# CMS' Progress Toward Implementing Value-Based Purchasing

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# CMS' Quality Improvement Roadmap

- Vision: The right care for every person every time
  - Make care:
    - Safe
    - Effective
    - Efficient
    - Patient-centered
    - Timely
    - Equitable

# CMS' Quality Improvement Roadmap

- Strategies
  - Work through partnerships
  - Measure quality and report comparative results
  - Value-Based Purchasing:  improve quality and avoid unnecessary costs
  - Encourage adoption of effective health information technology
  - Promote innovation and the evidence base for effective use of technology

# VBP Program Goals

- Improve clinical quality
- Reduce adverse events and improve patient safety
- Encourage more patient-centered care
- Avoid unnecessary costs in the delivery of care
- Stimulate investments in effective structural components or systems
- Make performance results transparent and comprehensible
  - To empower consumers to make value-based decisions about their health care
  - To encourage hospitals and clinicians to improve quality of care

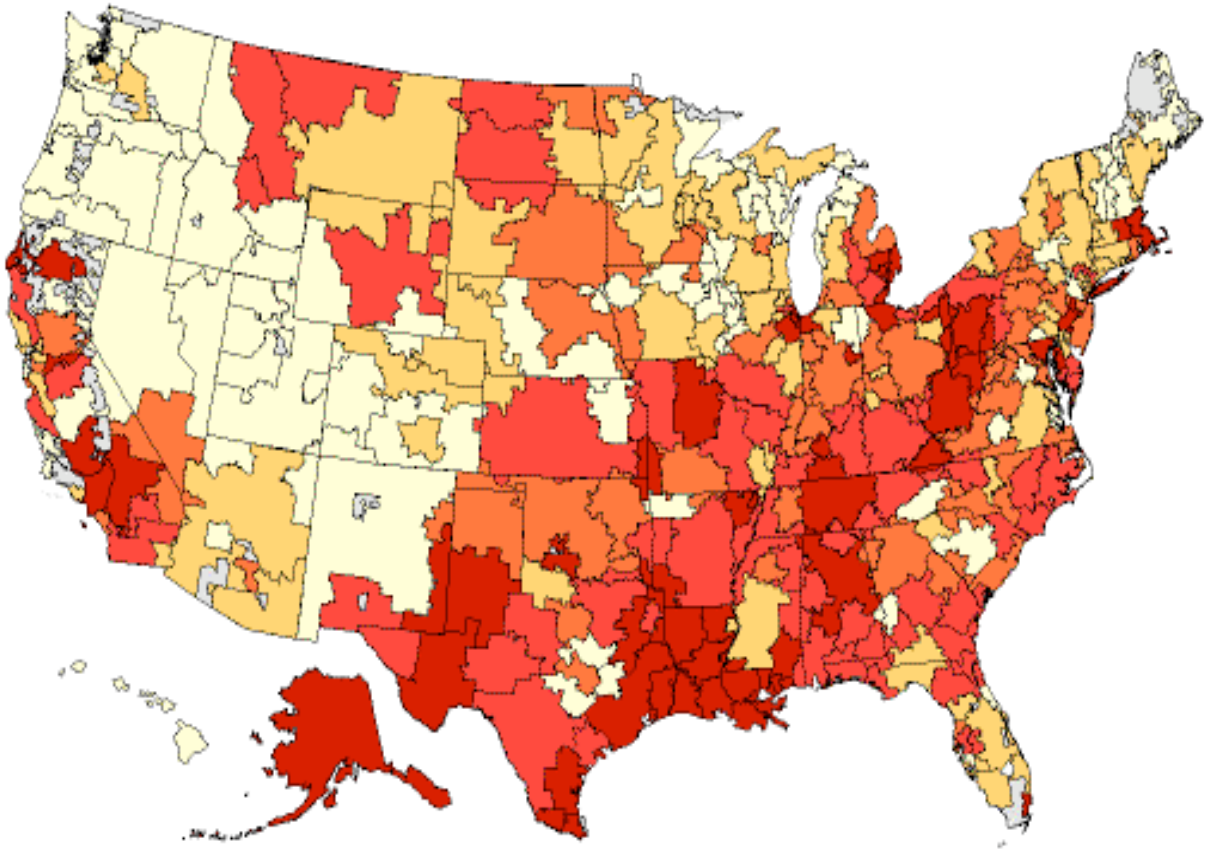
# What Does VBP Mean to CMS?

