Volume 7, Issue 12 December, 2016

Accountable Care NEWS

CMS' New Quality Measures: Is Your Organization Ready?

by Thomas Graf, M.D., FAAFP, and Cynthia Bailey

With the introduction of universal quality measures, the Centers for Medicare & Medicaid Services (CMS) has paved the way for a true quality revolution. The new metric sets, introduced in February, are an important step toward consistency in measuring, evaluating and comparing quality and health outcomes—critical functions in an increasingly value-based environment. The stakes will be high for provider organizations, clinicians and patients as the measures are used to assess and publicize performance, and determine financial rewards and penalties based on quality outcomes (MACRA's Physician Payment program promises an 18% year four differential in physician payments, with funds flowing from low performers to high performers).1

Leading health systems recognize that differentiating themselves based on quality performance will be critical in this new era; they are preparing by assessing their existing quality infrastructure and measurement/reporting systems and by developing comprehensive, systemic approaches to effectively integrate the new measures and improve quality performance overall.

Understanding CMS' Quality Measures

The national quality metrics were developed by the CMS-led Core Quality Measures Collaborative, with participation from the National Quality Forum (NQF), America's Health Insurance Plans (AHIP), national medical societies, employers and consumer groups in a collaborative effort to design and implement a standard set of quality metrics across payers. Expected benefits include simplified data collection and reporting for providers, reduced costs and more meaningful metrics for patients and physicians.

The initial sets assess quality performance across seven clinical areas:

1. Accountable care organizations (ACOs), patient-centered medical homes (PCMHs) and primary care
2. Cardiology
3. Gastroenterology
4. HIV and hepatitis C
5. Medical oncology
6. Obstetrics and gynecology
7. Orthopedics

"As payments are increasingly tied to measurable performance levels, there will be significant revenue at stake based on an organization's ability to effectively implement and integrate the new measures."

Adoption and implementation of the new metrics are moving quickly. CMS is already using measures from each of the core sets across applicable Medicare quality programs: the Health Care Payment Learning and Action Network (HCPLAN), a public-private collaboration established by CMS, will integrate the new measures into their efforts to tie Medicare payments to quality or value through alternative payment models; and commercial health plans are adopting the measures as modifications to existing contracts or as contracts come up for renewal. The Core Quality Measures Collaborative will continue to convene to monitor implementation progress, invite broader participation and add additional measures and measure sets.

For providers, the practical and economic implications of these new measures are considerable. Decisions regarding which metrics are selected and how they are defined and reported will impact how clinicians and health systems organize and resource care delivery and how they are evaluated by payers and patients. As payments are increasingly tied to measurable performance levels, there will be significant revenue at stake based on an organization's ability to effectively implement and integrate the new measures.

Expected Benefits and Risks for Providers

As the new metrics are implemented across the country, they will impact the what, who and how of clinical measurement. While much benefit is expected in terms of improved consistency, care and cost, there are also potential risks—particularly for small subpopulations or patients with unusual conditions that fall outside the current standards.

Continued on page 2

CMS' New Quality Measures: Is Your Organization Ready? … *continued from page 1*

Here's how the new measures might affect care delivery for patients, clinicians and provider organizations:

- "Good" vs. "best" care. Establishment of a single definition for performance across all payers would allow providers to focus improvement efforts on achieving targets that address broad population issues rather than individual payer preferences. Providers would be able to spend less time and money on data collection and metric development and more time on improving patient care and health outcomes. With consistency across payers, providers would no longer need to define the same metric in multiple ways in internal systems (e.g., a patient's blood pressure considered "in control" at 130/80 for payer A, 130/90 for payer B and 140/90 for payer C).

There will be less confusion regarding what is considered "good" versus "poor" performance (e.g., for diabetes control, % of patients with Hba1c <8, vs. % of patients with Hba1c >9). However, the potential downside of this drive for consensus is that some measures may be defined at a level that reflects "good care" rather than "best care."

For example, while Hba1c >9 is easy to agree upon (no patient should have a blood sugar level that high), it might not be optimal for every patient; the optimal level could vary with factors such as age and comorbidities and would be harder to agree upon (and measure). Inevitably, there could be patients whose optimal care dictates that they have a specific target that is different than the national standard. In addition, there would likely be a lag time of a year or more before new evidence could be incorporated into endorsed measures.

- **You are what you measure.** The increased national focus on care quality and the ability to evaluate organizations on their quality performance encourages all providers to focus more aggressively on achieving higher levels of quality performance and improving patient outcomes. It will be important, however, for providers to be diligent in maintaining focus on all the essential contributors to quality care for all their patients—not just the factors or populations being measured.

  For example, it might become difficult organizationally to continue resourcing even a robust program if it does not qualify within metric sets. Leadership must continue to emphasize critical areas (e.g., end-of-life care) that might not be part of the initial core measure sets. In addition, patients who are part of a small subpopulation, such as patients with inflammatory breast cancer or congenital heart disease who may never be part of this program—still need improved quality.

- **Translating metrics to meaning.** A clear and consistent understanding of what the new metrics mean within the context of a broader care plan and ultimate care outcomes would be essential for patients, providers and health plans. Armed with meaningful measures of quality, patients should be better able to compare and contrast clinicians, organizations and health plans. Effective patient education regarding metric definitions, targets and performance level comparisons and how to interpret variations in quality scores would be important to support the public's ability to interpret and use the new measures and make more informed choices regarding which providers they use.

  Within health systems and provider groups, clinical and administrative leadership would need to fully understand these new measures and how they fit within their broader approach to disease management and quality performance across a system. They also would need to develop expertise in communicating the meaning of the measures to current and prospective patients as they begin to compete on quality in a way never before possible.

