STRATEGIC HEALTH CARE

DR. KATE GOODRICH DISCUSSES HEALTH CARE QUALITY MEASUREMENT AND PERFORMANCE BENCHMARKING

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P R O C E E D I N G S

MR. OOSTRA: Hello, my name is Randy Oostra, President and CEO of ProMedica. I'm pleased to welcome you to this eight-part series of health care reform discussions with nationally recognized health policy experts. These interviews will discuss Medicare policy, including health care pricing, long-term care, and the social determinants of health. This series is part of an ongoing two-year effort by more than a dozen hospital CEOs from around the U.S. to urge Congress to take up significant health care policy reform legislation, largely by calling for the creation of a national commission on health care reform.

It is our intent that these policy reforms discussed during these interviews demonstrate our desire for substantive national reform. Moreover, that these interviews help to further inform congressional members and committee staff as they work to craft legislation to improve health care delivery and financing during the next Congress

Our motivation is straight forward. Well before the onset of the Covid-19 pandemic we were

adamant that race, age, and/or economic circumstances should not be defined as preexisting conditions, nor do we accept the premise that Americans should be resigned to live shorter lives in poorer health.

We invite you to listen to or to read the transcripts of all eight interviews. If you'd like to provide comment, you can do so via the contact information noted at the conclusion of these interviews.

DR. INTROCASO: Welcome to this series of eight interviews concerning federal health care policy reform. I'm the host, David Introcaso. With me to discuss health care quality reform is Dr. Kate Goodrich, currently Senior Vice President of Trend and Analytics at Humana, and just previously Chief Medical Officer and Director of CMS' Center for Clinical Standards and Quality.

Kate, welcome.

DR. GOODRICH: Thank you, David. Thanks for having me.

DR. INTROCASO: Dr. Goodrich's bio is posted with this audio's audio file and transcript.

On background, health care quality has been a

significant federal policy concern for decades. For example, in the mid-90s, President Clinton established an advisory commission on health care industry quality. In 2001 the IOM's widely referenced Crossing the Quality Chasm report called for fundamental changes in health care, as the report termed, to close the quality gap. And a landmark 2003 RAND study found that adults fail to receive recommended health care nearly half the time. That, the author's concluded, poses a "serious threat" to the health of the American public.

Currently, despite substantial federal efforts to develop quality measurement and performance benchmarking, moreover since the passage of the ACA in 2010, poor health outcomes persist. Americans also experience high rates of medical errors that include diagnostic errors, avoidable infections, and the mis- or overuse of anti-psychotics.

Also to the relationship or correlation between health care quality and health care spending, or the value of the the health care dollar spent, remains largely unknown. The result thereof, significant variation in health care spending across geographic

regions led Uwe Reinhart to quip, "The finest health care in the world costs twice as much as the finest healthcare in the world." These reasons and others led MedPAC, in rare instance of candor, to say in 2014, “Medicare's current quality measurement approach has gone off the track."

This conclusion led MedPAC in '18 and '19 to recommend the four Part A hospital quality programs be consolidated into one and recommended both Medicare Part B physician quality performance initiative, termed the Merit-based Incentive Payment System (MIPS) , and Part C, or Medicare Advantage's Quality Bonus Program, also be reinvented.

With me again to discuss health care reform is Dr. Kate Goodrich.

So, Kate, with that as a too lengthy background, let me begin by asking you generally what's your overall assessment of current quality measurement performance?

DR. GOODRICH: Thanks, David.

I think there have been small incremental improvements over time in a couple of ways. But I think

that there is way more that still needs to be done. And a lot of our foundational underpinnings of the quality measurement infrastructure needs to significantly evolve in order for that to happen, because it's not just a policy issue or a will to measure the right things. I think that has really changed over the last several years. But the infrastructure for it has not caught up.

And let me tell you what I mean by that. So, you know, CMS rightfully came under a lot of criticism by MedPAC and others for too many process measures, you know, not really being focused on the right things, and just really a -- a diffusion of focus across the entire system. And, to a point I know you've made many times, which is the how we're doing on quality really doesn't have any relationship to how we're doing on cost. Those two things are just not matching up. And I think CMS doesn't get enough credit for the fact that over the last several years that they really undertook a very concerted effort to significantly reduce the number of process measures, really focus on outcome and experience and cost, particularly in the hospital realm, and I would argue also in the post-acute care realm. Where

this has been much more challenging is on the clinician or outpatient side of the house.