- Transforming Medicare from a passive payer to an active purchaser of higher quality, more efficient health care
- Tools and initiatives for promoting better quality, while avoiding unnecessary costs
  - Tools: measurement, payment incentives, public reporting, conditions of participation, coverage policy, QIO program
  - Initiatives: pay for reporting, pay for performance, gainsharing, competitive bidding, coverage decisions, direct provider support

# Why VBP?

- Improve Quality
  - Quality improvement opportunity
    - Wennberg's Dartmouth Atlas on variation in care
    - McGlynn's NEJM findings on lack of evidence-based care
    - IOM's Crossing the Quality Chasm findings
- Avoid Unnecessary Costs
  - Medicare's various fee-for-service fee schedules and prospective payment systems are based on resource consumption and quantity of care, NOT quality or unnecessary costs avoided
    - Physician Fee Schedule and Hospital Inpatient DRGs
    - Medicare Trust Fund insolvency looms

# Practice Variation

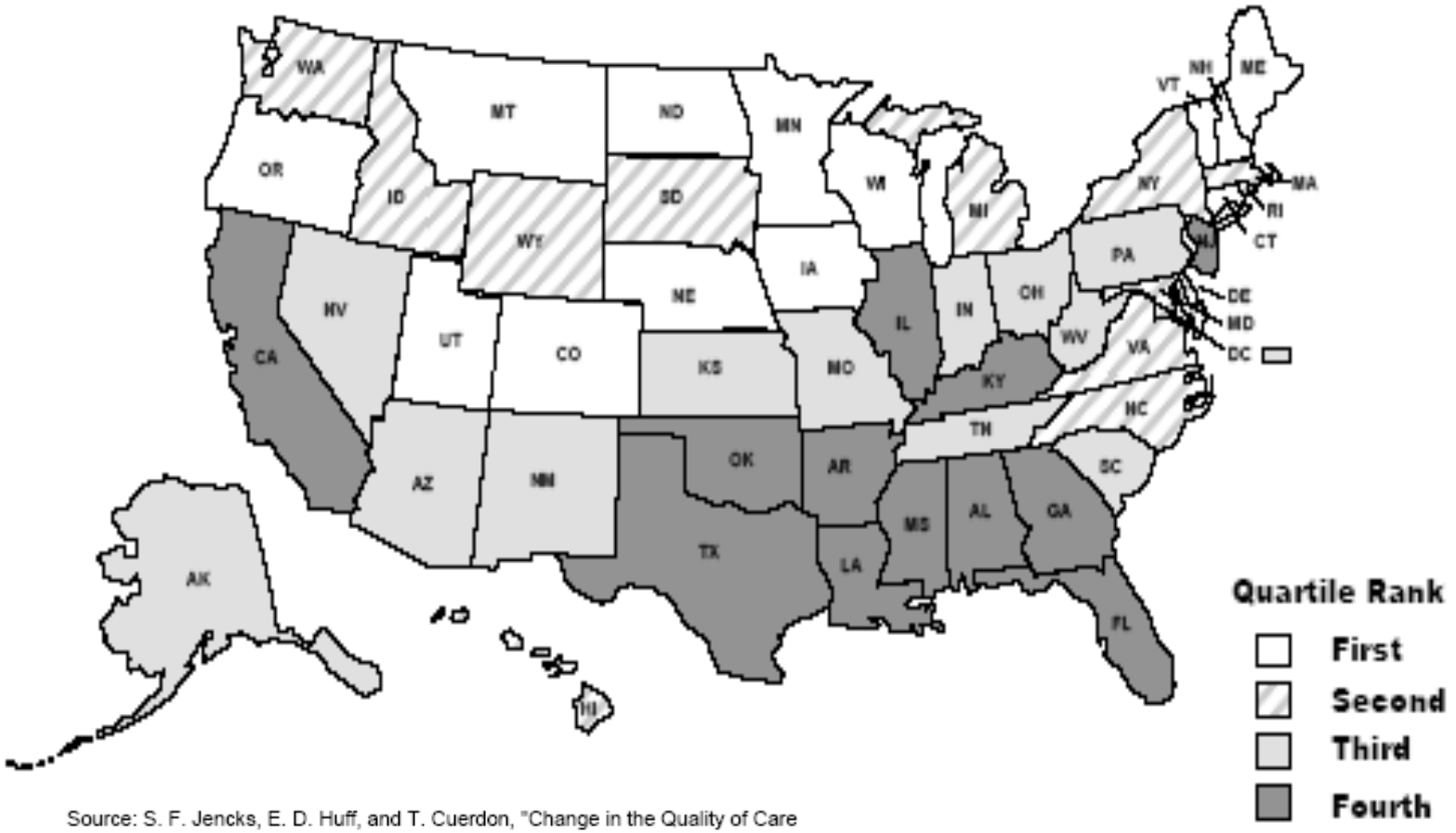


**Map 2.5. Inpatient Hospital Services per Medicare Enrollee**
by Hospital Referral Region (1995)

- $2516 to 3723 (61)
- 2321 to < 2516 (60)
- 2117 to < 2321 (61)
- 1893 to < 2117 (62)
- 1483 to < 1893 (62)
- Not Populated

