Gail R. Wilensky

REPRINT May 2015

hfm
healthcare financial management association hfma.org

developing the metrics for payment reform

There continues to be uncertainty about the extent to which payments in newer, alternative delivery systems under healthcare reform actually will be tied to value. Meanwhile, the questions of how best to tie physician payments to value will be a primary focus in the wake of Congress's recent passage of "doc fix" legislation.

In my March 2015 Eye on Washington column, I discussed the goals and timelines that the U.S. Department of Health and Human Services (HHS) has announced as part of its efforts to move Medicare payments toward a value-based payment structure. Many payment reform pilot or demonstration projects involve "bundled payments" (i.e., single payments that cover a number of services). The recipient of the bundled payment may be a hospital or a physician group that includes different provider types, including postacute care. The payment may depend on measures of quality and cost. However, most payments to physicians or hospitals within the bundle retain the use of the same DRGs or fee-for-service payments that have been in use for years.

What remains unclear is how much of base payments will be tied to value outside the demonstrations. HHS has stated that 85 percent of fee-for-service payments is to be linked to quality or value measures by the end of 2016, but it's not obvious what that means. If the base payment continues to be paid as it has been historically—that is, unrelated to value—there is some question whether the portion of any payment that is tied to value will be large enough to change behavior.

Paying on the basis of value obviously requires specifying the metrics that will be used to define *value*, and ensuring that the definition encourages physicians to strive for types of outcomes patients desire without being unreasonably burdened.

Interest in defining value and efficiency has increased significantly with the passage of legislation scrapping the flawed formula that combined the sustainable growth rate (SGR) with the relative-value scale used to update Medicare physician payments. This legislation provides strong financial incentives for physicians to move

away from the Resource-Based Relative Value Scale to an incentive system based on value and accountability (which is defined as either performance in accordance with certain metrics or participation in alternative delivery systems that take financial risk). The specific metrics that will be associated with the increase in payments and the risk of penalties will need to be defined through the regulatory process over the next one to two years. The involvement of private payers in patient-centered medical home demonstrations and other strategies to encourage efficiency and accountability only adds to the interest in the specific metrics that will be used in these alternative payment strategies.

Major Issues Requiring Resolution

Starting in 2019, the SGR repeal legislation calls for bonus payments of 5 percent of the preceding year's Medicare payments for physicians who derive a certain percentage of revenue from alternative payment models. Clearly, the first order of business is to determine the specific metrics that will factor into the new models, including those that do not feature both "upside" and "downside" financial risk. Fortunately, a lot of work has already been done by various organizations, such as the National Quality Forum and the National Committee for Quality Assurance (NCQA), and by various specialty societies, such as the American College of Surgeons. However, this effort still faces challenges.

Identifying effective outcome measures. Quality metrics should incorporate both clinical and functional outcome measures that are important to clinicians and patients and that do not primarily reflect process measures, even though the latter are much easier to obtain. An overemphasis on process measures has been a challenge with the Healthcare Effectiveness Data and Information Set (HEDIS) measures developed by NCQA and used by most health plans to reflect various dimensions of care, although outcome-related HEDIS measures have been added gradually.

Reducing the number of metrics used. The proliferation of quality metrics has become a major issue for many providers. The Agency for Healthcare Research & Quality has listed more than 4,000 measures in use, although obviously only a small fraction of these measures is ever used in a given initiative. Still, the use of different metrics by different payers or reviewers will need to be resolved, and the challenge to achieve a manageable number of metrics remains.

Setting benchmarks. In a related issue, accountable care organizations use their own historical measures of cost to set performance expectations. Over time, these measures should be replaced by regional, or perhaps national, benchmarks—there is debate about which is more appropriate.

Determining whether the primary focus should be on attainment or on improvement. One question is whether the focus of value-based initiatives should be on meeting established performance standards or on demonstrating improvement. The obvious answer is both need to be included. Early on, improvement may be seen as being equally important, but over time, attainment will likely take on greater weight.

Assigning weights to metrics. The issue of weighting is more challenging than setting benchmarks. If multiple metrics are to be used as part of the scoring, the challenges revolve around questions of how much weight to attach to each metric for various scoring purposes and whether to attempt to calculate an index reflecting multiple metrics, with explicit weights attached to each one.

Challenges Ahead

Four basic principles may be helpful in understanding and addressing these challenges.

First, all payment strategies have pluses and minuses. Fee for service encourages volume, but capitation encourages skimping. Thus, a blend of payments may be most attractive, such as partial capitation or salaried employees with a variable component to their compensation.

Second, flexibility will be needed to determine what models work best for different organization types—a one-size-fits-all approach won't work.

Third, because blends of measures probably will be needed, weighting will be necessary. In addressing this challenge, it will be important to allow for metrics to evolve over time.

Fourth, it also will be important to be mindful of the burdens being placed on clinicians and institutions. The metrics are important, but the focus should remain on the well-being of patients.

In view of the issues that will need to be resolved, the challenges of implementing value-based payment for physicians are daunting. But it will help if we keep in mind that the implicit assumptions underlying our current payment strategies—i.e., that payment is unrelated to quality and functional outcomes because there is so little difference among providers with respect to these measures, and that costs are unrelated to provider decision-making—are clearly wrong. As we struggle to develop more appropriate strategies, remembering where we've been will be crucial. ■

Gail R. Wilensky, PhD, is a senior fellow at Project HOPE; a former administrator of the Health Care Financing Administration, now the Centers for Medicare & Medicaid Services; and a former chair of the Medicare Payment Advisory Commission (gwilensky@projecthope.org).