# The Future of Healthcare Quality

## Recommendations from NCQA to the Biden-Harris HHS Transition Team

December 2020

Enabling a
Digital Quality
System

Advancing
Health
Equity

Moving to a Digital
Patient Experience
Measurement

Strengthening
Value-Based
Programs

NCQA
Measuring quality.
Improving health care.

| **To:** | Biden-Harris HHS Transition Team |
| **From:** | Peggy O'Kane, President, National Committee for Quality Assurance |
| **Subject:** | Recommendations for the Future of Healthcare Quality |
| **Date:** | December 2020 |

**The National Committee for Quality Assurance (NCQA)** congratulates President-Elect Biden and Vice President-Elect Harris on their victory. NCQA is a non-profit, independent organization that since 1990 has worked to improve healthcare through measurement, transparency, and accountability. We accredit health plans that represent nearly 180 million covered lives — including 9 million in ACA Marketplaces, 14 million in Medicare Advantage and another 44 million in Medicaid managed care. We also operate the largest Patient-Centered Medical Home (PCMH) program in the country, with 1 in 5 primary care clinicians practicing in an NCQA-recognized PCMH. For 25 years we have stewarded the Healthcare Effectiveness Data and Information Set (HEDIS®), which is the basis for nearly all value-based and performance measurement systems in the nation.

The recommendations that follow represent a vision for evolving the current quality measurement ecosystem while maintaining its most effective elements. A few key themes recur.

- The importance of refining and developing quality measurement to help stakeholders drive toward health equity and address social determinants of health.

- The potential to reduce burden and improve care by moving to a digital quality measurement system that captures quality data during care delivery and provides results and decision support much more rapidly.

- The essential role of data validation to ensure accurate payments in value-based models.

**Background.** The COVID-19 pandemic has highlighted the need for tools to better identify and address health disparities and under-performance throughout the healthcare system. The pandemic also bolstered the case to accelerate the move to value-based payment models. Entities in value-based models that focus on population health and accountability had systems of care in place. They were able to quickly adapt to the changing environment to provide services for their patients and escaped the severe financial disruptions experienced by the loss of fee-for-service revenue.

Yet, value-based payments require an assessment of quality and key stakeholders continue to raise concerns about the burden involved with measurement. Digitizing and automating the processes related to quality reporting, management, and improvement can result in better measures, better measurement systems, and better data – while also dramatically reducing this burden. Digital measures use data generated by clinicians and their teams in the course of caring for their patients and therefore greatly reduce manual processes and inefficient workflows, freeing clinicians to focus on patient care.

As we transition to a digital quality future amid tremendous disruption in society and the medical world, the clear view that quality measurement provides of where we stand and where we need to go is more important than ever. It is essential that we continue to monitor and reward quality while simultaneously building a platform for the future. The good news is that addressing equity, value and burden are not mutually exclusive. In fact, they are mutually dependent on the move to digital measurement.

# Principles

**NCQA believes that a more equitable, sustainable, and responsive healthcare system requires measurement that is:**

*Comparable.* The ability to compare quality and value across settings and models of care (managed care, ACOs, fee-for-service, etc.) is fundamental.  The burden and "noise" resulting from non-aligned measures that cannot be compared represents waste – in terms of time and money for all parties – and a lost opportunity to understand and prioritize what drives high-quality, person-centered care.

*Meaningful.* As we streamline the number of measures reported, how and what we measure must be determined with an eye toward higher quality, better outcomes, and more equitable results. This includes the ability to stratify measures based on race, ethnicity and language and capture information on social determinants of health that, in turn, inform the development of upstream solutions.

*Valid and Reliable.* Great gains have been made in the collection and sharing of healthcare data since the passage of the HITECH provisions in the 2009 stimulus bill.  Still, billions of dollars in performance-based payments are made each year based on data that is inadequately validated or merely attested to.  Strengthening standards and requirements for the validation of quality data and the platforms through which they flow will make the measurement and identification of high-value care more accurate and continuously improve the efficacy of future initiatives.

*Actionable and Timely.* HEDIS has enabled significant improvements in healthcare but it has been necessarily retrospective, yielding results months after care is provided.  Shortening the feedback loop on measurement will greatly enhance the ability to drive quality improvement longitudinally and at the point of care.

