Extreme Measures
Doctors are suffering QUALITY MEASUREMENT FATIGUE

Is relief on the way?

BY HOWARD BELL

Staff at the Mankato Clinic are concerned. The time it takes them to collect and report quality data has grown exponentially, according to Julie Gerndt, MD, a psychiatrist and the clinic’s chief medical officer. “The pace at which payers are asking us to report measures has reached a fevered pitch,” she says. “We’ve doubled our IT, quality resource and electronic health record staff, and changed workflows in every department. Different payers want different measures reported in different ways, to be used for different reasons—and new measures keep coming. It’s fueling burnout and stress for our providers. Smaller clinics can’t afford to handle this—which is unfortunate and ironic, since studies show smaller clinics often provide higher-value care.”

Large clinics are suffering measurement fatigue, too. “It’s confusing and resource-intensive,” says Paula Santrach, MD, chief quality officer at Mayo Clinic. “Our department has more than 200 employees. Most of them work on measures.”

Many, many measures
In 2001, the Institute of Medicine’s Crossing the Quality Chasm’ identified significant variations in health care outcomes and recommended that the U.S. health care industry enact fundamental changes in the way it measures and reports its performance. In the wake of the highly influential report, MN Community Measurement (MNCM) opened its doors four years later, driven by the notion that you can’t improve what you don’t measure. The Minneapolis-based nonprofit collects data about health care quality from clinics, hospitals and payers, and makes the information available to all who want it, including the public. MNCM’s goal is to generate findings that fuel positive change—in people’s health, health care costs, and equity of care throughout Minnesota.

To acquire various types of meaningful data, MNCM uses individual “measures” to assess particular aspects of health care.
MNCM routinely develops and tests new measures, and retires ineffective ones.

Currently, MNCM has 42 quality improvement measures for medical groups or clinics. Twenty-eight of those measures use data reported by clinics, and 14 use data reported by health plans. Some of the MNCM measures are also part of the Minnesota Department of Health’s Statewide Quality Reporting and Measurement System (SQRMS), which MNCM manages. Since 2010, clinics and hospitals have been required by law to report data for the SQRMS measures. [See sidebar, page 13.]

Along with collecting data for SQRMS and MNCM measures, clinics and health plans must provide data for Medicare and Medicaid measures. In addition, clinics often must report data for private payers’ own measure sets—and provide more data that health plans must report to stay accredited.

Many health plan measures are part of the Healthcare Effectiveness Data and Information Set (HEDIS), a widely used national set of 81 measures. Companies offering Medicare Advantage plans must also report on 53 “star rating” measures that can earn them bonuses and be used as a marketing tool to attract enrollees. Insurers rely on physician practices to provide much of that data.

On January 1, the measurement burden increased with the launch of Medicare’s new quality payment program, which includes the Merit-Based Incentive Payment System (MIPS). Part of the Medicare Access and CHIP Reauthorization Act of 2015, MIPS offers financial incentives for reporting on measures, and calls upon clinics to conduct quality improvement projects. MIPS creates financial incentives for the reporting of measures not only by primary care physicians but by specialists as well.

So there’s MNCM, SQRMS, HEDIS, star ratings, MIPS and more measures, including those required by Medicaid. Although there’s some overlap in the information they ask for, each of these measure sets is quite different from the rest. Adding to the

Paula Santrach, MD, chief quality officer at Mayo Clinic, acknowledges that alignment and other means of measurement simplification are important; but she cautions that simplification could create problems if taken too far. She points to diabetes care as an example.

Mayo endocrinologists often provide short-term, episodic diabetes consultations for patients whose condition is poorly controlled. Looking only at measure adherence, outcomes for these brief visits can appear to be very different than those for ongoing diabetes care.

“Out our endocrinologists may not perform all five of the D5 optimal diabetes care measures because some of them may have been performed elsewhere,” Santrach explains. “But if you don’t do all five, or have record of them being done, you don’t get credit for providing optimal diabetes care. I question whether these patients and providers should even be included in the measure since the outcome of the visit is a set of care recommendations for the ongoing care provider at home.”

When an outcome measure cohort includes patients receiving short-term care, that’s a complication—one that must be factored in when designing outcome measures, Santrach says. As medicine moves toward value-based payment, she stresses, it’s important to consider attribution—the designation of who a patient belongs to for quality measurement purposes.

According to Santrach, more than 150 attribution methodologies exist for quality measures. “The choice of the attribution methodology and its accuracy is just as important as the outcome measure itself,” she says. Last year, the National Quality Forum, which endorses measures, published a report acknowledging the need to start endorsing attribution methods as well.

As she anticipates increased national discussion about the topic, Santrach believes attribution must be factored into the measurement process in order to fairly reimburse providers across different types of practices. “When it comes to measures,” she says, “one size does not fit all.”
complexity are benchmarks that underlie each measure but often differ for the same measure, depending on whether the measure is being used to determine payment, improve quality of care, or report information to the public to help patients “shop” for quality.

