

Encore Health Resources

A World Evolving Toward Value

Rewarding Quality: Volume to Value

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Rewarding Quality: Volume to Value

The US healthcare industry is transforming from a volume-based fee-for-service (FFS) model to a value-based reimbursement model focused on improving population health while managing costs. The industry is in a state of tremendous transition as it experiments and innovates around the various models of payment and delivery reform. The roadmap to change is complex. Multiple payment and care models are emerging. The market response is fragmented and locally based. Value is front and center of these changes.

The focus on value is driving the creation of new care-delivery and payment models where reimbursement is hardwired to demonstrating value-based on quality and performance metrics through risk-based contracts. These include performance-based incentives, as well as shared savings for commercial and government contracts. Such models are driving the creation of new risk-bearing entities that are aligning hospitals, physician practices, and other care sites to collaboratively care, contract, and share risk for a defined population. All entities taking on risk require informed contracting, monitoring processes, and measuring outcomes to demonstrate improvement in overall performance and meet contractual requirements for incentives. Daily visibility to core performance metrics is required.

National initiatives are underway to evolve current quality measures from manual, paper-based abstracting to electronic formats and standard code sets (eMeasures) that support standardized analysis and reporting across incentive and value-based programs. Additionally, clinical data from hospitals and ambulatory clinics, in combination with existing claims and administrative data, will be required to produce the measures for demonstrating performance.

Provider organizations will have to build new or modify existing organizational and technical infrastructures to meet these requirements to successfully compete and thrive in this evolving market.

The new equation is:

Value = Quality (the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge – IOM) linked to **Payment** (the amount paid by the patient, employer, and government purchasers) for those health services, at equal or lower **Costs**.

Organizations will be required to:

- Respond to the performance measures in terms of the contract and organization (e.g., accountability and governance)
- Obtain and deploy tools to acquire, integrate, and aggregate data to calculate, monitor, analyze, track, and report performance against the measures
- Drive performance improvement (e.g., measures, quality, etc.) where there are gaps

In turn, this will help to:

- Obtain bonuses and/or incentives (shared savings)
- Manage costs (shared risk)
- Improve care quality in the network
- Fill the revenue loss gap

This rapid evolution, coupled with the complexity inherent in these new risk-bearing entities necessitates a new, unified approach to healthcare intelligence focused on quality, performance, cost, and risk analytics. This underscores the need for applying the fundamentals of health data, health intelligence, and performance improvement in a new way.

“The Problem”

Fee-for-service “rewards the overuse of services, duplication of services, use of costly specialized services, and involvement of multiple physicians in the treatment of individual patients. It does not reward the prevention of hospitalization or rehospitalization, effective control of chronic conditions, or care coordination.”¹

Karen Davis, Ph.D., President of the Commonwealth Fund

Costs: There are volumes written about unsustainable healthcare costs spiraling out of control in the United States (US). Our healthcare system has been built around an incentive model that rewards quantity of services, not quality of care. These payment models have produced a fragmented care-delivery system where payment is based on services provided in unconnected settings with no incentive to manage and coordinate care of an individual or populations across settings. These models have created significant inefficiencies (e.g., costs) with little incentive to change and improve.

Additionally, the rapidly changing demographics, including aging baby boomers and a growing population with chronic disease, are driving up healthcare costs through higher utilization of services and costly resources (e.g., pharmaceuticals).

Quality: The US spends more per capita than any other country in the world, yet it does not lead in terms of quality of care. A Commonwealth Fund Commission in a High Performance Health System report entitled *Why Not the Best? Results from the National Scorecard on US Health Performance: 2008* concluded that “the US health system continues to fall far short of what is attainable, especially given the resources invested. . . . Overall, performance on indicators of efficiency remains especially low and . . . the failure to improve makes efficiency the dimension with the greatest gap between US performance and achievable benchmarks.”²

To a large degree, the current FFS payment system requires no documentation or evidence of quality for a service to be reimbursed. Medicare withholds payment for certain “never events,” but overall there is no direct link between quality of the services performed and the payment for those services.

Although consensus exists that current systems are inefficient and perform sub-optimally, the definition of efficiency and performance (e.g., quality and utilization of resources) and the metrics used to measure it vary considerably among

commercial and government payers, providers, and quality organizations, such as The Joint Commission (TJC), the Centers for Medicare and Medicaid Services (CMS), and the National Committee for Quality Assurance (NCQA). Payers are inclined to define efficiency in terms of cost only. Providers and quality organizations emphasize a definition incorporating costs, as well as quality measurements.

Data: There is no question that aligning payment with performance will be fundamental to changing the economics of healthcare. In 2007, George Halvorson, CEO of Kaiser, wrote, “...we actually have a bigger problem. Even if we all had the right financial incentives, most caregivers would not be able to achieve any real process re-engineering success in American health care today because the major tool needed for reengineering simply does not exist in health care. What is that tool? Data. Healthcare lacks data. We all need to recognize the key fact that probably the single most important reason why CQI (continuous quality improvement) processes have not been used in healthcare is the almost total lack of usable data about relative healthcare processes.”³

The path to change is difficult, if not impossible, without applying analytics to the data captured electronically from the right technology that supports and informs clinical processes. Today, US healthcare is in the midst of the most significant health information technology (HIT) transformation ever experienced by the industry. Passage of the American Recovery and Reinvestment Act of 2009 with the Health Information Technology for Economic and Clinical Health (HITECH) Act (ARRA HITECH Act) and allocation of \$27B in funding launched the CMS Electronic Health Record (EHR) Incentive Program (Meaningful Use). The program stimulated hospitals and physicians to rapidly move toward implementation of certified EHRs that enable the electronic capture of clinical and administrative data. While this has advanced the agenda for establishing an electronic foundation for healthcare, it is just the first step to getting “usable” data to drive transformation in this new world.