*Outcome-Oriented.* While process measures closely tied to outcomes – such as cancer screenings – remain extremely valuable, the system needs better, more relevant outcome measures to help differentiate quality. Among these should be patient-driven outcome measures based on individualized needs and goals, particularly for people with complex conditions.

*Patient-Centered.* Attempting to measure quality at the individual clinician level, however well-intentioned, often leads to a fragmented, incomplete view of a patient's care.  The federal government's efforts to incentivize the move to system-based payment models (such as the Medicare Shared Savings Program and the Advanced Alternative Payment Model track in MIPS) acknowledge this reality. The Biden Administration should maintain and strengthen policies encouraging such models and pilot programs to drive patient-centered accountability for those practicing in a non-system environment.

*Digital.* As noted, the key to realizing many of the benefits described above is unleashing the transformative capabilities that the move to digital systems has demonstrated in other segments of the economy – from retail to transportation to entertainment.  We commend CMS for its declaration that all quality measures will be reported digitally by 2030 but believe the process requires explicitly rewarding the move to digital through prudent investments and forward-looking digital measure policy.

The underlying proposals in this package represent our strong belief in the potential of quality measurement to bring about a more equitable and efficient healthcare system.  We look forward to working collaboratively with the Biden Administration to realize our common goals.

# Enabling a Digital Quality System

**Vision:** A scalable, sustainable digital quality infrastructure "utility" that enables reduced waste and burden in quality reporting; allows measurement across levels of the healthcare system; more accurately identifies high-value care; and enables a "learning health system" that leverages existing guidelines and clinical inputs to improve care in real time.

**Background.** For the last 30 years quality measurement has driven remarkable improvements in healthcare. The Healthcare Effectiveness Data and Information Set (HEDIS®), the backbone of the measurement system, has revolutionized our ability to identify areas for improvement, drive that improvement and standardize expectations for high quality care. Adoption of HEDIS measures aimed at the prevention and treatment of colorectal cancer, high blood pressure and diabetes, to name a few, have resulted in millions of saved lives and avoided complications.

**Problem.** Today's sprawling quality enterprise can be labor-intensive, fragmented, and inconsistent. It is also largely retrospective. Eliminating unnecessary or duplicative work and expenditures related to quality measurement could result in massive cost savings and free up invaluable time for patient care. America needs a more automated, unified, accurate, prospective, and timely quality measurement and reporting system. Moreover, the federal government bases many of its performance incentives on insufficiently validated data processed through systems that are prone to error. This undermines CMS's goal of rewarding high quality care and ensuring that this is what patients receive.

While programs that utilize and audit HEDIS data, such as Medicare Advantage Stars, can be confident in the validity of the data used to evaluate quality, others have inconsistent – or nonexistent – validation regimens. The explosion in electronic clinical data with the adoption of EHRs makes it even more essential that CMS evolve technology-enabled approaches to validate and leverage clinical data sources for use in quality and incentive programs.

**Challenges.** The current approach to quality improvement and value-based incentives is fragmented and uncoordinated across health plans and delivery systems. This creates excessive burden on clinicians and hinders patient safety, efficacy, and affordability. This "non-system" produces care that is riddled with gaps, redundancies, and inefficiencies. Even physicians who attempt to coordinate and rationalize care are obstructed by the balkanization of data, the lack of a full picture of what is happening to their patients, and the inability to act effectively if care is not what it should be.

The quality measurement enterprise no doubt contributes to this dysfunction. The way that healthcare data are currently organized and shared impedes the delivery of seamless and coherent care. Improving the data and measurement infrastructure will result in more efficient, transparent, comparable, and consistent quality reporting, removing a key barrier to improving healthcare.

We need an evolution that embraces the essential features of successful quality programs – impartiality, accountability, data validation, evidence-based standards and measures – while breaking down barriers to data-sharing, cooperation, and adoption of a common set of tools and protocols that will improve healthcare for all Americans.

A key challenge to modernization is overcoming inertia and facilitating coordination among diverse stakeholders to build, test and implement a new digital quality infrastructure. Much of the necessary technology exists in disparate forms (e.g., standards) and places (e.g., demonstration projects, vendor proprietary implementations). Recent legislation, regulations

and industry consensus promise to address interoperability – including the need for standardization. But because there is variability in implementation, we are not yet achieving standardization in practice and will remain locked into an inefficient, costly model.  The best chance to accelerate adoption across parties is to demonstrate to regulators, developers, and users of quality measures how a uniform set of tools in a common, secure environment can facilitate better data flow and utilization for an array of quality efforts and entities.

