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Director
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TO: Reference Book Options DPHHS Subcommittee Members

FROM: Kris Wilkinson, Fiscal Analyst II, Marilyn Daumiller, Fiscal Analyst II, Lois Steinbeck, Senior Fiscal Analyst

RE: Quality Measurements Under the Medicare Program

During the August 2, 2010 meeting, subcommittee members heard public comment on the Reference Book option titled, Implement Treatment Protocols and Evidenced-Based Practices in Medicaid. Several comments discussed coordinating recommendations under this option with quality measurements being developed by the Centers for Medicare and Medicaid (CMS) for the Medicare program. This memo provides background information on the CMS efforts to develop quality measurements for various components of the Medicare program.

The Medicare Improvement for Patients and Provider Act of 2008 directed the federal Department of Health and Human Services (HHS) to enter into a contract on quality measures to:

1. Make recommendations on a national strategy and priorities;
2. Endorse quality measures, which involves a process for determining which ones should be recognized as national standards;
3. Maintain – that is, update or retire – endorsed quality measures;
4. Promote electronic health records;
5. Report annually to Congress and the Secretary of HHS

Currently, CMS has more than 375 quality measures in place with others in various stages of development. Table 1 shows the number of measurements in place by setting.

Table 1
Number of Quality Measures by Setting, As of February 2009

Hospital Inpatient	60
Physicians and Other Professionals (PQRI)	153
Nursing Home	19
Home Health	12
End Stage Renal Disease	22
Part D	23
Medicare Advantage	59

According to CMS's report *Roadmap for Quality Measurement in the Traditional Medicare Fee-for-Service Program*, the next steps in quality measurement need to focus on evidence-based measures that contain information relating to:

- Health outcomes for the patient
- Transition of the patient across settings
- Resources used to treat the patient

This information would focus heavily on the specific conditions having a high impact on the Medicare program by virtue of being largely prevalent in the beneficiary population. The report goes on to state that by re-directing attention to these measures and linking measurement efforts to incentives, it will be possible to drive change in how health care professionals and entities think about and deliver health care.

The goals of the measures are:

- Safety – where care doesn't harm patients
- Effectiveness – where care is evidence-based and outcomes driven to better manage diseases and prevent complications from them
- Smooth Transitions of Care – where care is well-coordinated across different providers and settings
- Transparency – where information is used by patients and providers to guide decision-making and quality improvement efforts, respectively
- Efficiency – where resources are used to maximize quality and minimize waste
- Eliminating disparities – where quality care is reliably received regardless of geography, race, income, language, or diagnosis