**Trying times**

Quality reporting has become more time-consuming in recent years, not only due to increasing numbers of measures required but also because fewer of those measures are process measures that can be gleaned from insurance claims data. Process measures pose questions about specific actions taken while providing care—for example, “Has the right test been ordered for the patient?” Increasingly, today’s measure sets include more outcome measures, which ask questions about a specific aspect of a patient’s health after receiving care—for example, “Has the patient’s depression improved?” Outcome measures are more useful for improving quality, but they take more time to conduct, as clinics must retrieve data from medical records, interview patients or ask patients to complete surveys.

Mankato Clinic reports various types of measures to multiple entities, including MNCM, the Centers for Medicare and Medicaid Services (CMS), and six different health plans, few of whose measures align with each other. “One payer wants us to measure depression remission at six months; another wants 12 months,” says Gerndt. “One payer wants us to measure diabetes care by whether patients are taking their medications, which is a process measure. Another wants us to measure it by how many patients have A1cs of seven or less, which is an outcome measure. One payer wants us to measure vascular care by whether patients are on statins. CMS wants us to measure asthma care using the process measure related to medication compliance. MNCM wants us to measure the outcome— is the patient better?”

“There are measures and more measures, without enough focus on which ones are really helpful for patients and physicians,” says Janet Silversmith, MMA director of health policy. “Over the years, measures have gotten better and are used in better ways, so we’re making progress, but physicians sometimes struggle to see the value and to justify the time spent on all these measurements.”

Nevertheless, they may continue to see that time commitment grow, as CMS and private payers are moving away from fee-based physician compensation to value-based compensation. Instead of paying doctors for procedures and services they provide, payers will compensate them based on how well they meet measures for providing the best care at the lowest cost.

**Signs of change?**

In 2015, the Institute of Medicine acknowledged how complex and burdensome quality reporting has become, and released its Vital Signs’ report, which concluded that there are too many measures that often don’t improve patient health. To address the issue, Vital Signs recommended universal adoption of 15 core quality measures. [See sidebar, page 14.]

The Vital Signs report, together with growing concerns from physicians about measurement burden, prompted the MMA to call for a moratorium on any new measures in Minnesota until some measures are retired and it can be decided how the state’s existing measures meet the standards suggested in Vital Signs. “The MMA supports measurement and improvement,” says Silversmith. “But it’s time to hit the pause button, step back, revisit what we want to accomplish, and determine what measures will be most effective at supporting that goal.”

Among the measures Minnesota clinics and hospitals must report are those from the Minnesota Department of Health’s Statewide Quality Reporting and Measurement System (SQRMS). Because most of the 19 ambulatory SQRMS measures are not aligned with those in Medicare’s Merit-Based Incentive Payment System (MIPS), the MMA has talked with the Minnesota Department of Health about how SQRMS measures are used. “The future role of SQRMS is uncertain," says Janet Silversmith, MMA director of health policy, "but simply eliminating it could pose problems."

SQRMS measures are built into contracts that payers have with providers. SQRMS is also a good apples-to-apples way of comparing clinics on quality of care because everyone reports the same SQRMS measures in the same way. MIPS takes a different approach by letting clinics choose which measures they report, which makes provider comparisons difficult.

Rather than getting rid of SQRMS, a better way to reduce measure reporting burden might be to align SQRMS measures with MIPS measures. The MMA hopes to draft legislation this year that would hasten such alignment.

MNCM president Jim Chase, however, thinks legislation could be counterproductive. “We all agree more alignment and simplification needs to be done,” he says, “but we don’t want the Legislature dictating what quality measures should be. That wouldn’t be based on science or collaboration, and it would make the measures harder to update or retire.”
Alignment efforts
One tactic that may offer ample opportunities for improvement is alignment—using the same measures to satisfy multiple reporting requirements. Aligning measure sets poses a huge challenge. It requires not only using the same measures but reporting them in the same way too.

Physicians might find it hard to believe, but Minnesota has already done more than most states to align measures, according to Jim Chase, MNCM president and vice chair of the National Quality Forum, which endorses measures for use across the country. “Getting payers, clinics and hospitals at one table to collaborate on measures and agree on which measures to use, and how to use them, is what we've always done at MNCM,” he says.

For example, MNCM and SQRMS measures are already aligned, except in cases where reporting formats differ. MNCM measures for health plans are aligned with 14 HEDIS measures and 13 star-ratings measures. And, Chase says, Medical Assistance (Minnesota’s Medicaid program) measures are “pretty well aligned” with MCMN measures. Medical Assistance, in fact, uses several MNCM measures.

For many physicians, the priority now is to align Minnesota measures with those that Medicare uses to pay physicians. To avoid payment penalties, most physicians must report six quality measures they choose from a list of 271 MIPS measures. Those quality measures represent 60 percent of physicians’ MIPS scores in 2017, which affects how much they’ll be paid in 2019.

