CMS' Value Based Purchasing: The Wave of the Future

Ninth National

Pay for Performance Summit

David Saÿen, MBA
Regional Administrator
Centers for Medicare & Medicaid Services
San Francisco

Betsy L. Thompson, MD, DrPH
Regional Chief Medical Officer
Centers for Medicare & Medicaid Services
San Francisco

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Overview

- CMS Strategy and Challenges ds
- Hospitals and Value Based Purchasing
- Physicians and Value Based Purchasing
- Other Initiatives and Programs
- Next Steps
- Questions and Comments

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Mapping the Road Forward

We will refine the way we do business...

by transforming business operations

ensuring financial stewardship of federal funds...

by improving payment models

by strengthening program integrity

to transform the healthcare system...

by improving quality care

by improving preventative health benefits

by expanding coverage

by strengthening consumer protections

and achieve our goals.

Goal 1: *Better Care and Lower Costs*

Goal 2: *Prevention and Population Health*

Goal 3: *Expanded Health Care Coverage*

Goal 4: *Enterprise Excellence*

Access the CMS Strategy on the CMS.gov website at:

http://www.cms.gov/About-CMS/Agency-Information/CMS-Strategy/index.html

THE CMS STRATEGY

OUR STRATEGIC GOALS

BETTER CARE, ACCESS TO COVERAGE AND IMPROVED HEALTH

The CMS Strategy is Built on Four Main Goals:

GOAL 1
Better Care *and* Lower Costs

Beneficiaries receive high quality, coordinated, effective, efficient care. As a result, health care costs are reduced.

GOAL 2
Prevention *and* Population Health

All Americans are healthier and their care is less costly because of improved health status resulting from use of preventive benefits and necessary health services.

GOAL 3
Expanded Health Care Coverage

All Americans have access to affordable health insurance options that protect them from financial hardship and ensure quality health care coverage.

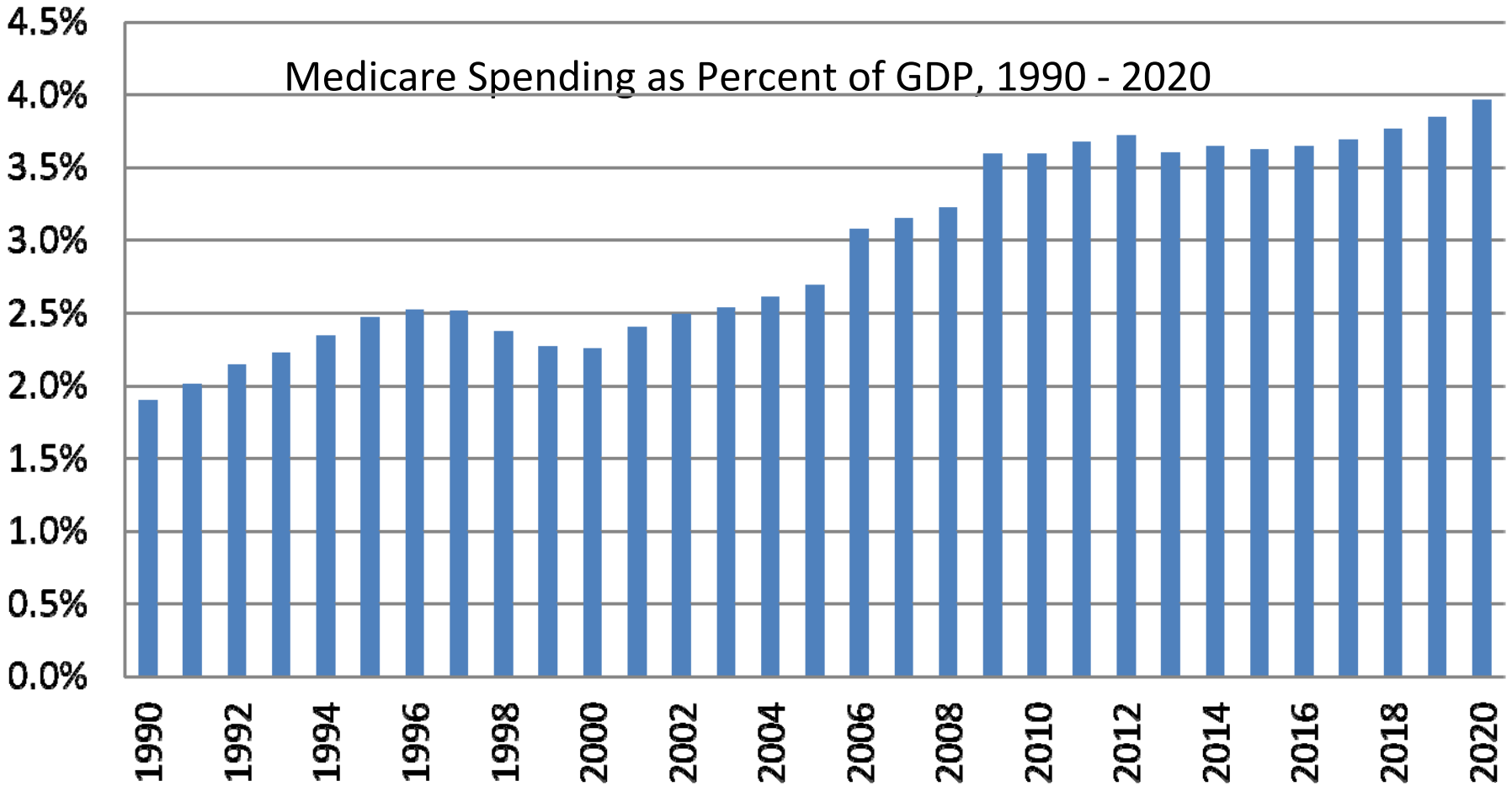
GOAL 4
Enterprise Excellence

We will have achieved "Enterprise Excellence" when CMS' high quality, diverse workforce develops, supports and utilizes innovative strategies, tools and processes, and collaborates effectively with its partners and agents to reach its goals.

