Strengthening Medicare Value-Based Programs

Vision: A strong and growing portfolio of value-based purchasing programs that drive patient-centered coordination, alignment, and accountability across levels of care, with reduced burden and the data necessary to identify, improve, reward and fund equitable, high-quality care for Medicare beneficiaries.

Medicare is a value-based purchasing leader. Indeed, the Medicare Advantage (MA) Star Ratings program is an exemplar of how appropriate financial incentives, aligned with transparent quality measurement, can drive improved outcomes, and provide consumers the tools with which to choose –from multiple plan options — the one that best fits their needs. The trends in MA enrollment speak to its success. The National Committee for Quality Assurance (NCQA) strongly supports value-based purchasing programs (VBPs), the vast majority of which rely on the measures in our Healthcare Effectiveness Data and Information Set (HEDIS®). We also see room to improve VBPs and the data that support them and look forward to working with the Biden Administration to this end.

Principles. Below we discuss program-specific areas in which we see opportunities to build on CMS's success with value-based purchasing. Several high-level themes emerge throughout the document.

- **Program Design:**
  - Stakeholders (including payers, clinicians, evaluators, quality measurement experts, etc.) should be involved early in the design and development of VBPs.
  - While clinician-level VBPs can drive better care, they should be designed and implemented to move healthcare toward systems of care, which are better prepared to improve coordination and outcomes.
  - The "carrots" of financial incentives should be balanced with down-side risk or other "sticks," such as financial, enrollment and other penalties for poor performance that could lead to removal from the program without improvement.
  - As critical outcomes measures are being defined and developed, it is essential to leverage evidence-based process measures closely tied to outcomes in the interim.

- **Data and Measurement Digital Strategies**
  - Trust is vital. VBPs only succeed when the data that informs them are validated and audited, the metrics of success are clear and meaningful for the entity they measure, and performance is comparable. Attestation of performance does not meet this standard.
  - The move to a digital quality system offers to dramatically bolster the accuracy and effectiveness of VBPs while reducing burden, enabling "smarter" measurement, and generating significant administrative savings.
  - The process of collecting and utilizing data used in performance and payment should be built into clinical workflows and provide both decision support and ongoing performance feedback.
  - The measurement of patient experience must be reimagined to allow for a more targeted approach and greater engagement, particularly if its weighting in VBPs is increased (as proposed for MA Stars).

Medicare Advantage Star Ratings. The Medicare Advantage Star Ratings program is the most successful VBP in healthcare. MA has seen a surge in enrollment, while also improving quality, containing costs and premiums, and enabling individuals to choose from an array of high-quality plans. It includes a broad range of meaningful measures, with all plans reporting the same measures, ensuring meaningful benchmarking and comparison. Measures have clear specifications and rigorous auditing for all measures and all plans occurs before reporting to give stakeholders confidence that the results are accurate and valid.

We support MA plans' goals to reduce the reporting burden of the program as well as the move toward increased outcome measures, more effective patient experience measures, and better behavioral health measures. We also support recommendations from MedPAC and others to require MA plans to report results at the state or local level. The current policy, which allows contract-level reporting, skews results as well as payments, and reduces transparency for consumers.

We strongly disagree, however, with suggestions from MedPAC and others to focus on just a small handful of outcome measures that exclude well-crafted process measures closely tied to outcomes—such as evidence-based cancer screening and management of chronic conditions. There is compelling evidence that process and intermediate outcome measures improve health, health plan performance and cost. Measures related to wellness, prevention, and chronic disease management (especially for beneficiaries with multiple chronic illnesses), have a significant impact on quality of life as well as cost avoidance.

Medicare Advantage enrollees are consistently more likely than fee-for-service (FFS) enrollees to receive appropriate breast cancer screening, evidence- based diabetes care, and cholesterol testing, a fact that is highly attributable to the process measures reported by MA plans. According to research, a 10 percent improvement in diabetes intermediate outcome measures by a plan was related to a significant increase in patients' physical and mental health. Other studies show similar improvements in outcomes where compliance with process measures improves. Moreover, using only—or primarily—outcome measures raises serious risk adjustment challenges and can unfairly hold plans and providers accountable for factors out of their control.

