



One Prince Street  
Alexandria, VA 22314-3318  
☎ 703.838.0033  
F 703.548.1890

June 8, 2017

To: Health Care Plan Learning and Action Network (HCPLAN)

From: AMGA

Re: HCPLAN "Alternative Payment Model (APM) Framework, Draft White Paper

On behalf of AMGA, we appreciate the opportunity to comment on the HCPLAN's May 22, 2017 "Alternative Payment Model (APM) Framework, Draft White Paper." AMGA, founded in 1950, represents more than 450 multi-specialty medical groups and integrated delivery systems representing about 177,000 physicians who care for one-in-three Americans. Our member medical groups are particularly interested in alternative payment model (APM) arrangements that improve primary care. AMGA members have a strong desire to improve the quality and effectiveness care delivery, or in achieving the triple aim of improving the experience of care, improving the health of populations, and reducing spending or the per capita costs of health care. (This is the fifth comment letter AMGA has forwarded to the HCPLAN over the past 18 months.)

AMGA has two overarching comments in response to the latest HCPLAN APM draft white paper. These comments largely reiterate those we made in our May 23, 2016 response to the "Performance Measurement" white paper and in our November 16, 2016 response to the "Primary Care Payment Models" white paper.

#### Adding Incentive Neutral Policies

AMGA appreciates the HCPLAN's recognition that "changing providers' financial incentives is not sufficient to achieve person-centered care" (page 2) and that payment reform is not a goal unto itself (page 4). We are pleased the HCPLAN in its final "Primary Care Payment Models" white paper published this past March deleted from its November 2016 draft the statement that *the* "catalyst for transforming primary care" are value-based payment arrangements, or that "value-based arrangements can drive system transformations."

As previously in our November 16, 2016 comments, the evidence in support of value-based agreements is unclear. The most recent synthesis report by the Cochrane Collaborative concerning financial incentives in the primary care setting concluded, "There is insufficient evidence to support or not support the use of financial incentives to improve the quality of primary care." <sup>1</sup> The United Kingdom is about a decade ahead of the US in implementing primary care pay for performance. Evaluative evidence concerning the National Health

Service's Quality and Outcomes Framework (QOF), which began in 2004, shows incentive payments have produced uncertain results. For example, a 2014 Nuffield Trust report that reviewed the QOF found “there is a lack of evidence for the impact on patient outcomes” and “there is a case for caution regarding what payment reform can achieve.”<sup>2</sup> In the US, Medicare's Premier Hospital Quality Incentive demonstration failed to improve quality measures and patient outcomes compared to the control group over the five year trial period.<sup>3</sup> More recently, a 2015 published study of Fairview Health Services' primary care compensation model, which tied 40 percent of physician compensation to quality outcomes, found no effect in improving quality metrics over comparable Minnesota medical groups.<sup>4</sup>

Added to indeterminate outcome evidence, primary care physicians, for example family medicine physicians and internists, are comparatively modestly compensated, if not undervalued. According to Medscape's 2016 compensation report, these physicians annually earn, for example, half that of orthopedists.<sup>5</sup> Absent substantial changes in how primary care compensation is calculated, or substantial changes to how primary care Relative Value Units (RVUs) are made, financial incentives are likely largely irrelevant in achieving pay for performance outcomes.

That primary care providers are under-compensated likely explains why, as the HCPLAN recognizes four out of five family medicine physicians are not aware of what percentage of their practice's revenue comes from value-based payments. This fact also likely explains why, according to a 2014 Physician Foundation survey, only 16 percent of primary care physicians believe ACOs will enhance care quality and reduce costs.<sup>6</sup> These points aside, financial rewards can be counterproductive by, among other things, undermining intrinsic motivation and producing adverse crowd out effects. In a 2012 [Health Affairs](#) blog post, researchers provided evidence that monetary incentives or rewards can actually backfire, findings similar to the Fairview study noted above.<sup>7</sup>

Further, despite the Physician Quality Reporting System's (PQRS) financial incentives, the provider community has been slow to participate. For example, in 2013, or six years after the program started, only half of eligible professionals were participating. As has been widely reported, only approximately one-quarter of ACOs earn shared savings and those that have been successful had comparatively substantially higher financial benchmarks. Concerning bundles, while there have been successful Bundled Payment for Care Improvement (BPCI) participants, it is unclear whether savings will be more than offset by increased volume.