So I think things are moving in the right direction, but -- especially on the clinician side, there's just so much more that needs to be done. And this is where I get to sort of more of the infrastructure issue. I think it is so much harder on the outpatient side because, you know, CMS has a mandate to measure performance in terms of quality and cost among, you know, other things, like meaningful use and improving activities -- we can talk about that if you want, but let's leave that off the table for now -- for every type of clinician in the country. And so what that has led to is a fairly large portfolio of measures that address each particular specialty. And even for specialties where you have a lot of measures, they still have traditionally been way too many process measures that were not focused on the right thing.

And so that led MedPAC and others to recommend, hey, let's focus our quality efforts on large population level metrics that really matter and on patient reported outcomes. I think that overall, like

if you could actually do that really well, you could really move the needle on quality. The challenge there is you don't really necessarily have the buy in from clinicians to get held accountable for things they -- that don't feel to them like it has anything to do with how they practice medicine. And you have I think, other than if you are measuring purely based on claims -- which is what those population level metrics are, right, they are claims based measures. And I've always been a fan of claims based measures when they are used in the right way. But I think we also have a problem of data, because we know in order to get more accurate in our measurement that we need clinical data. And the ability to capture that data, to have clinicians understand what their own performance is using the right data sources so that they can improve -- because remember, at the end of the day, all this is about improving care -- and clinicians need to understand what it is they need to do to do that -- we need to really bolster the data infrastructure and the exchange of data and the digital nature of data in order to be able to do that well. And I think, frankly, Covid has exposed a lot of these

problems, which we already knew were there, but have been made worse by the pandemic.

And so just -- you know, I know this is a long-winded answer -- I apologize for that.

DR. INTROCASO: No problem.

DR. GOODRICH: But I do want to acknowledge that progress has been made, but we haven't gotten yet to a place where the country is sort of uniformly focused on a key set of metrics that really matter for helping us to improve health and that are associated with -- that have a clinical relevance and association with cost so that our providers out there, whether they're clinicians or hospitals, or nursing homes, really have an understanding of what their performance is, what their targets are, so that they can actually do the good work and the very hard work of improving care for patients.

DR. INTROCASO: Okay. Helpful. Thank you.

So just to further follow up on some of the points that you've made, that obviously part of the impetus for quality measurement is to help provide the data to clinicians such that they can change or improve

their own performance. And the flip side of the coin, from the payer's perspective, is to financially reward superior quality performance. There are other reasons given, particularly of course most notably as a third selection, help patients or beneficiaries choose -- have more information to make an informed choice.

But let's stay with the clinician or the physician side that you've noted. And, again, relative to MedPAC, this is what's termed now MIPS, again, the Merit-based Incentive Payment System. This was created under MACRA legislation, as you well know, in 2015, and in 2021, per your noting, there are many measures. I did look. There are 206 measures for physicians from which physicians can choose if they're in the Part B Medicare program and are participating under MIPS.

So I know you are very involved in what CMS recommended a couple of years ago, and that was to in a sense reinvent the MIPS program. This was termed the MIPS Value Pathways, the MPV program. So can you explain what was the intent in moving the MIPS program to this renamed MVP?

DR. GOODRICH: Yeah. So maybe I'll give you a

little insight and the listeners a little insight into what CMS was thinking at that moment in time.

So I think we were trying to respond to some of the pitfalls of the program that we certainly understood ourselves and also, you know, were hearing from people like -- organizations like MedPAC, that really needed to change. And so I'll enumerate a couple of them that I think really drove this new thinking.

One is that because there were so many measures and clinicians could just choose whatever measures they wanted that you have to compare like to like, right. So the way MIPS is set up, it's essentially a tournament --

DR. INTROCASO: Right.

