Consumer-Purchaser DISCLOSURE PROJECT

Improving Health Care Quality Through Public Reporting of Performance

# CMS Roadmaps for Quality Measurement, Resource Use and Promoting Value in Medicare: Charting a Path that Could Support Transformation in Health Care

### February 2009

The Centers for Medicare and Medicaid Services (CMS) recently released three "roadmaps" to promote lower-cost, high-quality care in the traditional fee-for-service-based Medicare program. These roadmaps describe CMS' quality measurement, resource-use measurement, and value-driven healthcare efforts and are summarized below in more detail.

Overall, the three roadmaps highlight both how far Medicare has come, as well as how far we have to go to transform Medicare, and all of health care, into systems that base reimbursements and priorities on the value of services provided to patients — measured by both the quality and cost – rather than on the quantity of services delivered. To achieve that transformation, CMS needs more than roadmaps. CMS needs additional direction from Congress to change how it measures the performance of clinicians and others that contract with Medicare, how it pays for care and how it shifts it priorities to focus both on preventing disease and assuring those who need care the most get the right care at the right time. Congress and the new administration need to be bold while being thoughtful.

Many consumer, labor and employer organizations have strongly advocated the types of measurement, public reporting, and purchasing innovations described in these three reports. In many ways, the reports mark important steps toward CMS – in its own words – transforming itself "*from a passive payer of services into an active purchaser of higher-quality, affordable care*." The documents, however, also underscore the work-in-progress nature of the efforts to transform Medicare. There is much work ahead for CMS, the administration, Congress and all those who care about promoting higher quality and more affordable care to ensure we proceed down the right roads. These roadmaps are important tools both for how they chart the path forward, and for how they highlight areas where CMS and the nation need greater clarity on how to proceed.

## ROADMAP FOR QUALITY MEASUREMENT IN THE TRADITIONAL MEDICARE FEE-FOR-SERVICE PROGRAM

**http://www.cms.hhs.gov/QualityInitiativesGenInfo/downloads/QualityMeasurementRoadmap_OEA1-16_508.pdf or click HERE**

The *Roadmap for Quality Measurement in the Traditional Medicare Fee-for-Service Program* provides an inventory of the current and future performance measures CMS is using to assess physicians, hospitals and a range of important care settings; and then describes the future of quality measurement from CMS' perspective.

In cataloging current measures, CMS rightly reports that hospitals, physicians, nursing homes and others use hundreds of measures, but very few of these measures assess the actual results of the care in improving the health of patients (outcomes measures), how many resources they require or how effectively care is coordinated among health-care clinicians and settings (see Summary of Current CMS Measures on next page). In CMS' words: *"outcome, intermediate outcome, and resource use measures are currently under-emphasized,"* and *"few, if any, of the current measures encourage greater coordination of care and integration across different settings [and] they do not conceptualize care delivery across the full continuum."*

The report confirms what many people pushing for better performance measurement and reporting have long recognized: that in many areas we have only just begun to measure what matters. In these roadmaps, CMS highlights the gaps that must be filled if we are to promote better quality and more affordable care for all Americans.

*The Consumer-Purchaser Disclosure Project is an initiative that is improving health care quality and affordability by advancing public reporting of provider performance information so it can be used for improvement, consumer choice, and as part of payment reform. The Project is a collaboration of leading national and local employer, consumer, and labor organizations whose shared vision is for Americans to be able to select hospitals, physicians, and treatments based on nationally standardized measures for clinical quality, consumer experience, equity, and efficiency. The Disclosure Project is funded by the Robert Wood Johnson Foundation along with support from participating organizations.*
***For more information, contact questions@healthcaredisclosure.org or visit our website at http://healthcaredisclosure.org/.***

CMS has the correct diagnosis, and the roadmap provides part of the needed treatment plan. Now fleshing out and assuring that this plan is acted upon will be the job of the new administration, Congress and an array of public and private stakeholders that participate in the efforts to develop, endorse and get measures into the hands of those who can use them for improvement or decision-making.

Using strategies that consumers, labor, employers, and increasingly, members of the clinical community have been calling for years, CMS proposes to close these gaps by:

- Developing and using measures of health outcomes, such as whether patients with diabetes have their blood sugar under control; resource use, such as how tests or interventions are used or over-used; and the effectiveness of care coordination among the various providers who see patients both inside and outside the hospital, which can have an impact on whether patients have to be re-hospitalized;
- Developing measures for conditions with a high impact for Medicare such as heart disease, diabetes, joint disease/arthritis, cancer, renal disease, pneumonia and influenza, and chronic obstructive pulmonary disease. Taken together, these conditions reflect the bulk of Medicare spending, but as importantly, they reflect conditions that millions of Americans struggle with each day. For example, in 2005, beneficiaries with Congestive Heart Failure (CHF) accounted for 37 percent of all Medicare spending, and almost 50 percent of all hospital inpatient costs.[1] And spending by Medicare on cancer drugs alone went up 267 percent between 1997 and 2004, from $3 billion to $11 billion.[2]
- Continuing to foster measures in other important areas, such as racial and ethnic disparities, care at the end-of-life and the experience patients report with providers and the system.

