CMS Quality Measurement and Value Based Purchasing Programs

Kate Goodrich, MD MHS
Director, Quality Measurement and Health Assessment Group, CMS

American Urological Association
Quality Improvement Summit
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• Overview of CMS and Three Part Aim
• Early Results from Quality Initiatives
• CMS Quality Measurement Strategy
• PQRS and Value Based Purchasing for Physicians
• Future State
Size and Scope of CMS Responsibilities

• CMS is the largest purchaser of health care in the world.
• Combined, Medicare and Medicaid pay approximately one-third of national health expenditures (approx $800B)
• CMS programs currently provide health care coverage to roughly 105 million beneficiaries in Medicare, Medicaid and CHIP (Children’s Health Insurance Program); or roughly 1 in every 3 Americans
• Medicare program alone pays out over $1.5 billion in benefit payments per day and answers about 75 million inquiries annually
• Millions of consumers will receive health care coverage through new health insurance programs authorized in the Affordable Care Act
Quality Measurement and Health Assessment Group

- 4 divisions (ambulatory care, hospital, post-acute care, Program management support) and about 85 staff
- Implement 12 quality and public reporting programs, and support 17 others
- Partner with external stakeholders to align measures across public and private sectors
- Lead development of the quality measures and the CMS quality strategy
- Provide measure support to the Innovation Center, Exchanges, Medicaid and many others
Lean Culture Change

Manager Commitment
Priority – Part of Daily Work
Aligned to Strategic Objectives
Recognition

5-10% Improvement

30-40% Improvement
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
Four Years Later - Affordable Care Act
Early Example Results

• Cost growth leveling off - actuaries and multiple studies indicated partially due to “delivery system changes”

• But cost and quality still variable

• Moving the needle on some national metrics, e.g.,
  – Readmissions
  – Line Infections

• Increasing value-based payment and accountable care models

• Expanding coverage with insurance marketplaces and Medicaid
Reducing Early Elective Deliveries Nationally: Improvement from Baseline

Source: August 2013 HEN Submissions. Baseline and Current time periods vary by HEN.
Results: Medicare Per-Capita Spending Growth at Historic Low

Source: CMS Office of the Actuary, Midsession Review – FY 2013 Budget
Medicare All Cause, 30 Day Hospital Readmission Rate

Source: Office of Information Products and Data Analytics, CMS
CLABSI National Rates

Quarters of participation by hospital cohorts, 2009–2012

41% Reduction

1.133

CLABSIs per 1,000 central line days
Transformation of Health Care at the Front Line

- At least six components
  - Quality measurement
  - Aligned payment incentives
  - Comparative effectiveness and evidence available
  - Health information technology
  - Quality improvement collaboratives and learning networks
  - Training of clinicians and multi-disciplinary teams

Source: P.H. Conway and Clancy C. Transformation of Health Care at the Front Line. JAMA 2009 Feb 18; 301(7): 763-5
Quality Measurement Strategy
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>
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<tr>
<td>• EHR Incentive Program</td>
<td>• Medicare and Medicaid EHR Incentive Program</td>
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<td>• PPS-Exempt Cancer Hospitals</td>
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<td>• Inpatient Psychiatric Facilities</td>
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<td>• Outpatient Quality Reporting</td>
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<td>• Ambulatory Surgical Centers</td>
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Historically a siloed approach to quality measurement
  – Different measures and reporting criteria within each quality program
• No clear measure development strategy
• 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**

**Clinical quality of care**
- Care type (preventive, acute, post-acute, chronic)
- Conditions
- Subpopulations

**Person- and Caregiver-centered experience and outcomes**
- Patient experience
- Caregiver experience
- Preference- and goal-oriented care

**Care coordination**
- Patient and family activation
- Infrastructure and processes for care coordination
- Impact of care coordination

**Population/ community health**
- Health Behaviors
- Access
- Physical and Social environment
- Health Status

**Safety**
- All-cause harm
- HACs
- HAIs
- Unnecessary care
- Medication safety

**Efficiency and cost reduction**
- Cost
- Efficiency
- Appropriateness
CMS Vision for Quality Measurement

- Align measures with the National Quality Strategy and Six Measure Domains
- Implement measures that fill critical gaps within the 6 domains
- Develop measures meaningful to patients and providers, focused on outcomes (including patient-reported outcomes), safety, patient experience, care coordination, appropriate use, and cost
- Align measures across CMS programs whenever possible
- Parsimonious sets of measures; core sets of measures
- Removal of measures that are no longer appropriate (e.g., topped out or process distal from outcome)
- Align measures with states, private payers, boards and specialty societies
Three Categories of CMS Programs

Pay-for-Reporting
• Provider incentivized for to report information.

Pay-for-Performance
• Provider incentivized to achieve targeted threshold or clinical performance

Pay-for-Value
• Incentives linked to both quality and efficiency improvements.
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
Physician Quality Reporting System
2014 Measure Reporting Methods

- **EHR Reporting** for group practices and individuals
- **Certified Survey Vendor Option** for purposes of reporting the CG-CAHPS measures, available to group practices that register to participate in the Group Practice Reporting Option (GPRO)
- **New Qualified Clinical Data Registry (QCDR)** reporting option
- **Traditional PQRS Registry** reporting option
- **CMS Web Interface** for group practices of 10 or more
- **“G code” claims** (phasing out)
Qualified Clinical Data Registries (QCDRs)

