Quality Measures and Future Payment Models: Challenges and Opportunities

Ronald Adler, MD, FAAFP
Associate Professor
Family Medicine and Community Health
University of Massachusetts Medical School
Bolton, MA
September 17, 2016
Agenda

• We **have** to measure quality (MACRA/QPP)
• We **want** to measure quality
  – Essential to achieving the Triple Aim and delivering value
• It’s very **difficult** to do it well
• Inappropriate quality measures cause **harm**
  – Overtreatment
  – Waste
  – Opportunity costs
  – Clinician burnout
• **Does P4P even work?**
Life Expectancy at Birth and Health Spending per Capita, 2011

1.1.3. Life expectancy at birth and health spending per capita, 2011 (or nearest year)


StatLink: http://dx.doi.org/10.1787/888932916040
## Why Reform: US Overall Ranking

<table>
<thead>
<tr>
<th>Overall Ranking (2013)</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care</td>
<td>5</td>
</tr>
<tr>
<td>Effective Care</td>
<td>3</td>
</tr>
<tr>
<td>Safe Care</td>
<td>7</td>
</tr>
<tr>
<td>Coordinated Care</td>
<td>6</td>
</tr>
<tr>
<td>Patient Centered Care</td>
<td>4</td>
</tr>
<tr>
<td><strong>Access</strong></td>
<td>9</td>
</tr>
<tr>
<td>Cost Related Problem</td>
<td>11</td>
</tr>
<tr>
<td>Timeliness of Care</td>
<td>5</td>
</tr>
<tr>
<td><strong>Efficiency</strong></td>
<td>11</td>
</tr>
<tr>
<td><strong>Equity</strong></td>
<td>11</td>
</tr>
<tr>
<td>Healthy Lives</td>
<td>11</td>
</tr>
<tr>
<td>Health Expenditures /Capita, 2011</td>
<td>$8,508</td>
</tr>
</tbody>
</table>
CMS Quality Strategy Aims and Goals

Goal 1: Make care safer by reducing harm caused in the delivery of care.

Goal 2: Strengthen person & family engagement as partners in their care.

Goal 3: Promote effective communication & coordination of care.

Goal 4: Promote effective prevention & treatment of chronic disease.

Goal 5: Work with communities to promote best practices of healthy living.

Goal 6: Make care affordable.

Better Care

Healthier People, Healthier Communities

Smarter Spending
CMS Payment Reform

• By 2018, 50% of Medicare payments will use alternative payment models
• Fee-for-service is going away
  – Where it persists, it will be tied to value or quality
• A premium on controlling costs
• All roads lead to ACOs?
• Many clinicians and health care organizations are not ready
Continuum of Payment Methods: Moving to Value Based Payments

- Fee-for-Service (FFS)
- FFS and Care Management Fee
- Bundled Payments
- Global Payments
Accountable Care Organizations

• Provider-led organizations with a strong base of primary care that are collectively accountable for quality and total per capita costs across the full continuum of care for a population of patients.

• Payments linked to quality improvements that also reduce overall costs.

• Reliable and progressively more sophisticated performance measurement

Total Public and Private Accountable Care Organizations, 2011 to 2015 Q4

Source: Leavitt Partners Center for Accountable Care Intelligence.
MACRA (QPP) Timeline

Measurement begins January 1, 2017!

- Fee Schedule Updates: 0.5 for 2015 and earlier, 0.5 for 2016-2020, 0.75 for 2021, 0.25 for 2025
- MIPS: 4% for 2016, 5% for 2017, 7% for 2018, 9% for 2019
- Qualifying APM Participant: Medicare Payment Threshold Excluded from MIPS
- 5% Incentive Payment
- Excluded from MIPS

*Qualifying APM conversion factor
**Non-qualifying APM conversion factor
# MIPS: Performance Category Scoring