***The Path Forward.***  The digital quality utility we envision aligns closely with the "secure, data-driven ecosystem to accelerate research and innovation" contemplated in the 2020–2025 Federal Health IT Strategic Plan and would support the Centers for Medicare & Medicaid Services (CMS) goal of requiring all quality measures to be reported digitally by 2030. And it builds on growing interest among states and many private payers to move in this direction.

Digital quality measures (dQMs) are key to unlocking the potential of a reimagined quality enterprise.  They reduce the time and cost to distribute, implement, and maintain measures. Electronic Clinical Data System measures (ECDS), a subset of dQMs that use the HEDIS reporting standard, ease reporting burden by using data generated in the normal course of care delivery and captured in electronic health records, registries, health information exchanges (HIEs) and other digital sources. This rich clinical data allows for measuring more of what matters, including outcomes and care for individual patients rather than the general population.

A more digital quality system will enable rapid feedback and integrated content development across clinical guidelines and decision support, quality measures, and data specifications – each informing the other. This is the essence of a true learning health system.  Collaborative vehicles NCQA's Digital Measurement Community can incubate new ideas and solutions as the digital ecosystem evolves.  These efforts align with digital measurement initiatives underway at the Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention,  Office of the National Coordinator for Health IT and others.

***Next Steps.***  NCQA is scoping an end-to-end pilot of the essential components necessary to advance digital quality measurement.  From there we envision working with a diverse group of stakeholders to develop a platform that can continuously evolve and expand to incorporate new users, use cases and functionalities.  Users would be able to tailor the digital tools that emerge to their own goals and minimize the burden of maintaining organization-specific systems. In light of its broad potential to improve the system, and the ongoing cost of operation and maintenance, we believe a public-private partnership with seed funding from each sector and ongoing membership fees may be the appropriate governance model – with members empowered to influence development and priority use cases.

### A Digital Ecosystem for Better Clinical Practice and Quality Measurement
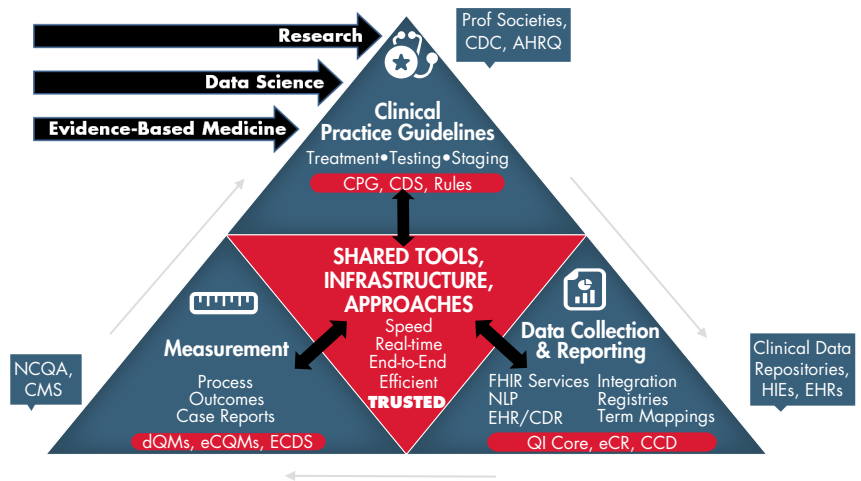


As an independent, trusted, non-profit organization with a strong record of building consensus, we feel well-suited to convening a collaborative effort on this front with participants from the public and private sectors.  We would welcome the chance to discuss the concept further.

# The Urgent Need to Advance Health Equity

**Vision:** A healthcare system that is enabled, fully resourced, and actively and effectively engaged in promoting health equity and holding stakeholders accountable for doing so.

**Problem.** Disparities in access, outcomes and cultural awareness continue to plague the healthcare system, as exemplified by the disproportionate impact of COVID-19 on minority communities. The pandemic has added millions of Americans to an already too large cohort of individuals whose health and well-being are negatively affected by the socioeconomic challenges they face. Progress will require commitment, resources, data, and strategy.