The Six Goals of the National Quality Strategy

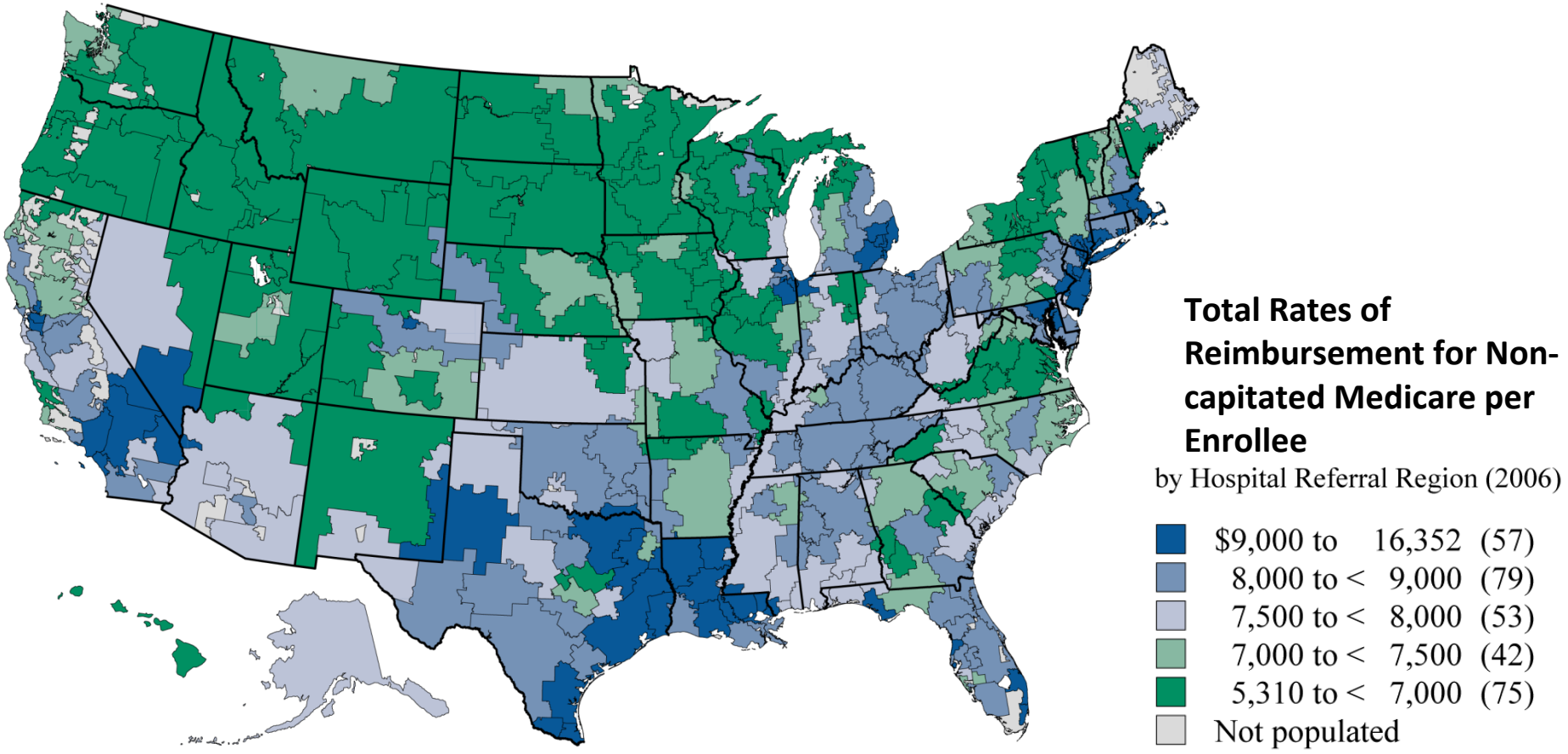
1. Make care safer by reducing harm caused in the delivery of care
2. Strengthen person and family engagement as partners in their care
3. Promote effective communication and coordination of care
4. Promote effective prevention and treatment of chronic disease
5. Work with communities to promote healthy living
6. Make care affordable

Challenge 1 :
Medicare Spending Continues to Grow



Source: Medicare Trustees Report - 2012

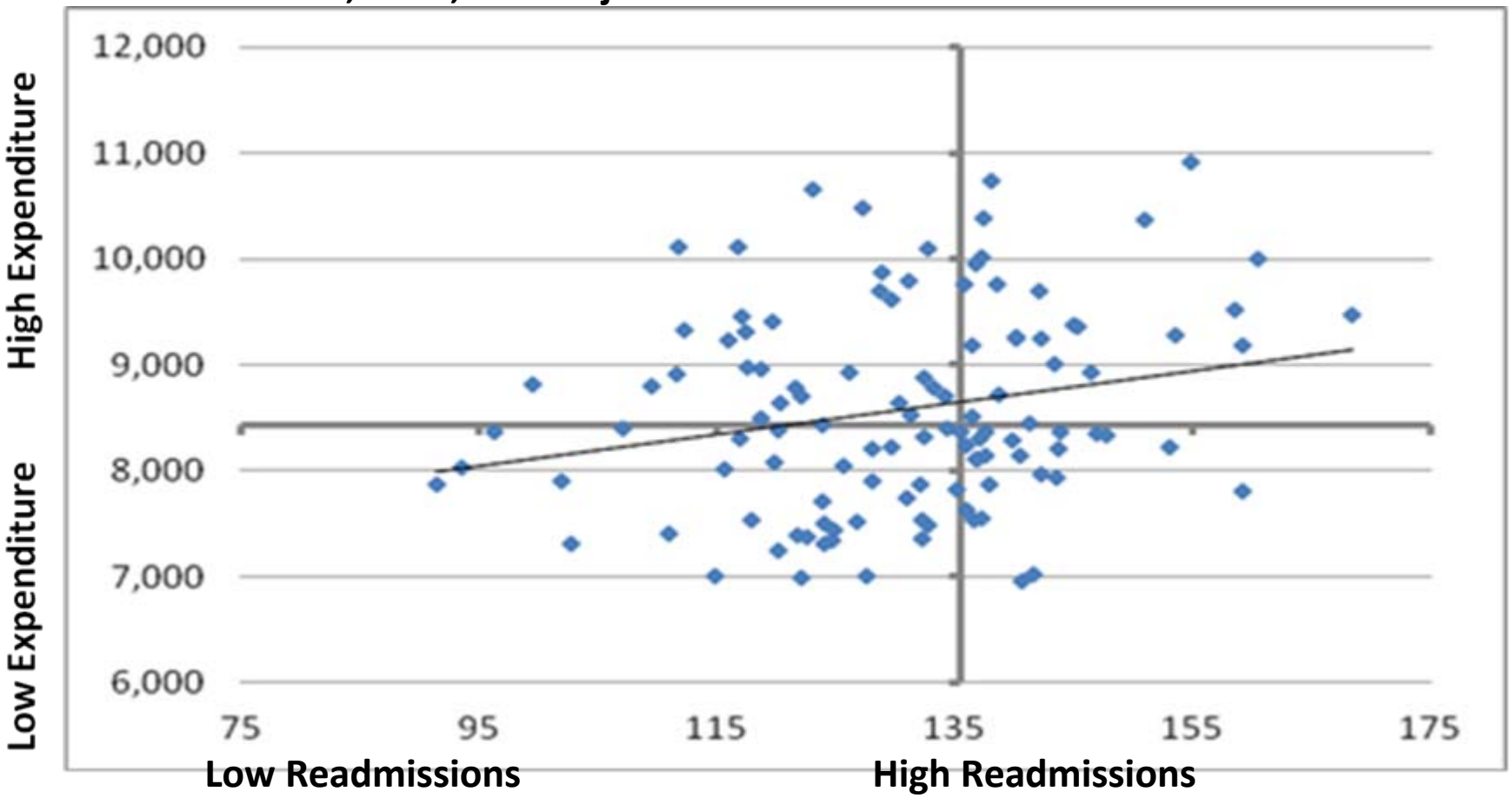
Challenge 2: Unwarranted Variation in Costs (and Quality)



Source: E. Fisher, D. Goodman, J. Skinner, and K. Bronner, *Health Care Spending, Quality, and Outcomes*, (Hanover: The Dartmouth Institute for Health Policy and Clinical Practice, Feb. 2009).