“The Goal”

The goal of healthcare reform is efficiency of care, with the lowest cost of resources producing the highest quality of outcomes. This is known as the “Triple Aim” of improving care for individuals, improving the health of populations, and reducing the per capita costs of care.⁴

The direction of change is clear: fee-for-service is not sustainable; the need to demonstrate value-based on performance and quality is the emerging model for reform in the US.

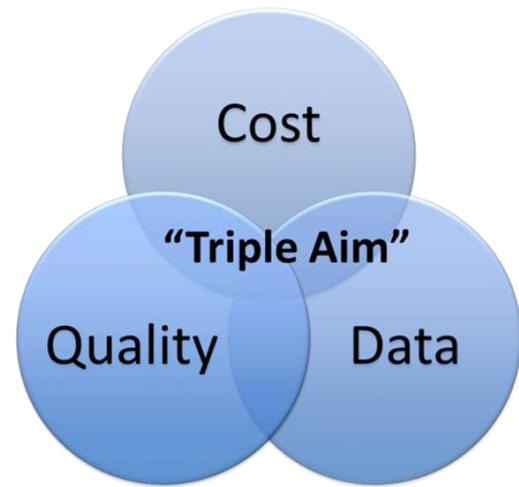


Figure 1

Emerging Models

US healthcare issues include unaligned incentives, as well as fragmentation and lack of coordinated care. Payment reform is addressing unaligned incentives through new reimbursement models that link payment based on performance for the quality of care for individuals and populations across settings. New care-delivery models address coordination and collaboration of care for individuals and populations across multiple care settings.

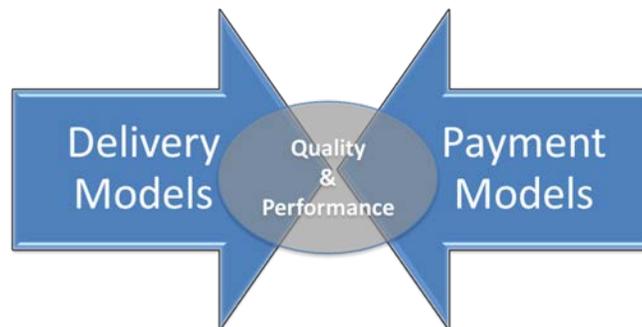


Figure 2

Delivery Models

New delivery models will be required to coordinate care across settings in conjunction with new payment models. Evidence-based protocols will be necessary to guide care. Quality measures will be required to determine performance in the care model. These models may include various payment models, but more importantly will require formal collaboration and coordination between providers and care settings. These settings will be supported by significant infrastructure investment including governance, organization and information technology (IT).

Payers and providers are innovating and experimenting with three major models: Clinically Integrated Networks, Accountable Care Organizations (ACOs), and Patient-Centered Medical Homes (PCMHs).

Payment Models

The intent of payment reform is to move away from the traditional FFS model to a model where providers take on risk for an entire population. However, this will be an evolutionary move. Many emerging models continue to have a FFS “chassis” (e.g., contracts are based on payment for services delivered plus incentives for meeting performance and/or quality measures). In all models, payment in parallel, providers will need new delivery models with supporting infrastructure to take on and manage full risk for a population.

Clinically Integrated Networks

In response to these dramatic changes, providers are entering into agreements with payers that are focused on controlling healthcare costs while providing improved coordination of care. Many providers lack the capacity to contract directly with payers on their own (e.g., lack IT infrastructure, the data, and capability to take on financial risk). These providers are contracting with integrated networks that, in turn, enter into payer agreements.

Additionally, the industry is looking to other avenues to raise capital, consolidate support costs, and promote new service development. This is driving the acquisition and consolidation of physician practices, hospitals, and healthcare systems.

Clinical integration is a physician-alignment model where groups of providers meet specific guidelines set by the Federal Trade Commission (FTC) to allow joint contract negotiations and payments. Clinical integration is fundamental to any physician alignment/risk-sharing model.

The FTC has determined that physicians working in separate practices are considered competitors, and, if they come together to jointly negotiate payments or contracts, these negotiations are considered price fixing unless they are integrated into a legitimate joint venture.⁵ The FTC has also concluded that these physicians are clinically integrated if evidenced by “the presence of organized processes to control costs and improve quality and by the significant investment of monetary and human capital in these processes.”⁶

The FTC considers organizations clinically integrated if they:

- Use systems from multiple sources
 - Aggregate data into one patient-centric system
 - Produce protocol compliance reports
- Follow agreed-upon and defined clinical protocols
 - Develop practice standards and protocols (evidence-based) to govern treatment and utilization
 - Measure the network’s performance against these protocols

Participants who fail to adhere to the network’s standards and protocols are subject to remedial action, including the possibility of expulsion

- Invest significant capital in information systems
- Refer and provide medical services within a network of providers⁶

