

# LegalNotes

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**LegalNotes** is a regular online *Aligning Forces for Quality* (AF4Q) publication that provides readers with short, readable summaries of developments in the law that collectively shape the broader legal environment for efforts to improve quality, reduce health care disparities, and improve the transparency of price and quality information.

## Medicare Quality Measurement and Reporting Programs: Opportunities for Alliances Under Health Reform

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*These programs provide several important opportunities for Alliances.*

—See page 4 for detail

### Introduction

One of the greatest challenges currently facing the U.S. health care system is that the explosive growth in the cost of care has generally not led to higher-quality health care. Evidence from leading researchers and experts such as Elliott Fisher<sup>1</sup>, Elizabeth McGlynn,<sup>2</sup> John Wennberg and colleagues,<sup>3</sup> and Francois de Brantes and colleagues<sup>4</sup> clearly demonstrates this challenge. At the community level, the Alliances participating in the Robert Wood Johnson Foundation's *Aligning Forces for Quality* initiative are working to address this challenge using private payer and Medicaid claims data. The same disconnect between increased spending and deficiencies in quality is evident in the Medicare program as well.

Traditionally, the Medicare program has paid for health care services on a fee-for-service basis with the exception of certain services such as inpatient hospital services, services of federally qualified health centers, services of rural health clinics, skilled nursing facility care, and home health care among others, which are paid on a bundled basis, and the Medicare Advantage and Medicare Prescription Drug plans, which are paid on a capitated basis. All payment systems tend to incentivize

something. Fee-for-service programs incentivize indiscriminate increases in the volume of care, while case-based or capitation systems incentivize reductions in volume. The challenge is to promote both quality and value while also apportioning financial risk appropriately. Because Medicare has relied principally on a fee-for-service approach to payment for physician and other services (and even while certain services are paid on a bundled basis), the program has experienced incredible growth in the volume of services. At the same time, Medicare lacks a program-wide and deliberate approach to promoting quality and value.

Over the years, Congress has passed a series of laws designed to move the Medicare program from a passive purchaser of volume-based health care to an active purchaser of high-quality, high-value health care based in large part on successful Medicare demonstrations as well as examples from the work of the Alliances. For instance, as authorized under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)<sup>5</sup> and extended by the Deficit Reduction Act of 2005 (DRA)<sup>6</sup>, hospitals that report on specific quality measures receive the full annual payment update. Failure to participate results

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in a two-percent decrease in the annual payment update. Similarly, as authorized by the Tax Relief and Health Care Act of 2006 (TRHCA)<sup>7</sup> and extended by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)<sup>8</sup> and Medicare Improvements for Patients and Providers Act of 2008 (MIPPA),<sup>9</sup> physicians who report on specific quality measures are eligible for a bonus payment. More recently, the American Recovery and Reinvestment Act of 2009 (ARRA)<sup>10</sup> provided significant financial incentives to Medicare (and Medicaid) providers that “meaningfully use” electronic health records (EHRs) to improve the quality of care delivery.<sup>11</sup> The Patient Protection and Affordable Care Act of 2010 (ACA)<sup>12</sup> expanded some of these existing programs and authorized new quality measurement and reporting programs as well. These reforms, in addition to existing value-based purchasing strategies, create new opportunities for the Alliances.

## Expanded and New Medicare Quality Measurement and Reporting Programs

The ACA sets forth a broad vision for quality measurement and reporting in the Medicare program. Components of this vision are: (1) Quality Measure Development, (2) Quality Measurement (including payment incentives), and (3) Public Reporting. In short, the ACA expands existing efforts noted above while introducing new tools by which the Medicare program can identify, measure and pay for quality care.

### Quality Measure Development

*Developing Measures:* The ACA defines a “quality measure” as a “standard for measuring the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services.”<sup>13</sup> The U.S. Department of Health and Human Services (HHS) Secretary, acting through the Centers for Medicare & Medicaid Services (CMS), is required to identify gaps where no quality measures exist, as well as existing quality measures that need improvement, updating or expansion, for use in federal health care programs (including Medicare, Medicaid and CHIP). Identified gaps must be reported on a publicly available website, and the Secretary must make awards to develop, update or expand quality measures. In developing new measures, priority must be given to measures that assess outcomes, functional status, coordination of care across episodes, shared decision-making, use of health information technology, efficiency, safety, timeliness, equity and patient experience. The Secretary also is required to develop (and update) outcomes measures for acute and chronic diseases and for primary and preventative care for hospitals and physicians.