CMS urges organizations that develop and endorse measures to design ways to meet the needs in these priority areas. Beyond merely seeking new measures, CMS underscores that the goal is not measurement for the sake of measurement. Rather, we need a new generation of measures to:

- Support quality improvements that will focus on evidence and results for all patients
- Be more actionable and user-friendly for patients, payers and providers; and
- Reform payments so that financial incentives reward providers that deliver better value and effectively coordinate care.

## CURRENT CMS MEASURES INVENTORY

*Source, Roadmap for Quality Measurement in the Traditional Fee-for-Service Programs, CMS, January 2009*

**Major Observations from the Consumer-Purchaser Disclosure Project:**

- **There are NO measures of efficiency or resource use for seven of the ten areas in which CMS is sponsoring measurement. In the absence of valid resource measurement it is impossible to create a "high value" health care system and foster affordability.**
- **There are hardly any outcomes or patient-centeredness measures. These measures resonate best with consumers and need to be core elements of efforts to move payments to foster improvements and reward performance that matters to patients.**
- **The large number of process measures may provide information for clinicians and other providers to improve, but few of them allow for discrimination of who is actually providing care that reflects high performance.**

| | EFFICIENCY | STRUCTURE | PROCESS | INTERMEDIATE OUTCOME | OUTCOME | PATIENT CENTEREDNESS |
|---|---|---|---|---|---|---|
| Hospital – Inpatient | 0 | 1 | 27 | 0 | 22 | 10 |
| Hospital – Outpatient | 2 | 0 | 8 | 0 | 0 | 0 |
| Physician | 0 | 0 | 143 | 5 | 3 | 0 |
| Nursing Home | 0 | 0 | 4 | 0 | 15 | 0 |
| Home Health | 0 | 0 | 0 | 0 | 12 | 0 |
| End Stage Renal Disease (ESRD) | 0 | 0 | 17 | 4 | 2 | 0 |
| Medication | 0 | 0 | 2 | 0 | 0 | 0 |
| Medicare Advantage | 4 | 3 | 33 | 6 | 2 | 6 |
| Medicare Advantage Special Needs Plan (SNP) | 0 | 0 | 5 | 0 | 0 | 0 |
| Medicare Part D | 1 | 5 | 9 | 1 | 0 | 7 |
| TOTAL | 7 | 9 | 248 | 16 | 56 | 23 |

While the report broadly charts the right course, some issues not well addressed include:

- While health outcomes are the top priority, CMS overlooks the need to measure functional status (e.g. an individual's ability to perform normal activities after treatment). This should be a priority.
- The report does not make the connection between the role health information technologies ("HIT") and electronic health records can play in fostering better performance measurement. HIT should play an integral role in making it easier to measure quality. The capacity to easily collect a growing set of performance measures should be integral to the design and implementation of these systems. At the same time, expanding the capacity of HIT to facilitate performance measurement must be linked to providing real-time feedback to clinicians providing care to support their efforts to improve.

[1] American Medical Association Press Release, November 12, 2008.
[2] Bach, Peter, MD., "Limits on Medicare's Ability to Control Rising Spending on Cancer Drugs," New England Journal of Medicine, February 7, 2009.

- The report highlights the importance of moving to episode-based measures as "the new unit of measurement," which is both an important advance and yet appears overstated. CMS and private purchasers should develop episode-based measures as one route to promote better care-coordination and reward more efficient care. At the same time, there are many questions about how to design and use these measures to assure that providers have tools to improve their care, consumers have information to make choices among clinicians or facilities, and purchasers can pay differentially to reward higher value. Episode measurement is certainly one part of improving performance measurement, but there remains much work to do in other fronts as well.
- By limiting the roadmap to "Traditional Medicare Fee-for-Service," the report fails to address the need for CMS to promote better alignment both across public programs and with the private sector. We need roadmaps that build coordinated multi-lane "measurement freeways," not independent and uncoordinated paths going in different directions. The need for alignment between public and private sectors is critical if we are going to transform health care in America.

**Overall "take home" for CMS' *Roadmap for Quality Measurement in the Traditional Fee-for-Service Program*:** CMS rightly views quality measurement as the cornerstone of transforming health care and acknowledges its role in fostering development of better measures and using those measures to foster improvement. The report's commitment to quality measurement as a "tool to support quality improvement programs, improve transparency, and enhance value, ultimately resulting in better care" is not only laudable but an essential recognition of the fact that performance measurement is the foundation for virtually all efforts to improve health care. The real accolades, however, will come when the roadmap has been implemented and consumers, purchasers, clinicians and other providers actually have information they can use to foster improvements in quality and affordability. That will take more than a roadmap; it will take dedicated resources and clear follow-through.

