



# Quality Measurement & Reporting: A Whole New Ballgame.

*By Zahid Butt, MD, FACC*

In the past, healthcare quality operated in its own silo, centered mainly on reporting data. Quality was important, but its use was generally restricted to meeting regulatory compliance. Improvements in quality measures did not directly impact a hospital's revenue in the old "pay-for-reporting" and "fee-for-service" payment models.

Today, the meaning of "quality" is much broader and its connection to payments is rapidly increasing. It incorporates patient safety, patient satisfaction, population health, and cost reduction into a new, "value-based" healthcare model.

In other words, it's a whole new ballgame.

Reasons for the dramatic shift most recently include the incorporation of the Institute for Healthcare Improvement's (IHI) Triple Aim in the Affordable Care Act, and a renewed payer interest toward alternative payment models. For providers, learning the rules of the game has meant realizing that (1) reimbursements linked to their performance on quality measures will represent an ever-increasing segment of their total reimbursement (Fig. 1), and (2) their market share will likely be impacted by public reporting of their performance data in the near future <sup>1</sup>. Furthermore, health systems will engage in public health concepts like sustainability, cost effectiveness and comparative effectiveness in ways they previously did not.<sup>2</sup>

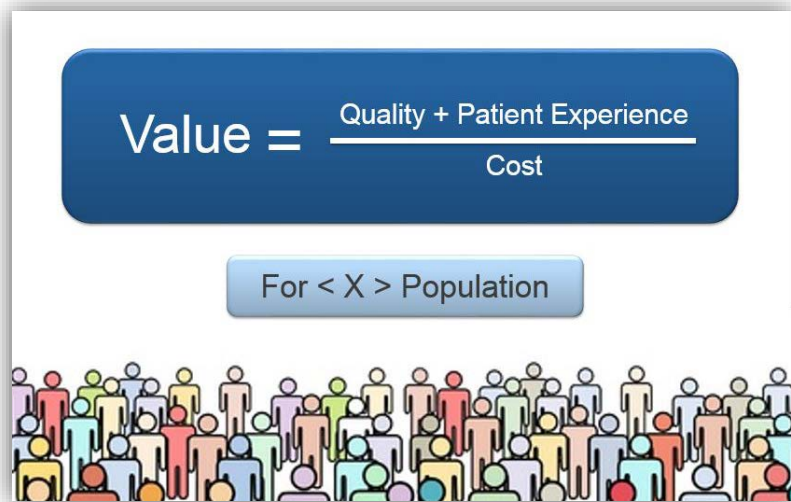


Figure 1. IHI's Triple Aim = Value-Based Population Health

## The New Name Of The Game

Over the next few years, the name of the game in quality reporting is **alignment**; with the ultimate goal of reducing the quality reporting burden for providers and hospitals.

The Center for Medicare and Medicaid Services (CMS) is working internally—and with the Joint Commission—to align quality reporting for both physicians and hospitals so that electronically reporting a measure once is credited to multiple programs, and the timely availability of the same data is also used to improve patient outcomes.

It is a difficult task that is still a work in progress but the ball has kept moving forward. In 2015, physicians will be able to report nine electronic Clinical Quality Measures (eCQMs) to CMS and get credit for both PQRS and EHR incentives with a single submission. Hospitals can electronically report eCQMs to partially fulfill their CMS Inpatient Quality Reporting (IQR) requirements, thus reducing the number of measures requiring data “abstraction” in 2015. In its recent final ruling, CMS has mandated electronic reporting of at least four eCQMs for hospitals in 2016. For its part, the Joint Commission has also announced its eCQM reporting option where hospitals could elect to submit all their quality data as eCQMs and would not be required to submit any abstracted data.

<sup>1</sup> “Hospital Performance Reports: Impact on Quality, Market Share, and Reputation,” Judith Hibbard, 2005. [http://www.researchgate.net/publication/7732759\\_Hospital\\_Performance\\_Reports\\_Impact\\_on\\_Quality\\_Market\\_Share\\_and\\_Reputation](http://www.researchgate.net/publication/7732759_Hospital_Performance_Reports_Impact_on_Quality_Market_Share_and_Reputation)

<sup>2</sup> “Improving Quality and Value in the U.S. Health Care System,” Niall Brennan, et al, Brookings, <http://www.brookings.edu/research/reports/2009/08/21-bpc-qualityreport>

## Some Will Win, Some Will Lose

CMS's commitment to move the healthcare industry toward new payment models remains strong, as evidenced in its four-pronged framework used to categorize payments to providers<sup>3</sup> (Fig. 2):

**Category 1** is fee-for-service with *no* link to value. Payments are based on volume of services with no link to quality or efficiency.

**Category 2** is fee-for-service with a link to value. At least a portion of payments vary based on the quality and/or efficiency of healthcare delivered. A good example is Medicare's programs to reduce readmissions and hospital acquired conditions.

**Category 3** is *alternative payments* build on a fee-for-service architecture.

Some payments are linked to the effective management of a population or episode of care. Payments are still triggered by delivery of services with opportunities for shared savings, or two-sided risk. Bundled payments and ACOs are examples of this payment category.