Challenge 3:
Inverse Relationship Between Cost and Quality

ACO Assigned Beneficiary Per Capita Total Expenditures Against 30-Day All Cause Readmission Rate, 2011, Risk-Adjusted



Source: CMS Integrated Data Repository, Benchmark Period Aggregate Expenditure/Utilization Trend Reports – 2011

CMS Quality Improvement Levers

Fraud & Abuse Enforcement

Target surveys

ACOs
Community Based Transitions Care Program
Dual Eligibles

Coverage of services
Physician Feedback report
Quality Resource Utilization Report
Physician Value Modifier
Readmissions

Demonstration Projects
Pilots

ESRD QIP
Hospital VBP
Plans for Skilled Nursing Facility and Home Health Agencies,
Ambulatory Surgical Centers

Partnership for Patients
Million Hearts
National Quality Strategy
Data.gov

QIOs
EQROs
ESRD Networks

HITECH
Hospital Inpatient Quality Reporting Programs

Hospitals, Home Health Agencies, Hospices, ESRD facilities

CMS Quality Strategy Foundational Principles

Eliminate disparities

Strengthen infrastructure and data systems

Enable local innovations

Foster learning organizations

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- Physicians and Value Based Purchasing
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- Questions and Comments

Hospital-Based Strategies

- CMS Hospital "Toolbox"
  - Hospital Acquired Conditions
  - Value-Based Purchasing (VBP)
  - Readmission Reduction Program
  - Partnership for Patients
  - Bundled Payments
- Progress and Next Steps
- Questions and Comments

Hospital Acquired Conditions and the Affordable Care Act

- **Public reporting of HAC rates in Hospital Compare by 2015**
- **Adjustment to payments for HAC, FY 2015**
  - **1% decrease for high rates (risk adjusted)**
  - **top quartile compared to national average**
  - **finalized criteria for ranking**

Hospital VBP Program

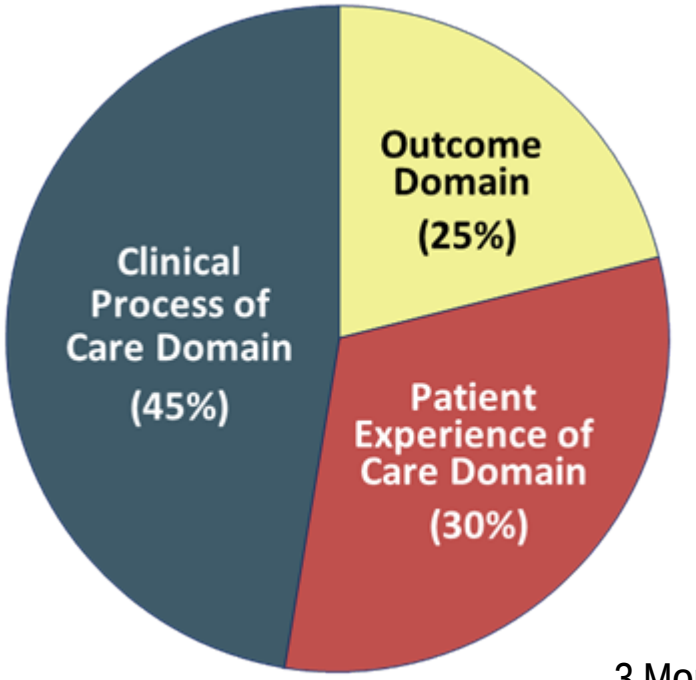
- **Required by the Affordable Care Act**
- **Built on the Hospital Inpatient Quality Reporting measure reporting infrastructure**
- **Next step in promoting higher quality care for Medicare beneficiaries**
- **Rewards better value, patient outcomes, and innovations, instead of just volume of services**
- **Funded by a withhold from participating hospitals' Diagnosis-Related Group payments**

FY 2014 Finalized Domains and Measures/Dimensions

13 Clinical Process of Care Measures

1. AMI-7a Fibrinolytic Therapy Received within 30 Minutes of Hospital Arrival
2. AMI-8 Primary PCI Received within 90 Minutes of Hospital Arrival
3. HF-1 Discharge Instructions
4. PN-3b Blood Cultures Performed in the ED Prior to Initial Antibiotic Received in Hospital
5. PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient
6. SCIP-Inf-1 Prophylactic Antibiotic Received within One Hour Prior to Surgical Incision
7. SCIP-Inf-2 Prophylactic Antibiotic Selection for Surgical Patients
8. SCIP-Inf-3 Prophylactic Antibiotics Discontinued within 24 Hours After Surgery
9. SCIP-Inf-4 Cardiac Surgery Patients with Controlled 6 a.m. Postoperative Serum Glucose
10. ★ **SCIP–Inf–9 Postoperative Urinary Catheter Removal on Postoperative Day 1 or 2.**
11. SCIP-Card-2 Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
12. SCIP-VTE-1 Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
13. SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis within 24 Hours

Domain Weights



8 Patient Experience of Care Dimensions

1. **Nurse Communication**
2. **Doctor Communication**
3. **Hospital Staff Responsiveness**
4. **Pain Management**
5. **Medicine Communication**
6. **Hospital Cleanliness and Quietness**
7. **Discharge Information**
8. **Overall Hospital Rating**

3 Mortality Measures ★

1. **MORT-30-AMI Acute Myocardial Infarction (AMI) 30-day mortality rate**
2. **MORT-30-HF Heart Failure (HF) 30-day mortality rate**
3. **MORT-30-PN Pneumonia (PN) 30-day mortality rate**

★ Represents a new measure for the FY 2014 Program not in the FY 2013 Program.

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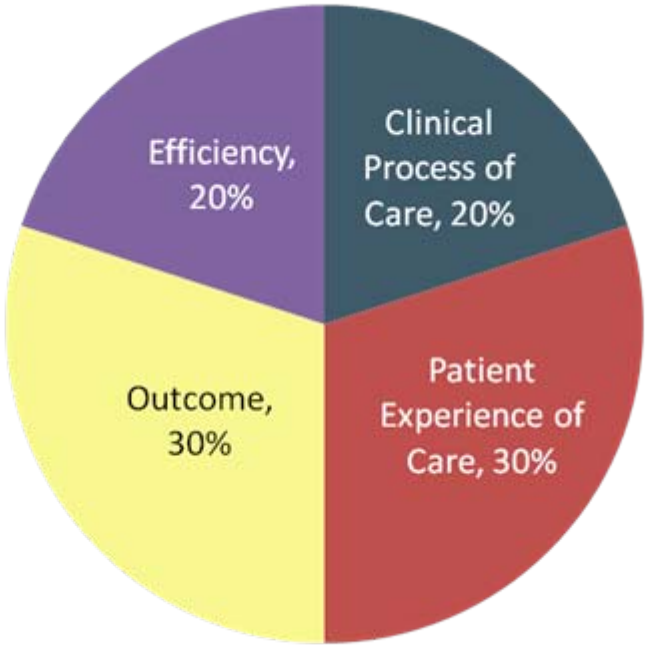

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1. Nurse Communication
2. Doctor Communication
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5. Medicine Communication
6. Hospital Cleanliness & Quietness
7. Discharge Information
8. Overall Hospital Rating

5 Outcome Measures

1. MORT-30-AMI Acute Myocardial Infarction (AMI) 30-day mortality rate
2. MORT-30-HF Heart Failure (HF) 30-day mortality rate
3. MORT-30-PN Pneumonia (PN) 30-day mortality rate
4. PSI-90 Patient safety for selected indicators (composite) ★
5. CLABSI Central Line-Associated Blood Stream Infection ★

1 Efficiency Measure ★

1. MSPB-1 Medicare Spending per Beneficiary measure

★ **Represents a new measure for the FY 2015 program not in the FY 2014 program.**

