MOVING TO VALUE: CMS STRATEGY FOR IMPROVING THE QUALITY OF CARE

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Centers for Medicare & Medicaid Services

People in Business

Her goal: Make quality health care affordable

By Norman Goode
THE DETROIT NEWS

Quality and cost are watchwords for Jean Moody-Williams.

She constantly stresses both in her new job as director of program services in Michigan for the Peer Review Organization (MPRO), based in Plymouth.

Moody-Williams

The organization, sponsored by 3,000 physicians through- been in peer review work as quality review supervisor for a peer review group in Pennsylvania; as director of quality assurance for several Texas hospitals; and as a review analyst for Blue Cross Blue Shield in Washington, D.C.

Manufacturing

Dow Corning Corp. in Midland promoted **Robert W. Grupp** to director of state affairs and government relations and made him a member of the firm's U.S. Area Operating Board. Grupp had been manager of external communications.

Grupp

Advertising

New moves at **D'Arcy Masius**

Our Healthcare System is Not Prepared

10,000 New Medicare Beneficiaries Every Day

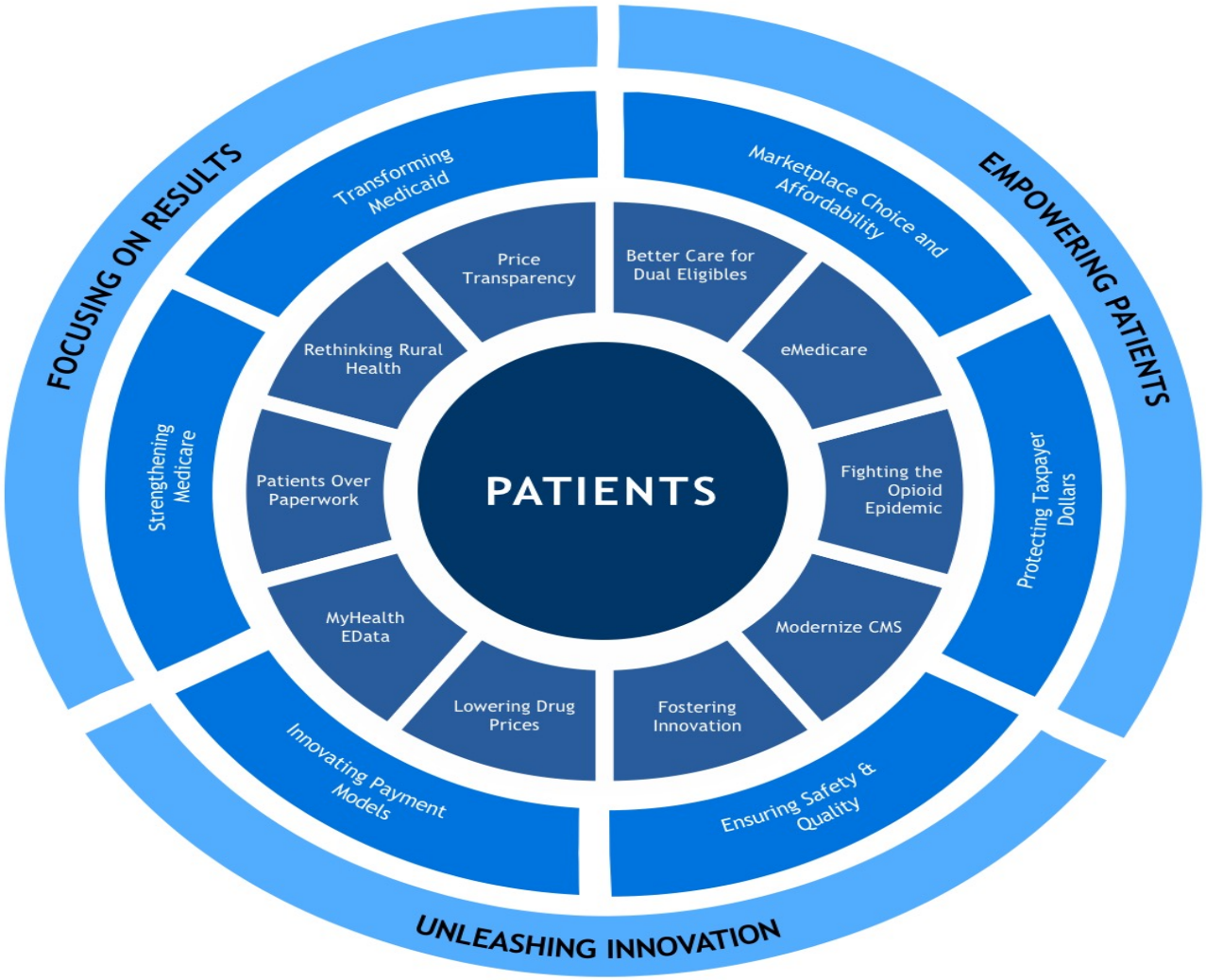
The number of Americans age 85 and older will increase by 189% between now and 2050