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Maximum Possible Points per Performance Category</th>
<th>Percentage of Overall MIPS Score (Performance Year 1 - 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality:</strong> Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-value measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.</td>
<td>80 to 90 points depending on group size</td>
<td>50 percent</td>
</tr>
<tr>
<td><strong>Advancing Care Information:</strong> Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.</td>
<td>100 points</td>
<td>25 percent</td>
</tr>
<tr>
<td><strong>Clinical Practice Improvement Activities:</strong> Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn “full credit” in this category, and those participating in Advanced APMs will earn at least half credit.</td>
<td>60 points</td>
<td>15 percent</td>
</tr>
<tr>
<td><strong>Cost:</strong> CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.</td>
<td>Average score of all cost measures that can be attributed</td>
<td>10 percent</td>
</tr>
</tbody>
</table>

TCPI participation scores full points here
### Relative Weights of MIPS Components

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality (PQRS)</strong></td>
<td>50%</td>
<td>45%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Resource Use</strong></td>
<td>10%</td>
<td>15%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>MU</strong></td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Clinical Process Improvement</strong></td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Reward/Risk</strong></td>
<td>+4% to -4%</td>
<td>+5% to -5%</td>
<td>+7% to -7%</td>
<td>+9% to -9%</td>
</tr>
</tbody>
</table>

* MU weight may be reduced to 15% if 75% of Eps are successful
MIPS: Costs

- 40+ episode-specific measures
- Higher score = more efficient use of resources
- Claims-based: no need to report
- Must see > 20 patients for each cost measure
MIPS: Quality

- Goal: align with private payer measures
- 6 measures selected by physician
- Includes 1 measure on patient outcomes
- 2 – 3 measures on population health
- ~200 available measures
Payment Reform

Demands

Value

Equals: Plus

Low Costs

High Quality
Payment Reform

Value

Equals:

High Quality

Current Measures

Care That Matters

Low Costs

Demands
Care That Matters

High Quality

Current Measures

Often miss the mark
- Don’t respect individual patient factors and preferences
- Undermine motivation and professional autonomy
- Lead to waste and harms

Ring true and therefore:
- Enhance meaning and fulfillment for clinicians
- Enhance intrinsic motivation
- → Increase joy and performance
Payment Reform

Demands

Value

Equals: Plus

High Quality

Current Measures

Low Costs

Produces

Care That Matters

Allows for
A Patient’s View of Quality:

- I can get an appointment
- I am treated with dignity and respect
- I am as involved as I want to be in decisions about my care
- As a person with long term condition/s I have a care plan that I was involved in creating
- I know who is coordinating my care, and they do it well
- As a carer/relative, I feel involved and supported
- The help and treatment I get makes me feel better
- I feel in control of my daily life
- As a bereaved person I feel that my dying relative was treated with dignity and respect
- As a bereaved person I feel that services worked well together in the last few months of my dying relative’s life.

Problems with Health Care Quality Measures

• There are too many
  – Administrative burden
  – Opportunity costs
• They often assess the wrong things ...  
  – By design: Surrogate endpoints
  – Unintentionally: Subject to gaming
• Most are not sufficiently patient-centered
• Sometimes they create conflict between the interests of the patient and those of the clinician
• They are often applied inappropriately:
  – Used in P4P
  – Don’t account for locus of control
  – Ignore social determinants of health and risk adjustment
Measurement Proliferation

• **546 distinct performance measures**

• Among 23 health plans serving 121 million commercial enrollees (= 66% of national commercial enrollment)

• Despite common areas of focus: CVD, DM, preventive services


Federal agencies use 1700 measures.*

US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures

Each year US physician practices in four common specialties spend, on average, 785 hours per physician and more than $15.4 billion dealing with the reporting of quality measures. While much is to be gained from quality measurement, the current system is unnecessarily costly, and greater effort is needed to standardize measures and make them easier to report.
The current system is far from being efficient and contributes to negative physician attitudes toward quality measures.

15.1 hours per week
Physicians: 2.6 hours
= 9 patients not seen

*Health Affairs, 35, no.3 (2016):401-406*
Harms Associated with Inappropriate Performance Measures

• Direct harms to patients
  – Falls associated with hypotension, hypoglycemia
  – False positives associated with excessive screening
  – Overdiagnosis/overtreatment of indolent conditions identified by screening

• Wasteful testing
  – excess A1cs, Mammography, etc.