**Category 4** is population-based payment. Payment is not directly triggered by service delivery, so volume is not linked to payment. Clinicians and organizations are responsible for the care of a beneficiary for a long period (often one year). Examples include Pioneer ACOs in years three to five and Maryland hospitals.<sup>4</sup>

CMS has set specific goals for the percentage of

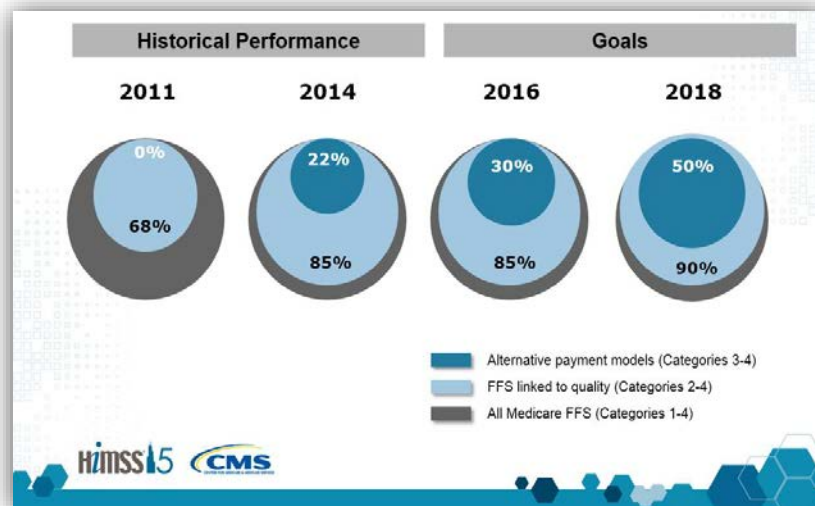


Figure 2. Target percentage of payments in "FFS linked to quality" and "alternative payment models" by 2016 and 2018.

payments in the various categories. By 2016, it hopes to have 85% of payments falling into categories 2 to 4 and 30% of payments falling into categories 3 to 4. By 2018, it hopes to have 90% of payments in categories 2 to 4 and 50% of payments in categories 3 to 4.<sup>5</sup>

<sup>3</sup> "Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume, January 26, 2015.

<http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html>

<sup>4</sup> "Global budgets pushing Maryland hospitals to target population health," Andis Robeznieks, *Modern Healthcare*, December 6, 2014.

<http://www.modernhealthcare.com/article/20141206/MAGAZINE/312069983>

<sup>5</sup> HIMSS speech by Kay Goodrich, CMS director of quality, April 2015.

<sup>6</sup> "Fewer hospitals have positive margins as they face financial squeeze," Beth Kutscher, *Modern Healthcare*, June 21, 2014.

<http://www.modernhealthcare.com/article/20140621/MAGAZINE/306219968>

Viewed individually, payment risks of 1% or 2% may not seem alarming. In aggregate, they can be significant. For example, in CMS's fiscal year 2017, hospitals are at risk of 3% for readmissions reduction, 2% for hospital value-based purchasing, 2% for inpatient quality reporting (IQR) and Meaningful Use, and 1% for hospital acquired conditions (HACs), for a total of 8%. Because payment years lag the actual performance years by as much as two years, hospitals are at risk of losing up to 8% of their Medicare payments for FY 2017 based on how they perform in CY 2015.

With average hospital operating margins hovering at just over 3%<sup>6</sup>, a single penalty could mean the difference between profit and loss. Quality improvement is thus vital to any health systems survival.

Alternative payment models with increased risk sharing clearly means providers must also think more like payers in controlling total cost per capita. Specifically, providers must begin to think about controlling not just the cost per unit but also utilization (unit volumes) (Fig. 3).

## Conclusion

In the past, the majority of the provider community paid little attention to regulatory policies regarding quality measurement and reporting. Today, knowledge and software tools to implement those regulations are an integral part of any comprehensive quality management system and

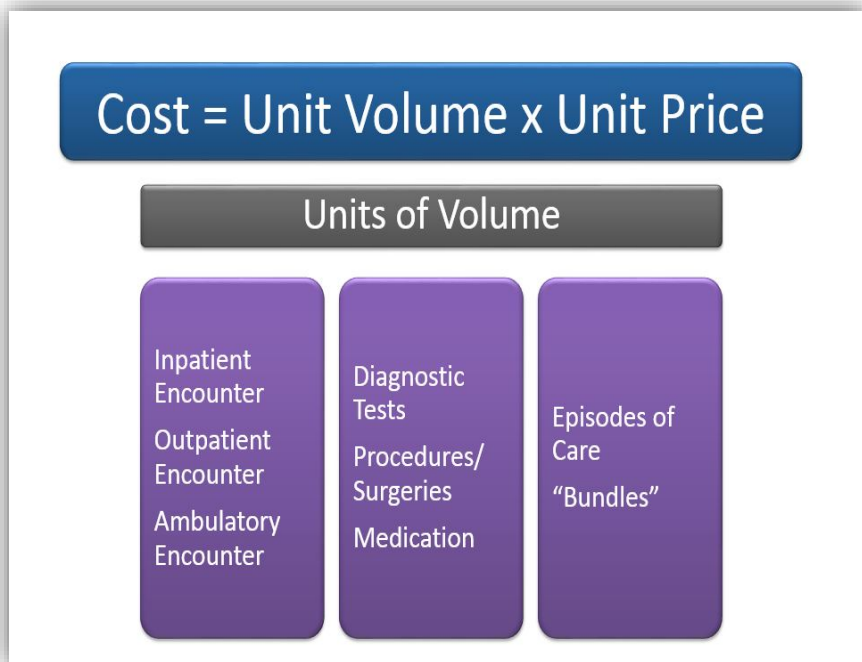


Figure 3. Thinking more like a payer in controlling costs can help hospitals succeed in an alternative payment model with shared risk.

key to positive payment adjustments in follow-on years.

Health systems must take a long view of their quality performance improvement capabilities, and stay abreast of changing CMS guidelines or face potentially significant revenue risk from future financial penalties or lost payment incentives.

A true culture of quality improvement and access to timely performance measurement information resources through meaningful partnerships, form the foundation of successful organizations in today's era of value-based care.

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