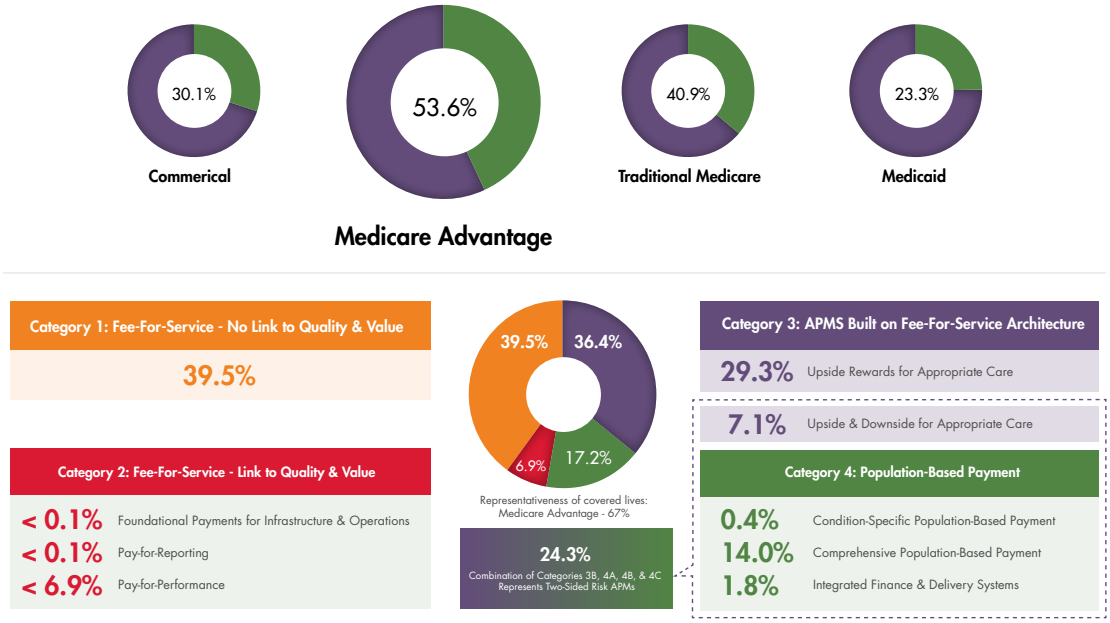
CAHPS/Patient Experience Measurement. We also are concerned with the increase in Medicare Advantage Stars patient experience measure weights that will, by 2023, make them greater than clinical outcome weights. We agree that it is essential to incorporate patient experience but note that the vast majority of stakeholders who commented opposed this change because of weaknesses in current patient experience measurement. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys have low and declining response rates due to heavy reliance on paper-based surveys. Results are difficult to act on because the survey goes to a random patient sample that is poorly suited to identifying concerns of specific groups such as racial and ethnic minorities or patients with multiple chronic illness. These concerns also apply to the many other programs that also use CAHPS.

Fortunately, an array of digital survey tools, widely used in other industries, would make it easy for beneficiaries give immediate feedback on their experiences on a smartphone, tablet, laptop or other electronic device through websites, email and other tools. This would allow for faster and more actionable results, and the ability to target specific populations, settings, or circumstances. NCQA has included recommendations on the topic within this compendium and would welcome working with the Biden Administration to improve the ability to capture more meaningful and actionable feedback. Please see *"Moving to Digital Patient Measurement."*

Merit-Based Incentive Payment System (MIPS). The attempt to measure clinician-level quality in Medicare's fee-for-service (FFS) model faces severe challenges. Many practices are too small to yield valid results. The array of measures is vast and easily gamed. Large multispecialty practices often report on primary care measures that provide no meaningful specialty care information. Auditing is challenging and inconsistent, and limited to a small, random set of providers. Results are highly questionable:98% of MIPS clinicians in 2021 will get positive payment adjustments and 84% an "exceptional performance" adjustment.

[1]Association of Health Plans' Healthcare Effectiveness Data and Information Set (HEDIS) performance with outcomes of enrollees with diabetes. Harman et al, Medical Care, 2010.

Mediare Advantage VBPs by Category



Source: Healthcare Payment Learning and Action Network

The move to MIPS Value Pathways (MVP), as CMS has proposed, will mean clinicians are reimbursed on a smaller set of specialty-specific, outcome-based measures, as well as population health measures. However, many specialties have few meaningful or relevant measures. In some instances, the availability of clinical evidence for appropriate or best treatment—a prerequisite for strong evidence-based quality metrics— is limited.