- A QCDR must collect medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. The following functions are required:
  1. Submit quality measures data or results to CMS
     - Must have in place mechanisms for the transparency of data elements, specifications, risk adjustment models, and measures. Must include at least 1 outcome measure.
  2. Submit to CMS quality measures data on multiple payers
  3. Provide timely feedback to physicians
  4. Possess benchmarking capacity
- Many specialties developing registries to meet these requirements
Measures for Urologists

• Many measures in the PQRS program available for general and sub-specialty surgeons
• However, breadth of surgical practice not covered
• QCDRs likely to be an attractive option for surgical sub-specialists
• CMS encouraging developers of surgical measures to include codes for other specialties such as anesthesiology where appropriate
• **CMS is most interested in short and longer term outcome measures of safety, function, appropriate use of technology and quality of life**
• CMS interested in implementing S-CAHPS
Value Based Purchasing
Value Based Purchasing

• Measuring and reporting comparative performance

• Paying Providers differentially based on performance

• Designing Health Benefit Strategies and incentives to encourage individuals to select high value providers and better manage their own care.
Value-Based Purchasing

• Goal is to reward providers and health systems that deliver better outcomes in health and health care at lower cost to the beneficiaries and communities they serve.

• Five Principles
  - Define the end goal, not the process for achieving it
  - All providers’ incentives must be aligned
  - Right measure must be developed and implemented in rapid cycle
  - CMS must actively support quality improvement
  - Clinical community and patients must be actively engaged

VanLare JM, Conway PH. Value-Based Purchasing – National Programs to Move from Volume to Value. NEJM July 26, 2012
FY 2014 HVBP Domains

Weighted value of each domain

- Outcomes domain (25%)
- Patient experience domain (30%)
- Clinical process of care domain (45%)

- FY 15 adding efficiency domain (20%) with total cost per beneficiary for admissions; increase outcomes to 30%, decrease process to 20%
- FY16 and 17 – more outcomes weighting and safety measures, align with NQS domains
Other Value Based Programs

• Starting in Oct 2012, hospitals with excess risk adjusted Medicare readmissions had payments reduced (5 conditions proposed for FY15)

• Payment reductions for hospitals in bottom quartile of healthcare acquired conditions starting Oct 2014
  – Finalized 2 domains: healthcare acquired infections (65% weight) and healthcare acquired conditions (35% weight)
  – Need to move beyond claims-based HAC measures over time
Physician Reporting Programs

- Principle of report once and receive credit for all programs: Physician Quality Reporting System, Physician Value-Based Modifier, EHR Incentive Meaningful Use, and ACO if applicable
- Need to have more measures applicable to hospital medicine
- Increased registry reporting and deeming concept
- Physician value modifier starts in 2013 (groups of 100 or more) and by 2017 adjusting all Medicare payments to physicians based on quality and cost
What is the Physician Value-Based Modifier?

• VM assesses both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule
• Implementation of the VM is based on participation in the Physician Quality Reporting System (PQRS)
• For payment in 2015 (2013 measurement year), we will apply the VM to groups of physicians with 100 or more physicians
  • In 2016 we will apply to groups of 10 or more (2014 measurement)
  • In 2017 we will apply to all physicians (2015 measurement)
• Must be budget neutral
• Challenging and complex program
CMS Innovation Center
Delivery system and payment transformation

Current State –
Producer-Centered
Volume Driven
Unsustainable
Fragmented Care Systems
FFS Payment Systems

Future State –
People-Centered
Outcomes Driven
Sustainable
Coordinated Care Systems

New Systems and Approaches
- Value-based purchasing
- ACOs Shared Savings
- Episode-based payments
- Medical Homes
- State Innovation
- Data Transparency, etc
CMS Innovations Portfolio: Testing New Models to Improve Quality

Accountable Care Organizations (ACOs)
- Medicare Shared Savings Program (Center for Medicare)
- Pioneer ACO Model
- Advance Payment ACO Model
- Comprehensive ERSD Care Initiative

Primary Care Transformation
- Comprehensive Primary Care Initiative (CPC)
- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home Demonstration
- Graduate Nurse Education Demonstration

Bundled Payment for Care Improvement
- Model 1: Retrospective Acute Care
- Model 2: Retrospective Acute Care Episode & Post Acute
- Model 3: Retrospective Post Acute Care
- Model 4: Prospective Acute Care

Capacity to Spread Innovation
- Partnership for Patients
- Community-Based Care Transitions
- Million Hearts

Health Care Innovation Awards

State Innovation Models Initiative

Initiatives Focused on the Medicaid Population
- Medicaid Emergency Psychiatric Demonstration
- Medicaid Incentives for Prevention of Chronic Diseases
- Strong Start Initiative

Medicare-Medicaid Enrollees
- Financial Alignment Initiative
- Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents
What does the future look like?
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
What can you do?

- Work to **eliminate patient harm**
- Focus on the **three part aim** for the patient population you serve
- Engage in accountable care and other alternative contracts that **move away from fee-for-service to model based on achieving better outcomes at lower cost**
- Invest in the **quality infrastructure** necessary to improve
- Measure and look at your **data** – frequently
- **Innovate** on QI activities to achieve good outcomes
- **Learn and Teach** others what works
- **Relentless pursuit of improving health outcomes**
Why do we do this work?

• As a practicing hospitalist physician – I see the need for system changes
• Left a hospital medicine and academic position I loved to help foster a broader system enabling others to drive improvement
• Almost all of us have family members in the populations we serve
• The nation needs our service
• We have seen success; now the question is how do we scale and spread?
Contact Information

Kate Goodrich, MD MHS
Director, Quality Measurement and Health Assessment Group
Center for Clinical Standards and Quality
410-786-7828
kate.goodrich@cms.hhs.gov