Size and Scope of CMS Responsibilities

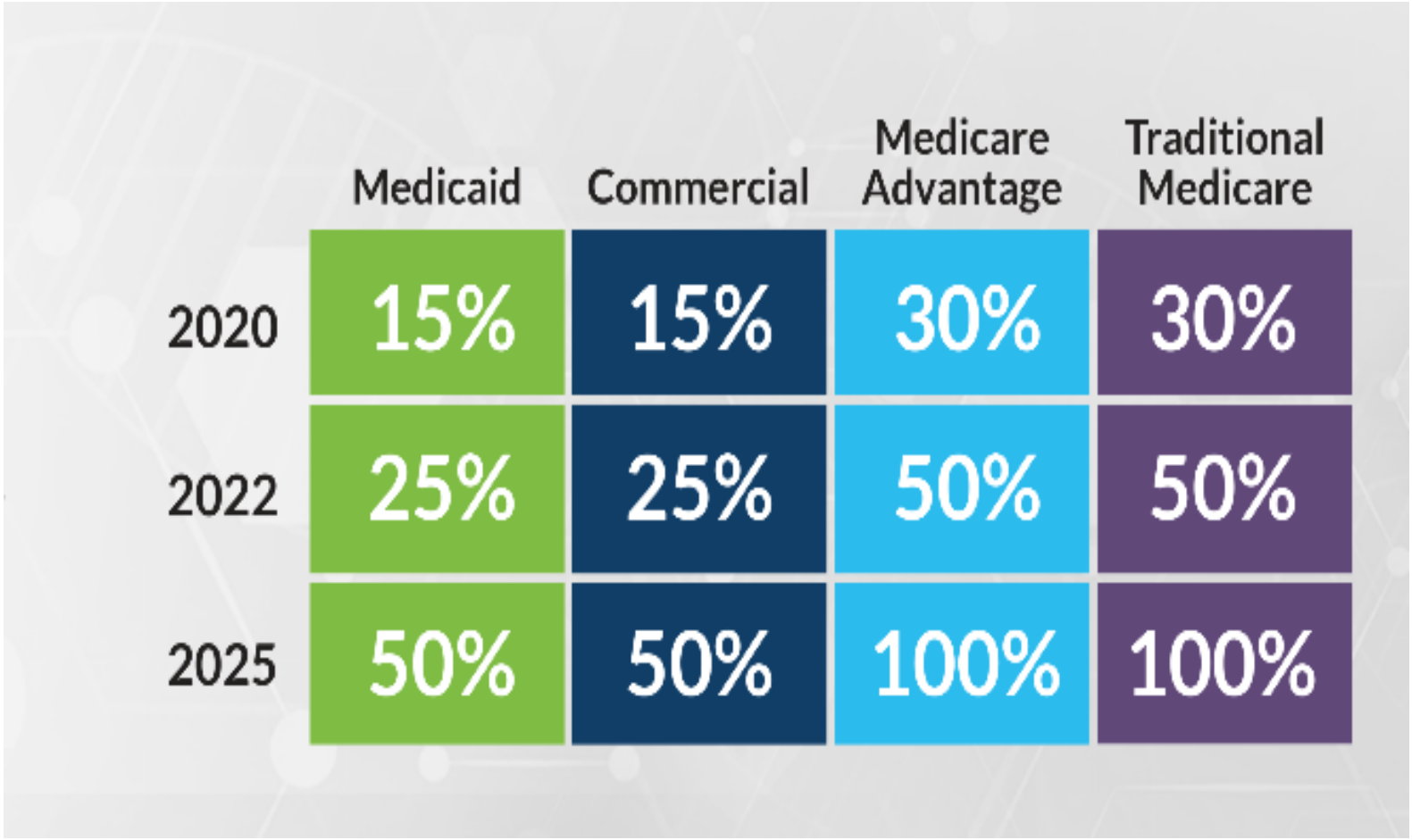
- CMS is the largest purchaser of health care in the world
- Combined, Medicare and Medicaid pay approximately one-third of national health expenditures (approx $800B)
- CMS covers 140 million people through Medicare, Medicaid, the Children's Health Insurance Program; or roughly 1 in every 3 Americans
- The Medicare program alone pays out over $1.5 billion in benefit payments per day
- Through various contractors, CMS processes over 1.2 billion fee-for-service claims and answers about 75 million inquiries annually