# Practice Variation

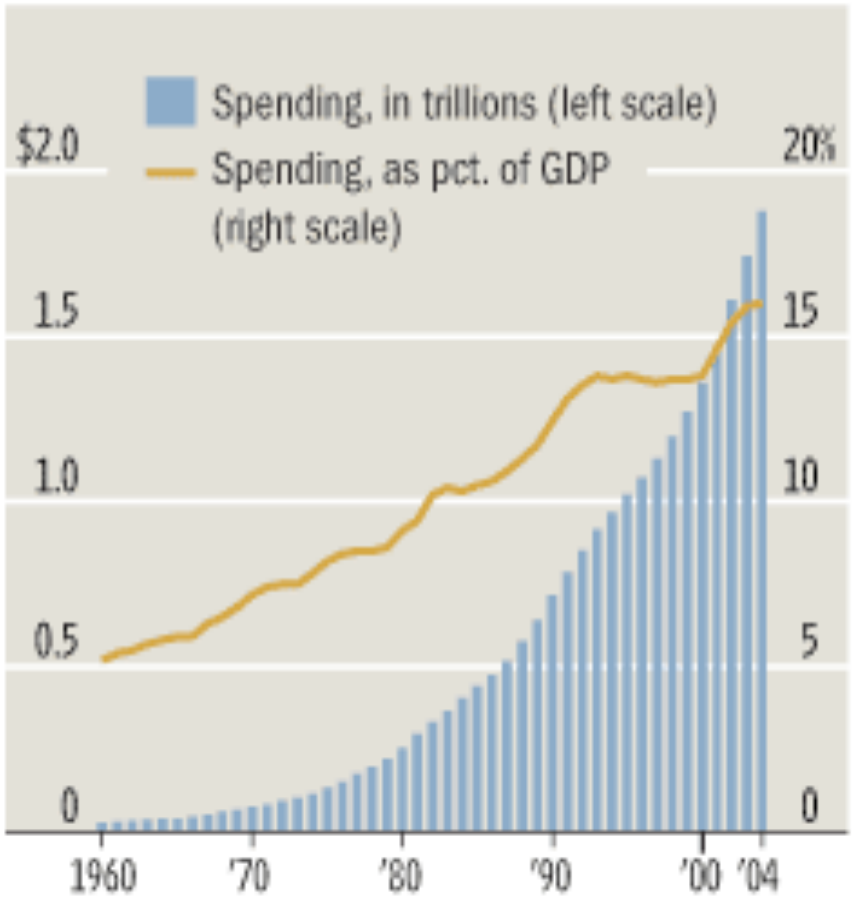
## Performance on Medicare Quality Indicators, 2000–2001



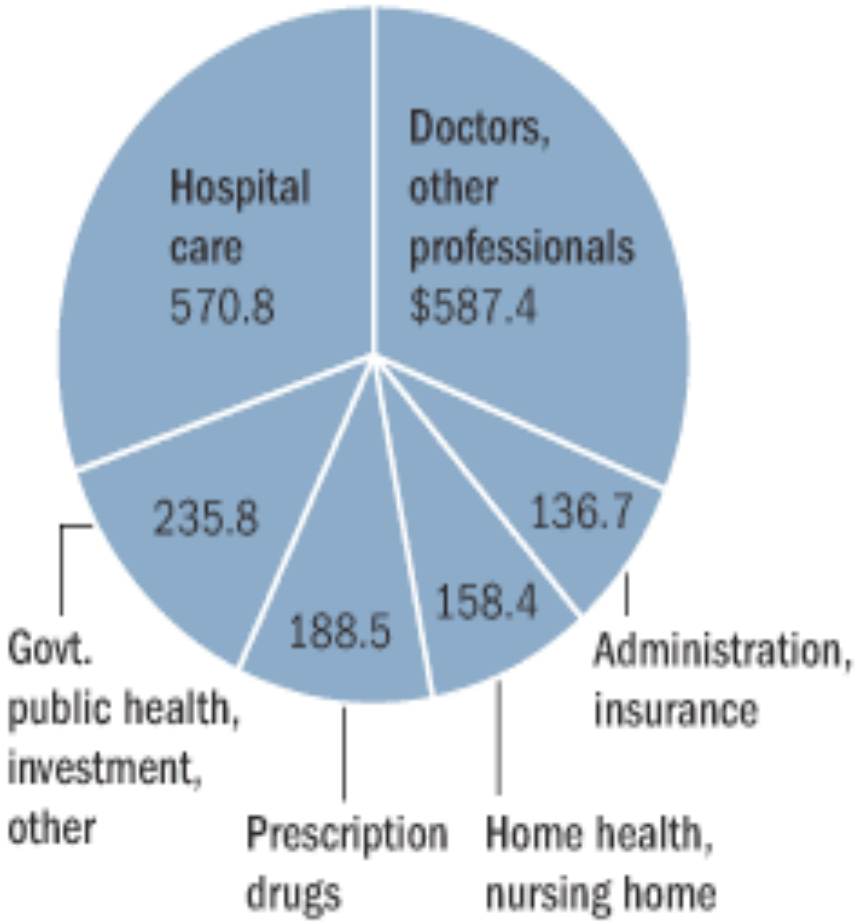

Source: S. F. Jencks, E. D. Huff, and T. Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289 (Jan. 15, 2003): 305–312.