DR. GOODRICH: -- where it has to be budget neutral. And so you score everybody and you have winners and you have losers. And the money taken away from the losers pays the winners, right. The problem is that, you know, you've got -- I don't know -- 1.4 million clinicians in the country, a smaller subset of that are actually eligible for MIPS or are not in an APM. But that's still hundreds of thousands of

clinicians. And because they're choosing different metrics you have very small numbers of clinicians that you can actually with any given metric compare to one another. So actually benchmarking becomes very hard because except for some broadly used metrics like hypertension control, you have such a small number of clinicians reporting on any given measure that the benchmarks just aren't stable. And, by the way, it just makes it nearly impossible for anybody -- certainly a consumer -- but for CMS, for policy makers, for clinicians themselves, to really understand how they are doing in the quality of the care that they deliver compared to other clinicians, because we just aren't comparing everybody to everybody else because of all the different metrics that are being used.

DR. INTROCASO: Mm-hmm.

DR. GOODRICH: So we were trying to solve for that.

And also I think, you know, people choose the metrics that they were really good at, and we knew people were doing that, right, because the performance on metrics -- and, again, these were at the time mostly

process metrics -- were pretty high.

DR. INTROCASO: So these were the topped out measure problems, correct?

DR. GOODRICH: Topped out measures, yeah. And -- and CMS, to their credit, you know, really has removed a lot, but not all, of the topped out metrics. The challenge is removing all the ones I think that they would want to would mean leaving some clinicians who have to participate in MIPS with no metrics to report at all because they didn't have any that were relevant to them. So that was always a challenge.

The other thing that we always envisioned MIPS to be, and I don't think we ever had any belief that we were going to get there in the first few years, the goal of MACRA is to move clinicians into alternative payment models, to take on some level of risk. And clinicians have to be ready for that. Their practice has to be set up in such a way that they feel they are capable of doing that. You know, a lot of small practices didn't feel they had enough capital to be able to -- if they didn't do well under a risk arrangement, that they could survive. And clinicians needed to really understand

very clearly what it is that they needed to do in order to be successful in a risk arrangement. And, you know, a lot of practices out there don't have the sophistication or capability from a data perspective to be able to understand that. And so they don't want to take that risk.

And, to be frank, lots of clinicians are doing well under the fee for service system and the MIPS program. So there weren't always the incentives there. But, actually, when you talk to clinicians, a lot of them really do want to be able to transition into those kinds of arrangements, they just need the help doing it.

And so we always felt like in the ideal state MIPS could be organized and set up in such a way that it would be less of a large leap between being in a pure fee for service environment into even -- even a partial risk arrangement. Well, so we started looking at, you know, what -- how do APMs hold providers accountable. And so we wanted to set it up so that the kinds of things that providers in APMs are accountable for, which does tend to be more indexed toward outcomes and total cost of care, we could start to transition MIPS in

that direction as well.

So those I would say were sort of the two big things that we were trying to -- to solve for in beginning to transition towards. And what we heard from clinicians and specialty societies and others, that that is exactly what they wanted us to do.

So in MVP was born out of not only I think the heads of people at CMS, but very much the heads of a lot of clinician societies that we talked to when I was there who -- we started thinking about these bundles of metrics. And I'm not talking about bundle payment here, but bundles or collections of clinically related metrics that -- for example, if you are a, you know, retinal surgeon, that all retinal surgeons, you know, who are part of MIPS would report on the same small set of metrics that are related to, you know, retinal surgery or retinal care. And that over time those bundles of metrics would be more outcomes oriented or mostly or only outcome oriented. And then you might only need one or two metrics. This is -- was going to be always in transition. And that the cost metrics clinicians are accountable for -- because, remember, the legislation

under metrics that MACRA says that costs us to account for 30 percent of your score under MIPS and that -- so we began some work when I was there to develop episode based cost metrics that could be developed to be clinically related to the related quality metrics.

So, again, let's stick with the retinal surgery idea that CMS could develop a retinal surgery or, you know, retinal ophthalmology cost metric that is an episode-based cost metric that we would use for retinal surgeons while they also reported on related quality metrics. And so that would be much more clinically meaningful to retinal surgeons and would be more meaningful to patients who are looking for retinal surgery. Again, we're talking ideal state here, right.

DR. INTROCASO: Mm-hmm.

DR. GOODRICH: That that would be easily displayed and described on a website so that a Medicare patient or any other patient could go on a compare site and be able to understand the differences in performance around quality and cost. And it would be an actual real difference in performance.

So those are the things we were trying to

solve for with the MVPs.

DR. INTROCASO: So to summarize, the idea would be fewer measures, which would lower the burden.