For these reasons and others, AMGA now recommends the HCPLAN consider recommending incentive neutral policies. As Robert Berenson and Thomas Rice wrote in a 2015 [Health Services Research](#) article, “public policy can support clinicians' intrinsic motivation through approaches that support systematic feedback to clinicians and provider concrete



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opportunity to collaborate to improve care.”<sup>8</sup> The authors argue financial incentives, particularly if they are marginal, may be less important in motivating providers to improve quality and reduce spending than embedded or intrinsic incentives. Financial incentives also risk “teaching to the test” problems, can undermine professionalism and commitment to the patient. Intrinsic or implicit incentives that reinforce working in collaboration and provide for non-public comparative data have proven successful. For example, the authors note CMS' Partnership for Patients initiative between 2010 and 2013 reduced patient harm by 17 percent, prevented 50,000 deaths associated with Hospital Acquired Infections (HAIs) and saved the Medicare program \$12 billion – all without financial incentives playing a substantial roll. The authors argued quality can be improved and spending reduced by “relying on professionals' intrinsic motivation and organizations' mission to improve care, accompanied by straightforward quality improvement methods to produce actionable, common sense steps.” The authors concluded that, “rather than having one provider pitted against another to distribute financial rewards and penalties, provision of technical assistance and encouraging quality-related collaborations can lead to more-desired results.”

#### Achieving Value

As in other HCPLAN documents, this document makes frequent mention of “value.” In this revised 43-page APM draft, “value” is noted 59 times. For example:

- At page 4: “The Health Care Payment Learning & Action Network (LAN) established its Guiding Committee in May 2015 as the collaborative body charged with advancing alignment of payment approaches across and within the private and public sectors. This alignment aims to accelerate the adoption of alternative payment models that reward quality and value in health care.”
- At page 5: “Therefore, a critical goal of the White Paper is to inform health care stakeholders about how value-based arrangements in PCPMs can drive delivery system transformations that strengthen primary care’s capacity to achieve better care, smarter spending, and healthier people, and to offer recommendations for structuring these types of arrangements.”
- At page 9: “Principle 1: New payment models will need to support high-value primary care . . . .”
- At page 12: “For these reasons, Category 4 PBP is ideally suited for PCPMs, because it frees primary care teams to focus more on tasks that create value for their patient populations.”

However, this document, like other similar works, including the HCPLAN performance measurement draft paper and CMS' “Quality Measurement Development Plan” never discuss “value” definitively, or as a health care outcome achieved relative to spending. Instead, the word is used simply as a proxy for quality.



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As in our May 23, 2016 performance measurement comments, quality, or more specifically an outcome, is a value component. Value is the sum of a performance or outcome numerator measured over a spending denominator. As Micheal Porter stated in a 2016 New England Journal of Medicine essay, value is "outcomes achieved relative to the costs." 9 "Performance measurement" absent calculating value or value improvement is why, for example, MedPAC stated in its June 2014 report to Congress, "Medicare's current quality measurement approach has gone off the tracks" 10 True quality measurement is not an input or sum total of inputs, for example the sum total of process measures, or even the outcome itself, but instead outcomes measured relative to spending or costs.

Measuring and rewarding quality independent of correlating to spending can and does produce perverse effects. These obviously needs to be avoided. For example, in a May 2016 Health Affairs' article researchers found CMS paid 231 hospitals participating in the 2015 Medicare Hospital Value-Based Purchasing (HVBP) program a financial bonus for spending efficiency despite the fact their quality scores were "significantly worse" than medium-and high quality hospitals that also received bonuses. 11 Not surprisingly, this meant there was little correlation between quality performance and spending. Similar results have been found in the Medicare Shared Savings or ACO program. In 2014, the most recent year for which data is available, CMS paid bonuses or shared savings to 86 MSSP ACOs despite the fact these ACOs had a mean quality score that was worse than the worst financially performing 67 ACOs, or those that exceeded their negative Minimum Loss Ratio. 12 Despite better quality none of these 67 ACOs received a financial bonus. Other research has shown similar results. For example, RANDS's Cheryl Damberg has shown hospital CAHPS scores have little relationship to efficiency. 13