• Opportunity costs
• Physician burnout
“Our businesslike efforts to measure and improve quality are now blocking the altruism, indeed the love, that motivates people to enter the helping professions. While we’re figuring out how to get better, we need to tread more lightly in assessing the work of the professionals who practice in our most human and sacred fields.”

“demoralizing physicians”

“Tethering physicians’ rewards to box checking and redundant documentation risks both substituting insurers’ priorities for patients’ goals and demoralizing physicians. Pay for performance can crowd out intrinsic motivation that keeps us doing good work even when no one is looking. A growing body of behavioral economics research indicates that when preexisting motivation is high, monetary incentives often undermine performance on complex cognitive tasks.”

Current “Quality” Metrics ...

• Are too numerous
• Are often inappropriately applied at the level of individual clinicians
• Lack evidence that they correlate with better health
• Compromise the patient-physician relationship
• Contribute to provider burnout
• Motivate diversion of resources and efforts away from more meaningful interventions
• Do not typically address harms associated with overtreatment
• Were often developed by prioritizing expediency
Streetlight Effect = Observational Bias

A policeman sees a drunk man searching under a streetlight and asks what he has lost. The drunk says he lost his keys, and they both look under the streetlight together.
Streetlight Effect = Observational Bias

After a few minutes, the policeman asks, “Are you sure you lost them here?”

The man replies, “No, I lost them in the park.” The policeman asks, “why are you searching here?”

The drunk replies, "this is where the light is.”
Quality measures should ...

• Be based on solid evidence that they correlate with better outcomes:
  – Better health
  – Lower costs
• Not create situations in which the doctor’s interests conflict with those of the patient
• Be applied in a manner that respects the fact that individual patient factors (including patient preference) sometimes supercede population-level recommendations
• Be applied at the appropriate level
Quality Measures: Organizations or Individuals?

- “Aligning payment systems and incentives with triple aim goals for organizations makes sense.”
- “Complex incentive programs for individual clinicians ... are confusing, unstable, and invite gaming.”

Harms in Healthcare

Direct Injury
• Adverse effects associated with appropriate Tx
• Adverse and “desired” effects associated with inappropriate Tx: Overdiagnosis, Overtreatment:
  – Treating risk factors
  – Treating to address surrogate measures
  – Treating indolent conditions

Opportunity Costs
• Spending resources (time, $) on unhelpful activities makes those resources less available for more meaningful activities

Pursuit of quality measures can drive all of these
Table 2. Comparison of typical performance measures and author recommendations.

<table>
<thead>
<tr>
<th>Current Approaches</th>
<th>Recommended Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Binary (cut-point) thresholds of risk</td>
<td>Continuous measures of risk</td>
</tr>
<tr>
<td>Surrogate outcomes</td>
<td>Patient-centered outcomes</td>
</tr>
<tr>
<td>No accounting of staff effort required to impact performance measure</td>
<td>Accounting of staff effort</td>
</tr>
<tr>
<td>Lack of emphasis on shared decision-making and eliciting patient preferences</td>
<td>Individualization and shared decision-making as a default expectation</td>
</tr>
<tr>
<td>No articulation of NNT, NNH, NNS</td>
<td>Transparency and referencing of NNT, NNH, NNS</td>
</tr>
<tr>
<td>Measures focused on individual risk factors</td>
<td>Aggregate risk measures</td>
</tr>
<tr>
<td>Isolated morbidities</td>
<td>Recognition that multimorbidity may modify or invalidate some measures in individuals</td>
</tr>
<tr>
<td>No accounting for social determinants of health</td>
<td>Inclusion of social determinants of health</td>
</tr>
<tr>
<td>Multiple metric sources with varying biases and transparency</td>
<td>Single, independent, transparent, unbiased source</td>
</tr>
</tbody>
</table>

* NNT: number needed to treat; NNH: number needed to harm; NNS: number needed to screen

doi:10.1371/journal.pmed.1001902.I002

[http://journals.plos.org/plosmedicine/article?id=info:doi/10.1371/journal.pmed.1001902](http://journals.plos.org/plosmedicine/article?id=info:doi/10.1371/journal.pmed.1001902)
Quality measures must ...

