

Does CMS' Meaningful Measures Initiative Boil Down to Cost-Benefit Analysis?

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In late 2017, CMS announced a “Meaningful Measures” initiative that it said would identify “the highest priorities for quality measurement and improvement” by assessing only “those core issues that are the most critical to providing high-quality care and improving individual outcomes.”¹ Skeptics noted that the matrix posted by CMS included 4 “strategic goals”; 6 “specific, overarching quality priorities”; 6 “cross-cutting criteria,” to include burden reduction; and 19 Meaningful Measure areas, which taken together seemed to contradict its accompanying promise to produce “parsimonious” measure sets.

Now, with the release of the Inpatient Prospective Payment System (IPPS) and other payment rules, application of the “burden reduction criterion” has become evident. The IPPS rule² introduced a new factor to be applied in determining whether to remove a measure from a value-based purchasing (VBP) program: “Factor 8: the costs associated with a measure outweigh the benefit of its continued use in the program.”

The proposed rule explained that to minimize costs associated with quality measures, CMS will consider “the burden associated with reporting” and “the costs associated with implementing and maintaining the program.” The rule also stated that “when these costs outweigh the evidence supporting the continued use of a measure in the Hospital VBP Program, we believe it may be appropriate to remove the measure from the program.”

Cost-benefit analysis is hardly new to federal rulemaking activity. Upon taking office in 1981, President Ronald Reagan promulgated an executive order (EO) mandating a formal cost-benefit analysis of new federal agency regulations. In 1993, President Bill Clinton ratified³ this structure in EO 12,866; it remains in force today.

Cass Sunstein, JD, the center-left legal scholar who served as federal “regulatory czar” under President Barack Obama, insists that “cost-benefit analysis has become part of the informal constitution of the US regulatory state.”⁴ But others further to the left strongly disagree.

Amit Narang, JD, of Public Citizen argues that “cost-benefit analysis is far more art than science and confers a false illusion of objectivity [and] should never be the basis for rejecting a proposed regulation—especially one required by law.”⁵ Along these lines, the Medicare Rights Center’s comment letter on the IPPS objected to

Factor 8 as not sufficiently “requiring the value of the measures to beneficiaries be meaningfully considered in making” determinations.⁶ Even Sunstein concedes that cost-benefit analysis raises “serious questions” about “values that are hard or impossible to quantify, such as human dignity.”

In my view, cost-benefit analysis poses no inherent harm. It is probably an implicit and underlying, if unconscious, calculation made anytime a regulation is or is not proposed. For instance, oysters are a source of foodborne illnesses, but nobody has seriously proposed banning raw bars. Why not? Because we intuitively understand that to deprive consumers of oyster bars would impose an intolerable cost relative to safety benefits. Formalized analyses are brought to bear in closer cases, and there is if nothing else a heuristic value to thinking about and attempting to quantify the costs of regulation and weighing them against the costs of nonregulation, which usually involve problems of information asymmetry and negative externalities. The latter problems aren’t hard to quantify, and plenty of proconsumer regulations have been promulgated under EO 12,866.

Factor 8 departs from precedent by performing an informal, impressionistic review rather than attempting to quantify costs and benefits. Looking at some of the actual measures that CMS would jettison under the cost-benefit test illuminates issues raised and sidestepped in the agency’s analysis.

A First Pass: The Elective Delivery Measure Is Out

In the IPPS, CMS proposed removing the elective delivery measure (referring to births) and 9 others under Factor 8, all of which probably could have been removed under existing removal factors. Elective delivery could have fallen under Factor 1 (no longer meaningfully differentiates performance), whereas the other 9 measures—6 patient safety measures that are also included in the Hospital Acquired Condition Reduction Program and 3 condition-specific cost measures that are rolled up into the Medicare per-beneficiary spending measure—all arguably fall under Factor 3 (availability of other measures).

Did CMS’ application of a cost-benefit test to the IPPS measures produce a more rigorous analysis than would have been presented under the other 7 factors? The thought here is no. For elective delivery, the rule presented a superficial discussion of an important topic.