AMGA believes APMs will ultimately be unsuccessful unless or until value is measured. CMS agrees with this concern, as evidenced by the Medicare Access and CHIP Reauthorization Act (MACRA) Merit-based Incentive Payment System (MIPS) inclusion of a cost component measure that will include specifically defined episode-based cost measures. There are numerous opportunities to incorporate value in the HCPLAN performance measurement discussion. The International Consortium for Health Outcomes Measurement (ICHOM) outcome measures could be used in conjunction with spending or reimbursement data to calculate APM value. More specifically, MACRA funds \$15 million annually between 2015 and 2019 to identify gaps in measures. The HCPLAN could recommend ICHOM measures under the call for measures as part of the call for measures in the MACRA final rule. HCPLAN could build on the work of others and recommend minimum quality and spending thresholds. For example, California's Integrated Healthcare Association's (IHA) value-based pay for performance program imposes both quality and cost thresholds. 14 If either or preferably both thresholds are not met a performance measurement score would be decreased. Better still, and as noted above, quality and spending are combined to determine a single "value" performance measurement score. For example, bundled payment arrangements lend themselves to value-base performance measurement



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scoring since they are intentionally designed to drive outcomes over spending or reimbursement.

The foremost goal of performance measurement ought to be organizing around measuring and achieving value or value improvement. Absent this we face, and are already facing, Michael Porter's 2010 admonishment that "cost reduction without regard to outcomes achieved is dangerous and self-defeating." This leads to, he said, false savings or "ill-advised cost containment" that results in "micromanagement of physician practices which imposes significant costs of its own." 15 MedPAC made the same argument in explaining its "off the rails" comment. The commission stated that current quality measurement left providers with "fewer resources" to "improve the outcomes of care, such as reducing avoidably hospital admissions."16 The Hospital Value-Based Purchasing (HVBP) and the ACO program rewards illustrate Porter's "ill advised" caution. Evidence of "significant costs" can be found in the estimated \$15.4 billion physician practices spent in 2014 to report quality measures. 17 In his comments at Health Affairs' May 12 value-based payment meeting, Commonwealth's David Blumenthal recognized the importance of choosing and prioritizing measures that drive value. To do so, he emphasized the need to be intentional such that pursuing the goal of improved value is necessary to gain the confidence and cooperation of providers, payers and other key health reform stakeholders. 18 Unless or until performance measurement actually measures performance, physicians of all stripes will find quality measurement, collection and reporting largely onerous and futile. If Medicare and commercial payers alike intend to migrate healthcare payments from volume to quality and value, they need to begin to define quality as outcomes relative to spending.

Thank you for your consideration of AMGA's comments. If you have any questions please do not hesitate to contact David Introcaso, Ph.D., Senior Director of Regulatory and Public Policy, at [dintrocaso@amga.org](mailto:dintrocaso@amga.org) or at 703.842.0774.

Sincerely,

Chet Speed, J.D., LL.M  
Vice President, Public Policy  
AMGA



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F 703.548.1890

## Endnotes

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2. Nuffield Trust, "The NHS Payment System: Evolving Policy and Emerging Evidence," (February 2014), at: [http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140220\\_nhs\\_payment\\_research\\_report.pdf](http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140220_nhs_payment_research_report.pdf). See also, for example, "Robert Fleetcroft, et al., "Incentive Payments Are Not Related to Expected Health Gains in the Pay for Performance Scheme in UK Primary Care: Cross-Sectional Analysis," *BioMed Central* (April 16, 2012), at: <http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-12-94>, Paramjit Gill, et al., "Pay-For-Performance and Primary Care Physicians: Lesson From the UK Quality and Outcomes Framework for Local Incentive Schemes," *Journal of the Royal Society of Medicine* (2015), at: <https://www.rbfhealth.org/sites/rbf/files/J%20R%20Soc%20Med-2015-Gill-80-2.pdf>, and Ruth McDonald and Martin Roland, "Pay for Performance in Primary Care in England and California: Comparison of Unintended Consequences," *Annals of Family Medicine* (March 2009): 121-127. At: <https://www.ncbi.nlm.nih.gov/pubmed/19273866>.
3. See: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalPremier.html>.
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✉ 703.548.1890

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