**Our Experience.** The National Committee for Quality Assurance (NCQA) is poised to play a primary role in driving the availability of standards and data necessary to identify disparities, enable positive change and measure outcomes. We have done this before with great success through our Healthcare Effectiveness Data and Information Set (HEDIS®), as well as our requirements on social determinants of health, demographic data collection and culturally appropriate care in several of our programs. We look forward to applying this experience as the Biden Administration tackles this crucial issue.
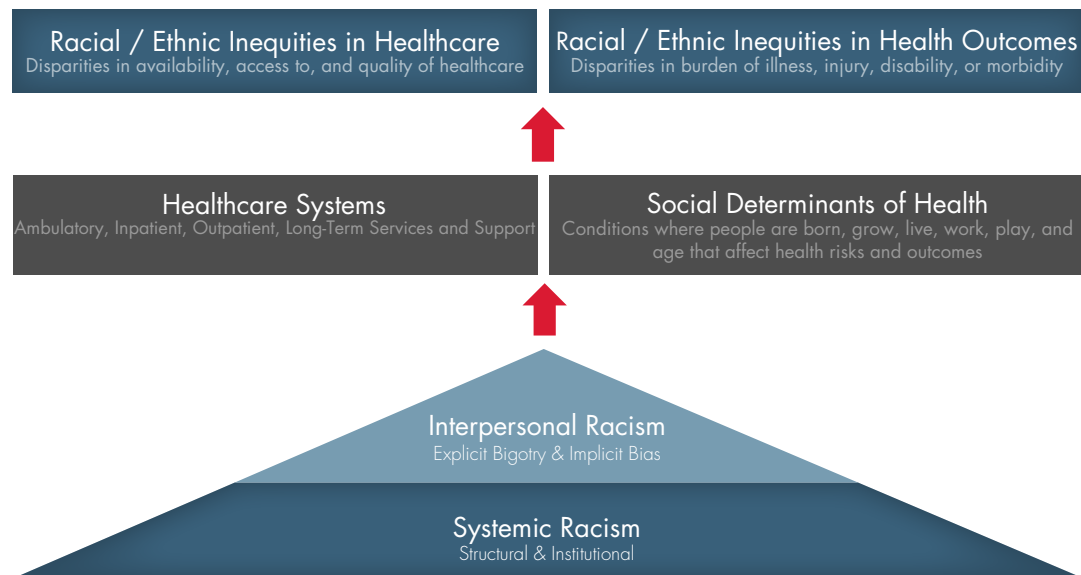
**Challenges.** Moving the country toward more equitable health outcomes starts by rooting out the longstanding structural, institutional, and interpersonal racism that drive disparities for Black, Latinx and other disadvantaged communities—in healthcare and society at large. For the former, this means a system where a person's clinician and health plan understand their cultural and linguistic needs and provide appropriate services to meet those needs. Policy-level change is required to ensure healthcare organizations have the necessary resources and infrastructure (including standards and measures) to reduce disparities. Finally, we must ensure that the system we build to intervene on these problems does not bake in racial bias and worsen inequities. Stakeholders across healthcare need to take a hard look at their infrastructures, hiring practices and training to be effectively engaged in eliminating inequities.

You cannot effectively address health equity without understanding the racial, ethnic and language composition of a population. Despite a decade of concerted effort, we have seen limited progress in the reporting of data stratified along these lines.

Patients in lower-income and racial minority communities, who have persistently received inequitable care, and faced a legacy of healthcare injustice, may be reluctant to share their data with providers. Combined with inconsistent efforts to collect and standardize documentation of race, ethnicity, language, and other sociodemographic characteristics, this deprives policymakers and payers of information necessary to uncover disparities and implement appropriate interventions. Most Medicaid and commercial plans do not consistently collect or report race or ethnicity data on their membership. As a result, these categories are often incomplete or derived from other sources, preventing effective evaluation and action. However, the Medicare Advantage (MA) program has proven that collecting and reporting this data is feasible. Over 80% of MA plans have complete or partially complete race data.

Once disparities are identified, one strategy to address them is to intervene on upstream, adverse social determinants of health (SDOH). Some payers have made significant strides in integrating health and social services to have coordinated efforts to address SDOH. Although 35 state Medicaid agencies require managed care organizations to address SDoH in some way, there are no nationally accepted, validated, and feasible standards and measures to guide organizations to

Better healthcare. Better choices. Better health.

