CMS Quality Measurement and Value Based Purchasing Programs

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

AAO/HNS Leadership Forum
March 3, 2014
Agenda

- Overview of CMS, CCSQ and QMHAG
- CMS Quality Measurement Strategy
- Measure Alignment
- Measure Selection Process
- Changes to Physician Reporting Programs
  - PQRS
  - Qualified Clinical Data Registries (QCDRs)
  - Resources
- Measures for ENT Physicians
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
Center for Clinical Standards and Quality Levers for Safety, Quality & Value

- Over 450 federal FTE’s, $1.5 billion in budget, and approximately 10K contractors focused on improving quality across the nation
- Contemporary Quality Improvement: Quality Improvement Organizations and QI initiatives (e.g. Partnership for Patients)
- Quality Measurement and Public Reporting: Hospital Inpatient Quality Reporting Program, PQRS, Post-acute care
- Incentives: Hospital Value Based Purchasing, ESRD QIP, Physician Value Modifier
- Regulation: Conditions of Participation (Hospitals, 15 other provider types) and Survey and Certification
- Coverage Decisions: coverage with evidence development, coverage for Preventative Services
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
CMS Quality Strategy

TO OPTIMIZE HEALTH OUTCOMES BY IMPROVING CLINICAL QUALITY AND TRANSFORMING THE HEALTH SYSTEM.
Our Three Aims

- Better Health for the Population
- Better Care for Individuals
- Lower Cost Through Improvement
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

INFORMATION NOT releasable to the public UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.
Foundational Principles of the CMS Quality Strategy

- Eliminate Racial and Ethnic disparities
- Strengthen infrastructure and data systems
- Enable local innovations
- Foster learning organizations
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>
</tr>
</thead>
<tbody>
<tr>
<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>
</tr>
<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>
</tr>
<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>
</tr>
<tr>
<td>• Inpatient Quality Reporting</td>
<td></td>
<td>• ESRD QIP</td>
<td>• CMMI Payment Models</td>
<td>• Medicare Part C</td>
</tr>
<tr>
<td>• HAC payment reduction program</td>
<td></td>
<td>• Hospice Quality Reporting</td>
<td></td>
<td>• Medicare Part D</td>
</tr>
<tr>
<td>• Readmission reduction program</td>
<td></td>
<td>• Home Health Quality Reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient Quality Reporting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ambulatory Surgical Centers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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
- 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

- 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
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
Measure Alignment
CMS Quality Measures Task Force

**Charge:**
Develop recommendations on CMS measure implementation with the goal of aligning and prioritizing measures across programs and avoidance of duplication or conflict among developing and implemented measures.

**Goals:**
- Establish and operationalize policies for program-specific and CMS-wide measurement development and implementation.
- Align and prioritize measures across programs where appropriate.
- Coordinate development of new measures across CMS.
- Coordinate measure implementation, development and measurement policies with external HHS agencies.
February 2012 leadership provided initial charge to align measures for:
- Hypertension control
- Smoking cessation
- Depression screening
- Hospital acquired conditions
- HCAHPS
- Care coordination (closing the referral loop)

Initial members include senior advisors from AHRQ, CMS (co-chairs), ASH, ASPE, CDC, CMS Medicare, CMS Medicaid, FDA, HRSA, IHS, NIH, OMH, SAMHSA

Convened in March, the Council meets bi-weekly and reports to the Deputy Secretary for HHS
Results to Date

• Hypertension Control
  – NQF 0018
  – MU Stage 2: percentage of patients aged 18-85 years with a diagnosis of hypertension whose blood pressure improved during the measurement period

• Smoking Cessation
  – NQF 0028, CHIPRA composite in development

• Depression Screening
  – NQF 0418 (screening with standardized tool and f/u)
  – NQF 0710 (12 month remission defined by PHQ-9 score)
  – NQF 1401 (post partum screen during child wellness visit)

• Other topics include HIV, Obesity, Peri-natal, Patient Experience, HACs

• Focused on both Retrospective and Prospective Alignment
Measure Selection Process
Measure Selection Process

Measure Implementation Cycle

- Program Staff and Stakeholders Suggest Measures
- Pre-rulemaking Assessment of Impact of Measures
- Pre-rulemaking MAP input due to HHS no later than February 1st, annually
- NPRM for each applicable program
- Public comment on Measures
- HHS implements Measures
- Measure Performance Review and Maintenance
- Pre-rulemaking measure list published by December 1st, annually

Measure Development

- Initial measure list
- Potential measures
- Candidate measures
- CMS-approved measures
- NQF-endorsed measures
Call for Measures for Physician Programs