The FTC considers the following as present in the long term, though not immediately upon program establishment:

- Engaging in case management, pre-authorization . . . and concurrent and retrospective review of inpatient stays
- Providing payers with detailed reports on the cost and quantity of services provided
- Hiring a medical director and support staff to perform the above functions and to coordinate patient care⁷

In all cases, legal review is required to determine whether an organization meets the intent of the FTC guidelines.⁵

With passage of the Patient Protection and Affordable Care Act (ACA), the formation of ACOs to contract with Medicare is encouraged as a model to create risk-sharing models for high-risk populations.⁸ An ACO is a type of provider network and could be at risk for anti-trust violation. In response, the FTC/Department of Justice (DOJ) issued the Antitrust Enforcement Policy Regarding ACOs on October 20, 2011. They viewed CMS’ proposed eligibility criteria as generally consistent with the intent of clinical integration described in the FTC/DOJ Statements of Health Care Antitrust Enforcement Policy.⁹ The requirement that CMS ACO Shared Savings Program applicants satisfy distinct clinical integration requirements from CMS on the one hand and FTC and DOJ on the other was deemed cumbersome. Therefore, the staff at the FTC and DOJ worked closely with staff at CMS to ensure that CMS’ clinical integration requirements would incorporate the antitrust agencies’ perspectives.⁵

Clinical Integration Attributes:

- Joint contracting for enrolled populations
- Joint legal responsibility for enrolled populations
- Commitment to and overcoming obstacles to standardized guidelines and protocols for the care of those populations
- Governance to support processes
- Change management for development
- Care coordination model
- Information transparency including aggregated quality and performance including utilization reporting of the providers to the payers
- IT infrastructure to support these capabilities
- Significant capital investment

*Interpretation of FTC Guidance

Accountable Care Organizations

Broadly defined, an ACO is a delivery model where a group of healthcare providers deliver coordinated care, manage chronic diseases, and thereby improve the quality of care for patients and populations. The organization's payment is tied to achieving healthcare quality goals and outcomes resulting in cost savings. The ACO supports the integration and collaboration of groups of physicians, hospitals, and other providers around the opportunity to receive additional payments by “achieving continually advancing, patient-focused quality targets and demonstrating real reductions in overall spending growth for the defined patient populations.”⁸

CMS has adopted ACOs as an innovative model for delivery and payment reform. The agency offers several ACO programs including the ACO Shared Savings Program and the Pioneer Program.

Attributes of an ACO participating in a CMS program are defined by the ACA/CMS final rules and include:

- Accountability for quality, cost, and care of Medicare beneficiaries
- Commitment to participating in the program for at least three years
- Formal legal structure to receive and distribute payments for shared savings
- Sufficient primary care professionals to treat a minimum of 5,000 Medicare beneficiaries receiving treatment from the ACO
- A leadership and management structure including clinical and administrative systems
- Defined processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care through the use of appropriate technologies
- Demonstrated ability to meet patient-centeredness criteria as defined by the Department of Health and Human Services (HHS)

Commercial ACOs have similar attributes. The models are all highly flexible, given the number of payment models that may exist in an ACO. Understanding the underlying payment model structure(s) is critical to building and framing the ACO. In all cases, a commercial ACO must meet the FTC guidelines for clinically integrated networks.

Clinical Integration and ACOs

All ACOs must be clinically integrated, but not all clinically integrated networks are ACOs. There are many clinically

integrated networks that are not ACOs, but can still jointly enter into fee-for-service or risk contracts with payers.

Patient-Centered Medical Homes

The concept of a medical home originated in the late 1960s in an effort by pediatricians to establish a central record for children's medical records. In 2006, several large national employers worked with primary care medical societies and health plans to form the Patient-Centered Primary Care Collaborative (PCPCC),¹⁰ a forum dedicated to making care delivery more efficient and comprehensive. In February 2007, four primary-care societies—the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association—developed the Joint Principles for the PCMH, summarized in these points:

- Ongoing relationship with a personal physician
- Physician-directed medical practice
- Whole-person orientation
- Coordinated and/or integrated care
- Quality and safety
- Enhanced access to care
- Payment that appropriately recognizes added value

The National Committee for Quality Assurance (NCQA) developed certification criteria for implementation of a PCMH.¹¹ The PCMH redesigns primary care reimbursement to reward physicians for aspects of care that are most important to good patient outcomes. For example, additional payments may be given to physicians to support care coordination and preventive activities that improve the health of the patient.

Key elements of a PCMH include:

- Comprehensive team-based care
- Disease management and quality tracking
- Accountability
- Reduced care variation
- Patient satisfaction
- Health information technology

Like other clinically integrated models, significant investments in governance, organization, and IT infrastructures are required.

Payment models for PCMH vary, but they are based on a blend of FFS, pay-for-performance, pay-per-episode, and some capitation.¹² Many may include a monthly care-coordination fee with or without risk adjustment.

Role of Care Coordination

Reducing care fragmentation is a key goal under healthcare reform. For all the new and emerging delivery models, care coordination across multiple settings is a critical component.

