunities to Strengthen Hospital Value-Based Purchasing," at: http://www.healthaffairs.org/events/2016_05_12_value_based_payment/media/slides.pdf.
8. Jill Yegian, et al. "Value Based Pay for Performance in California," (September 2013). At: <http://www.iha.org/sites/default/files/resources/issue-brief-value-based-p4p-2013.pdf>.
9. Porter (2010) Appendix 1.
10. MedPAC.
11. Lawrence P. Casalino, et al., "US Physician Practices Spend More Than \$15.4 Billion Annually to Report Quality Measures," Health Affairs (March 2016): 401-406. At: <http://content.healthaffairs.org/content/35/3/401.abstract>.
12. Blumenthal's comments are at: http://www.healthaffairs.org/events/2016_05_12_value_based_payment/.