## Health Inequity: Racial and Ethnic Disparities



| Racial / Ethnic Inequities in Healthcare | Racial / Ethnic Inequities in Health Outcomes |
|---|---|
| Disparities in availability, access to, and quality of healthcare | Disparities in burden of illness, injury, disability, or morbidity |

| Healthcare Systems | Social Determinants of Health |
|---|---|
| Ambulatory, Inpatient, Outpatient, Long-Term Services and Support | Conditions where people are born, grow, live, work, play, and age that affect health risks and outcomes |

**Interpersonal Racism**
Explicit Bigotry & Implicit Bias

**Systemic Racism**
Structural & Institutional

Adapted from Advancing Health Equity for Latinos through System Transformation, Sinsi Hernandez-Cancio

address health equity effectively and consistently. A roadmap on standards and measures is desperately needed to promote effective cross-sector collaboration and support value-based payment (VBP) arrangements to incentive health equity. And targeted quality improvement activities directed toward communities where we see a gap in outcomes and equity can effect positive change at the clinical level.

***The Path Forward.*** CMS, states, and communities are increasingly examining equity in performance measurement. There is strong interest in making healthcare disparities the focus of improvement efforts and incentive payments to insurers. Plans can serve as critical partners to effectively tackle the root causes of poor health and address disparities to improve the health of individuals and their communities. This is reflected in the continued investment and increase in supplemental benefits offered by MA plans to address SDoH (transportation, meals, etc.). Recently, the HHS Assistant Secretary for Planning and Evaluation (ASPE) recommended that CMS incorporate measures of health equity in its quality measurement and incentive programs. Some states already do so. For example, a portion of Michigan's incentives for plans depends on their ability to close gaps in racial disparities in care on targeted measures.

NCQA is working on a multi-pronged approach to developing health equity standards and measures to be used in VBP arrangements. Along with our existing work to improve data collection and stratification, we are taking the following steps to build a framework capable of driving awareness, improvement, and justice in the healthcare system.

- Identify and test standards that assess whether health plans have the structures and processes in place to help mitigate social risks and meet the health-related social needs of their members.

- Develop and test performance measures for plans that assess whether members are screened for health-related and broader social needs, as well as whether and how their social needs are met.

- Identify and test methods for assessing equity outcomes, such as developing benchmarks for equitable health outcomes for existing performance measures and examining approaches for using community-level outcomes for evaluating and incentivizing health plan performance. States like Pennsylvania have shown promising results at the community level by using programs such as NCQA's Multicultural Healthcare Distinction to require that plans collect data and work with healthcare providers to address healthcare disparities.

# Moving to Digital Patient Experience Measurement

**Vision:** A more robust, rapid, and targeted patient experience measurement system that empowers individuals and enhances the effectiveness of value-based payment (VBP) arrangements in driving higher quality and better outcomes.

**The Problem.** Twenty-five years ago, the Agency for Healthcare Research and Quality (AHRQ) launched the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, which established a standardized approach for measuring patient experience of care. It was a revolutionary step, and since then, CAHPS surveys have become critical components in a myriad of federal, state, and private value-based programs.  However, CAHPS has failed to keep pace with changes in the healthcare industry. Its shortcomings include:

- Surveys that are mostly paper-based mail or via telephone, which is costly and contributes to lagging feedback.
- Results that are difficult to act on because the survey goes to a random patient sample, which provides insights about typical health plan members but is poorly suited to identifying the concerns of specific patient groups, like racial and ethnic minorities or patients with multiple chronic illness and other negatively impacted by social determinants.
- A focus on clinician-level care which, in the many markets where insurers have largely the same clinicians in their networks, provides little differentiation between plans.