## MEDICARE RESOURCE USE MEASUREMENT PLAN

**http://www.cms.hhs.gov/QualityInitiativesGenInfo/downloads/ResourceUse_Roadmap_OEA_1-15_508.pdf or click HERE**

The good news about the *Medicare Resource Use Measurement Plan* is that it was produced at all. Without valid and accepted measures of how well the health care system deploys resources, from doctor visits and imaging tests to hospitalizations, it will be impossible to get to a global measure of value – that is, a measure of both the quality *and* cost of care.

The report supports measuring resource use with a method anchored in episode-based measures of care. As such, it is not truly a roadmap for measuring resource use; rather, it is a description of how CMS is proceeding on one particular type of measure. Within the description of episode measurement, the report rightly defines resources as "program costs to both Medicare and the beneficiary, rather than costs to the provider."

The report summarizes the results of research CMS has commissioned, which highlights some of the issues that any measurement effort must address, such as how patients are attributed to providers when they see multiple providers; how physicians are scored and compared; the sample size necessary to get an accurate snapshot, and how scores are adjusted for risk factors such as the severity of an illness.

However, the conclusions here do not do not reflect complementary efforts to test and address the measurement of resource use in the private sector. Similarly, the report describes ways that CMS could address the "need to balance the precision of the metrics with the manner they will be used," but in doing so it raises as many questions as it answers.

Some of the issues raised by this report include:

- While the other two reports discuss the purpose of measurement – to support quality improvement, provide transparency to clinicians, consumers, purchasers and others, and align payment with value – the connection between these goals and the resource-use measures is never articulated. For example, the report only discusses providing "confidential" feedback to physicians about resource use, which hardly fosters transparency for consumers.
- By focusing solely on episodes that cut across providers and settings, the report leaves unanswered where accountability – or even attribution – should fall. Who should be responsible for improvement? Who should be rewarded for better care? The report doesn't even ask these questions, let alone provide a path to answer them.
- There is no reference to the need to bridge public- and private-sector efforts to promote alignment of measurement.

- The report ignores a fundamental purpose for developing resource-use measures – to create a "common currency" that can support price transparency to enable better choices and better payment.
- Finally, and most troubling, is that instead of delivering a roadmap for getting resource measures of various types in use to promote more affordable care, the report details next steps as a continued series of research contracts with no foreseeable end in sight.

**Overall "take-home" for CMS' *Medicare Resource Use Measurement Plan*:** The fact that CMS is focusing on resource use is indeed good news. This report, like CMS' report on quality measurement in general, does a good job in diagnosing the problem, stating "in a time when the demand and cost of services is rising far faster than the resources available to pay for those services, identifying efficient care patterns is critical to any strategy to decrease the rate of growth and maximize the value of services provided." The treatment plan, however, is far less clear. Medicare beneficiaries and tax-payers need more than a "plan to research" resource use measurement. CMS needs to clearly articulate its plan to integrate resource use measurement into its performance improvement, public reporting and payment reform efforts.

## ROADMAP FOR IMPLEMENTING VALUE-DRIVEN HEALTHCARE IN THE TRADITIONAL MEDICARE FEE-FOR-SERVICE PROGRAM

**http://www.cms.hhs.gov/QualityInitiativesGenInfo/downloads/VBPRoadmap_OEA_1-16_508.pdf or click HERE**

The *Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program* is not really a roadmap to the future but an inventory of what CMS has done or is doing in Medicare to support purchasing based on quality and cost -- also known as value-based purchasing. CMS has done important work in building a foundation for implementing value-based purchasing. Over 22 activities are chronicled in the report, including:

- Pay-for-reporting initiatives (for hospitals, physicians [PQRI] and home health)
- Developing plans to implement broad-scale value-based purchasing programs (for hospitals and a plan for physicians due May 2010)
- Not paying for preventable conditions acquired during hospitalization
- Instituting demonstration projects (including pay-for-performance in hospitals, home-health and nursing homes, Physician Group Performance [PGP], medical homes, Acute Care Episode [ACE])
- Implementing incentives for e-prescribing

In the report, CMS describes its plans to work "within the currently established payment structure" with the multiple constraints that entails, such as putting doctors and hospitals in separate silos when it comes to payment. At the same time, CMS has tried to create bridges across the silos as evidenced by its work in health care-acquired conditions and the exploration of gain-sharing between hospitals and physicians.

CMS has submitted a report to Congress on hospital value-based purchasing and is waiting for action from Congress to proceed. For recommendations from 22 consumer, labor, and purchaser organizations on how this should be implemented go to: http://healthcaredisclosure.org/docs/files/CPDPMedicareHospital_VBPrecs4-19-07.pdf.

Additionally, CMS will be submitting a plan to Congress on physician value-based purchasing in 2010. Twenty consumer, labor, and purchaser organizations provided suggestions in the areas of measurement, incentives, data, and public reporting: http://healthcaredisclosure.org/docs/files/CPDPMedicareMD_VBPrecs12-16-08.pdf.

**Overall "take-home" on CMS' *Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for Service Program*:** Rather than a roadmap, this report is an inventory of existing programs which underscores the fact that the new administration and Congress must chart a path forward that continues to transform Medicare, and the entire health care system, to be centered around meeting patients' needs for high quality affordable care.