

The Daily Dish

Quality Measures and Health Care Policy

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The cost of health care – with a perennial focus on pharmaceuticals in particular – is back at the forefront of health policy issues. It can be frustrating to follow the debate. One of the most basic issues is that it is very difficult to measure quality in health care. And without the ability to measure quality, you have no real idea about the effective price. Is someone paying for higher quality? Or more quantity? Or a higher price? Health care is riddled with quality-measurement issues.

There is also the tricky issue of actions versus outcomes. Ideally, one wants to pay for high-quality outcomes. But what is the "outcome" of an annual checkup for Eakinomics that leads to preventive health measures? Conceptually, it is the reduced probability of a specific, acute care episode in the future. What probability? What episode? It is simply very hard to measure.

In the absence of the ability to plausibly measure the contribution to outcomes, there is a natural focus on actions (or inputs).

It should be noted for the record that difficulties in measuring quality are not unique to health. What is the "best" laptop computer, tablet, or phone? What is the best college for an undergraduate education? The issue abounds, but in private-sector settings there arises a private-sector industry of providing that information. There are rankings and ratings from all sorts of sources.

The difficulty in health is that it is addicted to federal dollars. And federal dollars come with federal strings. Among them are attempts – led by the federal government – to measure the quality of the activities funded by the government.

Now it is fair to wonder: What is this blog post about? Has Eakinomics had a small stroke?

Did I miss a statistical discussion in the vice presidential debate? None of the above. Instead, there was a news story about a decline in the equity value of a Medicare Advantage (MA) provider due to reports of a sharp decline in the rankings in the MA Stars program (Stars). This comes on the heels of an episode in the prior year of the Centers for Medicare and Medicaid Services (CMS) re-grading all the Stars ratings – and only providing better grades and not worse. (For the record: terrible incentives. Undergraduates would game this to the max.)

In some respects, this is unsurprising. The Stars program is super complicated. To give you a flavor of the factors used to measure quality, the following table is reproduced from a CMS fact sheet on the Stars program.

2023—2024 Average Star Rating by Part C Measure

Measure	2023 Average Star	2024 Average Star
Breast Cancer Screening	3.7	3.7
Colorectal Cancer Screening	3.8	3.7
Annual Flu Vaccine	3.2	3.1
Monitoring Physical Activity	3.2	3.0
Special Needs Plan (SNP) Care Management	3.3	3.4
Care for Older Adults – Medication Review	4.4	3.8
Care for Older Adults – Pain Assessment	4.3	3.9
Osteoporosis Management in Women who had a Fracture	2.6	2.6
Diabetes Care – Eye Exam	3.7	3.5
Diabetes Care – Blood Sugar Controlled	4.1	3.6
Controlling Blood Pressure	3.5	3.4
Reducing the Risk of Falling	2.9	2.9
Improving Bladder Control	3.3	3.2
Medication Reconciliation Post-Discharge	3.4	3.4
Plan All-Cause Readmissions	NA	2.9
Statin Therapy for Patients with Cardiovascular Disease	3.5	3.3
Transitions of Care	NA	2.5
Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	NA	3.0
Getting Needed Care	3.4	3.4
Getting Appointments and Care Quickly	3.5	3.5
Customer Service	3.4	3.6
Rating of Health Care Quality	3.4	3.3
Rating of Health Plan	3.2	3.1
Care Coordination	3.5	3.6
Complaints about the Plan	4.3	3.9
Members Choosing to Leave the Plan	3.5	3.6
Health Plan Quality Improvement	2.6	3.0
Plan Makes Timely Decisions about Appeals	4.6.	4.1
Reviewing Appeals Decisions	4.4	3.6
Call Center – Foreign Language Interpreter and TTY Availability	4.3	4.3

It clearly contains a mix of measures, and there is the further issue of arriving at a single quality metric for the MA plan overall.

So, quality matters and Stars is imperfect. But having something like it – ever-improving, one hopes – allows beneficiaries to choose plans wisely and directs money to high-quality plans. Those are central features of a successful, market-driven program.

Oh, and by the way, there is no (zero, zilch, nada) attempt to measure quality in traditional,

fee-for-service (FFS) Medicare. Unsurprisingly, providers love FFS, but taxpayers must foot a bill rising unsustainably.

The goal for health care policy should be to measure quality, ever better over time, in every dollar funded by the taxpayers.