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September 27, 2017

To: Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation

From: AMGA

Re: Request for Information, "Hospital Quality Star Rating on Hospital Compare, Public Input Period"

On behalf of AMGA, we appreciate the opportunity to comment on Yale's white paper titled, "Hospital Quality Star Rating on Hospital Compare, Public Input Period," subtitled, "Enhancement of the Overall Hospital Quality Star Rating" document. AMGA member medical groups, which provide care for approximately one in three Americans, have substantial interest in simultaneously improving care quality and reducing spending growth. In sum, AMGA members are motivated to improve health care "value" or outcomes achieved relative to spending. Improving how CMS manages the agency's Hospital Quality Star Rating project under Hospital Compare, which since 2013 includes the Hospital Value-Based Purchasing (HVBP) program, is therefore of inherent interest to us. How hospitals improve quality and reduce spending growth has a direct effect on how physician groups perform under various Alternative Payment Models (APMs), including the Accountable Care Organization (ACO) tracks.

The Yale paper states in part, "we welcome public input and insight on any aspect of the Overall Star Rating methodology." "The public may also offer," the paper states, "general suggestions regarding the Overall Star Rating project" and "CMS seeks in put regarding . . . future TEP and work group discussions." Our comment is limited to a "general suggestion" and/or future discussion that concern attaining health care value.

No Current Correlation between Quality and Spending

As their title indicated, Anup Das and his colleagues noted in their May 2016 Health Affairs essay, "Adding A Spending Metric To Medicare's Value-Based Purchasing Program Rewarded Low-Quality Hospitals," when CMS added a spending measure in 2015 to the HVBP program, low-spending hospitals that received bonuses increased from 38 percent in 2014 to 100 percent in 2015. This was despite the fact that low-quality hospitals, the authors found, "performed significantly worse on almost all measures of quality, compared to the medium- and high-quality hospitals that received bonuses."

Rewarding spending despite poor quality or ignoring the relationship between quality and spending is also the case in the ACO program. In a September 24, 2015 Health Affairs Blog,

David Introcaso and Gregory Berger found “there was no correlation between high quality performance and savings: among the 60 ACOS that earned quality scores at or above 90 percent, only 22 earned shared savings.” Alternatively, 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. (Despite better quality none of these 67 ACOs received a financial bonus.) Other research has shown similar results. This was again the case in ACO performance year 2015. In an October 1, 2016 THCB (The Health Care Blog) post, David Introcaso again found mean quality scores for the four ACO performance subgroups, those ACOs that fell beyond the negative Medical Savings Rate (MSR), those that fell within the negative MSR, those that fell within the positive MSR, and those that fell beyond the positive MSR, only ranged from 90 to 92 percent. Among the 115 ACOs that earned shared savings in 2015, 21 (or 18 percent) had imperfect quality scores, or below 90 percent and thus received less than their full amount of earned shared savings. RANDS's Cheryl Damberg has shown hospital CAHPS scores have little relationship to efficiency.

Because Das and his colleagues found “hospital quality had a weak and inconsistent association with spending,” they recommended that hospital quality ratings incorporate a minimum quality threshold in determining bonus payments. This concept is how CMS managed its physician Value-Based Payment Modifier program. The ACO program similarly penalizes providers with imperfect quality scores. AMGA strongly agrees with CMS' decision to extend this policy to hospital quality ratings.

CMS Should Work Towards Correlating Quality and Spending or Measure for Value

AMGA has argued repeatedly CMS should work toward equating quality with spending, or again calculate care outcomes achieved relative to spending. To date, CMS appears unwilling to move in this direction. For example, in the 2018 proposed MACRA rule, the MIPS cost component is again weighted at zero percent and the proposed rule vprovides no indication the agency will at some future date begin to correlate MIPS quality performance with cost or resource use.

AMGA has argued quality and spending be correlated in at least five comment letters: our June 2017 response to HCPLAN's Alternative Payment Model Framework; our April 2017 response to CMS' Episode-Based Cost Measure Development for the Quality Payment Program; our June 2016 response to the MACRA proposed rule; our June 2016 response to HCPLAN's Performance Measurement White Paper; and, in our March 2016 response to CMS' Proposed Quality Measurement Development Plan. (These comment letters are available at: http://www.amga.org/wcm/AAC/CMS/wcm/Advocacy/cCMS_advocacy.aspx?hkey=2e6b54aa-d6f2-44d0-9240-bdb086b1a9ae.)

