Linking Quality Measurement to Interventions: the Role of CMS

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CMS Plans for Transforming the payment system

CMS ROADMAPS OVERVIEW

- Roadmap for Quality Measurement in the Traditional Medicare Fee-for-Service Program
- Roadmap for Resource Use Measurement in the Traditional Medicare Fee-for-Service Program
- Roadmap for Implementing Value Based Purchasing in the Traditional Medicare Fee-for-Service Program
1. Selected Examples
   A. PQRI Program
   B. MIPPA Section 185
   C. QIO Program: Care Transitions Theme

2. Recommendations
Physician Quality Reporting Initiative (PQRI)

A Brief Overview
Physician Quality Reporting Initiative (PQRI)

The 2006 Tax Relief and Health Care Act (TRHCA: P.L. 109-432):

• Authorized establishment of a physician quality reporting system, “2007 PQRI”
• Included 1.5% incentive payment for satisfactory reporting quality data on covered professional services furnished to Medicare beneficiaries July 1, 2007 - December 31, 2007
2007 PQRI

• 74 clinical measures
• Consensus developed and endorsed
• Applicability depends on services rendered, not designated specialty
• Measures posted on website
  www.cms.hhs.gov/PQRI
2008 PQRI

- Published in 2008 Physician Fee Schedule (PFS) Rule November 2007
- 119 measures
  - 117 clinical measures
  - 2 structural measures
- Structural measures apply broadly across specialties and disciplines
  - EHR
  - eRx
2009 & 2010 PQRI

• MIPPA (2008):
  – Continues PQRI indefinitely
  – Increased incentive from 1.5% to 2.0%
• 153 measures
  – 18 measures through registries
  – Total of 7 measures groups now
• Choice of:
  – Two reporting periods
  – Claims-based or registry-based reporting
  – Choice of individual measures or measures groups
• 2010 PQRI program is determined by rule-making process for 2010 Physician Fee Schedule
Measures Groups

4 Clinically Related Measures Groups 2008 PQRI:

- Diabetes
  (5 measures)
- End Stage Renal Disease (ESRD)
  (4 measures)
- Chronic Kidney Disease (CKD)
  (4 measures)
- Preventive Care
  (9 measures)

For 2009, add: CABG, RA, Perioperative Care, Back Pain
Additional PQRI Resources

For more information on PQRI, see:
http://www.cms.hhs.gov/pqri
MIPPA Section 185

• Medicare Improvements for Patients and Providers Act (P.L. 110-275)
• Passed in July 2008
• Required CMS to specifically address quality reporting by race and ethnicity
Generating Medicare Physician Quality Performance Measurement Results (GEM) Project Summary

• Project Goal:
  – Generate & post performance information on healthcare services provided to Medicare beneficiaries using Medicare Fee For Service (FFS) administrative data.
  – Focused on 12 HEDIS ambulatory care measures.

• Data Sources
  – Medicare Part A, Part B and Part D claims
  – Standard Data Processing System (SDPS) database containing national enrollment, physician UPIN, and other tables derived from the Medicare Enrollment Database (EDB) and Part D Enrollment database
  – Data can include information on race & ethnicity (EDB)
  – Data analyzed for calendar years 2005-2007
• **Project Output:**
  - Performance results for the 12 measures were calculated and posted ([www.cms.hhs.gov/gem](http://www.cms.hhs.gov/gem)) for 2 measurement years: 2006 & 2007.
  - For each of the 12 measures, the following results were posted along with supporting technical documentation describing how the results were calculated:
    - Population based national benchmarks
    - Population based state benchmarks
    - Population based zip code level rates, if cell size requirements were met
    - Medical group practice performance rates

• It should be possible to compare these group practice performance rates to comparable MA plan geographic areas
Quality Improvement Interventions: the QIO Program

- QIO 9th Contract Cycle began 1 August 2008
- Incorporates all major principles of re-design as outlined in the 2006 IOM report
- Four projects illustrate our new attention to health care disparities:
  - Core Prevention
  - CKD
  - “Focused Disparities” (Diabetes)
  - “Care Transitions” (reduce hospital re-admissions)
Brief Overview of the QIO Care Transitions Theme

• To measurably improve the quality of care for Medicare beneficiaries who transition among care settings through a comprehensive community effort; and

• To reduce readmissions following hospitalization and to yield sustainable and replicable strategies to achieve high-value health care for sick and disabled Medicare beneficiaries.
Community Characteristics

• The Care Transitions Theme was awarded to 14 QIOs in 14 unique communities; these are:
  – Tuscaloosa HRR (AL)  
  – NW Denver (CO)  
  – Miami (FL)  
  – North-Central Georgia (53 zip codes)  
  – Evansville (IN)  
  – Baton Rouge (LA)  
  – Greater Lansing Area Community (MI- 40 zip codes)  
  – Omaha (NE)  
  – Whatcom County (WA)  
  – Harlingen HRR (TX)  
  – Providence (RI)  
  – Western Pennsylvania  
  – Upper Capital Region (NY- 84 zip codes)  
  – SW New Jersey
Baton Rouge (LA)

Providers:
• Hospitals – 5
• Skilled Nursing Facilities – 4
• Home Health – 7
• Zip Codes – 81
• Medicare Beneficiaries – about 90,000
• 30-day Readmission Rate – 19%
SW New Jersey

Providers:
• Hospitals – 2
• Skilled Nursing Facilities – 12
• Home Health – 7
• Other - 9

• Zip Codes – 44

• Medicare Beneficiaries – about 95,000

• 30-day Readmission Rate – 20%
Providence (RI)

Providers:
- Hospitals – 7
- Skilled Nursing Facilities – 58
- Home Health – 20

- Zip Codes – 41
- Medicare Beneficiaries – about 18,000
- 30-day Readmission Rate – 20%
Community Characteristics (QIO Care Transitions Summary)

Providers:
• Hospitals – 70
• Skilled Nursing Facilities – 278
• Home Health – 316
• Other - 89

• Zip Codes – 666

• Medicare Beneficiaries – over 780,000
• Total Number of 30-day Readmissions Avoided if goal is met: 2,500
## Opportunities to Address Disparities

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<thead>
<tr>
<th>Project/Disparity</th>
<th>Root Causes</th>
<th>Intervention Plans</th>
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| Project A: 16% 65+ live in poverty | Food Bank resources do not provide the nutrition required for CHF or diabetic diet. | ▪ Patient Education on Nutrition  
▪ Work with the Food Bank to supply and label heart healthy foods. |
| Project B: 21% readmissions attributable to those living in poverty. | High readmission rates for Pneumonia and low (42%) vaccination rate for Pneumonia | ▪ Patient education regarding vaccinations  
▪ Improve community and provider systems to increase pneumonia vaccinations offered. |
CMS Recommendations

• The most important quality measure information is provider specific information. Provider specific quality information is actionable.

• Benchmarking & specific quantitative goals are important, and helpful for providers.

See goals at:
www.nhqualitycampaign.org
CMS Recommendations

• A renewed attention to data accuracy and validation is needed, as payment systems are linked to quality systems.

• Measures of resource use and efficiency are very important. These include measures of:
  – Waste of resources
  – Complications
  – Adverse events
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Measuring Resource Use and Efficiency

• See www.cms.hhs.gov “CMS Highlights”
• See output of the “Physician and Hospital Resource Use Workgroup”