"What if we don't change at all ...
and something magical just happens?"

CMS Strategic Priorities for 2020



Goal - Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of shared accountability alternative payment models.



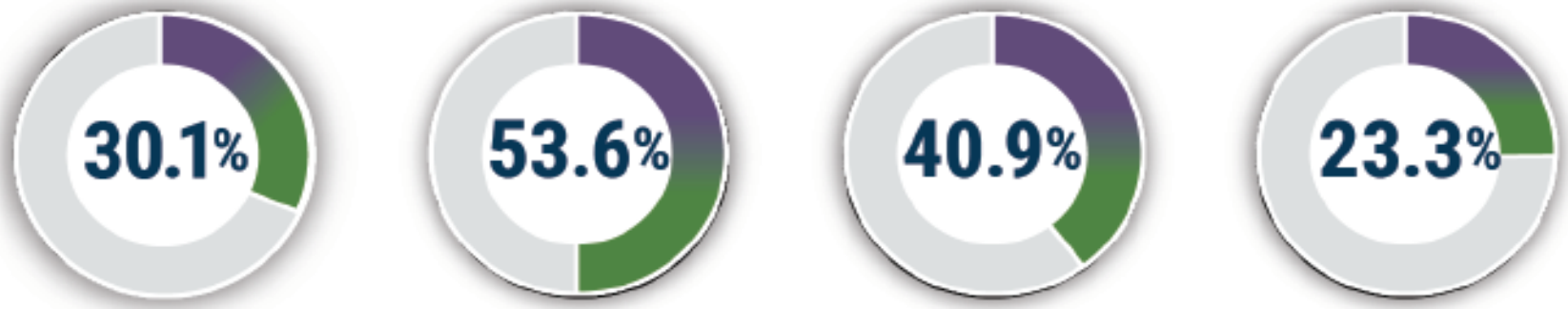
APM MEASUREMENT EFFORT

Commercial health plans, Managed Care Organizations (MCOs), state Medicaid agencies, Medicare Advantage (MA) plans, and Medicare voluntarily participated in a national effort to measure the use of Alternative Payment Models (APMs) as well as progress towards the LAN's goal of tying 30% of U.S. health care payments to APMs by 2016 and 50% by 2018.

In **2018,**

35.8% of U.S. health care payments, representing approximately **226.5 million** Americans and **77%** of the covered population, flowed through Categories 3&4 models.

In each market, Categories 3&4 payments accounted for:



COMMERCIAL | **MEDICARE ADVANTAGE** | **TRADITIONAL MEDICARE** | **MEDICAID**

Representativeness of covered lives: Commercial - 61%; Medicare Advantage - 67%; Traditional Medicare - 100%; Medicaid - 51%

HCPLAN
Health Care Payment Learning & Action Network

Lessons from the Field

A New Approach to Improving Outcomes

What is the Meaningful Measures Initiative?