# Health-Care Spending, American-Style

## Up, up and still up




## Where the money goes, in billions




Source: Centers for Medicare & Medicaid Services

# Support for VBP

- President's Budget
  - FYs 2006-09
- Congressional Interest in P4P and Other Value-Based Purchasing Tools
  - BIPA, MMA, DRA, TRHCA, MMSEA
- MedPAC Reports to Congress
  - P4P recommendations related to quality, efficiency, health information technology, and payment reform
- IOM Reports
  - P4P recommendations in *To Err Is Human* and *Crossing the Quality Chasm*
  - Report, *Rewarding Provider Performance: Aligning Incentives in Medicare*
- Private Sector
  - Private health plans
  - Employer coalitions

# VBP Demonstrations and Pilots

- Premier Hospital Quality Incentive Demonstration
- Physician Group Practice Demonstration
- Medicare Care Management Performance Demonstration
- Nursing Home Value-Based Purchasing Demonstration
- Home Health Pay-for-Performance Demonstration
- ESRD Bundled Payment Demonstration
- ESRD Disease Management Demonstration

# VBP Demonstrations and Pilots

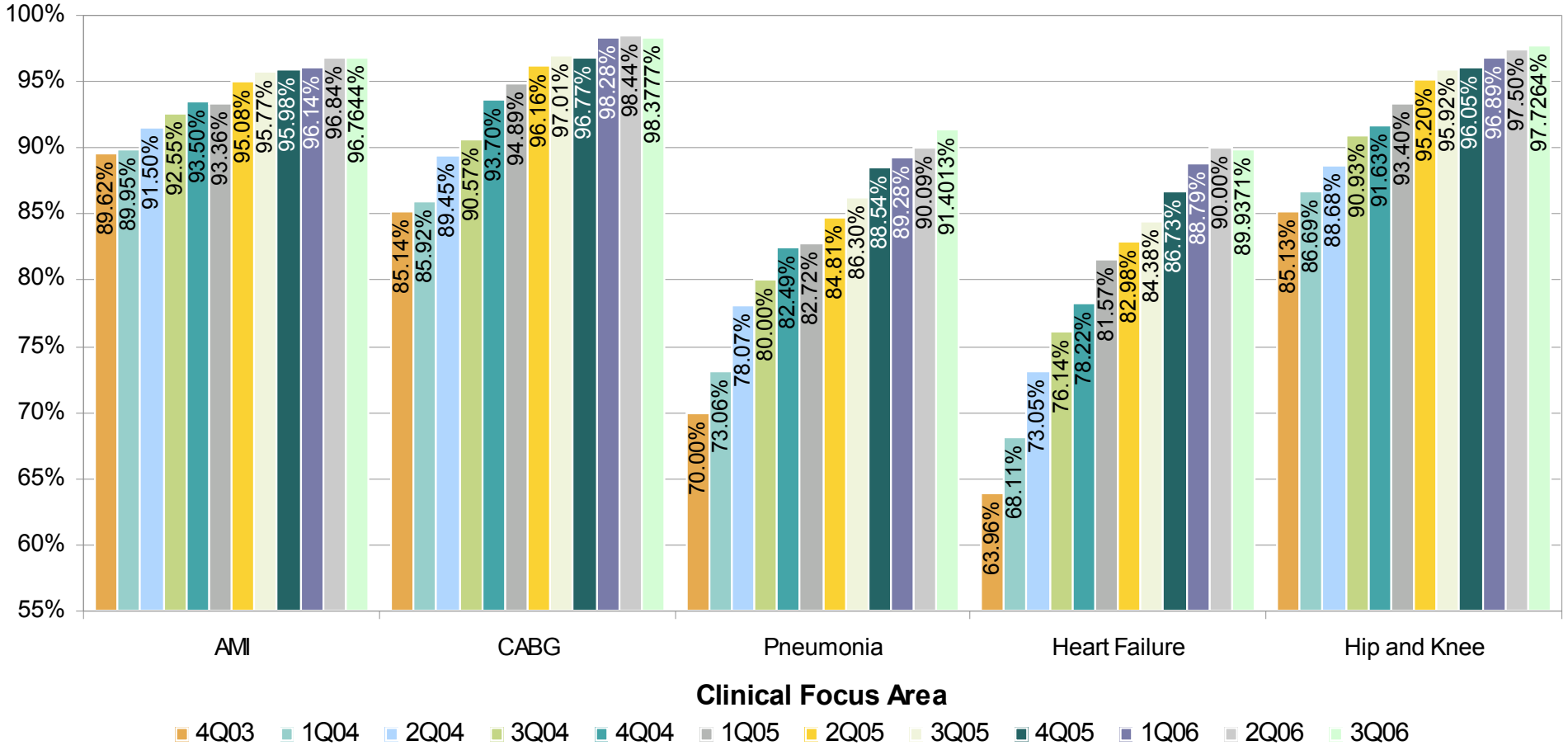
- Medicare Health Support Pilots
- Care Management for High-Cost Beneficiaries Demonstration
- Medicare Healthcare Quality Demonstration
- Gainsharing Demonstrations
- Better Quality Information (BQI) Pilots
- Electronic Health Records (EHR) Demonstration
- Medical Home Demonstration