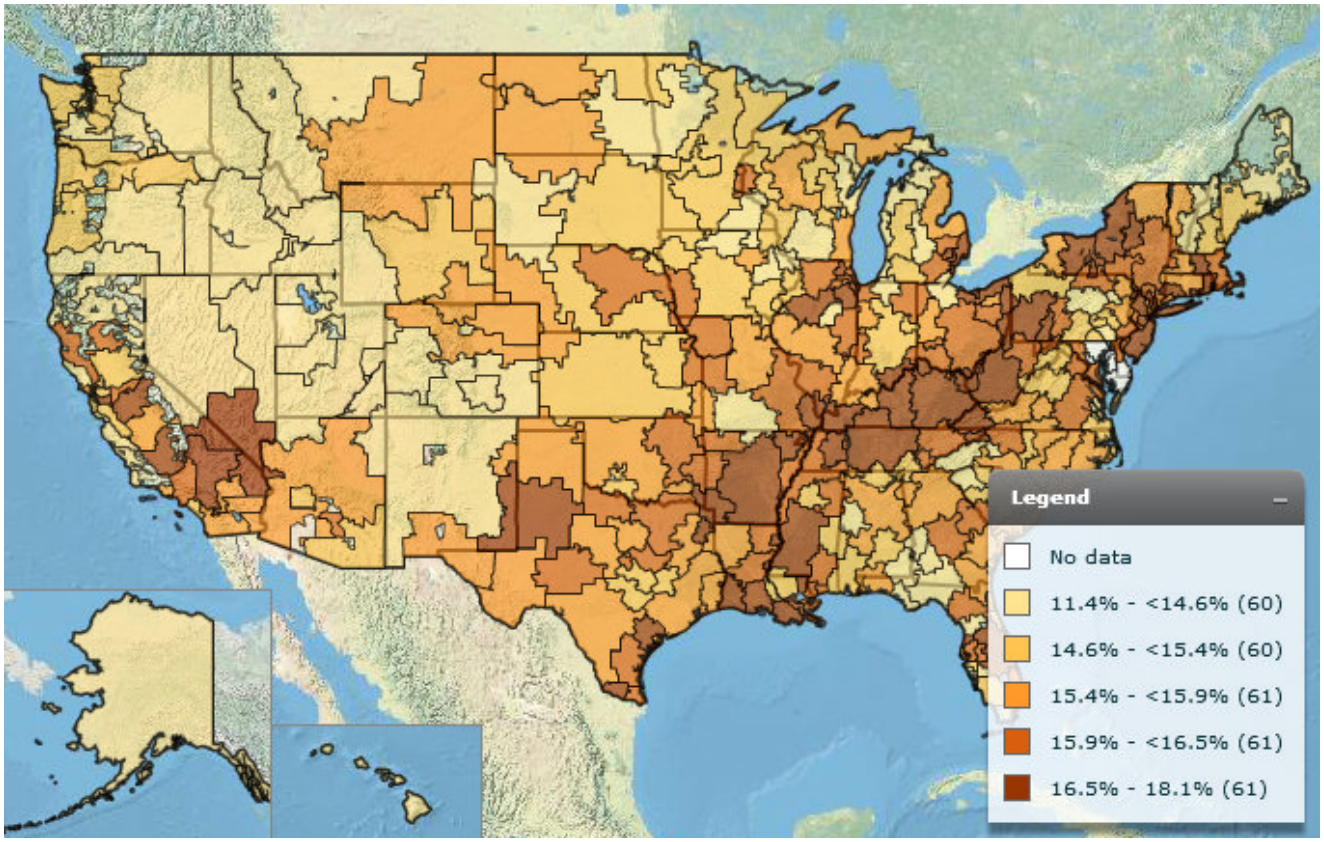
Hospital Readmissions Reduction Program

- **Requires Secretary to establish a Hospital Readmissions Reduction Program which**
  - **Reduces Inpatient Prospective Payment System (IPPS) payments to hospitals for excess readmissions**
  - **For discharges on or after October 1, 2012 (Fiscal Year [FY] 2013)**

- **Requires initial adoption of the National Quality Forum-endorsed 30-day Risk-Standardized Readmission measures:**
  - **acute myocardial infarction (AMI),**
  - **heart failure (HF),**
  - **pneumonia**

30-Day Readmission Rates, 2010

(Fee-for-service Medicare Beneficiaries)



Source: http://www.dartmouthatlas.org/data/map.aspx?ind=192&loct=3&ch=201

Payment Adjustment

- FY 2014, Based on readmissions for AMI, HF and Pneumonia
  - Algorithm introduced to account for planned readmissions
- In FY2015, adding 3 conditions
  - Acute exacerbation of chronic obstructive pulmonary disease
  - Elective total hip arthroplasty
  - Total knee arthroplasty
- Applies to hospital's base DRG payments for Medicare discharges starting October 1, 2012
  - FY 2014 no more than 2% reduction
  - FY 2015 no more than 3% reduction
  - Calculation methodology finalized in rule-making

Why are patients readmitted?

Provider-Patient interface

Unmanaged condition worsening
Use of suboptimal medication regimens
Return to an emergency department

Unreliable system support

Lack of standard and known processes
Unreliable information transfer
Unsupported patient activation during transfers

No Community infrastructure for achieving common goals

Partnership for Patients

partnershipforpatients.cms.gov

GOALS:

40% **Reduction in Preventable Hospital-Acquired Conditions**

1.8 Million Fewer Injuries | 60,000 Lives Saved

20% **Reduction in 30-Day Readmissions**

1.6 Million Patients Recover without Readmission

$35 Billion Dollars Saved

Status:

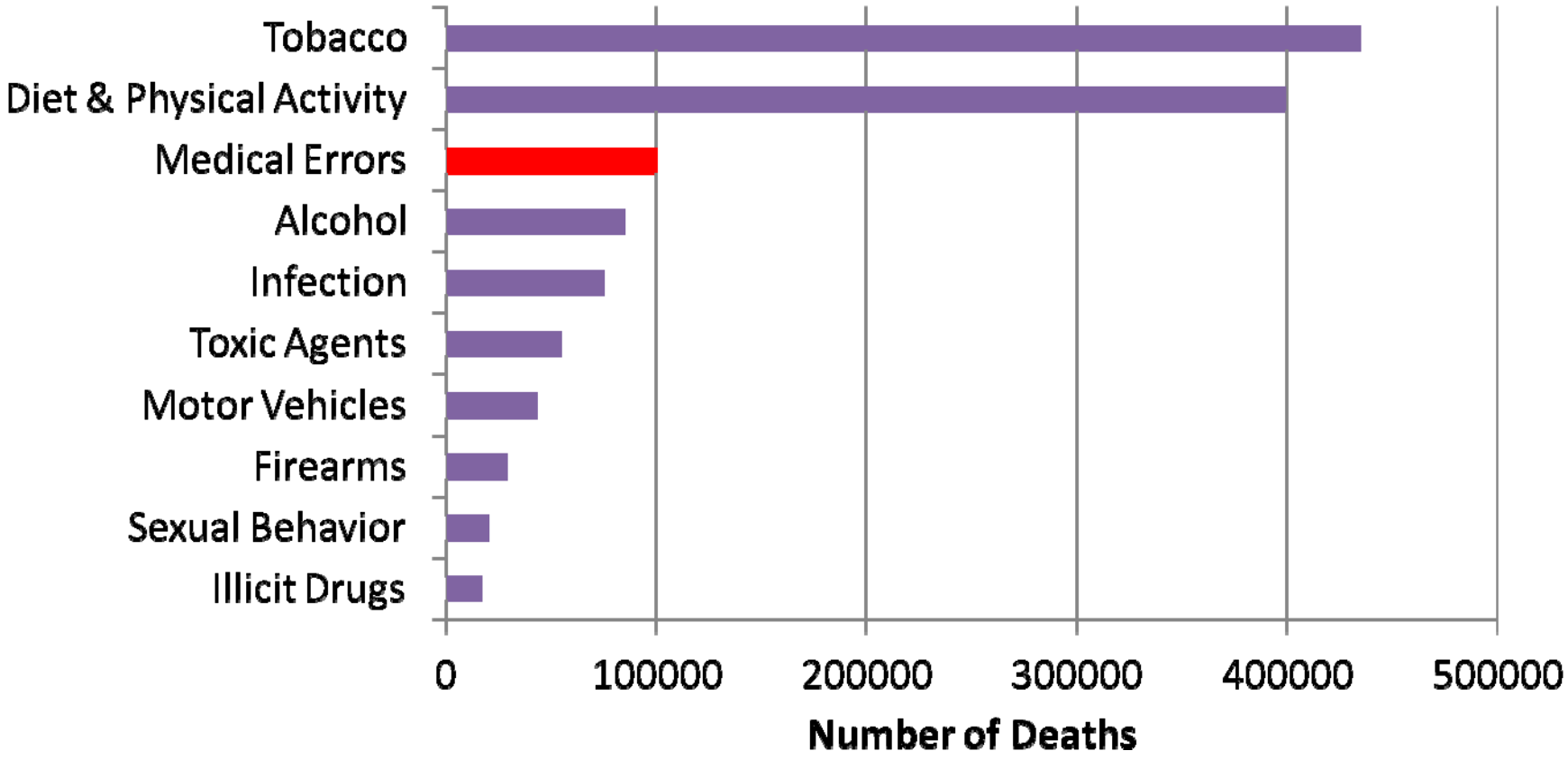
- Over 3700 hospitals have signed the pledge
- Hospital readmission rates down from 18.9% to 17.7% in first year (unpublished data)