DR. GOODRICH: Yes.

DR. INTROCASO: Ideally over time they'd be increasingly claims based. That they're -- you would have solved for the apples to apples issue or comparison.

My --

DR. GOODRICH: I might correct one thing quickly.

DR. INTROCASO: Sure, please.

DR. GOODRICH: I -- I don't know that we always -- we feel like -- when I was there -- I don't want to speak for CMS now, but when I was there we didn't always feel like claims based was necessary because it's really hard to get enough rich clinical information, particularly when you talk about outcome metrics and you maybe deduce some risk adjustment. You may not always have all the information you need from claims. So this is where actually sort of the specialty registries came in. And I -- I often use the

ophthalmology example because of the IRIS registry that AAO put forward where they actually have developed a number of good outcome focused metrics for ophthalmology. That they've developed a way to be able to ingest those data from EMRs in clinicians' offices that then calculate the measures for them.

So we also were doing some work, you know, on sort of the -- I'll call it sort of the technology and data side -- to be able to facilitate a movement towards more electronic -- often through registry based measures, but that rigor around them, right, and that were using appropriate standards that could really, through the use of these standards, like the FHIR standard, ultimately be able to really lower the burden on the actual clinician practices in the reporting, to where it can be done almost automatically. But, you know, we're certainly not at a point where that is a reality for all clinicians, but it is certainly a lot closer than it was even two or three years ago.

DR. INTROCASO: Okay. Thank you. I was only intending that ideally claims based reduces reporting burden on clinicians.

DR. GOODRICH: Mm-hmm, mm-hmm.

DR. INTROCASO: So that's -- that's --

DR. GOODRICH: True.

DR. INTROCASO: That's the ideal.

Let -- let me go to -- well, I will say, relative to MedPAC's recommendation -- and I'm assuming you would be opposed to this idea -- and that was that in MedPAC's rec that a modified MIPS program be voluntary. I'm assuming you would not agree with that?

DR. GOODRICH: I think that if we really -- one thing the MIPS program did do that I think was good, you know, for all of its challenges, let's say (laughing) -- one thing we know it did from lots of surveys of clinicians that we and others have done is that it really got people focused on quality. And it was kind of a -- you know, it was kind of a moment I think when MACRA passed for a lots of reasons, but it also -- it really did for a lot of practices force them to get focused on -- on quality in ways they may not have been and often were not previously.

So I think it had that effect. Now, how that ultimately pans out in terms of improving outcomes for

patients, we just don't know yet. And that is ultimately what it's trying to do of course, and to lower costs.

So I do think that physicians and other clinicians in this country should be as focused on quality as they are on, you know, almost anything else in their day to day practice. That's not quite a reality yet, but I think that's important. And so I do think payers need to hold -- I mean payers, you know, want to buy high quality care for their members or for their beneficiaries. And so for that reason I do think that in some fashion that the payers need to hold providers accountable for quality and cost. I -- I would say they're -- I'd like to -- I think moving to alternative payment models is a better way to do it than MIPS, but I think if MIPS can be a genuine effective pathway to get there, then I would say no it shouldn't be voluntary. Although, there -- as you know, there are provisions in MACRA to exclude certain types of clinicians if they, you know, don't see enough Medicare patients or what have you.

DR. INTROCASO: Right.

DR. GOODRICH: So there are some exclusions, yeah.

DR. INTROCASO: Right. Low volume.

Let's -- let's -- I think I can combine this question by bringing in the -- the -- the APM pathway under MACRA legislation.

DR. GOODRICH: Mm-hmm, mm-hmm.

DR. INTROCASO: So these are alternative payment models. Moreover, relative to participation -- we're talking largely accountable care organizations or termed the Medicare Shared Savings Program under the ACA.

And let me go to -- and this was mentioned -- you've commented -- I mentioned in my opening -- you've commented on this -- and this is the value issue. And so as I mentioned in the opening statement, there is a best a tenuous relationship between quality and cost or spending. As you're well aware and as you noted under MIPS, quality and cost are scored separately not simultaneously. And this is similar in the leading of P4P, pay-for-performance programs, including ACOs. So under the ACO program, obviously, there's a quality

measure set. ACOs reward -- or the ACO program will reward shared savings, or can reward shared savings to low quality performance -- performing ACOs whom however have reduced spending or spent below their benchmark.