Unsurprisingly, response rates have steadily declined to below 40% in Medicare Advantage and below 20% for Medicaid and Commercial health plans.  These issues also severely limit the ability to support the VBP arrangements that are becoming more widespread, sophisticated, and inclusive of greater shared financial risk.
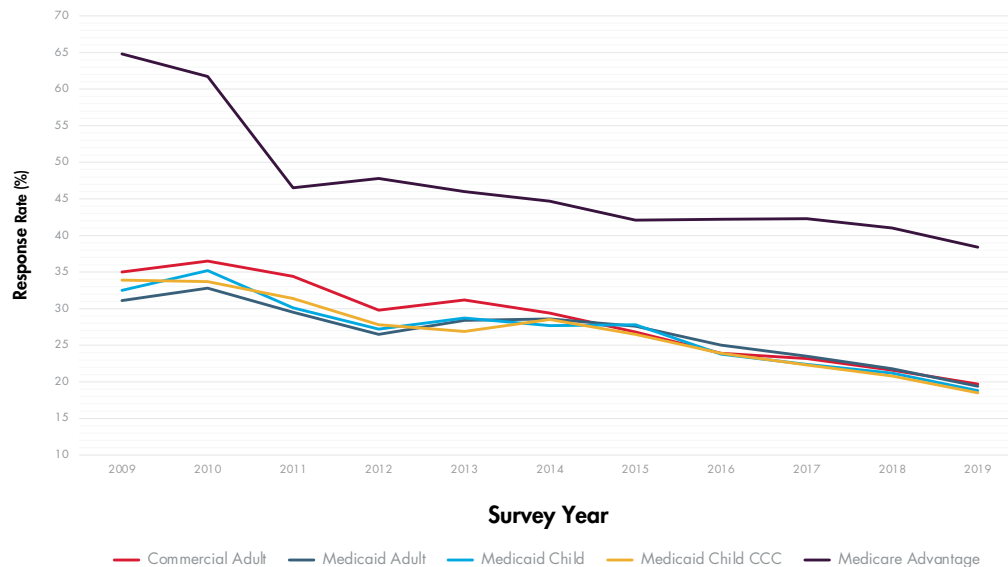
Recently, CMS announced it would increase patient experience measure weights in Medicare Advantage Stars so that by 2023 they will count more than clinical outcome weights. NCQA, and the vast majority of stakeholders who commented, opposed this change for a variety of reasons, including weaknesses in current patient experience measurement.

**Challenges.** CMS is essential to the development of a consensus on the best way to move to digital patient experience measurement, particularly if the new administration intends to maintain the inadvisable change in the weighting of CAHPS in the Stars methodology.  There is broad and growing agreement on the need to develop better tools to measure patient experience and there is technology already available and widely used that could be employed to do so.  Indeed, some health plans are already moving toward alternative survey modalities similar to those with which consumers are more familiar and comfortable, such as the ratings on Yelp and Amazon. Others are measuring net promoter scores like their counterparts throughout the private sector.

Without the Biden Administration's leadership in this area, we run the risk of either creating parallel patient experience enterprises that dilute the positive effects of measurement and distract plans from a focus on their members or clinging to a system outgrown by advances in technology and measurement.

**The Path Forward.** As noted above, there is an array of digital survey tools, widely used across the economy, that make it easy to respond on a smartphone, tablet, laptop or other electronic device. CMS should take full advantage of these in redesigning the measurement of patient experience.  They shold also identify and learn from the experience of others

## CAHPS Response Rates by Product Line



Legend: Commercial Adult — Medicaid Adult — Medicaid Child — Medicaid Child CCC — Medicare Advantage

who've made the leap. Convenience and accessibility will certainly improve response rates, but a digital approach can also provide more targeted and actionable results and allow surveys to ask the smallest set of questions needed to obtain meaningful data and to focus with greater precision on:

- Aspects of care for which the patient is the best or only source of information.
- Only the care patients have themselves experienced or observed.
- An explicit reference time frame, event and clinician, organization, or facility.

Technology can also improve the process of identifying populations from whom feedback is most needed, including high users, people with multiple chronic conditions, those negatively affected by social determinants of health, and those who have filed appeals and grievances. Targeted feedback can enable plans, practices, and health systems to focus improvement efforts where they most need it and to thrive in the value-based environment. And digital measurement allows faster cycles and linking surveys to a specific encounter rather than "over the last 6 months." This may open a range of new quality improvement and measurement opportunities. For example, plans could use heat map-like tools to identify which practices in a network are generating specific types of patient concerns and which types of patients have the most concerns.