Healthcare Associated Infections and Deaths

- **1 in 5 Medicare patients are readmitted within 30 days of discharge**
- **1 in 20 hospitalized patients develops a healthcare association infection[1]**
- **1 in 7 Medicare patients is harmed in the course of their care**
- **100,000 Americans die from preventable medical errors in hospitals every year**

[1]Klevens, RM et al. *Public Health Re*ports. 2007;122:160-166.

Underlying Causes of Death in the United States, 2000



Community-Based Care Transitions Program

GOALS: Test models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries

- **Open to community-based organizations partnered with hospitals**
- **Currently 102 participants**
- **$300 million in total funding**
- **Participants in all 10 CMS Regions**

Hospital Engagement Networks

$218 million awarded to 26 organizations to operate hospital networks across the country that will make patient care safer by:

- **Developing learning collaboratives**
- **Identifying solutions and strategies for improvement and spread them**
- **Providing intensive training programs and technical assistance**
- **Establish data system to monitor hospital progress in meeting quality improvement goals**

Hospital Engagement Networks: Ten Areas of Focus

- Adverse Drug Events
- Catheter-Associated Urinary Tract Infections
- Central Line Associated Blood Stream Infections
- Injuries from Falls and Immobility
- Obstetrical Adverse Events
- Pressure Ulcers
- Surgical Site Infections
- Venous Thromboembolism
- Ventilator-Associated Pneumonia
- Preventable readmissions

Bundled Payments

	Model 1	Model 2	Model 3	Model 4
Episode	All acute patients, all DRGs	Selected DRGs + post-acute period	Post acute only for selected DRGs	Selected DRGs
Services included in the bundle	All part A DRG-based payments	Part A and B services during the initial inpatient stay , post-acute period and readmissions	Part A and B services during the post-acute period and readmissions	All Part A and B services (hospital, physician) and readmissions
Payment	Retrospective	Retrospective	Retrospective	Prospective
Participants	3 representing 32 health care facilities	55 representing 195 health care organizations	14 representing 165 health care organizations	37 representing 75 health care facilities

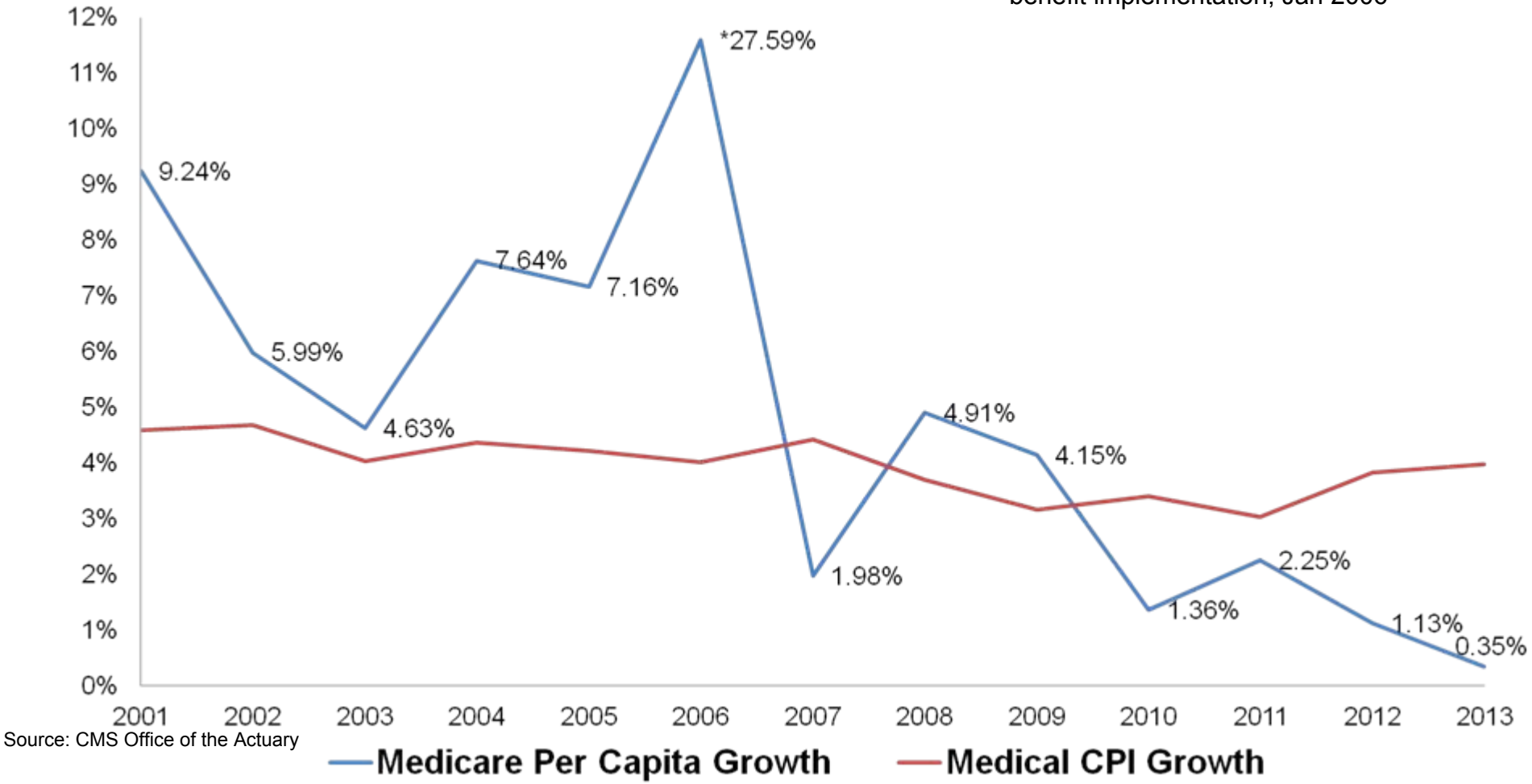
Results Being Seen Nationally

Cost trends are down, outcomes are improving & adverse events are falling

- **Total U.S. health spending grew only 3.9 percent in 2011 and 2012 (preliminary)**
- **130,000 fewer readmissions during past 18 months**
- **Hospitals have reduced early elective deliveries dramatically leading to decreased NICU admits**
- **Hospital acquired conditions continue to decrease**