Other MIPS challenges are even more daunting, such as attribution. Which clinicians are responsible for which patients (the average Medicare FFS enrollee sees a half-dozen doctors a year)? And how do we account for social determinants of health that can have a greater impact on outcomes than clinical care? These and other unanswered questions ultimately underscore the need to accelerate the move away from FFS to VBP. The Physician-Focused Payment Model Technical Advisory Committee (PTAC) has recommended a handful of alternative payment models that would bring specialty care into VBP arrangements, including NCQA's "Medical Neighborhood Model." The incoming Secretary of Health and Human Services should closely consider these recommendations and begin piloting them early in the administration.

Centers for Medicare and Medicaid Innovation (CMMI) Programs. NCQA supports CMMI and its critical mission. However, only a small handful of CMMI initiatives have meaningfully improved on quality or achieved significant savings. We believe several factors outlined below may help to explain why.

Practice-Level Assessment. Many CMMI demonstrations, such as Comprehensive Primary Care and Primary Care First, attempt to assess quality at the practice level. This generates the same concerns we outlined above for MIPS. CMMI should work to incorporate practice-level efforts up to the system-level.

Fragmented Approach. CMMI developed many of its multiple and often overlapping demonstrations in an ad hoc manner without a coherent strategy or forethought to how they would interact. This makes it difficult to assess the impact of individual demonstrations and separate out any potential spillover effects in our complex healthcare ecosystem. Now that the number of pilots has increased, CMMI should establish a comprehensive framework for how each of its programs intersects, overlaps, or contributes to a broader and more synergistic approach, and explore how its assessments can focus on the true impact of specific initiatives.

Reliance on Attestation. CMMI often allows demonstration participants to merely attest to meeting program requirements without any meaningful documentation or other verification. This limits the ability to know whether a demonstration failed to achieve desired results because of its design or because of limited compliance with its requirements. Accurate assessment of program effects requires that CMMI take steps to ensure that demonstration participants comply with program requirements.

Arbitrary Quality Measure Limits. CMMI requires new demonstrations to use only a very small number of measures, usually five or fewer, which limits CMMI's ability to truly assess quality. Many newer initiatives also use only a very few outcome measures impacted by factors for which clinicians and other providers have limited influence. CMMI instead should use a sufficient, but still parsimonious, set of measures most appropriate to assessing a given demonstration's potential or known impact on quality and cost. This includes well-crafted process measures closely tied to outcomes for which it is fair to hold clinicians and other providers accountable.

Begin with the End in Mind: CMMI often waits until very late in demonstration development to determine the quality measures it will apply and seek input from quality experts and other stakeholders on whether the chosen measures are appropriate. Quality measure consideration should be among the first steps in demonstration development and include robust, iterative discussion with quality measure experts, specialty societies who represent potential participants and other relevant stakeholders.

Limited Initial Stakeholder Input: As with measure selection, CMMI often develops demonstrations internally with limited opportunity for input from potential participants, and other stakeholders. This has at times required CMMI to revise programs after announcing them. CMMI should make program development a more open and iterative process that includes all relevant stakeholders.

Voluntary Participation: Participants can choose whether to join CMMI demonstrations, attracting those who are most likely to succeed or most committed to quality improvement, skewing results. To avoid selection bias, models should include mandatory participation by a representative sample of those who would participate if the program becomes permanent and inclusive of all potential participants.

Level of Shared Risk: Finally, there is robust debate on the appropriate level of financial risk in CMMI demonstrations such as the Medicare Shared Savings Program. Some believe significant risk for both sides is needed to achieve real change. Others believe it is better to allow less risk or even just shared savings to speed the movement away from FFS. There is validity to both arguments.

Some flexibility may be required, and a phased approach allows for variability in readiness. For those starting out in the VBP world, less risk can be a tool to drive the move away from FFS. Greater risk with even greater shared savings, though, is the key to taking VBPs to the next level and realizing their full potential. Many CMMI models have such separate risk tracks today. We encourage CMS to conduct data-driven analyses to inform what level of risk brings the most movement away from FFS and what level of risk achieves the most cost and quality improvement.

Conclusion. Medicare has blazed a trail for value-based programs in healthcare and should work to consolidate the gains already realized and learn from the successes and setbacks. CMS should align its VBPs around a few fundamental pillars: integrity (of data and performance assessment); coordination (of structure and expectations across programs with the goal of moving toward systems of care); and collaboration (with all relevant stakeholders in designing and implementing VBPs).