Launched in 2017, the purpose of the Meaningful Measures initiative is to:

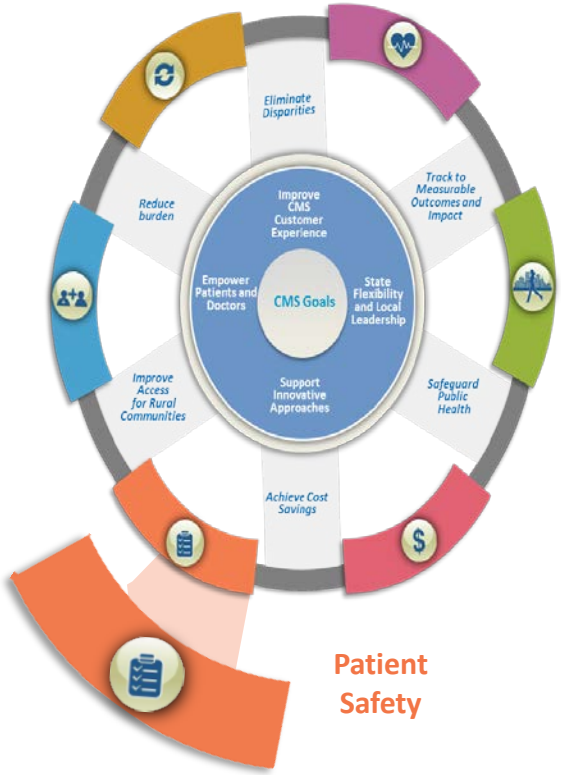
- Improve outcomes for patients
- Reduce data reporting burden and costs on clinicians and other health care providers
- Focus CMS's quality measurement and improvement efforts to better align with what is most meaningful to patients and clinicians
- Develop a measurement strategy that recognizes the need for new measurement strategies to accommodate the changing care delivery system

Meaningful Measures

Advancing Electronic Sources

- Developing more APIs for quality measure data submission
- Prototype the use of the FHIR standard for quality measurement
- Interoperable electronic registries – incentivizing use
- Harmonizing measures across registries
- Timely and actionable feedback to providers
- Working with CMMI on use of artificial intelligence to predict outcomes

Population Based Measurement - Make Care Safer by Reducing Harm Caused in the Delivery of Care



Patient Safety

Meaningful Measure Areas

Healthcare-Associated Infections

Preventable Healthcare Harm

Measures

Central Line-Associated Bloodstream Infection (CLABSI) HACRP, LTCH QRP, Medicaid & CHIP, QIO

Surgical Site Infections (SSI) IQR

Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia Outcome Measure LTCH QRP, IRF QRP