“The good news is, primary care providers can use MNCM measures to meet MIPS measure requirements,” says Chase. That’s because some MNCM measures are also on the lengthier MIPS measure list. A big exception is the patient experience measure, for which Medicare requires a very different format. “Aligning the patient experience measure should be a priority,” Chase says. “Otherwise, when it comes to primary care, we're well aligned with MIPS. Not too many other states can say that.”

MNCM must now decide whether aligning more of its measures with MIPS includes adopting additional measures already included in the federal set. “If we do,” says Chase, “it’ll increase provider burden. If we don’t, it may jeopardize physician compensation.”

For example, MNCM hasn’t used the MIPS measure for osteoporosis screening because Minnesota providers are concerned it might lead to overuse of screen-
ing. "But Minnesota providers may lose money on this if we don’t adopt it and improve our rates of performance," Chase says. "One approach to the dilemma is to go ahead and adopt the MIPS measure, then encourage CMS to change it in a way that avoids overuse."

Another example: MNCM’s optimal diabetes care measure is widely used by Minnesota clinics, but it doesn’t include the MIPS measure requirement for having patients get dilated retinal exams. Adopting this sub-measure would cost time and money, but it has to be done, according to MNCM board chair Tim Hernandez, MD, a family physician and chief quality officer for Entira Family Clinics in St. Paul. “This will require a different relationship with eye doctors that’s going to take work and time for us,” he says. “It also requires a different approach to data collection and workflow. But we’ll give it priority because it determines our CMS payments.”

MNCM is also considering adopting several other MIPS measures, including the osteoporosis measure for women following a fracture, an asthma medications ratio measure, and measures for 30-day all-cause hospital readmission, medication reconciliation within 30 days of discharge, and use of high-risk medications with the elderly.

Meanwhile, alignment is a two-way street. As MNCM has explored adopting some MIPS measures, CMS has adopted seven MNCM measures and sub-measures—many of them outcome measures—regarding depression, asthma, colorectal cancer screening and diabetes. MNCM is the national “measure steward” for all of these measures, meaning the Minnesota organization developed and tested them, and will update them as needed.

Minnesota is already a leader in using outcome measures. They can require more work than process measures do, but once it’s determined whether a patient is better, Chase says, “you can sometimes eliminate looking at test scores or other aspects of care. CMS has told us they want more of what Minnesota is using—more outcome measures.”

But CMS will probably never be able to use as many outcome measures as Minnesota does, according to Chase. Some insurers and providers elsewhere in the country resist using them, he says, because they take more work—and because many states don’t have the collaborative culture it takes to create, agree upon and use them. “Minnesota doctors appreciate that we’ve moved toward more useful outcome measures, even though they do increase burden,” Chase says. “Now we need to balance that by eliminating other measures that don’t provide as much value.”

### Alignment dilemma

So, will Minnesota keep using all its outcome measures? Or, to simplify its efforts and maximize CMS payments received, will the state adopt some MIPS process measures?

“It’s a dilemma,” says Silversmith. “We need to align our measures with CMS measures so there are not parallel data-collection burdens. But we don’t want to lose the high-value measures we have.”

It’s probably not an either/or situation, Silversmith says. CMS wants more outcome measures, and Minnesota is in a position to provide those. But lots of other groups have outcome measures they’d like CMS to adopt, too.

“There’s only so much we can do here in Minnesota to align our measures with MIPS measures,” says Chase. “A lot of it is up to CMS.” He says CMS may delegate that alignment task to state Medicaid agencies. That might be a good thing for Minnesota, he says, “because we’re already ahead of others on measurement alignment, and we’d be in a better position to keep using our high-quality outcome measures, rather than converting to a federal measure set of mostly process measures that’s likely to add burden with less benefit for patient health.”

Santrach worries that state and federal efforts to align measures “will just make things more complicated,” she says. “I don’t think we’ve found the right answer yet.” Gerndt says that if federal measures were imposed on Minnesota, “It would be a big step backward.” Hernandez says it’s happening already. “We’re seeing a gradual, intentional shift from state measures to federal measures that’s not good for medicine in Minnesota,” he says. “Outcome measures are more valuable than process measures. We’ve worked hard in Minnesota to refine, align and innovate useful measures. But I’m afraid we’re going to have a lot less say in what measures we use here.”

Regardless of who’s adopting whose measures, alignment alone won’t be enough, according to Jeff Schiff, MD, MBA, medical director for Minnesota’s Department of Human Services, which runs Medical Assistance. “We need a major change of focus with four goals in mind,” he says. They are:

- Measure what matters most.
- Measure outcomes rather than processes, whenever possible.
- Link measures to clinical opportunities to improve.
- Make clinical relevancy a higher priority than administrative relevancy.

Meeting those goals will be no easy task, Schiff admits. “Measurement transformation is a quest. It doesn’t happen overnight. The measurement system needs to be linked closer to practice transformation, because right now measurement’s purpose to improve health and well-being is accomplished too intermittently and too slowly.”

Whatever happens, says Silversmith, “The goal is to reduce measure burden on our doctors. That’s critical.”

Howard Bell is a medical writer and frequent contributor to Minnesota Medicine.

---

**REFERENCES**