Broadly defined, "Care coordination is a function that supports information sharing across providers, patients, types and levels of service, sites, and time frames. The goal of coordination is to ensure that patient's needs and preferences are met and that care is efficient and of high quality. Care coordination is most needed by persons who have multiple needs that cannot be met by a single clinician or by a single clinical organization and that are ongoing, with their mix and intensity subject to change over time."¹³

These new delivery models call for new organizational structures for communication and decision making. New roles will be required. Successful care coordination entails a means to measure, monitor, report, and improve the effectiveness and efficiency of the coordination of care of individuals and populations for which the providers are contractually responsible. Care coordination becomes the critical link between payment for services and the performance of those services for a defined population across multiple settings.

It is recognized there will be a cost for the care coordination, and several models allow for payments and fees to support these activities.

Payment Models

Sharing Risk

Shared risk is defined as "payment models in which providers share in a portion of the savings they achieve (upside), but are also at risk for a portion of spending that exceeds a target (downside)."¹⁴

Risk impacts vary by stakeholders. Linking payment to quality changes the risk equation toward the providers and away from the payer.

Emerging Medicare Models

Medicare Hospital Inpatient Value-Based Purchasing:

Payment based on performance against quality measures. According to CMS, in fiscal year 2013, "an estimated \$850 million will be allocated to hospitals based on their overall performance on a set of quality measures that have been shown to improve clinical processes of care and patient satisfaction. This funding will be taken from what Medicare otherwise would have spent, and the size of the fund will gradually increase over time, resulting in a shift from payments based on volume to payments based on performance."¹⁵ The final rule lowers payments to hospitals by one percent and allows hospitals who achieve the quality measures to receive higher payments. Value-Based Purchasing (VBP) facts:

- Largest quality initiative for hospitals to date
- **12 clinical process of care measures**
- **8 patient-reported experience of care measures (HCAHPS – Hospital Consumer Assessment of Health Providers and Systems)**
- Achievement score based on hospital performance surpassing the CMS-defined achievement
- Incentive/bonus-based payment for achievement

This program will align with the current Medicare Inpatient Quality Reporting incentive program. "The Hospital VBP program marks a shift in CMS reforms from 'pay-for-reporting' to 'pay-for-performance.'"¹⁶ In 2003, the voluntary Hospital Inpatient Quality Reporting (IQR) Program introduced the core-measures concept. Some two years later, hospitals that did not successfully report data under the IQR program were penalized by a 2.0 percentage point reduction in their applicable percentage increase. The Hospital VBP program continues using payment incentives and takes the next logical step "in promoting higher quality care for Medicare beneficiaries and transforming Medicare into an active purchaser of quality health care for its beneficiaries."¹⁶ The Hospital VBP program now directly ties payment amounts to a hospital's performance score. CMS began measuring hospital performance for incentive payments in July 2012. To fund the Hospital VBP incentive program, CMS will reduce the base operating diagnosis-related group (DRG) payment by 1% in FY 2013 and increase withholding by 0.25% each year until it peaks at 2% in FY 2017. As a result, approximately \$850 million will be allocated for the Hospital VBP program in FY 2013".^{17, 18}

Implementation date: Oct 1, 2012

Medicare Readmission Program: On August 18, 2011, CMS issued a final rule outlining the Hospital Readmissions Reduction Program under the ACA. The program stipulates that "payments to those hospitals under section 1886(d) of the Act will be reduced to account for certain excess readmissions." The final rule includes: "(i) Those aspects of the Hospital Readmissions Reduction Program that relate to the conditions and readmissions to which the Hospital Readmissions Reduction Program will apply for the first program year beginning October 1, 2012; (ii) the readmission measures and related methodology used for those measures, as well as the calculation of the readmission rates; and (iii) public reporting of the readmission data."¹⁹

Implementation date: October 1, 2012.

Medicare National Pilot Program on Payment Bundling:²⁰

This CMS initiative will allow providers participating in the Medicare program to receive a bundled payment for an episode of care such as a heart attack or a stroke. The program, the Bundled Payments for Care Improvement Initiative, is voluntary and "providers have great flexibility in selecting conditions to bundle, developing the health care delivery structure, and determining how payments will be allocated among participating providers," according to a CMS website.²¹ Additionally, CMS will allow "applicants for these models to decide whether to define the episode of care as the acute care hospital stay only (Model 1), the acute care hospital stay plus post-acute care associated with the stay (Model 2), or just the post-acute care, beginning with the initiation of post-acute care services after discharge from an acute inpatient stay (Model 3). Under the fourth model, CMS would make a single, prospective bundled payment that would encompass all services furnished during an inpatient stay by the hospital, physicians, and other practitioners."²¹

Medicare Shared Savings Program: CMS has established a Medicare Shared Savings Program (Shared Savings Program) to facilitate coordination and cooperation among providers to improve the quality of care for Medicare FFS beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an ACO.²²

The Shared Savings Program is based on providers implementing measures to reduce spending below the level the payer expected; the providers are rewarded a portion of the savings. Participating entities, referred to as Medicare ACOs, that meet quality and performance standards are eligible to receive payments for shared savings.