The initiative to reduce early deliveries began with a well-known quality improvement success story, when Intermountain Health researchers discovered that early deliveries resulted in a small but statistically significant number of very costly complications and neonatal intensive care admissions.⁷ It's disappointing that the rule would not take note of this problem or the costs that have been avoided by holding providers accountable to restrict this practice. There is no discussion of any sentinel effect that retention of this measure could have in preventing backsliding.

With regard to costs, CMS engaged in some contortion to find a "burden" associated with this measure. The actual costs of collecting these data would be worth noting, because this is a measure that involves abstracting medical records. But because hospitals must continue to report the measure, the only relief from "burden" comes from "reduc[ing] costs and potential confusion for providers and clinicians to track the measure in both the Hospital IQR [Inpatient Quality Reporting] and Hospital VBP Programs, which may include reviewing different reports and tracking slightly different measure rates across programs." One tries to imagine the marginal burden of having 2 subbullets on the agenda for hospitals' perinatal quality improvement meetings. If there really is an additional cost, why didn't the rule cite any stakeholder communications in support of this proposition? Nor is there discussion of the more onerous option of having federal programs stop paying for early elective deliveries, which was rejected by then CMS Administrator Marilyn Tavenner as too burdensome, in favor of including a measure in the quality program. With its performative air and *ipse dixit* conclusions, one suspects this cost-benefit exercise was written up hastily to satisfy ideological and political imperatives, not to reform CMS quality programs.

A Second Pass: The Outpatient Vaccination Measure Is Out

A month later, in the Outpatient Prospective Payment Rule,⁸ CMS applied a more satisfying analysis to measure burdens, now discussing (although still not quantifying) the burden of chart abstraction and reassuring stakeholders that this alone will not provide sufficient justification for removal. Here, CMS scrapped the requirement that facilities report on influenza vaccination coverage among healthcare personnel. As the rule explained, the measure is reported through the National Healthcare Safety Network (NHSN) system, and "enrolling in NHSN is a 5-step process that...takes an average of 263 minutes per facility." The discussion goes on to enumerate multiple hassles posed by submission that will be familiar to anyone who has used the federal government's clumsy information technology systems, noting that hospital outpatient departments jump through these hoops only for the single measure. In terms of benefit, the rule points out that for 99.7% of outpatient facilities, vaccination history is already reported through the IQR program for most of the same workers.

A Third Pass: A Patient-Reported Outcome Measure on the Bubble

Perhaps the biggest puzzle to emerge from Factor 8 was the proposed removal of improvement in patients' visual function following cataract

surgery from the outpatient measure set. This is a rare functional outcome measure in a Medicare quality program, and it was ironic to see it targeted when "patient-reported functional outcomes" is listed among CMS' Meaningful Measure areas. What was concerning to patient advocates and payers who hope to see more patient-reported outcome measures (PROMs) adopted is that the very real logistical complexity of collecting these data cited in the proposed rule, involving survey administration, is a burden inherent in PROMs.

It appears that providers who report this measure—reporting is voluntary—objected vociferously, because CMS reversed itself in the final rule. However, the agency's explanation did not clarify the rationale behind the retreat; the text says that the voluntariness of reporting negates burden and that the measure offers "valuable data to consumers," but, as in the previous discussions, no attempt is made to expand on or quantify the benefits, which presumably include the value of improved outcomes resulting from competition. In short, there remains a cloud over the future of mandatory PROMs.

It's not clear that CMS delivered on its promise of parsimonious measure sets in the 2018 payment rules: Although the Hospital VBP Program is now down to 7 measures for 2021, its outpatient counterpart retains 19. The End-Stage Renal Disease Quality Incentive Program still contains 11 measures, including 3 weighted at 3% or less of the performance score. It would seem that the essence of the Meaningful Measures initiative is cost-benefit analysis, and if that is so, the project deserves more thorough and thoughtful implementation. ■

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