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A Future Vision of Medicare Value-Based Payment

Medicare will soon begin paying physicians and other clinicians for the value rather than volume of care they provide. This transition is advancing through the Medicare Access & CHIP Reauthorization Act (MACRA), a law recently enacted with broad bipartisan and multi-stakeholder support. MACRA includes a Merit-Based Incentive Payment System (MIPS) that will adjust fee-for-service (FFS) payment based on performance. MACRA also encourages clinicians to develop and participate in Alternative Payment Models (APMs) that move toward greater compensation for value instead of volume. Current quality measurement abilities can help to start this important advancement. However, the optimal future state of measurement to support performance-based clinician pay requires more work that must begin now. This paper suggests for discussion potential principles for achieving that optimal future state:

***PRINCIPLE A**: Every Medicare enrollee needs a dedicated and well-organized primary care team.*

***PRINCIPLE B**: Measurement must be specified appropriately for each different unit of accountability.*

***PRINCIPLE C**: Measurement should support rapid improvement and clinical decision making.*

***PRINCIPLE D**: A core set of measures will let all stakeholders make comparisons across programs.*

***PRINCIPLE E**: Quality measure results should be easy for consumers and payers to get and use.*

PRINCIPLE A**: **Every patient should have a dedicated and well-organized primary care team.

A dedicated primary care team that coordinates all care for each enrollee by organizing and interpreting care from all other clinicians and includes the patient as a full partner is essential. Dedicated primary care teams engage patients and/or family caregivers as partners in their own health and care, support population management and improve quality, cost and experience of care. They also, importantly, mitigate fractured care that makes it exceedingly difficult to assign, or hold clinicians accountable, for the quality of care delivered to individual or groups of patients. Assigning accountability is essential for meaningful and actionable performance-based payment.

The current dispersion of care among many disconnected clinicians and sites must be addressed. Medicare enrollees usually see two primary care clinicians and five specialists each year.[1]

[1] Pham et al, Care Patterns in Medicare and their Implications for Pay for Performance, NEJM, March 2007.

Over one in five enrollees do not see one clinician enough to assign accountability for their care to any clinician. For another third, assignment would change from year to year. The typical primary care clinician coordinates with 229 other clinicians in 117 practices, equivalent to an additional 99 physicians and 53 practices for every 100 Medicare beneficiaries they manage.[2]

Patient-Centered Medical Homes (PCMHs) are specifically designed to create dedicated primary care teams to address this challenge. A growing body of evidence documents that PCMHs improve the quality, cost and experience of care while also reducing socioeconomic disparities in care.[3] PCMHs provide significantly greater continuity of care and substantial reductions in Medicare payments.[4] Increased continuity of care from the same clinician lowers use of high-cost services.[5] Patient-Centered Specialty Practices (PCSP), in turn, are specifically designed to help specialists meet their important responsibility to communicate effectively with primary care teams.

MACRA actively promotes PCMHs and PCSPs by giving them automatic credit under MIPS, and by giving successful PCMH demonstration sites automatic APM status. MACRA thus intentionally provides a solid foundation for helping more practices become PCMHs and PCSPs and getting more enrollees PCMH and PCSP care. It is important for Medicare to have robust requirements for PCMHs and PCSPs to provide patient- and family-centered care, as in NCQA's programs.

However, to get the most benefit from dedicated primary care teams, patients need a strong allegiance to these teams so they do not seek uncoordinated care from multiple clinicians. Medicare and other stakeholders should explore ways to encourage patients to rely on dedicated primary care teams.

PRINCIPLE B: Measurement must be specified appropriately for each different unit of accountability.

Clinicians in different payment models, from uncoordinated FFS to more coordinated APMs, Accountable Care Organizations (ACOs) and Medicare Advantage (MA) plans have differing abilities to measure and improve quality. Measures therefore must be specified for each payment model, or unit of accountability, yet still facilitate comparison between and among all payment models. Measures also must be tailored for the different types of care furnished by clinicians in different payment models. For example, clinicians in MIPS will have less ability to coordinate care across settings than clinicians in APMs, ACOs or Medicare Advantage plans.

Population-based measures, such as preventable hospital admissions, readmissions, emergency department visits and mortality rates, are particularly important. They can be used to calculate benchmarks and facilitate quality comparisons within and across payment models both nationally and within specific geographic regions. However, the specifications for population-based measures must be appropriate for each unit of accountability in order to work effectively.

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[2] Pham et al, Primary Care Physicians' Links to Other Physicians through Medicare Patients: The Scope of Care Coordination, AIM, February 2009.

[3] NCQA, *Latest Evidence: Benefits of the Patient-Centered Medical Home*, June 2015.

[4] Perry et al, *Examining the Impact of Continuity of Care on Medicare Payments in the Medical Home Context,* RTI International, 2012

[5] Romaire et al, *Primary Care and Specialty Providers: An Assessment of Continuity of Care, Utilization and Expenditures*, Med Care 2014.

Population-based measures are generally not appropriate for individual clinicians in MIPS who have little ability to influence population outcomes. Holding individual clinicians responsible for such outcomes when they lack shared accountability frameworks may create adverse incentives to avoid vulnerable and complex patients.

The Medicare Payment Advisory Commission suggested aggregating clinicians in a community or geographic region for measures that have limited meaning for individual clinicians.[6]
While individual clinicians might wonder about their contribution to a geographic region's performance, stakeholders need to understand the performance among the large number of clinicians outside coherent accountable entities. Local aggregation would allow comparisons of population-based measures among clinicians in a region under MIPS versus those in APMs, ACOs and MA plans. For non-aggregated assessments of individual clinicians, measures of processes proven to improve outcomes, like cancer screenings and good chronic care management, are appropriate.