But this is the generic issue again of producing value in health care delivery, particularly since -- I should mention as an aside -- since we're moving to price transparency. So if we want people to shop, just knowing the price certainly wouldn't be enough. And this, I'm sure you're well aware, references Michael Porter's long-time complaint. In fact, I'll quote a statement he made in a 2010 New England Journal piece where he noted the failure to adopt value as a central goal in health care and measure value are arguably the most serious failures of the medical community.

So my question, long-winded here, is how do we get to or how do we move to -- you could phrase it as simultaneously measuring cost and quality? I think the MVP program is trying -- is trying to get there. Or phrased otherwise, how do we correlate as a numerator-denominator outcome achieved relative to

spending?

DR. GOODRICH: Mm-hmm, yeah. You know, I think there's a couple of ways that this is happening now, neither perfect of course. One is, you know, there's definitely been a movement within alternative payment models that really measure total cost of care, right, which doesn't necessarily get you to a direct correlation with the quality metrics that, you know, providers are also held accountable for. So within most APMs total cost of care is -- is the cost metric. And that probably makes sense for -- in -- in some instances. And I -- I think -- I think that's actually a really important metric over all. And I think in particular when you're talking about like a global budget or something like that, that -- that total cost of care makes sense.

But I think what you're talking about that -- you're right, this is what we started to really work on in MIPS and actually I think could be applied to certain types of APMs, particularly if you're talking about like specialty focused APMs.

DR. INTROCASO: Or bundles.

DR. GOODRICH: Or bundles. Exactly.

DR. INTROCASO: Right.

DR. GOODRICH: Yeah, yeah, bundles. Right. Where the cost metric that you're using -- you know, I would say in the ideal state is kind of co-developed with the quality metrics that should be outcome oriented. And, frankly, there is one space in which CMS did this. And that actually was a set of quality and cost metrics that -- that when I was there were developed for the hospital programs. So we had spent a lot of time even before I was there working on readmission and mortality measures for acute myocardial infarction, or heart attack, congestive heart failure, and pneumonia. And that's now expanded to COPD and -- and cardiac bypass as well, and stroke. And there's a methodology to developing those that are actually all aligned with one another. You know, I'm not going to get too meaty here, but, you know, the risk adjustment methodology or how you define the patient population, how you define your exclusions, all those kinds of things. There's so many details that go into crafting a metric that frankly are in many are in many ways almost

like little mini policy choices you have to make. They're not just all about math.

And then when we were developing -- we said, look, it -- it -- we think it's really important to be able to compare, you know, the cost of care at the hospital level for these same conditions. And so we developed a set of metrics that were cost of care for pneumonia, for heart attack, for congestive heart failure. And those were developed using the same methodology that was used for the quality metrics on those same clinical conditions.

So -- and we've done something similar actually for orthopedic surgery, for hip and knee replacement. And actually on hospital compare, that we displayed those side by side. Now, that was really more for the -- the use for those measures turned out to be -- were for transparency. They weren't use for -- the cost side of those metrics weren't used for accountability. But I think that that was, you know, CMS's first foray into doing that and that really informed how, when I was there, we started thinking about the MVPs and how cost and quality metrics really

needed to be aligned in every way, because the details of measures actually matter. They actually impact how, you know, a clinician may report the measure, how they made -- what -- what behavior changed that measure drives, et cetera. So if the cost and quality measures are not sort of co-created in the same way, then you definitely are leaving some opportunity on the table to really drive behavior change on cost and quality, sort of in the value equation together. And that is the vision for the MVPs on the cost and quality side is to be able to do that. The way it's starting, we're sort of starting with what we have, which is, you know, a set of quality measures that are often specialty specific, that weren't necessarily --in fact usually were not developed by the same -- in the same way or by the same entity as the cost measures.

So I think it's a good start because we're going to be able to bundle those things together, but they're not going to look exactly alike. And so there's a lot of opportunity I think to -- to move more in the direction of sort of that co-creation to really then have that metric of value.

DR. INTROCASO: Okay. Thank you. I'll just note as an aside, maybe you noticed as well, but this past congressional session, the chair of the HELP committee, Senator Alexander, passed out of -- out of HELP the Lower Health Care Cost Act of 2019. Section 303 would have created a non-governmental entity to report national health care costs, but interestingly as well, that provision includes reporting cost, quality, and value data. Of course, the bill didn't get to the floor, but clearly this was on the mind of the HELP committee this past session.