Catheter-Associated Urinary Tract Infection (CAUTI) IRF QRP, LTCH QRP, QIO

Early Elective Delivery Medicaid & CHIP

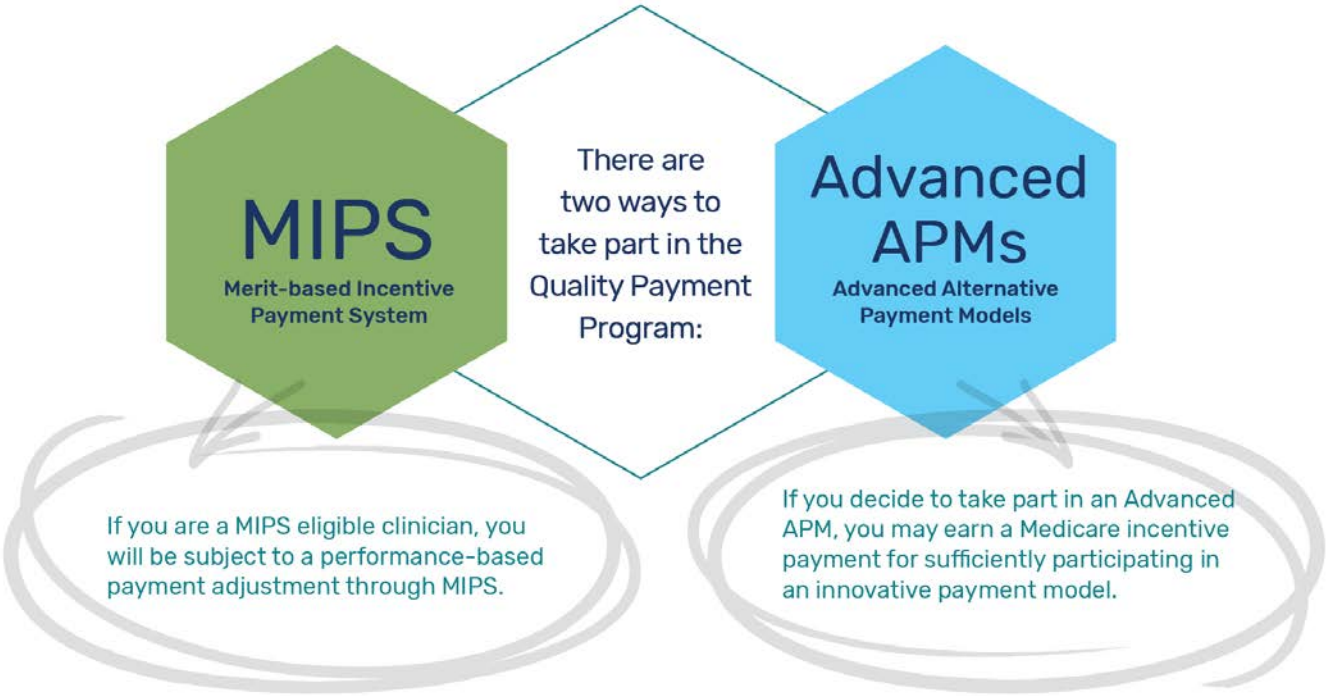
Percent of Patients or Residents with Pressure Ulcers that are New or Worsened IRF QRP, LTCH QRP, SNF QRP, HH QRP

Programs Using Illustrative Measures

Hospital-Acquired Condition Reduction Program (HACRP)
Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
Medicaid and CHIP (Medicaid & CHIP)
Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
Skilled Nursing Facility Quality Reporting Program (SNF QRP)
Hospital Inpatient Quality Reporting (IQR) Program
Home Health Quality Reporting Program (HH QRP)
Quality Improvement Organization (QIO)

Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, that provides two participation tracks:



Current Structure of MIPS (In 2020)	New MIPS Value Pathways Framework (In Next 1-2 Years)	Future State of MIPS (In Next 3-5 Years)

MIPS moving towards value; focusing participation on specific meaningful measures/activities or public health priorities; facilitating movement to Advanced APM track

Endocrinologist chooses from same set of measures as all other clinicians, regardless of specialty or practice area

Four performance categories feel like four different programs

Reporting burden higher and population health not addressed

Clinician/Group CMS

Endocrinologist reports same "foundation" of PI and population health measures as all other clinicians but now has a MIPS Value Pathway with measures and activities that focus on diabetes prevention and treatment

Endocrinologist reports on fewer measures overall in a pathway that is meaningful to their practice

CMS provides more data; reporting burden on endocrinologist reduced

Clinician/Group CMS

Endocrinologist reports on same foundation of measures with patient-reported outcomes also included

Performance category measures in endocrinologist's Diabetes Pathway are more meaningful to their practice

CMS provides even more data (e.g. comparative analytics) using claims data and endocrinologist's reporting burden even further reduced

Clinician/Group CMS

MIPS Value Pathways for Diabetes

QUALITY MEASURES

- Hemoglobin A1c (HbA1c) Poor Care Control (>9%) **(Quality ID: 001)**
- Diabetes: Medical Attention for Nephropathy **(Quality ID: 119)**
- Evaluation Controlling High Blood Pressure **(Quality ID: 236)**