The Shared Savings Program:

- Requires only a "pay for reporting" approach to quality measure reporting for performance year one and a phase in over three years of the number of "pay for performance" measures used to calculate the Medicare ACO's performance score
- Encourages greater use of EHRs for overall Medicare ACO scoring purposes by double weighting a quality measure that represents the percent of primary care providers who successfully qualify for the EHR Incentive Program payment
- Contains no requirement to have a hospital as part of the CMS ACO
- Requires reporting on 33 Quality Measures²²

Medicare's Pioneer Program: This program is a CMS Innovation Center initiative designed to support organizations with experience operating as ACOs or in similar arrangements in providing more coordinated care to beneficiaries at a lower cost to Medicare. The Pioneer ACO Model will test the impact of different payment arrangements in helping these organizations achieve the goals of providing better care to patients and reducing Medicare costs.²³ This is considered an alternative model to the Shared Savings Program. It is a shared savings payment arrangement with higher levels of savings and risk than in the Shared Savings Program. Participants will enter into a full-risk population-based payment arrangement in year three of the program (once certain requirements are met). Quality measure requirements match the Shared Savings Program.

CMS named an additional 89 ACOs to participate in its Medicare Shared Savings Program in July 2012, adding to the original 27. The new organizations officially joined the program on July 1, which brought the total number of Medicare ACOs—including 32 Pioneer ACOs and 6 Physician Group Practice Transition Demonstration organizations—to 154.²⁴

Emerging Private-sector initiatives

Many other related payer-provider risk arrangements have emerged, and the Medicare related programs are being adopted by the commercial payers. Based on a recent study by the Commonwealth Fund, it was noted that:

- Payer-provider shared-risk models are in early development

- Shared-risk definitions vary, as do the related program designs
- Providers generally do not have the infrastructure to take on and manage risk
- Shared-risk models typically evolve from shared-savings programs²⁵

Summary definitions from The Commonwealth Fund study: (Provider Risk Models)

Risk Model	Definition	Examples
Bonus Payment at Risk	Provider is at risk of not receiving a bonus payment based on quality and/or efficiency performance	Blue Cross Blue Shield of Minnesota Preferred One
Market Share Risk	Patients are incentivized by lower copays or premiums to select certain providers so providers are at risk of loss of market share	Buyers Health Care Action Group
Risk of Baseline Revenue Loss	Built on a fee-for-service "chassis"; providers face a financial or payment loss if they fail to meet certain cost or quality thresholds, and/or if actual costs exceed a target cost	Blue Cross Blue Shield of Massachusetts AQC Blue Cross Blue Shield of Illinois-Advocate Health Care
Financial Risk for Patient Population (Whole or Partial)	Providers manage patient treatment costs for all or a designated set of services within a predetermined payment stream and are at risk for costs that exceed payments (e.g., partial/full capitation, global budget)	State Employees Health Commission (State of Maine) <i>(planned)</i> Anthem/WellPoint <i>(planned)</i>

Figure 3. Summary definitions of Provider Risk Models from The Commonwealth Fund study.²⁵

Summary

Payment reform is in its infancy. All early models are built around FFS. While there are no true global capitation models in place today, the industry is rapidly innovating around various models that link payment and quality as a basis for models that take on full risk for populations.

Measuring Quality

US healthcare issues include unaligned incentives, as well as fragmentation and lack of coordinated care, which results in high costs with sub-optimal quality. Payment reform is addressing unaligned incentives through shared savings, as well as bundled payments for patients across settings. New care models will be required to coordinate care across those settings in conjunction with new payment models. Evidence-based protocols will be required to guide care. Quality measures will be required to determine performance in the care model. Linking quality to payment is central to the healthcare reform initiatives underway today.

Quality and performance measurement and reporting is essential to improving healthcare and enabling the success of health reform. Effective quality and performance measures are the underpinning of informed decision making by consumers, of payment reform, and of information that providers and patients can use to transform care.²⁶

Quality Programs

The passage of the HITECH Act and CMS EHR Incentive Program reinforced the link between payment and quality and required clinical quality measures to be captured and reported in an electronic format, giving birth to the electronic measure (eMeasure). The 2010 Patient Protection Affordable Care Act formally set into motion the transformation of the healthcare industry toward value-based reimbursement, as well as payment-based quality and performance measures.

Today, at least eight federal programs require quality reporting along with a large number of state programs (e.g., state health departments, state-based registries), health plans (e.g., risk based contracts), and other regulatory (e.g., Centers for Disease Control and Prevention) and accrediting bodies (e.g., TJC, American College of Cardiology, National Association of Children's Hospitals and Related Institutions, NCQA).

With the passage of the HITECH Act as well as ACA, efforts were initiated to begin quality program "harmonization" as well as to develop common measures and standards.

In January 2009, a competitive contract was awarded by HHS to the National Quality Forum (NQF), a nonprofit organization dedicated to improving the quality of US healthcare, for a four-year period. This contract included:

- Formulation of National Strategy and Priorities for Health Care Performance Measurement
- Implementation of a Consensus Process for Endorsement of Health Care Quality Measures
- Maintenance of Consensus Endorsed Measures
- Promotion of Electronic Health Records
- Focused Measure Development, Harmonization, and Endorsement Efforts to Fill Critical Gaps in Performance Measurement²⁷

"You can't improve what you don't measure; you can't measure what you don't understand; and you can't understand what you don't collect."²⁸

Today, the number of NQF endorsed measures exceeds 700, and 30 percent of these assess patient outcomes and experience with care. While the measures come from many sources, those endorsed by NQF have become a common point of reference. Eighty-five percent of the measures used in federal programs are NQF-endorsed.²⁹

Why measure?