There are two specific issues about quality metrics I'd like to get to, and one is the issue of social factors or social determinants and your view thereof. You're probably aware that in September ASPE, the Assistant Secretary of Planning and Evaluation, came out with a report recommending quality measures used in pay for performance measures -- arrangements rather -- not be adjusted for social determinants or social risk factors. This issue has been topical for the last, I'd say, probably five years. Interesting as well, most recently physician payment for '21 -- and the final rule

just out two weeks ago -- CMS will allow physicians to code for social determinants when they're billing for their Evaluation and Management services, which is 40 percent of physician billing.

So at one end you're hearing to leave social determinants in weighting quality measures, and from another perspective we're going to allow for it in how physicians code for their E&M charges.

So what's generally your sense of where social determinants place in quality metric performance?

DR. GOODRICH: It's a really interesting and important part of the consideration around performance. This is something I spent a lot of time thinking about when I was at CMS and, frankly, you know, still do. You know, to -- to, you know, completely oversimplify it for a moment, you know, the thinking is if you aren't accounting for social risk, which is what we've sort of came to call it when we were -- when I was at HHS -- it means the same thing -- if you aren't accounting for social risk, if people -- clinicians or providers who take care of patients at high social risk, high poverty, poorly educated, low literacy, you know, low income.

DR. INTROCASO: Housing insecure, et cetera.

DR. GOODRICH: Housing --

DR. INTROCASO: Yes.

DR. GOODRICH: Housing insecurity, food insecurity, all those things. Quite, you know, obviously those patients -- you know, we know that those are the things that drive, you know, health outcomes, you know, more than medical care. And so it -- it is, you know, in some instances more work, I would argue often rewarding work, to care for those patients. But they -- they come to you for -- a practicing clinician, you know, with already, you know -- at -- at a disadvantage from a health perspective. And so if you -- if those -- if providers who take care of those patients do worse on quality measures, sometimes it may be because they care for a high proportion of payments at high social risk, and we shouldn't penalize them for that. That's -- that's the thinking on -- on that side. And -- and if you do, then they're going to stop taking care of those patients and then those patients will have even worse access than they already do.

So that is the argument there.

DR. INTROCASO: Right. This is the reverse Robin Hood effect, correct?

DR. GOODRICH: Yeah, right, right. (Laughing)

And there's, you know, a whole body of literature as I -- as I said about, you know, the fact that social determinants of health, you know, influence health more than medical care does, right.

The challenge is that there's also a whole body of literature that says that people who are at higher social risk and also, frankly, minorities, although this doesn't enter into the conversation quite as much, but this is true from what the medical literature, and all kinds of literature, tells us, get worse care. They -- even within -- within a health system that may be overall -- you know, has some level of -- whatever level of performance, that people at higher social risk within that same setting get worse care than people who are not as disadvantage.

And so I think the challenge with risk adjustment has been that if you risk adjust for those factors then you are leveling the playing field for all clinicians and you are potentially holding clinicians

who may be actually providing risk care -- you're -- you're -- you're sort of, you know, not accounting for that. Because the things that you want to risk adjust for when you're talking about a quality measure are the things that are absolutely not under the control at all of the provider and that don't in and of -- don't have a relationship in and of itself to the quality of care that's provided. And I think there's two schools of thought on that as it relates to social risk. Some would say, well, of course, doctors don't have any control over patients' social risk factors. Well, that's true. But on the other hand, what they do have control over is whether or not they provide the same high quality care, in line directed care, for example, as they would somebody who is not at elevated risk from a social perspective.

And so that's really been the push and pull here in this topic. And so, you know, I think Congress has long recognized this and MedPAC has long recognized this. And I think the feeling was that, you know, by ASPE, was probably -- and this is, you know, having not looked at the report in a very long time, so forgive me

if I get the details wrong -- but was, you know, by risk adjusting you are also, you know, masking disparities in care and you are, you know, sort of holding providers harmless who actually do provide lower quality care to people at higher risk. And you don't want to do that.

What you want is transparency into the quality of care provided and you, frankly, want to be able to do everything you can to help low performers become high performers.