- **Standardization vs. customization.** Implementation of the core measure sets should result in administrative simplification and reduced time spent on data collection and reporting, thereby freeing up providers to focus on actual performance improvement. A universal, single set of metrics would give providers clarity around specific targets and help focus their improvement efforts. Disagreement regarding particular metrics, however, might become more difficult for individual clinicians or physician groups to resolve if there is reduced flexibility for local customization. Some physicians may question the validity of some of the measures handed down from a national board; they might be concerned about loss of autonomy and decision-making power regarding how best to care for their patients. With potential income and professional reputation at stake, physicians might question how these measures would be tracked and monitored and how/if appropriate variances would be accepted.

  "Physicians and other clinicians might become frustrated by a flavor-of-the-month expansion of "quality" initiatives... Real advances could only be achieved through a comprehensive, outcomes-focused approach that effectively integrates data sources, reporting and management across the system to improve the health of a population."

- **Managing the measures.** As more and more measures are introduced over time, health systems might struggle to effectively focus on and manage all the different components. In the absence of a well-developed, thoughtful approach, organizations might find themselves chasing the latest measure in a reactionary (rather than proactive) way. This type of one-off approach could lead to a massive commitment of organizational resources with high potential for overlap, duplication and conflicting goals that could sap resources and divert attention from other worthy endeavors that actually better advance the health of the population.

Continued on page 3

CMS' New Quality Measures: Is Your Organization Ready? … *continued from page 2*

Physicians and other clinicians might become frustrated by a flavor-of-the-month expansion of "quality" initiatives. This frustration could easily add to the burnout and disengagement of medical professionals, who are struggling to meet administrative demands that are multiplying exponentially. Real advances could only be achieved through a comprehensive, outcomes-focused approach that effectively integrates data sources, reporting and management across the system to improve the health of a population.

Integrating the New Measures: Next Steps for Providers

The new measurement system represents an opportunity for health systems to assess and further develop their existing quality performance infrastructure and capabilities and to deepen their engagement with patients. Organizations would benefit from a comprehensive approach that is outcomes-focused and integrates the new measures across the full continuum of care and within the context of the broader condition management program. A specific action plan, with detailed work steps, timeframes and accountabilities, could help organizations move forward with their assessment and improvement plans.

Key steps should include:

1. **Understanding the new CMS measures and their implications.** It will take some time for providers to fully understand the new measures within the context of their population(s), community and existing condition management programs and the likely impact on their programs, clinicians and patients. The metrics would need to be thoughtfully integrated into the current measurement system; needed changes and modifications would need to be identified and addressed. Organizations would benefit from a broad, systemic approach; if providers simply implement individual metrics one-by-one, they risk redundancies, inconsistencies and missed opportunities for true quality improvement. The focus must remain on ultimate care outcomes—both achieving and demonstrating superior quality performance.
2. **Developing physician and administrative leaders to champion the effort.** Strong leadership is essential to guide the organization toward superior quality performance. Physician and administrative leaders who can understand, translate and communicate data and reports to their colleagues would go a long way toward aligning the organization and building forward momentum. An effective and well-respected chief quality officer with a broad vision for quality improvement across the organization and an ability to bring people on board could help the organization to view change as a welcomed opportunity.
3. **Expanding a quality infrastructure, as needed.** Given the heightened requirements to demonstrate quality performance, many organizations would need to expand their ability to capture and robustly report quality performance data and to engage a larger variety of clinical teams in required care redesign. Early and comprehensive assessment of an organization's current process from data capture through deployment and iteration of new care processes would be critical. Additional staff and knowledge/skillsets might be required for the quality and transformation teams to conduct multiple, simultaneous program redesigns with diverse clinical teams. Reassigning and retraining staff from previously payer-specific, reporting and management functions would help offset some of these needs and provide coordination across work streams.

   "Early and comprehensive assessment of an organization's current process from data capture through deployment and iteration of new care processes would be critical."
4. **Getting IT involved early.** Implementing the new metric sets would, in most cases, require updating of measurement and reporting systems. It would be important, for example, to be able to view outcomes across all age groups rather than by payer as is currently common. Bringing IT in early would ensure there is enough time for thoughtful design and implementation of a system-wide program (through internal systems or external partnerships) to ensure an organization has the capability to monitor, report and respond to measurement as a broad system; these can no longer be isolated, department-by-department programs.
5. **Engaging and educating patients.** Patients will likely require education and support in understanding and making sense of the new metrics. It would be important for patients to see how the measures fit together and are relevant for their particular condition(s). Figuring out the best ways to communicate or display outcomes data would help providers engage patients around their own health and well-being and inform careful assessment of the care they are receiving.

With the development and unveiling of the core measure sets, CMS has paved the way for quality performance differentiation to directly drive payment; the MACRA 18% differential in physician payments based on quality is just the beginning of a true quality revolution. A comprehensive quality improvement program could help organizations compete successfully in an era of accountability for quality and cost. The work to reliably deliver measurably better care is challenging and has a long lead time from conception to results. Moving quickly and intentionally to improve and demonstrate superior quality performance will create a durable advantage for providers in an increasingly competitive and value-based environment.

[1] "Quality Payment Program." Centers for Medicare and Medicaid Services. Accessed Dec. 12, 2016.

Thomas Graf, M.D., FAAFP, is national director of population health management for The Chartis Group. Cynthia Bailey is manager, Chartis Physician Leadership Institute. They may be reached at tgraf@chartis.com and cbailey@chartis.com.