The success of healthcare reform is dependent on the ability to measure and report quality and performance. Measures are fundamental to this healthcare transformation. There are three major focuses and uses for measures that constitute the basis for the healthcare reform initiatives underway today and in the future.

Quality: Measures drive improvement. Teams of healthcare providers who review their performance measures are able to make adjustments in care, share successes, and probe for causes when progress comes up short — all on the road to improved patient outcomes.

Satisfaction: Measures inform consumers. As a growing number of measures are publicly reported, consumers are better able to assess quality for themselves and use the results to make informed choices, ask questions, and advocate for good healthcare (e.g., HCAHPS). Providers post performance measures on their websites, and consumers can consult national sources such as HospitalCompare.hhs.gov (a website that allows consumers to compare the quality of hospital services).

Payment: Measures influence payment. Increasingly, private and public payers use measures as preconditions for payment and targets for bonuses, whether that means paying providers for performance or instituting non-payment for complications associated with NQFs list of “Serious Reportable Events.”

Anatomy of a Measure

The effort to collect and report measures is complicated, largely manual, and by nature produces delayed results that make timely performance improvement difficult. It is recognized that a major obstacle is the lack of electronically available data. The CMS EHR Incentive Program (Meaningful Use) is driving adoption of EHRs across hospitals and physicians’ practices, providing the foundation for electronically available clinical and administrative data that, in turn, enables quality and cost improvements. This is the first significant effort to capture and report quality measures electronically on a national level. The clinical quality measures in the program are defined as eMeasures.

eMeasures

An eMeasure is the electronic format of a quality measure and:

- Defines the data elements that can be derived from an EHR (standard formats and structure)
- Defines the value sets for each of the elements based on established taxonomies/standards
- Uses SNOMED CT, RxNorm, LOINC, and other accepted standards
- Describes the computer logic needed for calculations³⁰

This format makes the measure machine readable and reduces (does not fully eliminate) the ambiguity around definitions and calculations.³¹

The NQF is the primary organization for endorsing national consensus standards for measuring and publicly reporting on performance. Currently NQF has endorsed and published 113 quality measures that have been retooled as eMeasures.³²

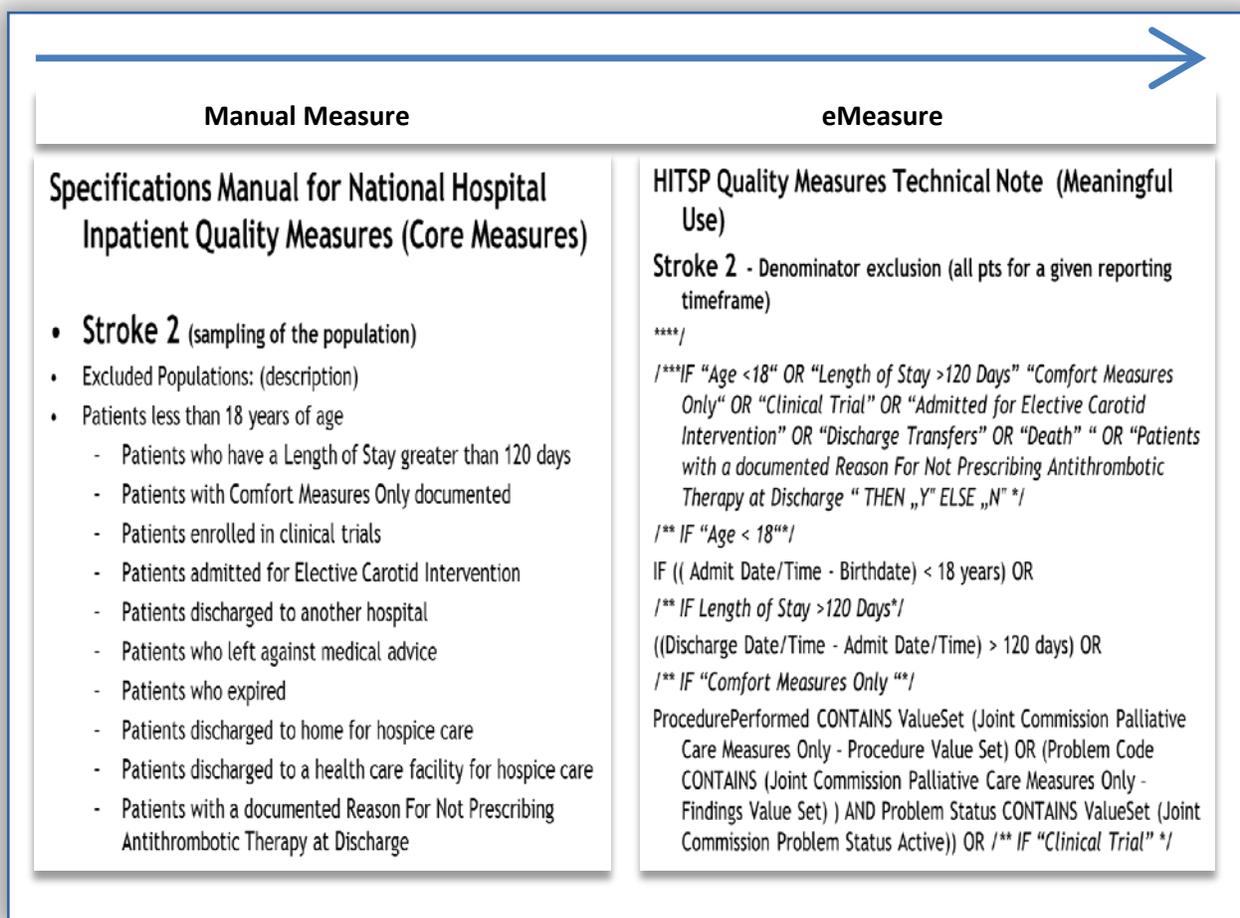


Figure 4. Manual measure versus eMeasure, Encore Health Resources©

The national effort to implement certified EHRs is a first step in making this process more efficient and accurate. But the ability to inform, intervene, and ultimately improve a quality or performance process requires more than just collecting and reporting on a measure electronically.