Appropriate physician level measures are essential for patient decision-making, accountability and care improvement. For all clinicians, measures must rely on credible electronic clinical data sources, including claims whenever possible for the most reliable, robust information, and ease in reporting. Measure collection from both clinicians and patients must increasingly be built into care delivery workflows, and provide real-time actionable data for care improvement. All measures, whether from electronic or other sources, must be audited and appropriately risk-adjusted to ensure that results are accurate and appropriate to use for comparisons and payment purposes. Measurement must include reliable, valid patient experience measures and leverage patient-generated data as much as possible as measurement science and data collection evolve. Existing patient experience surveys and measures must be improved to increase response rates and utility to clinicians.

PRINCIPLE C: Measurement should support rapid improvement and clinical decision making.

Beyond assessing and paying for value, measurement also needs to help clinicians rapidly identify gaps in quality in order to improve their performance. Feedback must be much faster than the current lag of months or years. Quality information also can help to inform and strengthen shared decision-making tools that help patients and clinicians together make more informed treatment choices based on patients' own priorities.

Health information technology can be enhanced and embedded in clinical workflows to capture data for measurement and rapid feedback that supports care management and other functions that clinicians want. The EHR "Meaningful Use" program that MACRA incorporates into MIPS already encourages use of data for population health, decision support, and measuring quality. Meaningful Use requirements must include accurate, prompt reports for clinician quality improvement efforts. Ideally clinicians will get the data at the point of care, a goal that will be difficult for physicians under MIPS and more likely achieved by well-organized systems.

[6] Medicare Payment Advisory Commission, *Report to Congress: Medicare and the Health Care Delivery System, Chapter 3, Measuring Quality of Care in Medicare*, June 2014.

For example, patient-reported outcome measures (PROMs) can be collected at the point of care for many purposes. PROMs can inform care planning, support patient self-management, provide data needed for rapid-cycle improvement and measure performance. It therefore will be helpful to develop workflows that facilitate widespread use of PROMs in clinical care.

PRINCIPLE D: A core set of measures should let all stakeholders make comparisons across programs.

A core measure set will allow comparison across MIPS, APMs, ACOs and MA. Core measures will be specified appropriately for the differing situations for individual clinicians, practice teams, ACOs and MA plans, yet aligned in concept and intent to allow meaningful comparisons. The measures will draw from data in claims, electronic health records (EHRs) and patient surveys to aggregate up to levels that matter most to consumers, clinicians, plans, the community or state. They should maximize use of patient-generated data about experience and outcomes. They must be relevant and meaningful to patients, clinicians and other stakeholders alike. Measures also must continually evolve for advances in clinical evidence, progress on measures that top out with little room for improvement, and improvements in measurement science and methods of data collection.

Core set measures will address a common set of domains, identified with multi-stakeholder input, such as those identified by the National Quality Strategy.[7] Many existing measures address possible core domains, such as preventive and evidence based care, and could facilitate cross-program comparison.

The core set can then support nesting of measures needed for other purposes. For example, groups of measures can be used as building blocks that are aggregated for each core quality domain. Domain scores meet the needs of consumers who prefer higher-level quality data, and other stakeholders seeking to focus on a reduced measure set.

Measures also are needed outside the core set for certain sub-sets of populations and types of clinicians. These include measures that specifically address the unique needs of vulnerable populations, including patients with functional and cognitive limitations and serious mental illness. They also include measures for specific medical specialties providing unique services not addressed in the core set. It is essential to have measures appropriate for all needed purposes, and to not discard measures that help clinicians improve value for the simplistic purpose of parsimony or fewer measures overall. The desire to reduce burden should focus on selecting high-value, high-impact measures and efficient data collection, not arbitrarily limiting the number of measures.

PRINCIPLE E: Quality measure results should be easy for consumers and payers to get and use.

All stakeholders need user-friendly information to make meaningful comparisons across all payment models. However, formats and level of detail will likely differ among stakeholders. Translating complex quality data into user-friendly information for each type of stakeholder is particularly important.

Consumers usually want cost information along with quality information, but it is a challenge to present such complex information in a manner suitable to all levels of health literacy and numeracy. Current efforts often hinder consumers' ability to use value data effectively.

[7] http://www.ahrq.gov/workingforquality/

Many consumers may prefer to have quality information rolled up into composite scores, such as star ratings. Other consumers will want more details on the multiple dimensions of clinical quality and how they compare across different clinicians and payment arrangements. Those who want deeper understanding will need plain-language explanations of how the information might affect care and guide choices. To ensure that information genuinely facilitates consumers' ability to make value-based decisions, consumer and patient advocates need to be included throughout the process, from measure selection to information display.

Measurement must account for the move toward bundled payments that Medicare already is making and that APMs may accelerate. Bundled payments, which cover all clinicians and facilities participating in care for a specific condition or episode, should be packaged in ways that make sense to patients, and not be clinician-centric.

Salient messages are essential for making value data actionable and useful to consumers.

Clinicians need more specific data about how they compare to local and national peers to identify improvement opportunities and achieve value-based payment rewards. They need timely, actionable feedback as close as possible to delivery of care. Embedding results in clinical care workflow, as described above, is essential. Policymakers, employers and insurers need even broader data to set payments, focus improvement efforts and assess networks.

Conclusion

The powerful consensus and legislative mandate to move away from volume-driven fee-for-service payment to instead reward value provides an historic opportunity to improve the quality, cost and experience of health care. Groundbreaking efforts over the last quarter century to use performance measurement to improve care are an excellent beginning, but not at all sufficient.

Now is the time for all stakeholders to again join together to advance the breadth and depth of measurement that this opportunity requires. We hope the principles we have outlined in this paper help to promote a robust dialogue on what is needed to move forward. We look forward to working with all our colleagues to develop a clear plan of action for achieving the best value-based payment results.