DR. INTROCASO: Mm-hmm.

DR. GOODRICH: And that clinicians and other providers who care for a lot of patients at high social risk actually need more resources and need more help. And that is true. I definitely believe that.

So we sort of came up with -- well, we didn't actually at CMS -- MedPAC and -- and Congress, you know, also following I think some of MedPAC's recommendations -- came up with this idea of sort of peer grouping, right.

DR. INTROCASO: Correct, yes.

DR. GOODRICH: Where -- comparing like to like. So comparing in the hospital world, you know,

hospitals that have a very high proportion of dual eligible patients get -- get compared to one another. And you -- you know, I think we divided into quintiles, right. And so there were five strata and -- and hospitals within each quintile were compared to one another. And that quintile was defined by a proportion of patients who were dually eligible.

And I think that was a -- a really good compromise, if you will, to risk adjusting versus, you know, doing nothing because it felt fair to providers, and yet it also allowed for that transparency. And, you know, it took into account the fact that it is harder to take care of patients who are higher social risk. It takes more effort. When I say harder, all I mean is it takes more effort.

DR. INTROCASO: Right.

DR. GOODRICH: Because you have to account for more than just like dispensing a medication. You have to do a lot of care coordination, right, and interacting with community organization and that kind of thing to care for these patients. And it -- and it -- it accounts for that. But also leaves sort of the

transparency on the performance in place.

DR. INTROCASO: Yes, thank you. On the peer grouping I'll just mention the complaint was when CMS, per the BBA on site-neutral payment, MedPAC came up with a recommendation that because hospital HOPDs may see patients that are more compromised, that they employ a peer grouping because the -- the comparison was that free standing physician practices did not see -- or saw generally a healthier population. Site-neutral then did not account for differences in patient populations.

We have time for I think two more questions. You did mention patient reported outcome measures. You do know there's been an effort in quality measurement toward greater us of PROMs, Patient Reported Outcome Measures. You're well aware, led in part by this international group, the iInternational Consortium for Health Outcome Measurement, the use of quality measures, PROMs, are more relevant to patients, they better engage them and, again, as I noted, they can help lower reporting burden for clinicians.

The U.S. has been somewhat slow -- I would say comparatively slow to adopt PROMs measures. What's your

sense of how we'll progress in the use of patient reported outcome measures?

DR. GOODRICH: So, to me, the challenge with patient reported outcome measures is more of a technical challenge than it is a policy or a strategic challenge. I -- I will tell you, during my time at CMS I was very hard-pressed to find almost anybody -- certainly on the patient and consumer side, but also on the physician and provider side, who felt like that -- who felt like PROMs, you know, wasn't the way to go. Like that -- I would -- I don't know if that's universal, but you would have pretty broad agreement that PROMs would be so much better than like all the process measures we have now for all the reasons that you cited. And in -- in I would say the more sophisticated settings, where -- that are using PROMs daily to help them take care of their patients -- and there are some in this country -- you know, orthopedic practices that use the HOOS and the KOOS, you know, primary care practices that are using the PHQ-9. For practices that actually meaningfully use these types of metrics, not because the payer is telling them to, but because it actually helps them, like they'd

never go back. And -- and they -- it has been worth it to them to invest in the infrastructure needed to be able to capture this information and to be able to use it.

So the -- the -- the reason it's been difficult to implement broadly is a couple of things. One has to do with measure creation itself. These measures actually are, you know, I think much -- because they are more sophisticated, they rely on mostly survey instruments. I don't mean surveys like the CAHPS survey, but like a -- you know, a Likert Scale around symptoms, like the PHQ-9 is -- is a survey, if you will. So it relies on those types of instruments. And then being able to capture that information very easily and -- and consistently is something that we don't yet have broadly, nationally, the infrastructure to be able to do.