It requires the:

Right data and standards

- Standards including ICD-9-CM/ICD-10-CM, CPT, LOINC, RxNorm and SNOMED
- Structured without undo impact on workflow

Right content and rules

- Supporting order sets, clinical documentation, and assessment
- Clinical decision support built on best practices and evidence-based guidelines
- Valid capture methodology and logic based on published requirements

Right process

- Workflows that support efficient data capture (right data and content)
- Workflows targeted around specific quality and performance guidelines and measures

Right decision making

- Governance for decisions around how data will be represented, reported, and captured in the EHR
- Governance for change control around new designs as new requirements emerge to ensure data quality in its original form

Right technology (certified technology)

- Capability to capture the data
- Capability to share and exchange the data
- Capability to aggregate, calculate, analyze and report the data^{33, 34}

Payment and Measures

Today, payment and quality are not tightly linked. Quality reporting is a separate activity from billing and coding. Reports are filed anywhere from two to three months after the fact. Data quality is questionable.

But current and future reform initiatives will link payment to quality. Reporting will be required from a certified technology. The billing and coding process will be blended with the requirement to demonstrate and provide evidence of performance against specific measures.

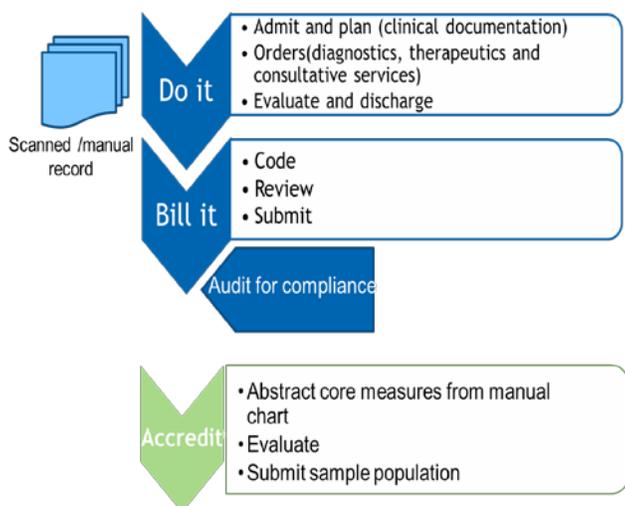


Figure 5. Current
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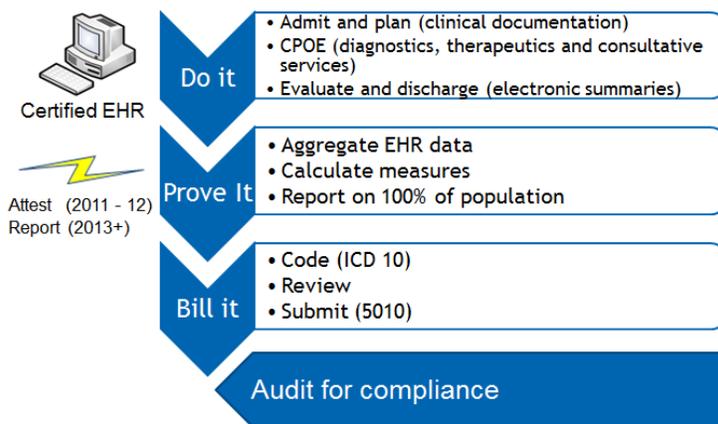


Figure 6. Evolving Toward
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Reporting Requirements

Today, key programs have different reporting requirements that sometimes use the same measures. While efforts to harmonize measures across programs have gained heightened attention, there is still considerable work to be accomplished. The table to the right illustrates where measures are shared among the key programs.

Common CMS Hospital Measures Grid					
Programs**	Measures	CMS-ACO	MU Stage 2	HVBP	HIQR*
CMS - ACO	33	33	0	1	0
MU Stage 2	29	0	29	6	12
HVBP	13	1	6	13	13
HIQR*	55	0	12	13	55

© Encore eMeasures 101, 2012

* 59 measures total - suspended data collection for 4 measures starting January 1, 2012

** All Programs have HCAHPS requirements - represented as a count of one per program in grid
3 measures common to Meaningful Use Clinical Quality Measures (CQM), Hospital Value-Based Purchasing (VBP), Hospital Inpatient Quality Reporting (IQR)

Full electronic reporting from a certified technology is in the near future. CMS has established a pilot program for the EHR Incentive Program (Meaningful Use). The final rules for Stage 2 provide guidance on electronic quality reporting submission from a certified EHR technology by 2014. However, other related CMS programs may not be ready to accept electronic reporting. CMS has acknowledged the need for program harmonization, but no firm dates have been established.