IMPROVEMENT ACTIVITIES

- Glycemic Management Services **(IA_PM_4)**
- Chronic Care and Preventative Care Management for Empaneled Patients **(IA_PM_13)**

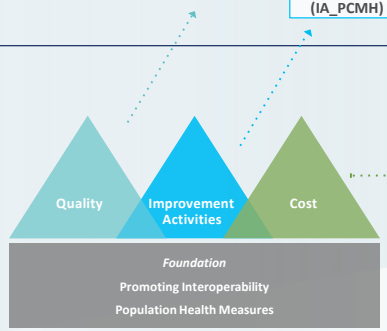
OR

- Electronic Submission of Patient Centered Medical Home Accreditation **(IA_PCMH)**

COST MEASURES

- Total Per Capita Cost **(TPCC_1)**
- Medicare Spending Per Beneficiary **(MSPB_1)**

*Measures and activities selected for illustrative purposes and are subject to change.



Population Health Measures: a set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues; CMS provides the data through administrative claims measures, for example, the All-Cause Hospital Readmission measure.

Putting Data in the Hands of Patients

What this means for CMS

- Blue Button 2.0
  - Developer-friendly, standards-based API
  - Developer preview program – open now (over 1200 developers so far)
  - Data security is of the utmost importance
- Promoting Interoperability Program for Hospitals and Clinicians
  - Program alignment
  - Strong emphasis on interoperability and privacy/security
  - 2015 edition Certified EHR Technology
- Prevention of Information Blocking
- Star Ratings
- Interoperability Rule out for public comment
- API development for sharing quality data
- Price Transparency

Beneficiary Care Activities & Transitions

BENEFICIARY CARE ACTIVITIES & TRANSITIONS

Between March-May of 2018, 46 people with Medicare and their caregivers shared stories of care transitions. This graphic illustrates the activities and types of transitions that are the most challenging in the eyes of people with Medicare.

VERSION 1.2

BURDENSOME ACTIVITIES

Five activities were reported as being particularly challenging to people with Medicare and their caregivers, and occur during all types of care transitions.

CHOOSING CARE

To help choose providers or care settings, people look at quality, convenience, location, coverage, recommendations, and physician specialty and training, to name a few. To make the best decisions, people with Medicare need access to consolidated, usable information.

PAYING BILLS

Getting high cost medical care is even more stressful when people do not know how much a procedure will cost beforehand. People with Medicare want to know how much they will have to pay for a treatment or procedure before receiving the bill.

KEEPING HEALTH RECORDS

People use spreadsheets, notebooks, and memory to track their medical records completely and accurately in hopes of more thorough care. People want to be able to place more trust in providers to record, store, and read their medical history so as to provide the best care possible.

MANAGING MEDICATION

Prior authorizations, changing costs, and the danger of drug interactions add difficulty to people's lives. People want prescriptions to be managed more completely, a Medicare Part D that is easier to understand, fewer sudden changes in coverage, and more affordable prescription drug prices.

IMPLEMENTING CARE PLAN

The best care plan is worthless if someone does not have the ability to put it into action. Issues such as a lack of in-home support, no access to transportation, and low health literacy are obstacles to following a care plan. People need more help planning and preparing for daily life beyond the appointment.

BURDENSOME TRANSITIONS

The care transitions listed here were revealed as being exceptionally burdensome for people with Medicare.

1 Ambulance Transport

When faced with health emergencies, many people look to ambulances for access to care, not understanding that most ambulance trips are not covered. Consequently, many people end up paying large ambulance bills. To curb ambulance costs, some people now use ride-sharing services or taxis.

"I remember fighting with the insurance company. I used to take her to church but it got to be so hard to get her in and out of the car that I had to quit taking her to church. She went to the hospital after a fall and the insurance company didn't want to pay for the return ambulance trip." - Person with Medicare also acting as Caregiver

2 Hospital ↔ Home

Returning home is challenging when discharge plans do not account for details of life beyond the hospital. Transitions can be particularly difficult when a person misunderstands his or her care plan, does not have at-home support, or lacks proper medical equipment, all of which are crucial to implementing care plans.