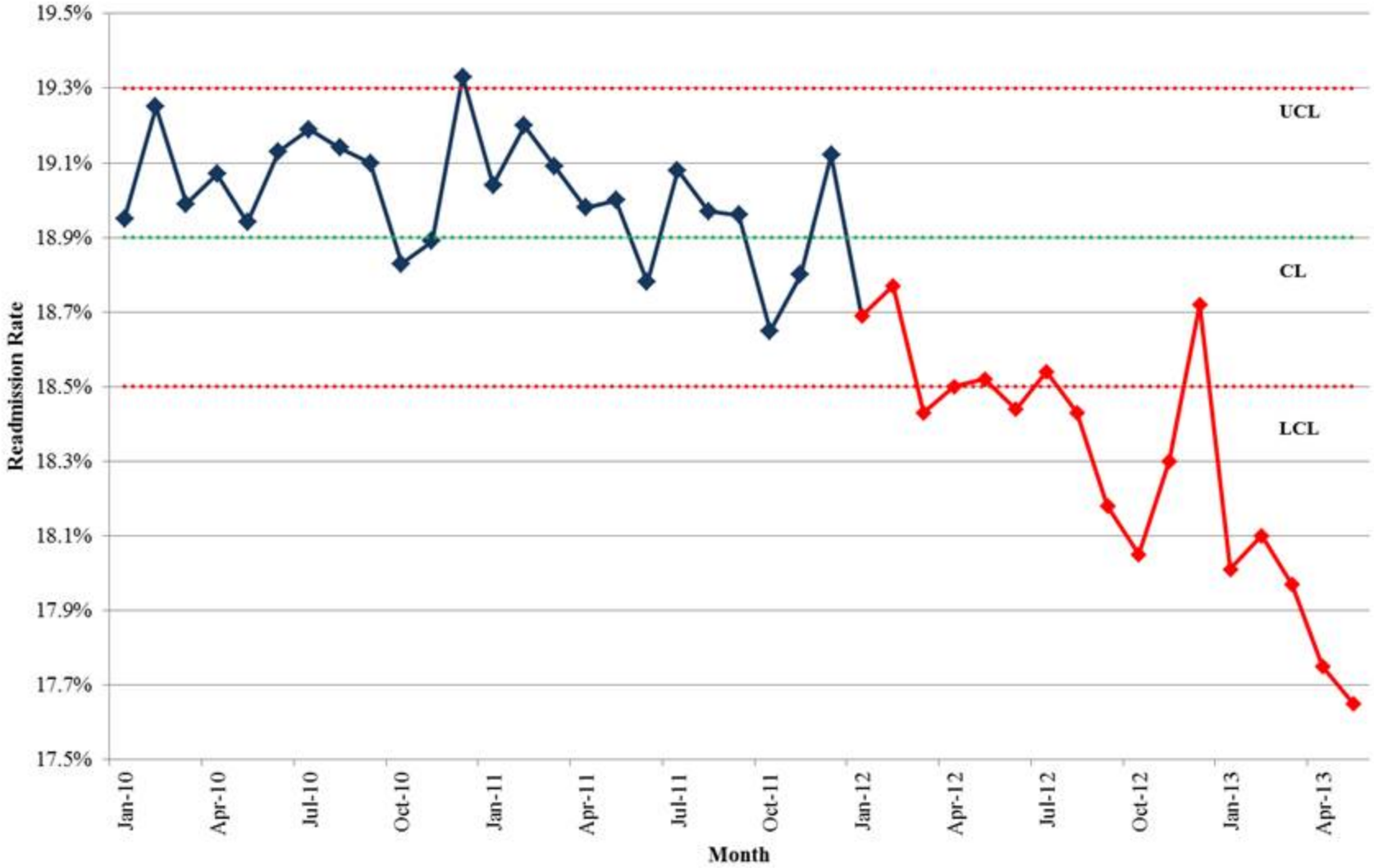
Medicare Per Capita Spending Growth at Historic Lows