"We continue to believe there are important synergies with respect to the two programs. We believe the financial incentives under the HITECH Act for the adoption and

meaningful use of certified EHR technology by hospitals will encourage the adoption and use of certified EHRs for the reporting of clinical quality measures under the Hospital IQR Program. Through the EHR Incentive Programs we expect that the submission of quality data through EHRs will provide a foundation for establishing the capacity of hospitals to send, and for CMS to receive, quality measures via hospital EHRs for Hospital IQR Program measures in the future." Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2012 Rates (Federal Register 5/2011).³⁵

The New Fundamentals

The movement toward value-based reimbursement is expected to intensify. While the roadmap to complete payment and delivery reform is not fully defined, leaders in the industry have made some assumptions about the next three-to-five years.³⁶

Assumptions

Decreased reimbursement: It is strongly believed that there will be government pricing controls through slowed payment rate growth or rate reductions. At the same time, payers will resist the historical practice of taking on these costs (known as cost-shifting). Internal cost controls and containment by providers will grow.

Controlling costs and utilization: There will be increased focus on high cost areas such as end-of-life care, chronic diseases, reduction of readmissions, as well as avoiding hospitalization. Primary care will be targeted and potentially incented to coordinate care across settings, including utilization of resources and ultimately costs.

Shifting risk: Shared accountability and risk will drive an increased need for partnerships and integration in communities and markets. Providers will have to develop joint contracting, manage networks of providers, and determine how to take on risk in the most effective way.

Increased market demand for value with transparency: Employers, consumers, government, and private payers will continue to demand greater value for the healthcare dollar, including better outcomes of care and more efficiencies of care (reducing costs). The demand for transparency (more communications and accountability); access to easily understood information on pricing (as well as quality of care by providers) will increase.

The game is clearly changing. While no single model is emerging, commonalities related to organizational capabilities and supporting HIT driven by federal programs are becoming evident.

The New Fundamentals

Encore’s position is that organizations will need these four new fundamentals to navigate the complexities of a rapidly changing environment.

Health Data: The right data electronically captured, shared and exchanged in the right secure format and structure/standards supported by the right workflows at the source (e.g., EHR) is fundamental to this path of reform. Without the right data, there can be no real health intelligence or performance improvement. Additionally, integration and sharing of hospital clinical and financial data with physician offices and physician documentation data, as well as other external systems such as external labs will be required.

New fundamentals:

1. Create system implementation methods and processes focused on how the data will be used, not just how the data will be input.
2. Incrementally develop data governance structures that will build a strong foundation for data quality.

Health Intelligence: Organizations will need the capability to acquire, aggregate, analyze, and report/present focused quality and financial information to create new knowledge and insights required to change and transform in this new world of fee for value. This includes technical capabilities as well as organizational capabilities. An important component will be harmonization of the many organizational quality and performance programs (e.g., Meaningful Use, Core Measures, TJC) to ensure the organization begins by selecting the right measures. The second comes from using health data once for these many initiatives versus using the multiple systems to monitor and measure the same thing. New skill sets will be required to acquire and manage this new information.

Information and value-based Performance Improvement Lifecycle (Figure 7):

While health intelligence presents the state of quality and costs, the capability to improve based on these insights requires information-based performance improvement programs. The basis of quality is the ability to continually monitor and improve performance and outcomes based on specific measures. Additionally, managing cost requires reduction in variability in processes, as well as developing new processes such as collaborative-care coordination to reduce the use of high cost resources.

This new value model requires a continuous performance improvement lifecycle. This lifecycle is based on defined quality and performance measures and thresholds. It requires certified EHR technology to capture data in the right workflows and have that data be available for data aggregation, analytics and reporting capabilities with a program to monitor, track and improve processes.

C3 Collaborate, Coordinate, and Contract: The new delivery and payment models require capabilities to form partnerships and legal entities for risk contracting and to develop clinically integrated networks, ACOs, PCMHs, or some combination of the three with sophisticated care-coordination processes. Organizations will require skills to negotiate risk-based contracts that are financially and clinically sound.

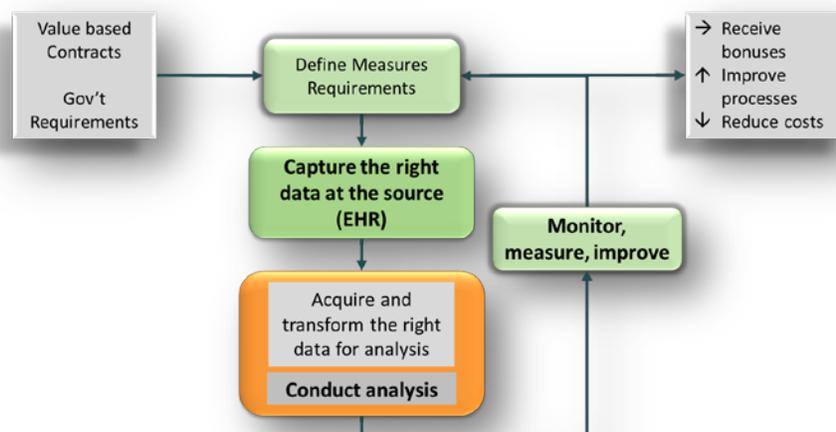


Figure 7. Value Based Performance Improvement Lifecycle
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