There's also work that needs to be done to really understand what are meaningful differences in scores on these metrics between point A and point B. So the ways these work is -- let's just take the PHQ-9 and the depression measures -- depression remission

measures. You measure, you know, PHQ-9 on the patient at point A and then nine months later at point B and you look for a change, hopefully improvement, in that score over time. There's still some work -- a lot of work to do I would say -- and I'm not speaking to this measure specifically, but in general around PROMs, around what are meaningful differences where we can actually compare providers to one another on those scores and, you know, pay differentially on those scores. What's meaningful there. And so -- and what's fair. Is a difference of one point for this particular type of -- of PRO meaningful and five points on this other PRO meaningful? That -- that is research that is underway but needs to happen with each of these types of metrics. So I would say these are -- we're earlier in our understanding of the measurement science, but we're not beginning. There's been a lot of work done here, but we are earlier in our understanding of the measurement science of what the legal differences are with -- with PROMs than we are even with other types of outcome metrics. And we don't have the technology infrastructure because we have such, you know, dispersion of different types of EMRs and of

different health systems to be able to capture these data, again, at a national scale in a standardized way. I think as we continue to evolve the standards, and of course as we are working towards, you know, broader implementation of the FHIR and other types of standards, that we will get there. I think we're definitely on the right path.

But those have been the barriers. It hasn't been for lack of belief that these -- these are the right kinds of metrics to use. I think there -- we're in good shape there.

DR. INTROCASO: Okay, thank you. Let me try this one last question in our remaining few minutes. And that's I know you're being from Louisiana, you're interested in the adverse health effects, particularly disproportionately on minority communities, the climate crisis is having. This month you may know that health affairs for the first time in its history addressed the climate crisis by publishing a series of climate and health-related articles. Several articles argued health care organizations report as a quality measure their greenhouse gas emissions, also too that climate

relevant clinical measures, for example, instances and treatment of heat stroke and heat exhausted, be used in scoring pay-for-performance arrangements, such as ACOs, and that payers, including the Medicare program, offer providers financial incentives to de-carbonize because, of course, their emissions contribute to the -- to total emissions that, of course, compromise patient health, particularly seniors and the frail elderly.

What's your perspective on building into quality measurement performance measures related to the health effects resulting from warming?

DR. GOODRICH: Yeah. So in answering this question, first I'll say I'm very much speaking for myself here. I don't want to speak on behalf of the CMS or Humana --

DR. INTROCASO: Sure

DR. GOODRICH: -- on this answer because it's not something that I think payers have thought a lot about. But I -- you know, thank you for sharing these articles with me. And a while ago you sort of alerted me to this -- this thinking here. And I just find it fascinating as somebody who personally cares deeply

about addressing climate change. I mean, you know, the -- the incoming administration has made it very clear that they see addressing -- you know, climate change is -- is an existential threat. I mean there's just no question about that in my mind. And that it is -- I believe this administration is likely to take some pretty significant action to, you know, address this. And I think there's a lot of will for that to happen, you know, nationally.

And what I think that's going to end up meaning is that a lot of actors in our country who have not really necessarily traditionally thought of themselves as having an accountability or responsibility for addressing the climate crisis, or at least in ways that, you know, they haven't necessarily thought of before, are, you know, going to be held accountable or should be held accountable. And so it's been remarkable to me to be educated by you and others about the extent to which health systems and hospitals actually -- you know, what their carbon footprint is. And these are organizations that are dedicated to improving the health of people.

And so I think that it's a very interesting idea to think about how can that -- if you have a national agenda on addressing climate change that holds multiple types of organizations accountable for this, you know, for let's just say hospitals, although you could, you know, pick on other facilities as well I'm sure, you know, measurement to improve is something that they're very familiar with. And so I think, you know, it would be really interesting to have an agenda to think about what are exactly the right metrics, how do we measure them, and then what do we need to do to hold hospitals and others accountable for it?

So it's a very intriguing concept to me. It is something that, you know, now that this is becoming more broadly recognized as an issue and this is I think a -- a very potentially impactful way to try and address it -- because think about it, if you can actually measure it and you can make it transparent, transparency alone is a big driver for improvement. And then, you know, maybe ultimately you get to, you know, holding people accountable from a financial perspective for it. But even just the transparency alone around the carbon

footprint, however you decide to measure that, of any individual entity will probably be a really important first step to making change.

DR. INTROCASO: Okay, thank you, Kate. We're at our time, so I genuinely appreciate this overview. Of course, we could go on for hours about quality measurement and performance benchmarking, but this is a very good assessment by you relative to reform possibilities here in -- in the quality space, so I thank you for that.

DR. GOODRICH: Thank you, David. I really appreciate it. Enjoyed talking to you.

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