*Medicare Part D prescription drug benefit implementation, Jan 2006

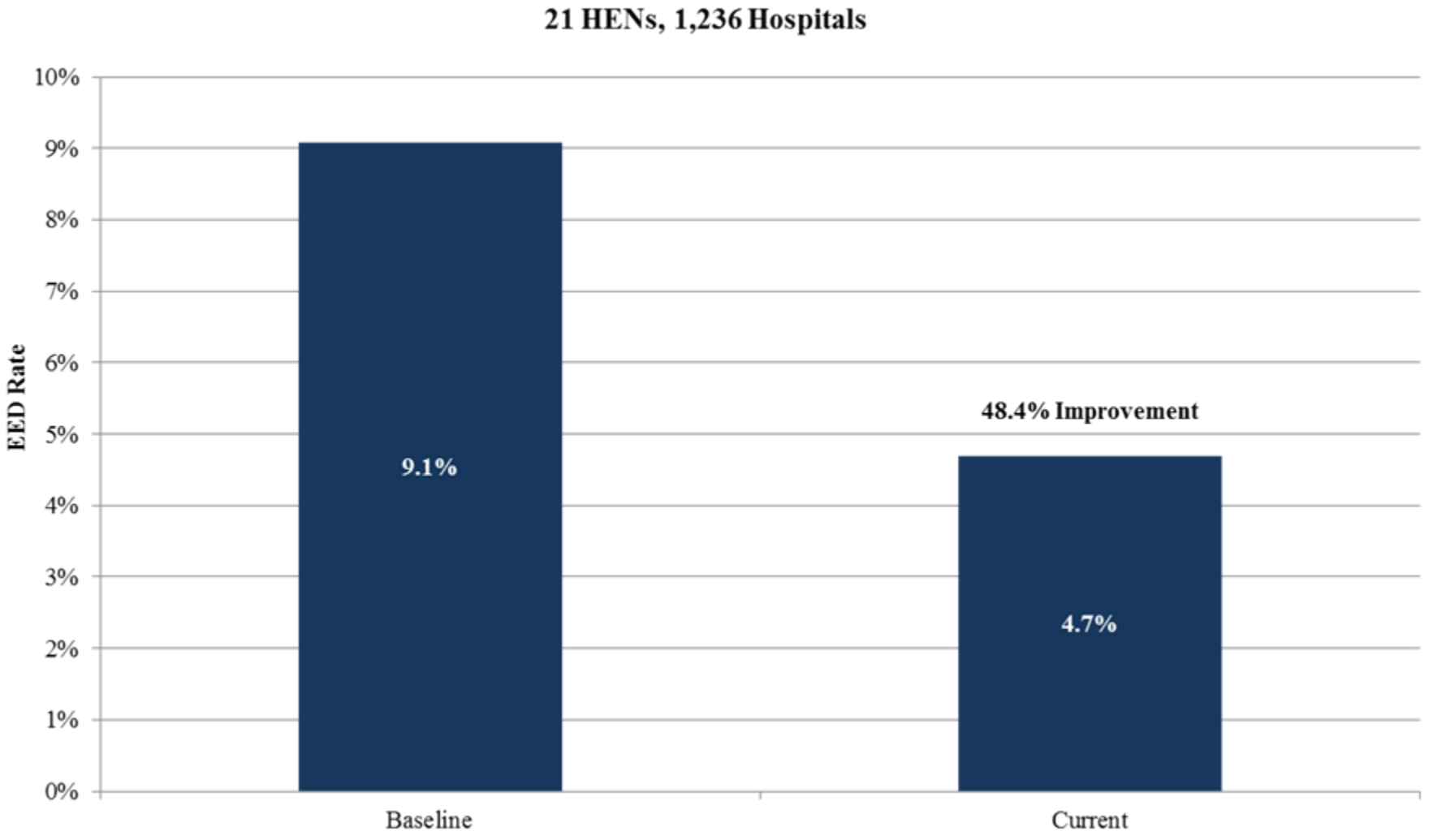


Source: CMS Office of the Actuary

Medicare FFS 30-Day All-Cause Readmission Rate, January 2010-May 2013 (all hospitals)

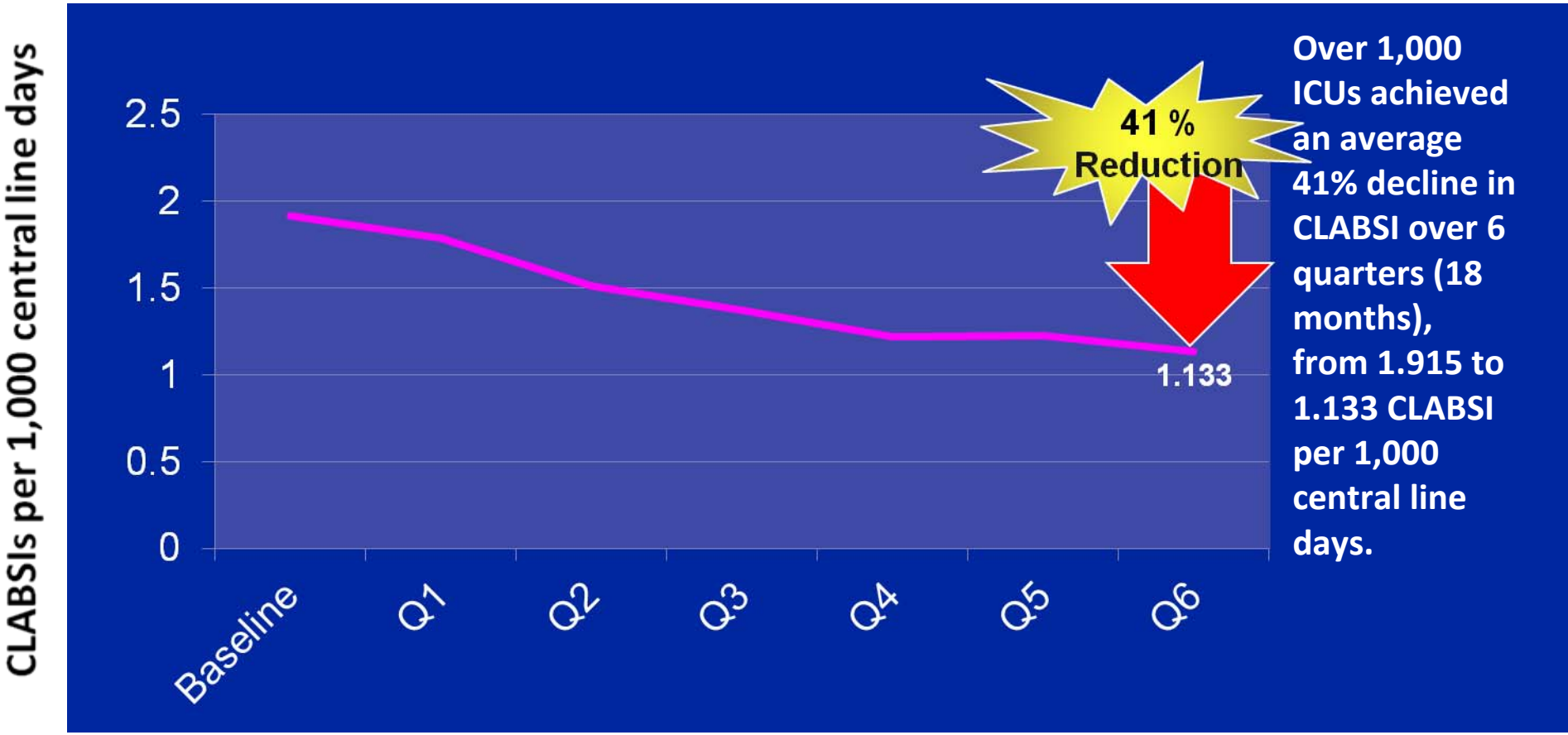


Reducing Early Elective Deliveries Nationally Improvement from Baseline



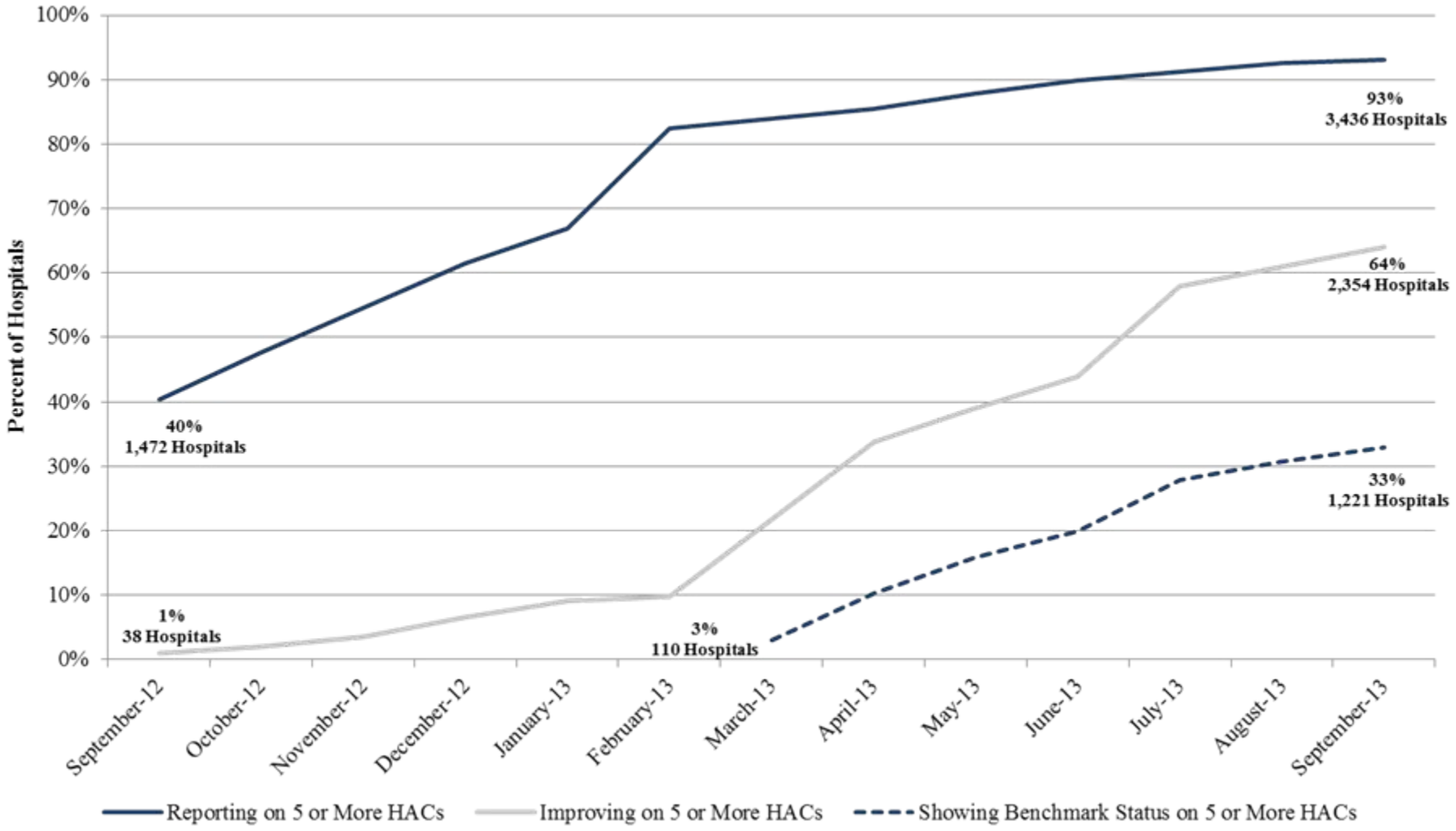
Source: August 2013 HEN Submissions. Baseline and Current time periods vary by HEN.