"Be sure the social worker sees the patient to plan for release back home or to a facility. [Ask] what is needed? Is there support at home? If not, does the patient need inpatient nursing care or will home nursing care be sufficient? Does the patient need to be trained to care for things like a feeding tube? Who provides that training, support, and follow-up?"
- Person with Medicare

3 Hospital ↔ Nursing Home

Oftentimes moving between a hospital and a nursing home is cyclical and stressful in itself even without the added stresses of Medicare rules. People report confusion about the 3-day rule, feeling rushed to make decisions, and lacking usable, consolidated information to help them choose a nursing home.

"It's difficult to be hospitalized, we all know that. But then you're thinking about going to a nursing home, and then we add upon that the difficulty of understanding payment, dealing with a difficult situation mentally, and then there's paperwork and you might not understand all of that, so it kind of compounds that burden.
- Subject Matter Expert

4 Home Health

Although many people want to receive care in their own homes, finding reliable home health agencies, who are also covered by Medicare, is not an easy task. Caregivers are often either stuck with sub-par care, or are forced to pay out-of-pocket for better care.

"I pay privately for aides. We tried 3 different home health agencies covered through CMS and it was awful, actually it scared me, so I said, 'I'm paying.' I went down to see who was coming to his apartment and they were someone new every day …so that's a big part of burden is trying to set up home health care and then getting that right care.
- Caregiver of a Person with Medicare

5 Provider ↔ Provider

For many people, going to a new provider feels like a long game of telephone. Incomplete medical records, disconnected electronic health record (EHR) systems, privacy rules, and a lack of collaboration across providers make the continuous, comprehensive care that people with Medicare desire nearly impossible to achieve.

"I don't find that doctors transfer data anyways. I mean you even have a hard time getting information from your pulmonologist to your general practitioner and back. I mean with the general practitioner you're working with your blood pressure medicine, and then that's it. But the blood pressure medicine affects your breathing." - Person with Medicare

Common Challenges for Beneficiary Care Transitions

COMMON CHALLENGES FOR BENEFICIARY CARE TRANSITIONS

Wanting to better understand the challenges that people face when undergoing care transitions, the Centers for Medicare & Medicaid Services listened to the stories of 46 people with Medicare and their caregivers. In recounting their experiences, people spoke of a broad range of obstacles they confront. Some of these obstacles were noted as not being unique to care transitions. This graphic depicts 11 insights, informed by this research, on the most commonly shared challenges.

When her mom needed a walker, she just went out and spent the $500 because, "She didn't know how to navigate Medicare, and she didn't feel like dealing with the hassle."
- Caregiver of Person with Medicare

Off-Road Options

Not understanding their benefits, high cost, and a lack of convenience push people with Medicare to seek medication and durable medical equipment (DME) through informal and often unregulated channels.

"I had a hospital send me a bill for outpatient surgery [for my late husband] and I said, 'he's never been to this hospital and if he has I want to see a picture because he's been dead for 2 years.'"
- Caregiver of Person with Medicare

Lost in Transfer

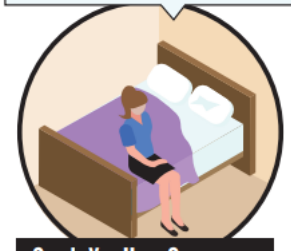
Even when people with Medicare go to great lengths to track and document their health data, problems with Electronic Health Records (EHR) systems, privacy policies, provider collaboration, and human error make it difficult to maintain complete, accurate health records.

"Intimately, care-giving has impacted us. Literally every nook and cranny of our lives. Our decisions about where to live, our professional lives, decision not to have children."
- Caregiver of Person with Medicare

A Full-Time Job

Caregivers find themselves sacrificing career and personal aspirations to be readily available to provide care to the person they are supporting and to respond to the demands of insurance.

