Value-Based Payment NEWS

Doctor Group to HHS: 'Define Value the Same for Everyone'

Saying that "different requirements create a needless burden," AMGA reports encouraging the US Department of Health and Human Services to "reform Medicare rules, align reporting measures across its three main offerings and more clearly define cost and quality measures for value-based care."

Responding to a Request for Information from HHS' assistant secretary for planning and evaluation, AMGA "recommended that the Centers for Medicare and Medicaid Services revise and align regulations for quality performance, risk adjustment and financial benchmarks across Medicare fee-for-service, Medicare Advantage and the Medicare Shared Savings Program," according to a statement from the doctor group. Now, it adds, "Medicare regulations differ substantially across each program, creating a burden for physicians and provider organizations, which are reimbursed and evaluated on quality in different ways in each program."

Adds Jerry Penso MD MBA, AMGA's CEO and President: "Medicare rules vary depending on whether a patient is enrolled in Medicare Advantage, traditional FFS or an Accountable Care Organization, which means participants must navigate different rules for each program. Aligning the rules across the three programs would provide a level playing field so we can compare each program." AMGA says it also "stressed the importance of defining and appropriately measuring value in healthcare" in the RFI response, and noted that "costs and quality are measured separately and there is often little correlation between quality performance and spending efficiency. For payments to be truly value-based, Medicare needs to incentivize performance on outcomes achieved relative to spending." Says Penso: "AMGA knows that value-based care has the potential to drive improvements in patient outcomes, but for it to be truly meaningful, Medicare needs to measure for results."

The RFI notes that each HHS agency is reviewing and seeking public comments on Medicare regulations that the government says "reduce or restrict competition and choice;" HHS is looking for ideas for "a more competitive system." And the AMGA letter to HHS adds that the group "thoroughly supports improving premium affordability, consumer choice, provider innovation and market competition" and so makes "two overarching Medicare-related recommendations: competing Medicare's siloed programs and simultaneously promulgating regulatory reforms that drive or increase value or outcomes achieved relative to spending." AMGA adds it's "confident that will improve beneficiary choice and premium affordability, spur innovation in the clinical practice setting, drive competition and address 'excessive consolidation' and 'abuses of market power'."

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Health Data Manager Validic Offers Tips for Maximizing Technology in Value-Based Care

Company offers providers and payers four considerations for connected health strategies to capitalize on 2018's digital health trends.

Here's how a statement from Validic, a leading data connectivity solutions provider, begins: "As resources continue to be strained in the value-based care shift, the only way to ensure greater output with diminishing resources is through the scaled use of technology." In a new white paper, *The 2018 State of Connected Health: The Shift from Hospital to Home-Based Care*, Validic CEO Drew Schiller says he "identifies several action points healthcare leaders should consider when planning 2018 digital health strategy" and "sheds light on the trends to watch, the initiatives to launch and the technologies to integrate."

Schiller adds: "It's likely that in the coming year, we will see a lot of moving plates. From the growth of value-based care to the increased consumerization of healthcare, providers need to devise a strategy that integrates the best tools and data to scale for future change." Here are the action points identified in the white paper:

- ***Adopt alternative payment models that embrace value-based care.*** "Accountable Care Organizations cover about 10% of the US population," the statement says, "or about 32.4 million lives, and new payment models are becoming increasingly common." As well, it adds, "the unbundling of CPT code 99091 allows Quality Payment Program-participating providers to be reimbursed separately for time spent collecting and interpreting patient-generated health data. As new policies encourage the integration and use of PGHD in remote monitoring, providers will benefit from learning about and adopting new payment models that incentivize and support such programs."

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