# Premier Hospital Quality Incentive Demonstration

## CMS/Premier HQID Project Participants Composite Quality Score:

Trend of Quarterly Median (5th Decile) by Clinical Focus Area

October 1, 2003 - September 30, 2006 (Year 1 and Year 2 Final Data, and Yr 3 Preliminary)



# VBP Initiatives

- Hospital Quality Initiative: Inpatient & Outpatient
- Hospital VBP Plan & Report to Congress
- Hospital-Acquired Conditions & Present on Admission Indicator
- Physician Voluntary Reporting Program
- Physician Quality Reporting Initiative
- Physician Resource Use
- Home Health Care Pay for Reporting
- Ambulatory Surgical Centers Pay for Reporting
- Medicaid

# Hospital-Acquired Conditions and Present on Admission Indicator Reporting

# Value-Based Purchasing and Hospital-Acquired Conditions

- The Hospital-Acquired Conditions provision is a step toward Medicare VBP for hospitals
- Strong public support for CMS to pay less for conditions that are acquired during a hospital stay
- Considerable national press coverage of HAC has prompted dialogue of how to further eliminate healthcare-associated infections and conditions

# Statutory Authority: DRA Section 5001(c)

- Beginning October 1, 2007, hospitals must begin submitting data on their claims for payment indicating whether diagnoses were present on admission (POA)
- Beginning October 1, 2008, CMS cannot assign a case to a higher DRG based on the occurrence of one of the selected conditions, if that condition was acquired during the hospitalization
- This provision does not apply to Critical Access Hospitals, Rehabilitation Hospitals, Psychiatric Hospitals, or any other facility not paid under the Medicare Hospital IPPS

# Statutory Authority: DRA Section 5001(c)

- CMS is required to select conditions that are:
  - High cost, high volume, or both
  - Assigned to a higher paying DRG when present as a secondary diagnosis
  - Reasonably prevented through the application of evidence-based guidelines

# Inpatient Prospective Payment System (IPPS) FY2008 Final Rule

- Complications, including infections, acquired in the hospital can trigger higher payments:
  - MS-DRGs may split into three different levels of severity, based on complications or comorbidities (no CC, CC, or MCC—major complication)
    - The CCs and MCCs generate higher payment
    - The more severe the complicating condition, the higher the payment assigned to that CC or MCC DRG

# Questions to Address

- Burden
  - Incidence, cost, morbidity, and mortality
- Preventability
  - Guidelines and interventions exist
  - Application can prevent these infections
    - Interpretation of "reasonably"
- Measurement
  - Events appropriately detected using ICD-9 codes

# IPPS FY2008 Final Rule Structure

Each condition considered was placed in one of three categories:

1. Conditions selected for implementation – These conditions will have payment implications beginning in October 1, 2008.
2. Conditions being considered during FY2009 IPPS rulemaking – These conditions raise one or more implementation or policy issues that need to be resolved before they can be selected. We will work to address these issues and propose to reconsider these conditions during the FY 2009 IPPS rulemaking process.
3. Conditions needing further analysis – After exhaustive consideration, we determined that further analysis is required before considering these conditions.

# HACs Selected for FY2009

- Object left in surgery
- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection
- Decubitus ulcers
- Vascular catheter-associated infection
- Surgical site infection – mediastinitis after CABG
- Falls – specific trauma codes

# Category 2 HACs

- Ventilator Associated Pneumonia (VAP)
- Staphylococcus Aureus Septicemia
- Deep Vein Thrombosis (DVT)/ Pulmonary Embolism (PE)

# Category 3 HACs

- Methicillin Resistant Staphylococcus Aureus (MRSA)
- Clostridium Difficile-Associated Disease (CDAD)
- Wrong Surgery

# POA Indicator General Requirements

- Present on admission is defined as present at the time the order for inpatient admission occurs -- conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.
- Phased implementation

# POA Indicator General Requirements

- POA indicator is assigned to
  - principal diagnosis
  - secondary diagnoses
  - external cause of injury codes (**Medicare requires reporting only if E-code is reported as an additional diagnosis)**

# POA Indicator Reporting Options

| **POA Indicator Options and Definitions** | |
|---|---|
| **Code** | **Reason for Code** |
| **Y** | Diagnosis was present at time of inpatient admission. |
| **N** | Diagnosis was not present at time of impatient admission. |
| **U** | Documentation insufficient to determine if condition was present at the time of inpatient admission. |
| **W** | Clinically undetermined. Provider unable to clinically determine whether or not the condition was present at the time of inpatient admission or not. |
| **1** | Unreported/Not used. Exempt from POA reporting. This code is equivalent code of a blank on the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. |

# The Goal: Successful Documentation

" A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures."

