

# Accountable Care NEWS

## CMS' New Quality Measures: Is Your Organization Ready?

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

**W**ith 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).<sup>1</sup>

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.

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## CMS Star Ratings Fail to Reflect True Clinical Quality

by Frank Mazza, M.D.

**H**ospital executives and other stakeholders should be aware that a new research study<sup>1</sup> challenges the idea that CMS hospital star ratings based solely on patient experiences can serve as a reliable indicator for clinical quality. This study follows a wake of industry criticism regarding a recent research letter published in *JAMA Internal Medicine* based on a study approved by the institutional review board at the Harvard T.H. Chan School of Public Health. The highly controversial Harvard study suggests that consumers could choose five-star hospitals without a concern for their clinical quality, and a 5-star rating may in fact guide patients to better institutions.<sup>2</sup> This conclusion is misleading and may actually steer patients to hospitals with poor clinical outcomes.<sup>3</sup>

The new study linked CMS hospital star ratings from Hospital Compare based on federal fiscal year 2014 Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys with risk-adjusted outcomes data for the same period using the CMS Medicare Provider Analysis and Review File.<sup>4</sup>

The analysis reveals<sup>5</sup> that hospitals with star ratings of two, three or four had more than three times the percentage of hospitals in the top 10% in the nation than five-star hospitals. Equally, if not more surprisingly, one-star hospitals actually outperformed five-star hospitals with 6% experiencing composite outcome scores in the top 10% of the nation (≥ 90th percentile) compared to only 4% of five-star hospitals.

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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.
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.

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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.

<sup>1</sup> “Quality Payment Program.” Centers for Medicare and Medicaid Services. Accessed Dec. 12, 2016.

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These findings clearly confirm that consumers cannot safely assume that hospitals with a CMS five-star rating will provide better clinical quality than other star-rated hospitals. In fact, reliance on five-star ratings will place them at substantial risk<sup>6</sup> of choosing a hospital that provides sub-standard care.

The study also investigates whether a positive correlation exists between actual patient experience scores and composite outcome scores across 3,456 star-rated hospitals based on their percentile ranking. The study indicates<sup>7</sup> there wasn't a positive correlation between patient experiences and composite outcomes. Instead, a slightly negative correlation was observed, but the results were not statistically significant.

After evaluating each individual outcome measure, the study found a significant negative correlation between mortality and patient experiences; although, the association was weak. A non-significant negative correlation existed between complications and patient experiences. Only patient safety had a positive correlation; however, the association was very weak.

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Here are potential reasons that findings from the study performed at Harvard's School of Public Health differs from the Quantros study:

- The Harvard study linked HCAHPS patient experience data from second quarter 2014 through first quarter 2015 with 2013 patient outcomes data from the 100% Medicare Inpatient File. This resulted in inconsistent data periods for determining associations (i.e., patient experience ratings were linked with outcomes associated with a completely different patient population).
- The Harvard study only assessed patient outcomes for mortality and readmissions across three conditions (acute myocardial infarction, pneumonia and heart failure) rather than evaluating a more extensive set of clinical outcomes across all conditions commonly treated by hospitals.

In July, CMS released another star rating system designed to measure the overall quality of hospital care using additional measures beyond patient experiences. The industry has already expressed concerns over the new methodology, indicating it puts certain hospitals, such as academic medical centers and safety-net hospitals, at a disadvantage because the data are not risk-adjusted and do not account for socioeconomic factors.<sup>8</sup> More research will be needed to validate if these ratings provide a reasonable solution for measuring the quality of hospital care in an equitable manner.

### The True Measure of Care: Safety and Quality

While it is commendable for hospitals to deliver positive patient experiences, the healthcare industry needs to recognize that CMS star ratings are a poor proxy for guiding patients to safe, high-quality care.

Despite flaws in the CMS star rating methodology,<sup>9</sup> hospital executives should continue to seek ways to improve performance. They could look for areas where performance is most influenced by a rating, such as patient complications, mortality or safety, using internal data to determine if there has been improvement in an area that is not evident because of outdated information. They should also focus on making improvements in a few key areas that will have the biggest impact on a rating.

That said, there is simply no substitute for measuring the actual safety and quality of care delivered. Quality and safety indicator measurements could be captured automatically and electronically to reflect true quality and safety using coding modifiers that identify when a medical event doesn't meet specifications for a true failure or is present on admission.

This requires a unique blend of specific functionality that centers on three fundamental areas: safety risk management and surveillance, pay-for-value reporting and performance analytics. The combination of SaaS-based solutions and information services should be made available on a stand-alone or fully integrated basis to more effectively monitor and measure clinical and financial performance with precision and conviction.

When captured in a structured taxonomy, incidents of medical error could be aggregated and prioritized for performance improvement. Because errors and adverse events occur relatively frequently in healthcare, no organization can afford to maintain resources that target them all for improvement at one time. But organizations could efficiently and effectively learn and improve through prioritization of their efforts following review of their data.

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Information technology vendors are creating software solutions to automate outcomes data collection and aggregation, and embedding the standard sets in electronic medical records. A data platform to allow voluntary provider benchmarking and learning on a condition-by-condition basis is under development. Determining standard sets of outcomes for each medical

condition is a practical and necessary step for accelerating value improvement in healthcare.<sup>10</sup>

Furthermore, episode evaluation systems that span the entire continuum of patient care and have the capacity to capture all clinically related encounters and assign them to a single episode of illness regardless of care setting allow hospitals and providers to accurately compare benchmarks against peer groups, national norms and best practices. This gives them the power to measure what matters using meaningful and reliable information for assessing safety and quality care across the continuum of care.

<sup>1</sup> "CMS Hospital Star Ratings Based on Patient Experiences Shown to Be a Poor Proxy for Clinical Quality." Quantros. Aug. 15, 2016.

<sup>2</sup> Wang D.E. Tsuawa Y, Figueroa J.F, Jha AK. "Association Between Centers for Medicare and Medicaid Services Hospital Star Rating and Patient Outcomes." *JAMA Internal Medicine*. June 2016;176(6):848-850.

<sup>3</sup> "CMS Hospital Star Ratings Based on Patient Experiences Shown to Be a Poor Proxy for Clinical Quality." Quantros. Aug. 15, 2016.

<sup>4</sup> *Ibid.*

<sup>5</sup> *Ibid.*

<sup>6</sup> *Ibid.*

<sup>7</sup> *Ibid.*

<sup>8</sup> Punke H. "CMS Releases Overall Hospital Star Ratings: 12 Things to Know." *Becker's Infection Control and Clinical Quality*. July 27, 2016.

<sup>9</sup> "CMS Hospital Star Ratings Based on Patient Experiences Shown to Be a Poor Proxy for Clinical Quality." Quantros. Aug. 15, 2016.

<sup>10</sup> Porter ME, et al. "Standardizing Patient Outcomes Measurement." *New England Journal of Medicine*. Feb. 11, 2016.

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