Performance Measurement in CMS Programs

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Mind the Gap: Improving Quality Measures in Accountable Care Systems
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Delivery system and payment transformation

**Current State –**
Producer-Centered

- Volume Driven
- Unsustainable
- Fragmented Care
- FFS Payment Systems

**Future State –**
People-Centered

- Outcomes Driven
- Sustainable
- Coordinated Care

**New Payment Systems**
(and many more)

- Value-based purchasing
- ACOs, Shared Savings
- Episode-based payments
- Data Transparency
<table>
<thead>
<tr>
<th>Description</th>
<th>Category 1: Fee for Service – No Link to Quality</th>
<th>Category 2: Fee for Service – Link to Quality</th>
<th>Category 3: Alternative Payment Models on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery</td>
<td>Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but, opportunities for shared savings or 2-sided risk</td>
<td>Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (eg, &gt;1 yr)</td>
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<table>
<thead>
<tr>
<th>Examples</th>
<th>Medicare</th>
<th>Medicaid</th>
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<tbody>
<tr>
<td>Medicare</td>
<td>Limited in Medicare fee-for-service. Majority of Medicare payments now are linked to quality.</td>
<td>Varies by state</td>
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<tr>
<td></td>
<td>Hospital value-based purchasing. Physician Value-Based Modifier. Readmissions/Hospital Acquired Condition Reduction Program.</td>
<td>Primary Care Case Management. Some managed care models.</td>
</tr>
<tr>
<td></td>
<td>Eligible Pioneer accountable care organizations in years 3 – 5. Some Medicare Advantage plan payments to clinicians and organizations. Some Medicare-Medicaid (duals) plan payments to clinicians and organizations.</td>
<td>Some Medicaid managed care plan payments to clinicians and organizations. Some Medicare-Medicaid (duals) plan payments to clinicians and organizations.</td>
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</table>

Value-Based Purchasing Program Objectives over Time Towards Attainment of the Three-part Aim

Initial programs FY2012-2013
- Limited to hospitals (HVBP) and dialysis facilities (QIP)
- Existing measures providers recognize and understand
- Focus on provider awareness, participation, and engagement

Proposed and near-term programs FY2014-2016
- Expand to include physicians
- New measures to address HHS priorities
- Increasing emphasis on patient experience, cost, and clinical outcomes
- Increasing provider engagement to drive quality improvements, e.g., learning and action networks

Longer-term FY2017+
- VBP measures and incentives aligned across multiple settings of care and at various levels of aggregation (individual physician, facility, health system)
- Measures are patient-centered and outcome oriented
- Measure set addresses all 6 national priorities well
- Rapid cycle measure development and implementation
- Continued support of QI and engagement of clinical community and patients
- Greater share of payment linked to quality

Vision for VBP
Recommendations for Improving Accountable Care Measurement

1. Identify and Prioritize Measure Gaps
2. Use Alternative Measurement Approaches
3. Use the most Meaningful Measure Types
4. Address Barriers to Measurement
5. Assess Opportunities to Continuously Improve
Our quality improvement strategy is to concurrently pursue three aims:

**Better Care**

Improve overall quality by making health care more patient-centered, reliable, accessible and safe.

**Healthy People / Healthy Communities**

Improve population health by supporting proven interventions to address behavioral, social and environmental determinants of health, in addition to delivering higher-quality care.

**Affordable Care**

Reduce the cost of quality health care for individuals, families, employers and government.
# The Six Goals of the CMS Quality Strategy

1. Make care safer by reducing harm caused in the delivery of care
2. Strengthen person and family engagement as partners in their care
3. Promote effective communication and coordination of care
4. Promote effective prevention and treatment of chronic disease
5. Work with communities to promote healthy living
6. Make care affordable

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Foundational Principles of the CMS Quality Strategy

- Eliminate Racial and Ethnic disparities
- Strengthen infrastructure and data systems
- Enable local innovations
- Foster learning organizations
CMS has a variety of quality reporting and performance programs, many led by CCSQ

<table>
<thead>
<tr>
<th>Hospital Quality</th>
<th>Physician Quality Reporting</th>
<th>PAC and Other Setting Quality Reporting</th>
<th>Payment Model Reporting</th>
<th>Population” Quality Reporting</th>
</tr>
</thead>
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<td>EHR Incentive Program</td>
<td>Medicare and Medicaid EHR Incentive Program</td>
<td>Inpatient Rehabilitation Facility</td>
<td>Medicare Shared Savings Program</td>
<td>Medicaid Adult Quality Reporting</td>
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<tr>
<td>PPS-Exempt Cancer Hospitals</td>
<td>PQRS</td>
<td>Nursing Home Compare Measures</td>
<td>Hospital Value-based Purchasing</td>
<td>CHIPRA Quality Reporting</td>
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<tr>
<td>Inpatient Psychiatric Facilities</td>
<td>eRx quality reporting</td>
<td>LTCH Quality Reporting</td>
<td>Physician Feedback/Value-based Modifier</td>
<td>Health Insurance Exchange Quality Reporting</td>
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<td>Inpatient Quality Reporting</td>
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<td>ESRD QIP</td>
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<td>HAC payment reduction program</td>
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<td>Hospice Quality Reporting</td>
<td>CMMI Payment Models</td>
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<td>Readmission reduction program</td>
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<td>Home Health Quality Reporting</td>
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- EHR Incentive Program
- PPS-Exempt Cancer Hospitals
- Inpatient Psychiatric Facilities
- Inpatient Quality Reporting
- HAC payment reduction program
- Readmission reduction program
- Outpatient Quality Reporting
- Ambulatory Surgical Centers
Landscape of Quality Measurement