*ICD-9-CM Official Guidelines for Coding and Reporting*

# Opportunities for HAC & POA Involvement

- IPPS Rulemaking
  - Proposed rule in April
  - Final rule in August
- Hospital Listserv Messages
- Updates to the CMS HAC & POA website
- Hospital Open Door Forums

# HAC & POA Indicator Reporting

- Further information about HAC & POA indicator reporting is available on the CMS website at: http://www.cms.hhs.gov/HospitalAcqCond/

# Hospital Value-Based Purchasing

# Hospital Quality Initiative

- MMA Section 501(b)
  - Payment differential of 0.4% for reporting (hospital pay for reporting)
  - FYs 2005-07
  - Starter set of 10 measures
  - High participation rate (>98%) for small incentive
  - Public reporting through CMS' Hospital Compare website

# Hospital Quality Initiative

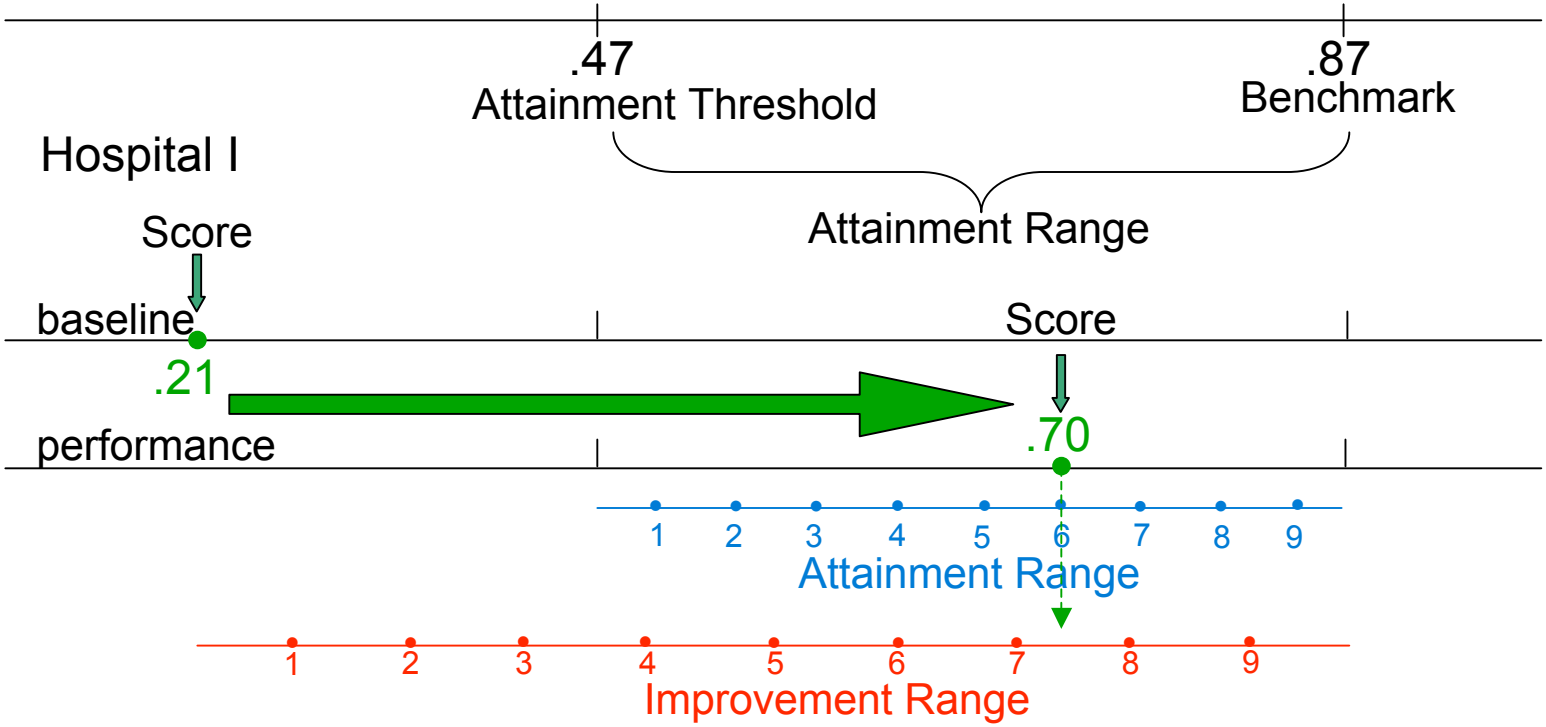
- DRA Section 5001(a)
  - Payment differential of 2% for reporting (hospital P4R)
  - FYs 2007- "subsequent years"
  - Expanded measure set, based on IOM's December 2005 *Performance Measures* Report
  - Expanded measures publicly reported through CMS' Hospital Compare website
- DRA Section 5001(b)
  - Report for hospital VBP beginning with FY 2009
    - Report must consider: quality and cost measure development and refinement, data infrastructure, payment methodology, and public reporting