"I'm both the patient and the caregiver which is very hard."
- Person with Medicare



Surely You Have Someone

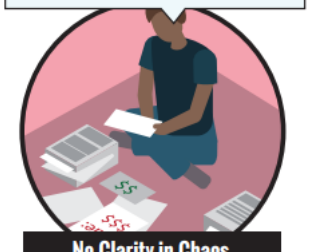
Many believe that Medicare is built on the assumption that people with Medicare have large support networks to lean on at all times. In actuality, more and more people today are acting as their own caregiver.

"The snow scared me to death...The State doesn't have a plan for dealing with dialysis patients during the snow...So it's on, it's up to you and your family."
- Person with Medicare

Coordination of Care

People with Medicare feel like providers often under-value the realities of how they live their lives and how these realities affect their ability to follow their care plan.

"But even with Medicare, you never know what things are going to cost... You're never told and you never really find out... Like my husband says, 'You go to buy a car and you know what you're going to be charged, and on medical you don't have a clue.'"
- Person with Medicare



No Clarity in Chaos

Coverage options create multiple decision points for people with Medicare. Even with a growing number of resources meant to help people with Medicare navigate the system, confusion is common, particularly when dealing with complex costs and coverage rules.

"I went home and got on the internet and figured out what I was pretty sure I had...I made the mistake of telling a doctor...He totally dismissed me. He had no interest in what I knew about my body that could have helped accelerate the diagnosis process."
- Person with Medicare

Dr. Google™

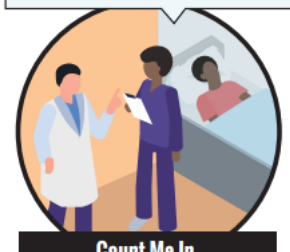
Doctors are no longer the single source of information that people with Medicare rely on to understand their medical conditions. Similarly, what the doctor suggests is just one of many opinions that people consider when making health decisions.

"I was a Medicare beneficiary due to disability. I found it rather unusual the way Medicare is administered and why if you are put on disability then you wait two years to qualify for Medicare. Generally, with an ovarian cancer patient, a two year wait is a long, long time."
- Person with Medicare

One Size Fits All?

Medicare often uses a one size fits all approach, and leaves people with specific needs such as people with disabilities and chronic diseases, people who speak English as a second language, or dual-eligible individuals, jumping through additional hoops to get the care they need.

"You know I've seen situations where doctors stand outside a patient's room and they have their meeting...Patients [are thinking], 'What are they talking about?' If a patient is truly part of the team, the meeting should be at the bedside. Then we get engaged patients."
- Person with Medicare



Count Me In

In contrast to the widely held belief that a shared understanding between providers and patients is about priorities, values, and goals as the basis of good care, people with Medicare largely feel like they are not being heard and are excluded from decision-making.

"Treat the whole patient! Treat the whole body and all its side effects. Keep the quality of life going. Don't just pay for the patient to be treated for the [lymphedema]. Buy the pump that will allow the patient to be proactive at home to keep the arm or leg usable." - Person with Medicare

Snapshot Treatment

People with Medicare receive treatment based upon the symptoms they present in the moment, unless the patient or caregiver can advocate for inclusion of important information from the past or desired outcomes for the future.

"I'm on a large amount of opioids and when I was on morphine it numbed my brain, it was too hard to figure out Medicare and Medicaid."
- Person with Medicare

Diminished Ability, Increased Responsibility

During a care transition, the moments that require the most decisions often coincide with the times that people with Medicare have the lowest capacity due to stress, fear, or the side effects of medication.

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WHAT

CMS APM Adoption Strategy Listening Session

WHEN

Wednesday, February 26, 2020
10:30 to 11:30 AM ET

WHERE

Baltimore, Maryland 21201

Please email your RSVP to

The Centers for Medicare & Medicaid Services (CMS) invites you to participate in a listening session to gather feedback about CMS's Alternative Payment Model (APM) Adoption Strategy.

This session is an ancillary event to the 2020 CMS Quality Conference and does not require conference registration.

Please note: This session is for invitees only. Attendance is voluntary, and participation by CMS officials is not indicative of any commitment to a specific policy initiative or program.