



Advising the Congress on Medicare issues

Measuring quality across Medicare's delivery systems

John Richardson, Sara Sadownik, and Nancy Ray

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Today's presentation

- Review of Commission's positions on quality measurement
- Concerns with current FFS Medicare policy
- Possible alternative approach across delivery systems
- Results from preliminary analysis highlighting issues for discussion
- Issues for discussion and future work

Review of the Commission's quality measurement recommendations

- Recommended quality measurement and reporting for specific FFS provider types and Medicare Advantage (MA) plans
- Recommended pay-for-performance for specific types of FFS providers and MA plans
- Recommended approach to compare FFS Medicare and MA on quality in local areas

Concerns with Medicare's current quality measurement approach

- Provider-level process measures may reinforce FFS incentives, care fragmentation
- Some process measures weakly associated with outcomes
- Burden from growing number of measures, harder to coordinate with private payers
- Focuses on quality within silos, away from coordination among patients' providers
- Large number of process measures diffuses providers' attention and resources

Possible alternative direction for discussion

- Delivery system-level approach
- Measure and compare quality of FFS, MA, and ACO delivery systems at local level
- Use small set of population-based outcome measures
- Employ measures that use readily available data sources
 - FFS claims and MA plan encounter data
 - CAHPS patient experience surveys

Example of possible measure set

Dimension of care	Measures
Outcomes of care	Potentially preventable hospital admissions
	Potentially preventable emergency department visits
	Mortality rates (within 30 days of hospital discharge)
	“Healthy days at home”
Patient experience	Patient experience surveys (CAHPS)

Potentially preventable hospital admissions and ED visits

- Population-based measures of potentially preventable hospital admissions (PPAs) and emergency department visits (PPVs)
- Reflect coordination of a region's ambulatory care
- Used definitions and methods developed by 3M Health Information Systems
- Measured at the hospital service area (HSA) level, reflecting local healthcare markets

Potentially preventable hospital admissions (PPAs)

- PPAs: admissions for conditions that might have been avoided with adequate ambulatory care
- Includes short-term complications of chronic conditions and procedures whose appropriateness questioned by clinical experts
- Analysis excludes readmissions within 30 days

Potentially preventable ED visits (PPVs)

- PPVs: ED visits for care that could have been prevented or treated in an ambulatory setting
- Treat and release ED visits
- Excludes visits that result in hospital admission
- Exclude visits for surgical procedures

Methodology

- 100% Part A and B claims for 2010 and 2011
- Risk adjusted for age and disease burden, using 3M's methods
- Measured at the hospital service area (HSA) level
 - Excluded HSAs with less than 400 beneficiaries

PPAs and PPVs account for a large share of all admissions and ED visits

- PPAs: 23% of all initial hospital admissions in 2011
 - Annual rate ~ 78 per 1,000 beneficiaries
 - Heart failure most frequent clinical reason
- PPVs: 55% of all ambulatory ED visits (treat and release) in 2011
 - Annual rate ~ 227 per 1,000 beneficiaries
 - Abdominal pain most frequent clinical reason

Less variation among larger HSAs

HSAs with at least 5,000 beneficiaries

Ratio of actual to expected events, 2011		
	Potentially preventable admissions (PPA)	Potentially preventable ED visits (PPV)
Minimum (highest performing HSA)	0.40	0.16
First quartile	0.91	0.87
Second quartile (median)	1.02	1.05
Third quartile	1.14	1.24
Maximum (lowest performing HSA)	1.76	2.11

HSA (hospital service area). Ratios are risk-adjusted by the age and disease severity of the beneficiaries who reside in the HSA. PPA rates exclude readmissions.

Source: 3M analysis of 2010 and 2011 100 percent Medicare claims data.

Issues for discussion and future work

- How to define area for measurement?
- How to define population?
 - What is providers' collective responsibility for quality in MA, ACO, and FFS Medicare?
- Which quality measures to use?
 - Small set of outcomes measures?
 - Feasibility of implementing selected measures, including data availability and risk adjustment

Issue for discussion and future work

- Measures to address FFS incentives?
 - Ambulatory services overuse measures
 - Hospital patient safety measures
 - Per capita or per episode spending measures
- Measures to address underuse incentives?
 - HEDIS (or similar) measures for MA and ACOs