*Development of Outcome Measures:* The Secretary is also required to develop and update provider-level outcome measures for hospitals and physicians as well as for other providers as appropriate. The measures should address the five most prevalent and resource-intensive acute and chronic medical conditions and the care of distinct patient populations such as healthy children, chronically ill adults, and infirm elderly individuals.<sup>14</sup>

*Quality Measure Selection:* The ACA requires the entity selected by the Secretary to develop quality measures (currently the National Quality Forum [NQF] as authorized under MIPPA) to convene multi-stakeholder groups to provide input on the selection of quality measures and national priorities, as well as on the development of efficiency measures, through an open and transparent process.<sup>15</sup> Selected measures will be used for existing and new Medicare (as well as Medicaid and CHIP) quality reporting and payment programs described below.

### Quality Measurement

*Improvements to Physician Quality Reporting System:* The ACA re-authorizes incentive payments under the Physician Quality Reporting Program through 2014 (maximum one percent of estimated allowed charges) and institutes a penalty for failure to report beginning in 2015 (maximum two percent). The ACA also authorizes an additional incentive payment (one-half percent) for eligible professionals who satisfactorily submit data on quality measures through a Maintenance of Certification Program (such as a qualified American Board of Medical Specialties Maintenance of Certification Program). Finally, the Secretary is required to provide feedback to eligible professionals on their performance on reported quality measures and develop a plan to integrate reporting on quality measures with reporting on the meaningful use of EHRs.<sup>16</sup>

*Quality Reporting for Long-Term-Care Hospitals, Inpatient Rehabilitation Hospitals, and Hospice Programs:* The ACA establishes new quality measurement and reporting programs for these providers. Once these systems are operational, if a facility does not report selected quality measures, the facility’s annual update will be reduced by two percentage points. The quality reporting programs for long-term-care hospitals, inpatient rehabilitation hospitals, hospice programs and psychiatric hospitals will be effective beginning with fiscal year 2014. Selected measures and reporting procedures must be published by October 1, 2012.<sup>17</sup>

*Quality Reporting for PPS-Exempt Cancer Hospitals:* The ACA establishes a new quality measurement and reporting program for cancer hospitals that are exempt from the inpatient hospital prospective payment system (PPS). Once measures are operational, if a cancer hospital does not report selected quality measures, the hospital's annual Medicare market basket update will be reduced (a specific penalty not prescribed). Selected quality measures must include measures related to process; structure; outcome; patient's perspective on care; efficiency; and costs of care that relate to services furnished by a cancer hospital. The quality reporting program for PPS-exempt cancer hospitals will be effective beginning with fiscal year 2014. Selected measures and reporting procedures must be published by October 1, 2012.<sup>18</sup>

*Value-Based Purchasing Programs:* The ACA moves beyond quality measurement and reporting and requires implementation of (or plans to implement) value-based purchasing programs for several classes of providers. Value-based purchasing programs link payment rates to performance (not just reporting) on specific quality measures and/or improvements in performance. Specifically, the ACA requires the implementation of value-based purchasing programs for hospitals (other than psychiatric hospitals, rehabilitation hospitals, children's hospitals, long-term-care hospitals, and certain cancer treatment and research facilities)<sup>19</sup> and for physicians (through the use of a payment modifier).<sup>20</sup> The value-based purchasing program for hospitals will be effective beginning with fiscal year 2013.<sup>21</sup> The value-based purchasing program for physicians (through a payment modifier) will be effective beginning with calendar year 2015. In addition, the ACA requires the Secretary to develop plans to implement value-based purchasing programs for ambulatory surgery centers, skilled nursing facilities and home health services. The plans to implement value-based purchasing programs must be completed by January 1, 2011 for ambulatory surgery centers<sup>22</sup> and October 1, 2011 for skilled nursing facilities and home health services.<sup>23</sup>

*Meaningful Use of EHRs:* Existing and newly developed quality measures authorized by ARRA also will be used to determine whether participating providers are "meaningfully using" EHRs to improve the quality of care delivered and therefore qualifying for incentive payments.<sup>24</sup>

## Public Reporting

*Public Reporting of Performance Information (Physician Compare Website):* The ACA requires CMS to establish a Physician Compare website that will publicly report information on physicians and other eligible professionals who participate in the Physician Quality Reporting System. Information reported must include the quality measures collected under the Physician Quality Reporting System as well as assessments of patient health outcomes, risk-adjusted resource use, efficiency, patient experience, and other relevant information deemed appropriate by the HHS Secretary. Physicians must have a reasonable opportunity to review their results before the information is made public.<sup>25</sup> The Physician Compare website was made available as required by January 1, 2011, with quality and patient experience measures to be added by January 1, 2013.