1. address clinically meaningful, patient-centered outcomes;
2. be developed transparently and be supported by robust scientific evidence linking them to improved health outcomes in varied settings;
3. include estimates, expressed in common metrics, of anticipated benefits and harms to the population to which they are applied;
4. balance the time and resources required to acquire and report data against the anticipated benefits of the metric;
5. be assessed and reported at appropriate levels; they should not be applied at the provider level when numbers are too small or when interventions to improve them require the action(s) of a system.

Saver, Martin, Adler et al. *PLOS Medicine*
DOI:10.1371/journal.pmed.1001902 Nov 17, 2015
Core Measure Collaborative

CMS 2016

Aim I

Reduce the total number of measures by eliminating low value metrics and introducing consistency across payers in their requirements for quality reporting

Aim II

Refine the measures that remain to further ease the burden of collection

Aim III

Relate measures to patient health outcomes, focusing on “measures that matter”

Governing Principles for Core Measure Sets

Core Quality Measures Collaborative
Suggested Patient-Centered Performance Measures

- Medication reconciliation in home after discharge
- Home visits for indicated patients and coordinated care to meet their needs
- Screening for and addressing fall risk
- Patient self-assessment of health status (change over time)
- Reduction of food insecurity
- Ability to chew comfortably and effectively with dentition
- Vision assessment and correction in place (e.g., patient has satisfactory glasses)
- Hearing assessment and correction in place (e.g., satisfactory hearing aids)
- Reduction in tobacco use
- Reliable access to home heating and cooling
- Reliable transportation to appointments
- Provision of effective contraception
- Effective addiction care
- Effective chronic pain care

P4P?

"What gets measured gets done, what gets measured and fed back gets done well, what gets rewarded gets repeated."

- John E. Jones

“Rewards do not create a lasting commitment. They merely, and temporarily, change what we do.”
Why Incentive Plans Cannot Work: The True Costs

1. Pay is not a motivator
2. Rewards punish
3. Rewards rupture relationships
4. Rewards ignore reasons
5. Rewards discourage risk-taking
6. Rewards undermine interest

Does P4P Work? Systematic Review

“We found no evidence that the largest hospital-based pay-for-performance program led to a decrease in 30-day mortality.”


“Although evidence suggests modest effectiveness for P4P in improving preventive activities, such as immunization rates, there is little evidence that P4P is effective for other outcomes at this time.”

Does P4P Work?

“Rewards should reinforce, not undermine, intrinsic motivation to pursue needed improvement in health system quality.”


“Findings suggest that P4P can potentially be (cost-)effective, but the evidence is not convincing; many studies failed to find an effect and there are still few studies that convincingly disentangled the P4P effect from the effect of other improvement initiatives”

The Puzzle of Motivation: Intrinsic vs Extrinsic Motivators

“Research has consistently shown that any contingent payment system tends to undermine intrinsic motivation.”


**POWER Measures:**

- Patient
- Oriented
- With
- Evidence
- Required

**True North:**

Is ________ likely to improve the health of my patient?
Future Challenges of P4P

Increasing use of outcome measures:

• Change from process measures
  — Process measures often easier to measure
  — Process measures more closely tied to fee for service models

• More challenging to determine physician responsibility for health outcome
  — Outcome measures reflect shift toward population-based payment

• More challenging to determine valid outcome measures
Summary

• Measurement of quality in health care will grow ever more important.
• There are substantial burdens associated with collecting and reporting data.
• Inappropriate measures are harmful and costly; they contribute to provider burnout.
• It is therefore essential that PCPs advocate for better measures.
• P4P is probably not effective.
Get Involved

- http://www.carethatmatters.org/
- http://lowninstitute.org/
  - Right Care Alliance Primary Care Council
- http://www.choosingwisely.org/
- High-Value Care: https://hvc.acponline.org/
- National Physicians Alliance: http://npalliance.org/
Care That Matters

• A group of clinicians committed to better health for our patients and appropriate stewardship of health care resources.

• We seek to achieve these outcomes through advocacy regarding a new generation of health care quality measures.

• Appropriate quality measures ...
  – are supported by evidence that they correlate with better health.
  – do not create situations in which the doctor’s interests conflict with those of the patient
  – acknowledge the importance of individual patient factors and promote shared decision-making

Carethatmatters.org