• Traditionally has been from May to July
• Moving to a “rolling” call for measures soon
• Because of the pre-rulemaking process, there will always be a deadline for getting measures on the MUC list
• Once measures are reviewed by MAP, they do not need to be reviewed again
Measure Groups

- Can be suggested to CMS by anyone
- Must have consistent denominator populations
- Minimum of 4 measures
- Registry-based format
Physician Reporting Programs
2014 Measure Reporting Changes

• Emphasis on 2014 Incentive AND avoiding 2016 Payment Adjustment

• New satisfactorily reporting requirements via claims, registry and EHR to receive incentive: **9 measures across 3 National Quality Strategy domains** (this will also allow EPs to avoid the payment adjustment)

• Registries can report less than 9 measures for EPs to potentially receive incentive and report less than 3 measures for EPs to avoid the payment adjustment.
  – Due to this requirement, a **new registry MAV process** will be implemented

• All measures Groups reportable via **Registry Only**

• Measures Changing Reporting Options
  – EHR reporting option **removed** from 6 measures
  – EHR reporting option **added** to 11 measures
  – Claims-based reporting option **removed** from 17 individual measures
2014 Measure Reporting Changes

- **Added EHR Reporting** for group practices
- **Elimination of Administrative claims** for purposes of avoiding the 2016 PQRS payment adjustment
- **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)
  - CG-CAHPS measures are required for group practices of 100+ reporting measures via the GPRO Web Interface
- **New Qualified Clinical Data Registry (QCDR) reporting option**
Qualified Clinical Data Registries (QCDRs)

- A QCDR is a CMS-approved entity that has self-nominated and successfully completed a qualification process that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. A qualified clinical data registry must perform the following functions:
  1. Submit quality measures data or results to CMS
     - Must have in place mechanisms for the transparency of data elements, specifications, risk models, and measures.
  2. Submit to CMS quality measures data on multiple payers
  3. Provide timely feedback
  4. Possess benchmarking capacity
QCDR Requirements

• Meet minimum requirements specified in final rule
• Submit a self-nomination statement
  – Deadline: January 31
  – Deadline to submit measures information: March 31
• Submit data in an XML format
  – If reporting e-measures that are also available under the EHR Incentive Program, the entity may also submit e-measures data in a QRDA III format
QCDR Measure Parameters

- Must have at least 9 measures, covering at least 3 of the 6 NQS domains, available for reporting
- Must have at least 1 outcome measure available for reporting
- May report on process measures
- Must provide the appropriate analytical structure (i.e., numerator, denominator, denominator exceptions/exclusions, etc.)
- Must provide to CMS descriptions for the measures for which it will report to CMS by no later than March 31, 2014. The descriptions must include:
  – name/title of measures, NQF # (if NQF endorsed)
  – descriptions of the denominator, numerator, and
  – when applicable, denominator exceptions and denominator exclusions of the measure
- QCDRs must calculate the composite score for CMS and provide the formula used for calculation
Where to Call for Help

• **QualityNet Help Desk:**
  – Portal password issues
  – PQRS/eRx feedback report availability and access
  – IACS registration questions
  – IACS login issues
  – PQRS and eRx Incentive Program questions

  866-288-8912 (TTY 877-715-6222)
  7:00 a.m.–7:00 p.m. CST M-F or qnetsupport@sdps.org
  You will be asked to provide basic information such as name, practice, address, phone, and e-mail

• **Provider Contact Center:**
  – Questions on status of 2012 PQRS/eRx Incentive Program incentive payment (during distribution timeframe)
  – See **Contact Center Directory** at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

• **EHR Incentive Program Information Center:**
  888-734-6433 (TTY 888-734-6563)
Resources

- **PFS Federal Regulation Notices**
  
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html

- **CMS PQRS Website**
  
  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS

- **Medicare Shared Savings Program**
  
  http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html

- **CMS Value-based Payment Modifier (VM) Website**
  
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

- **Medicare and Medicaid EHR Incentive Programs**
  

- **Frequently Asked Questions (FAQs)**
  
  https://questions.cms.gov/

- **Physician Compare**
  
  http://www.medicare.gov/physiciancompare/search.html
Measures for ENT Physicians
## 2014 ENT Measures