As we previously noted, the need to measure for value is well recognized. For example, in its June 2014 report to the Congress, the Medicare Payment Advisory Commission (MedPAC) stated explicitly, "Medicare's current quality measurement approach has gone off the tracks." With an overemphasis on process measures, providers were left with, the commissioners stated, "fewer resources" to "improve the outcomes of care, such as reducing avoidably hospital admissions." MedPAC's comment echoed Michael Porter, who in a 2010 New England Journal of Medicine essay, Porter argued, "The failures to adopt value as the central goal in health care and to measure value are arguably the most serious failures of the medical community." This, he said, has among other things, "resulted in ill-advised cost containment, and encouraged micromanagement of physician practices which imposes significant costs of its own." Per this

latter point, a March 2016 article published in [Health Affairs](#) by Lawrence Casalino and his colleagues found physician practices in four common specialties spent more than 15 hours per physician per week reporting external quality measures. This time translated to an estimated \$15.4 billion in total costs.

CMS' Proposed Quality Measurement Development Plan (MDP), and the agency's related "2016 CMS Quality Strategy Update" document note "value" numerous times. For example, the MDP states "quality measures" are "levers" "in the transition to value-based healthcare." Noting quality measures are necessary to achieve "value-based healthcare" or are important in achieving "cost reduction" makes sense as the MDP is a tool to ultimately guide the agency's design of APMs that are intended to improve value, that is reduce Medicare spending growth.

However, as we noted in our March 2016 response to the MDP, there is no discussion in the MDP or the Quality Strategy about quality measures that actually measure quality over expenditures or measure outcomes achieved relative to expenditures. That is, there is no discussion of how the agency will achieve value, or make APMs successful, via quality measurement. Achieving quality without correlating quality performance to reductions in expenditures is self-defeating. It's worth noting that none of the 34 Medicare Shared Savings Program (MSSP) or ACO quality measures meet this definition. Also, none of the 34 measures quality or expenditures that is defined as the full cycle of care. This problem is not unique to the MSSP. HEDIS measures suffer the same shortcomings.

CMS has ample opportunity to being measuring for value. MACRA funds \$15 million annually between 2015 and 2019 to identify gaps in MIPS quality measures. These funds could be used to develop new Part A quality measures that align with MACRA's goal to develop "measures that reflect efforts to lower costs and significantly improve outcomes." CMS could look to and work with the International Consortium for Health Outcomes Measurement (ICHOM) to both exploit and develop additional and much needed outcome measures. Working with ICHOM also provides an opportunity to compare Medicare program performance internationally. As noted above, CMS also could create a minimum quality threshold. For example, California's Integrated Healthcare Association's (IHA's) value based pay for performance program imposes both quality and spending thresholds. If neither threshold is met, the provider or provider group's performance score is reduced. (Andrew M. Ryan and his colleagues recently published in [Medical Care Research and Review](#) a review of seven methodological approaches that combine quality and spending to measure for efficiency.) Measuring for value could also be forwarded via how the agency builds out MACRA required care episode and patient condition group codes that are intended to improve resource use measurement. Hospital-based bundled payment arrangements ideally lend themselves to value-base performance measurement scoring since they are intentionally designed to drive improved outcomes over spending.

In his comments at Health Affairs' 2016 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. Unless or until there's an association between quality performance measurement and spending, providers of all stripes will find quality measurement, collection and reporting largely onerous and futile. Effectively, it will amount to little more than a compliance exercise. 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.

Performance improvement or innovation in healthcare cannot ultimately be achieved via the same conventional thinking that measures quality and spending separately or not simultaneously. Achieving one without the other and/or defining quality as, or a proxy for, value will produce as Porter stated, "ill-advised cost containment." If CMS expects providers to continue to buy into and succeed in a pay for value or a foregone revenue world, they need to measure and make known the causal relationship between outcomes and spending.

Thank you for your consideration of AMGA's comments. If you have any questions please do not hesitate to contact David Introcaso, Ph.D., Senior Director of Regulatory and Public Policy, at dintrocaso@amga.org or at 703.842.0774.

Sincerely,

A handwritten signature in black ink that reads "Ryan O'Connor". The signature is written in a cursive style with a large, looping initial "R".

Ryan O'Connor
Interim President and Chief Executive Officer
AMGA