# Scoring Performance

- Scoring Based on Attainment
  - 0 to 10 points scored relative to the attainment threshold and the benchmark
- Scoring Based on Improvement
  - 0 to 10 points for improvement based on hospital improving its score on the measure from its prior year's performance.

# Earning Quality Points Example

## Measure: PN Pneumococcal Vaccination




Hospital I Earns: 6 points for attainment
7 points for improvement

Hospital I Score: maximum of attainment or improvement
= 7 points on this measure

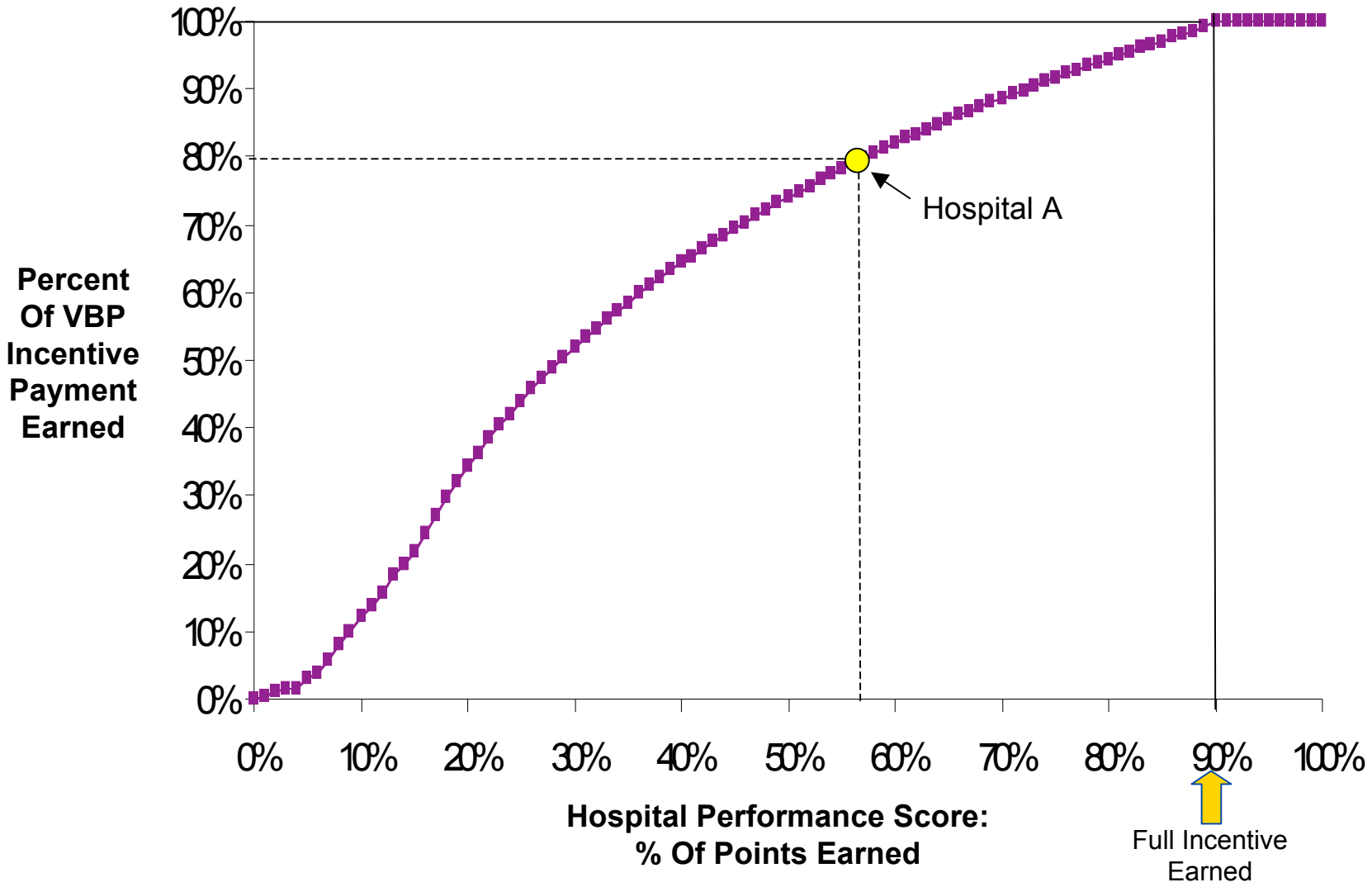
# Calculating the Total VBP Performance Score