<table>
<thead>
<tr>
<th>PQRS#</th>
<th>Measure</th>
<th>National Quality Strategy Domain for 2014</th>
<th>Reporting Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.</td>
<td><strong>Perioperative Care: Timing of Prophylactic Parenteral Antibiotic – Ordering Physician</strong>&lt;br&gt;Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics, who have an order for prophylactic parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours), prior to the surgical incision (or start of procedure when no incision is required)</td>
<td>Patient Safety</td>
<td>Claims, Registry, Measures Group (Periop)</td>
</tr>
<tr>
<td>21.</td>
<td><strong>Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin</strong>&lt;br&gt;Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis</td>
<td>Patient Safety</td>
<td>Claims, Registry, Measures Group (Periop)</td>
</tr>
<tr>
<td>22.</td>
<td><strong>Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)</strong>&lt;br&gt;Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral antibiotic, who have an order for discontinuation of prophylactic parenteral antibiotics within 24 hours of surgical end time</td>
<td>Patient Safety</td>
<td>Claims, Registry, Measures Group (Periop)</td>
</tr>
<tr>
<td>23.</td>
<td><strong>Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)</strong>&lt;br&gt;Percentage of surgical patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time</td>
<td>Patient Safety</td>
<td>Claims, Registry, Measures Group (Periop)</td>
</tr>
<tr>
<td>PQRS#</td>
<td>Measure</td>
<td>National Quality Strategy Domain for 2014</td>
<td>Reporting Options</td>
</tr>
<tr>
<td>-------</td>
<td>---------</td>
<td>------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>91.</td>
<td>Acute Otitis Externa (AOE): Topical Therapy: Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations</td>
<td>Effective Clinical Care</td>
<td>Claims, Registry</td>
</tr>
<tr>
<td>93.</td>
<td>Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use: Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy</td>
<td>Communication and Care Coordination</td>
<td>Claims, Registry</td>
</tr>
<tr>
<td>128.</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up: Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters: Age 65 years and older BMI &gt; 23 and &lt; 30; Age 18 - 64 years BMI &gt; 18.5 and &lt; 25</td>
<td>Community/Population Health</td>
<td>Claims, Registry, EHR, GPRO Web Interface/ACO, Measures Groups (Prev Care)</td>
</tr>
<tr>
<td>130.</td>
<td>Documentation of Current Medications in the Medical Record: Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency and route of administration</td>
<td>Patient Safety</td>
<td>Claims, Registry, EHR, Measures Groups, (Oncology)</td>
</tr>
<tr>
<td>PQRS#</td>
<td>Measure</td>
<td>National Quality Strategy Domain for 2014</td>
<td>Reporting Options</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>131.</td>
<td><strong>Pain Assessment and Follow-Up:</strong> Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present</td>
<td>Community/Population Health</td>
<td>Claims, Registry</td>
</tr>
<tr>
<td>226.</td>
<td><strong>Preventive Care and Screening: Tobacco Use:</strong> <strong>Screening and Cessation Intervention:</strong> Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user</td>
<td>Community/Population Health</td>
<td>Claims, Registry, EHR, GPRO Web Interface/ACO, Measures Groups (CAD, COPD, HF, IBD, IVD, Prev Care, HTN, Cardiovascular Prevention, Oncology)</td>
</tr>
<tr>
<td>261.</td>
<td><strong>Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness:</strong> Percentage of patients aged birth and older referred to a physician (preferably a physician specially trained in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after presenting with acute or chronic dizziness</td>
<td>Communication and Care Coordination</td>
<td>Claims, Registry</td>
</tr>
<tr>
<td>317.</td>
<td><strong>Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:</strong> Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated</td>
<td>Community/Population Health</td>
<td>Claims, Registry, EHR, GPRO Web Interface/ACO, Measures Group (Cardiovascular Prevention)</td>
</tr>
</tbody>
</table>
## 2014 ENT Measures (cont’d)

<table>
<thead>
<tr>
<th>PQRS#</th>
<th>Measure</th>
<th>National Quality Strategy Domain for 2014</th>
<th>Reporting Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>331.</td>
<td><strong>New for 2014: Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Appropriate Use):</strong> Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 7 days of diagnosis or within 10 days after onset of symptoms</td>
<td>Effective Clinical Care</td>
<td>Registry</td>
</tr>
<tr>
<td>332.</td>
<td><strong>New for 2014: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis:</strong> Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, without clavulanate, as a first line antibiotic at the time of diagnosis</td>
<td>Effective Clinical Care</td>
<td>Registry</td>
</tr>
<tr>
<td>333.</td>
<td><strong>New for 2014: Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse):</strong> Percentage of patients aged 18 years and older with a diagnosis of acute sinusitis who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis</td>
<td>Efficiency and Cost Reduction</td>
<td>Registry</td>
</tr>
<tr>
<td>334.</td>
<td><strong>New for 2014: Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse):</strong> Percentage of patients aged 18 years and older with a diagnosis of chronic sinusitis who had more than one CT scan of the paranasal sinuses ordered or received within 90 days after date of diagnosis</td>
<td>Efficiency and Cost Reduction</td>
<td>Registry</td>
</tr>
</tbody>
</table>
Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear: Percentage of patients aged birth and older referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after presenting with a congenital or traumatic deformity of the ear (internal or external)
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