### CMS Star Ratings for Medicare Advantage Plans Weights by Measure Category

|  | 2020 | 2021 & 2022 | 2023 |
|---|---|---|---|
| Patients' Experience, Complaints, and Access Measures | 1.5 | 2 | 4 |
| Clinical Process | 1 | 1 | 1 |
| Outcome | 3 | 3 | 3 |

In 2021, NCQA is planning to convene an expert panel of stakeholders from across the healthcare landscape to inform the plan for a bold, digitally-based reimagining of patient experience measurement. We would, of course, welcome the support and participation of the Biden Administration in this effort. The optimal new paradigm will combine the standardized approach that is essential for consistent, high-quality measurement with the adoption of leading-edge technology driving improvement in quality and consumer choice in other industries.

# 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:**
  - o Stakeholders (including payers, clinicians, evaluators, quality measurement experts, etc.) should be involved early in the design and development of VBPs.
  - o 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.
  - o 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.
  - o 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**
  - o 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.
  - o 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.
  - o 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.
  - o 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.
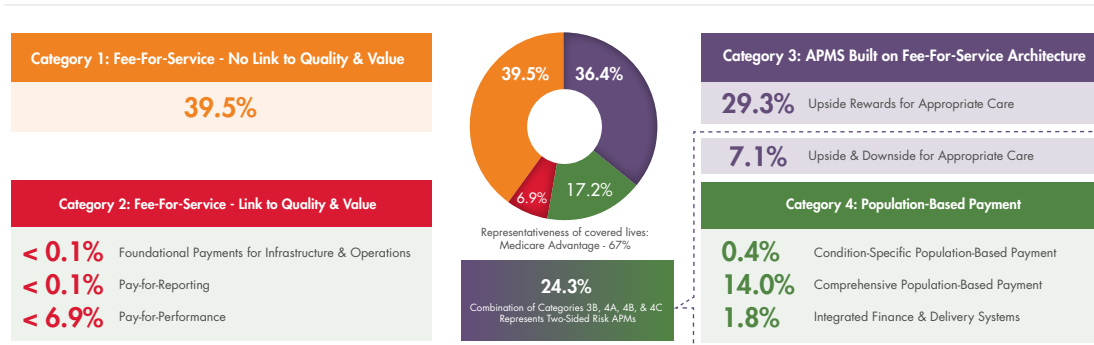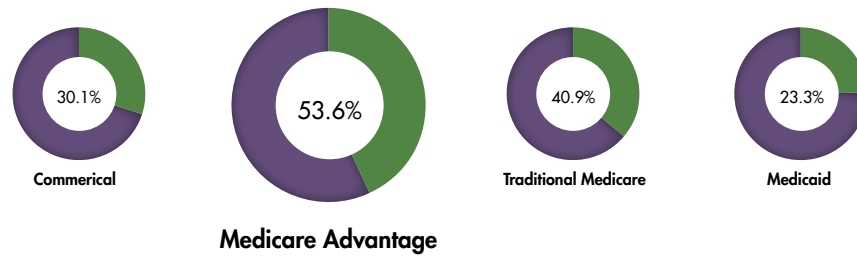
**CAHPS/Patient Experience Measurement.** We also are concerned with the increase in Medicare Advantage Stars patient experience measure weights that will, by 2023, make them greater than clinical outcome weights. We agree that it is essential to incorporate patient experience but note that the vast 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.

## Medicare Advantage VBPs by Category



| | | | |
|---|---|---|---|
| 30.1% | 53.6% | 40.9% | 23.3% |
| Commerical | Medicare Advantage | Traditional Medicare | Medicaid |

**Category 1: Fee-For-Service - No Link to Quality & Value**

**39.5%**

**Category 2: Fee-For-Service - Link to Quality & Value**

< 0.1%  Foundational Payments for Infrastructure & Operations
< 0.1%  Pay-for-Reporting
< 6.9%  Pay-for-Performance

39.5%   36.4%
6.9%    17.2%

Representativeness of covered lives:
Medicare Advantage - 67%

**24.3%**
Combination of Categories 3B, 4A, 4B, & 4C
Represents Two-Sided Risk APMs

**Category 3: APMS Built on Fee-For-Service Architecture**

**29.3%**  Upside Rewards for Appropriate Care

**7.1%**  Upside & Downside for Appropriate Care

**Category 4: Population-Based Payment**

**0.4%**  Condition-Specific Population-Based Payment
**14.0%**  Comprehensive Population-Based Payment
**1.8%**  Integrated Finance & Delivery Systems

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).