- Each domain of measures is scored separately, weighting each measure in that domain equally
- All domains of measures are then combined, with the potential for different weighting by domain
- Possible weighting to combine clinical process measures and HCAHPS:

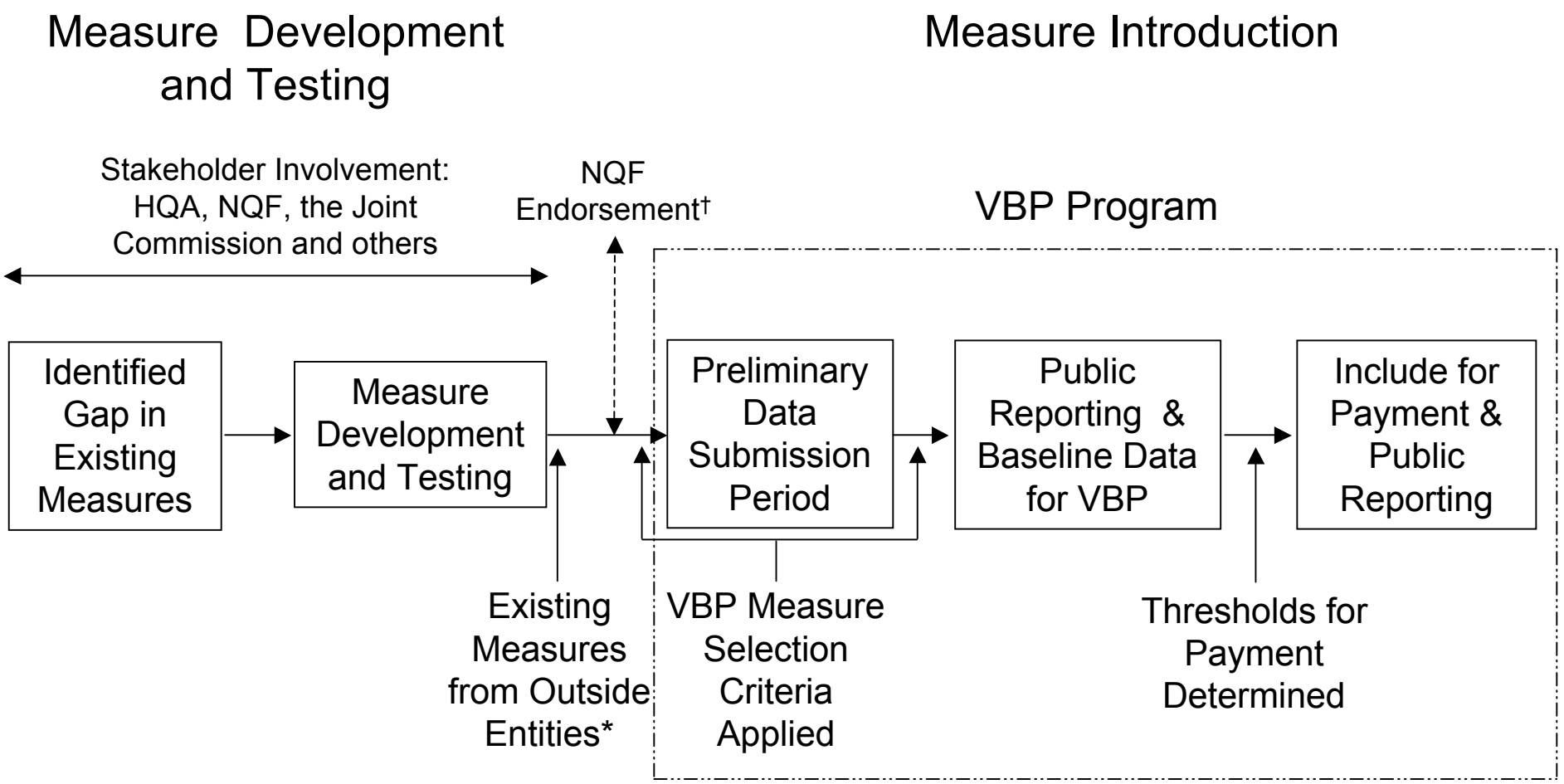
  70% clinical process + 30% HCAPHS

- As new domains are added (*e.g.,* outcomes), weights will be adjusted

# Translating Performance Score into Incentive Payment: Example



# Proposed Process for Introducing Measures into Hospital VBP




*Measures without substantial field experience will be tested as needed

†Measures will be submitted for NQF endorsement, but need not await final endorsement before proceeding to the next step in the introduction process

# Hospital VBP Report to Congress

- The Hospital Value-Based Purchasing Report Congress can be downloaded from the CMS website at:

  http://www.cms.hhs.gov/center/hospital.asp

# *Thank You*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