*Public Reporting of Quality Information for Other Providers:* The newly authorized quality reporting programs for long-term-care hospitals, inpatient rehabilitation hospitals, psychiatric hospitals, hospice programs and PPS-exempt cancer hospitals also require the Secretary to make reported quality information available to the public after the providers have had an opportunity to review this information.<sup>26</sup>

## Implications for *Aligning Forces for Quality*

### Align Measures with Medicare Program

The ongoing and expanded quality measurement and reporting programs provide several opportunities for the *Aligning Forces for Quality* Alliances. The Alliances are leaders in terms of developing and implementing quality measurement and reporting programs at the local level. Towards that end, Alliances should continue to align their measurement programs that use private payer and Medicaid data with that of the Medicare program to encourage greater use and impact of a core set of measures across public and private measurement and reporting programs. Where possible, the Alliances also should work to encourage alignment of the incentives offered by the Medicare programs with similar programs at the local level to maximize participation and value of the incentives.

### Build Relationships Across Providers and Settings to Develop and Test Measures

Where the Medicare program will be developing and implementing new quality measurement and reporting programs (e.g., long-term-care hospitals, inpatient rehabilitation hospitals, hospice programs and PPS-exempt cancer hospitals), the Alliances should work with these providers in their communities, if they are not already doing so, to encourage the availability of information on the quality of care delivered in these settings. Given their ongoing work, the Alliances have the unique opportunity to build relationships with and across providers in order to develop and test measures that may be incorporated into these new Medicare programs. Furthermore, the Alliances also may be able to develop and test new measures that encourage greater coordination of care for patients across settings.

### Provide Feedback to CMS

In addition, the Alliances are uniquely poised to provide constructive and insightful feedback to CMS as it develops and implements these new quality reporting programs. CMS has solicited, and will continue to solicit, feedback through open-door forums, listening sessions, e-mail comments, and the notice-and-comment process for federal rulemaking. When possible, the Alliances should provide CMS with lessons learned from their work at the local level as well as information on challenges and opportunities that will enable the Medicare program to develop productive, functional programs. Specific areas where CMS will be looking for feedback include selection of measures; appropriate risk-adjustment methodologies that reflect the patient panel for these types of providers; attribution or assignment of accountability for care delivery and performance on selected measures; and available sources of data to support quality measurement and reporting (e.g., administrative, clinical, paper or electronic). Alliances also should consider providing feedback on challenges associated with incorporating the measures into practice, including constructing them using actual data, verifying their accuracy, and reporting the results either confidentially or publicly. Real-life examples of how the Alliances have addressed these issues will be particularly instructive for CMS.

### Focus On Equity and Cost Data

Two other critically important areas on which Alliances might focus and drive forward are (1) the importance of the collection and use of race, ethnicity and language information to improve the quality of care delivered across the entire population and reduce disparities; and (2) the need for cost-of-care information, including defining, measuring and reporting cost information. Identification and collection of this type of information continues to be a challenge across quality measurement and reporting programs. The Alliances are uniquely suited to guide the development and incorporation of these areas of measurement in ongoing and new Medicare programs as well as other related programs.

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- 9 Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110-275) § 131(b) (2008), amending Social Security Act § 1848(k).
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- 11 Social Security Act § 1903 (a)(3)(F) [42 U.S.C. § 1396b et seq.] (as added by ARRA § 4201(a)(1)).
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- 14 Patient Protection and Affordable Care Act (Pub. L. 111-148) § 10303 (2010), adding Public Health Service Act §931(f).
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- 17 Patient Protection and Affordable Care Act (Pub. L. 111-148) § 3004 and §10322 (2010), amending Social Security Act §§ 1886(m), 1886(j), 1814(i) and 1886(s) respectively.
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