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Paying for Value

You Know it When You See it, or Do You?

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The passage of the Medicare Access and CHIP Reauthorization Act of 2015, also known as MACRA (1), mandates a dramatic change in compensation for American health care. Although this is a change for health care in particular, it is widely known that government agencies require quality assurance details for virtually every product they purchase. The schematics for military aircraft include excruciating analysis of the performance characteristics of every gauge, meter, computer, and wing structure down to the bolts. At the same time, these programs have not exactly been the model of economic success, with many costing far more than budgeted, including the notorious F-35 Lightning II, the Department of Defense's most expensive weapon system ever (2).

Prior to MACRA, the cost of health care was budgeted on the basis of population size and the rate of inflation. As in the case of military aircraft, cost overruns were eventually paid through Congressional action that increased available funds. This yearly process for healthcare—the doctor fix—resulted in payment delays and provider frustration and never addressed the underlying problem of too little funding for the care provided. At the same time, there were very limited requirements that mandated quality assurance in the purchased products. Over the last several years, hospital payments have moved incrementally to outcome-based pay, with bonuses and penalties distributed on the basis of core measure reporting, and readmission causing financial jeopardy. The provider side of the equation has experienced limited risk as well with the Physician Quality Reporting System (3) and EHR Incentive Program (Meaningful Use) (4), among others.

The key concepts of MACRA change this process. There will be no need for the yearly "doctor fix" that was the result of inadequate funding of the existing patient base. Instead, adequate funding will be available with the proviso that providers actually deliver quality health care.

The concept of getting paid to provide quality health care seems obvious to most of us, as we thought we were already providing quality care. It is hard to imagine that any of us would head off to work each day and tell our families and friends that our job was to provide poor quality health care to the patients. It is our goal to do the right thing for our patients; in fact, it is part of our taken oath.

The next question is to clearly determine what qualifies as "the right thing." When I was an intern, albeit a very long time ago, I recall lamenting to my senior resident that I was having trouble memorizing the correct doses of drugs to be given during a cardiac arrest. He wisely told me that if I could always choose the correct medications to use, someone would help me find the correct dose.

In passing the MACRA legislation, Congress was actually quite ingenious in defining the details. The language leaves the determination of what is right to the physicians. This is brilliant. Compare it to Monopoly. If you were to develop a board game called Medicare Monopoly, how would you design the system to have the right incentives, encourage innovation, provide care for everyone with great access, maintain low cost, and encourage high satisfaction among providers and patients? In our field of cardiac and vascular medicine, what parameters would you have in place? What would you measure, and how would you do it?

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In-depth chart reviews of most cardiologists' offices will find some opportunities for improvement. I am confident that one would find some patients who have a reduced ejection fraction that are not on maximal medications, and a few patients who could benefit from an implantable cardioverter-defibrillator. How many patients who should be on a statin are actually on the medication and are also treated appropriately? How many hypertensive patients have well-controlled blood pressure?

It seems we will have to start with the basics. It is imperative that despite assumptions of good intentions, our results must match. On the outpatient side, the American College of Cardiology's PINNACLE Registry (5), cardiology's largest outpatient quality improvement registry that captures data on coronary artery disease, hypertension, heart failure, and atrial fibrillation, is the place to start. Physician practices can get the snapshot of the care they are actually providing via online benchmark reports that help them validate their quality care and pinpoint opportunities for improvement. By tracking these data over time, being able to say that "85% of my eligible patients are on goal for their lipids and I am working to get the rest there," seems better than "I treat my patients well."

On the inpatient side, the NCDR (National Cardiovascular Data Registry) (6) registries capture and report trusted and reliable data that helps participants measure, benchmark, and improve cardiovascular care. Is that not the goal of every provider?

We perform imaging that is both lifesaving and expensive. The old 3-view planar thalliums are now replaced by positron emission tomography imaging with stress ejection fraction. Participation in accreditation programs, like those offered through the Society of Cardiovascular Patient Care, the American College of Cardiology's new accreditation arm, is a necessary step to be sure the technology is meeting its potential. In addition, the cardiac catheterization correlation conferences are a helpful reminder that every technology has limitations and cardiac catheterization still remains a helpful tool.

Measuring patient satisfaction has challenges, and clearly many patients are more satisfied with incremental and unnecessary testing. I would argue that a larger number are more interested in having a provider who cares about them as individuals and will take the time to discuss options in the most frank way possible. I have heard many patients extol the virtue of the doctor whose opinion was that additional testing and procedures would not change their outcome.

MACRA will be frustrating, and some may even view it as insulting, as the initial metrics will likely be very basic until new measures that accurately capture the complexity of patient care and outcomes can be developed. In the end, however, if MACRA results in an ongoing systematic review of the care we provide in any setting, my guess is that the results will be very helpful and interesting.

In the new world, we will still be providing quality care. The difference now is that we will finally be able to prove it.

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