- Historically a siloed approach to quality measurement
  - Different measures and reporting criteria within each quality program
- No clear measure development strategy
- Heavy on Process Measures
- Diffusion of focus – too much “noise”
- Confusing and Burdensome to stakeholders
- Burdensome to CMS with stovepipe solutions to quality measurement
CMS framework for measurement maps to the six National Quality Strategy priorities

- Measures should be patient-centered and outcome-oriented whenever possible
- Measure concepts in each of the six domains that are common across providers and settings can form a core set of measures
CMS Vision for Quality Measurement to Drive High Value Healthcare

• Align measures with the National Quality Strategy and Six Measure Domains – fill critical gaps in these domains

• Develop measures meaningful to patients and providers, focused on outcomes (especially patient-reported outcomes), safety, patient experience, care coordination, appropriate use, and cost

• Prioritize “cross-cutting” measures that are applicable to populations, may be disease-agnostic (function, symptom management, QoL)

• Align measures across CMS programs whenever possible – also with states, private payers, boards, etc.

• Parsimonious sets of measures; core sets of measures

• Removal of measures that are no longer appropriate (e.g., topped out, lack of performance variation)
Focusing on Outcomes

Focusing on the end results of care and not the technical approaches that providers use to achieve the results

Measure 30 day mortality rates, hospital-acquired infections, etc...

Allows for local innovations to achieve high performance on outcomes
Challenges in Measuring Performance

Determining indicators of outcomes that reflect national priorities

Recognizing that outcomes are usually influenced by multiple factors

Determining thresholds for ‘good’ performance

Recognizing that Process Measures don’t always predict outcomes
Principles for Measure Development in the Future Payment Environment

• Measures should explicitly align with the CMS Quality Strategy and its goals and objectives.

• Measures should address a performance gap where there is known variation in performance, not just a measure gap.

• Patient/caregiver input is equally important to provider input in the development of measures.

• Measure developers should collaborate with other developers freely, and share best practices/new learnings.
Principles for Measure Development (cont’d)

• Reorient and align measures around patient-centered outcomes that span across settings – move away from narrow setting-specific snapshots.

• Develop measures meaningful to patients/caregivers and providers, focused on outcomes (including patient-reported outcomes), safety, patient experience, care coordination, appropriate use, and cost.

• Monitor disparities and unintended consequences.
Critical Challenges in Measure Development

- Defining the right outcome/performance gap
- Engaging patients in the measure development process
- Advancing the science for critical measure types: PROMs, resource use, appropriate use, etc.
- Robust feasibility, reliability and validity testing
- Developing measures that reflect and assess shared accountability across settings and providers
- Reduction of provider burden and cost to reporting measures
- Length of time it takes to develop measures
How does CMS determine which measures to use/develop?

- **MedPAC recommendations (from 2014 report)**
  - Reduce process measures
  - Add population-based outcome measures, CAHPS family
  - Add Appropriate Use measures
  - Administrative claims and EHR-based data sources

- **Measure Applications Partnership**
  - Same as MedPAC recommendations
  - Specific measure gaps; families of measures

- **Expert panels**
  - Patients/caregivers, National clinical and methods experts
  - Data analytics

- **CMS Quality Strategy Objectives**
Evolution of the CMS measure portfolio

• Hospital programs
  – Removed several “topped out” process measures
  – In HVBP, weighted more heavily outcome, patient experience and safety measures

• Physician programs
  – Proposed removal of 73 measures – almost all process measures that are topped out or low bar
  – Proposed addition of 28 measures – more outcomes, safety, etc.
  – Proposed requirement to have clinicians report on 2 of 18 “cross-cutting” measures
ACO Measures: Current State

ACO Quality Performance Standard made up of 33 measures intended to do the following:

• Improve individual health and the health of populations while lowering costs
• Address quality aims such as prevention, care of chronic illness, high prevalence conditions, patient safety, patient and caregiver engagement and care coordination
• Monitor for unintended consequences including over- and under-use of services
• Align with other incentive programs like PQRS and EHR
• Exhibit sensitivity to administrative burden
ACO Measures: Current State

• Total of 33 measures
  – 7 CAHPS measures (patient experience)
  – 4 Administrative claims/data measures
    • Readmissions, ambulatory care sensitive condition admissions, meaningful use of EHRs
  – 22 Web Interface measures (preventive care, at-risk populations)
    • Screening
    • Diabetes, Heart Failure, HTN
    • Frail elderly (medication reconciliation, falls)
ACO measures: 2014 proposals (immediate future state)

- Remove 7 process measures – guideline changes, redundant with other measures
- Add 4 claims-based population outcome measures
  - SNF readmissions
  - All-cause unplanned admissions for patients with:
    - Diabetes
    - Heart Failure
    - Multiple Chronic Conditions
- Patient Reported Outcome Measure: Depression Remission at 12 months
Recommendations for Improving Accountable Care Measurement

1. Identify and Prioritize Measure Gaps
   - Traditional approaches
   - Rapid cycle data analytics

2. Use Alternative Measurement Approaches
   - Global outcome measures for accountability
   - Layered Measures

3. Use the most Meaningful Measure Types
   - Balance of cross-cutting and disease specific measures
   - Patient Experience, use of PROMIS, other tools

4. Address Barriers to Measurement

5. Assess Opportunities to Continuously Improve
   - Still room for improvement
   - Data analytics
Future Vision

• Technology and innovation focused on eliminating patient harm
• Best practices spread rapidly
• Payment and incentive systems reward eliminating harm and improved patient outcomes
• Electronic health records, monitoring, and data analytics utilized to drive improvement
• Learning from other industries (e.g., reliability science, LEAN, etc) applied to health care
• Systems redesign achieves better health, better care, and lower costs through improvement
Contact Information

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