National Bloodstream Infection Rate



Quarters of participation by hospital cohorts, 2009–2012

Increased Hospital Reporting, Improvement and Achievement in More Harm Areas



Hospital Acquired Condition Rates Show Improvement

- **2010 – 2012 - Preliminary data show a 9% reduction in HACs across all measures**
- **Many areas of harm dropping dramatically between 2010 and 2013:**

Ventilator-Associated Pneumonia (VAP)	Early Elective Delivery (EED)	Obstetric Trauma Rate (OB)	Venous thromboembolic complications (VTE)	Falls and Trauma	Pressure Ulcers
55.3% ↓	52.3% ↓	12.3% ↓	12.0% ↓	11.2% ↓	11.2% ↓

Summary

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Physician-Based Strategies

- CMS' Physician "Toolbox"
  - Physician Quality Reporting System (PQRS)
  - ePrescribing Program
  - EHR Incentive Program
  - Value Based Payment Modifier (VM)
  - Accountable Care Organizations
  - Comprehensive Primary Care initiative
- Progress and Next Steps

- Questions and Comments

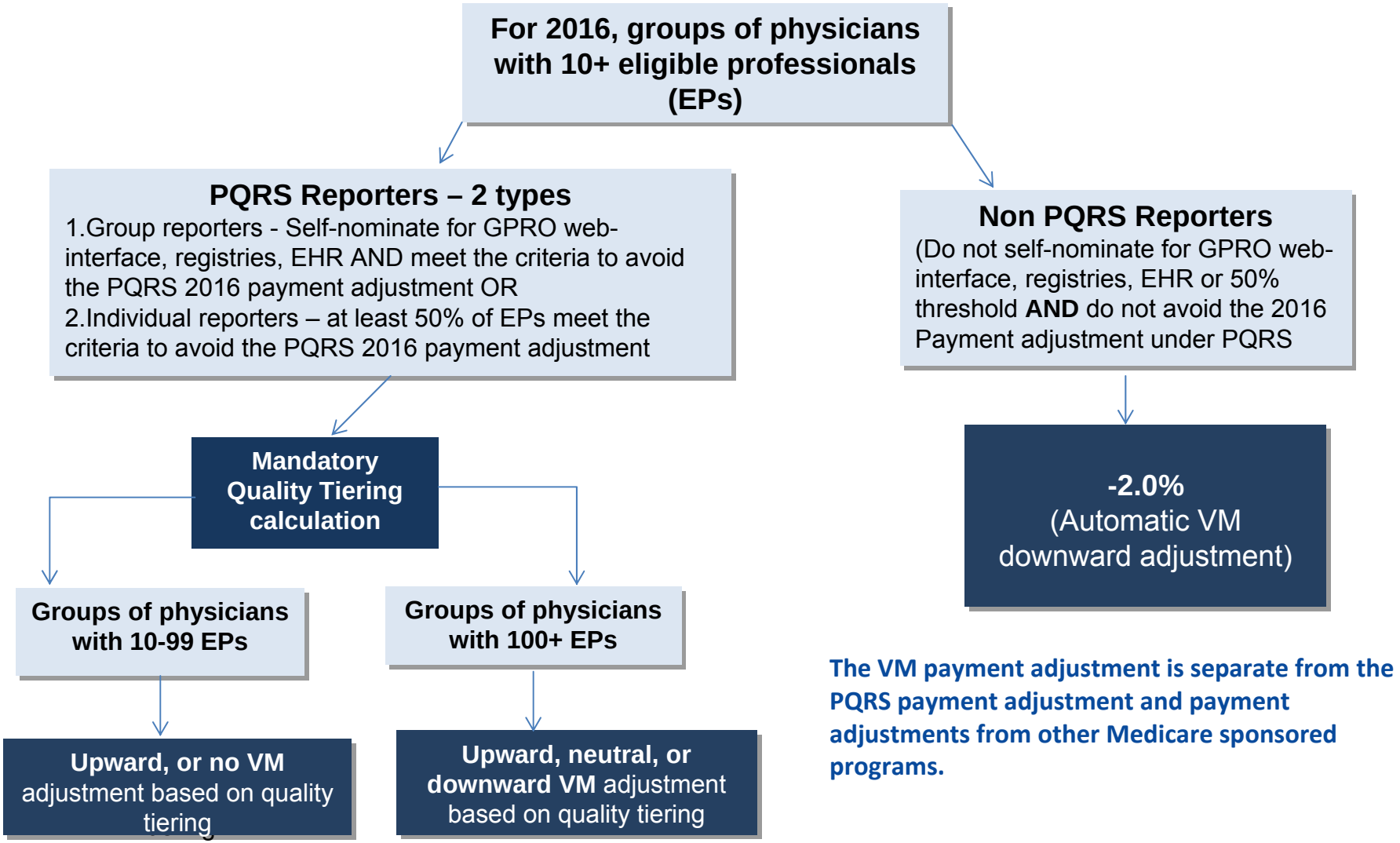
PQRS Overview

- Reporting program began in 2007
- Eligible Professionals (EPs) or group practices who satisfactorily report quality data earn an 0.5% incentive payment for CY 2012 - 2014
- Additional 0.5% for the Maintenance of Certification Program Incentive, if applicable
- 2014 – Last year for incentive
- 2015 – Payment adjustment of -1.5% based on CY2013 participation
- 2016 - Payment adjustment of -2.0% based on CY2014 participation

Value-Based Payment Modifier

- VM assesses both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule
- Begin phase-in of VM in 2015, phase-in complete by 2017
  - 2015 - VM applies to physician payment for groups with ≥100 EPs
  - 2016 - VM applies to physician payment for groups with ≥10 EPs
  - 2017 – VM applied to all, or nearly all, physician payments
- Based on participation in PQRS

Value Modifier and Physician Quality Reporting System



The VM payment adjustment is separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs.

What Quality Measures will be Used for Quality Tiering?

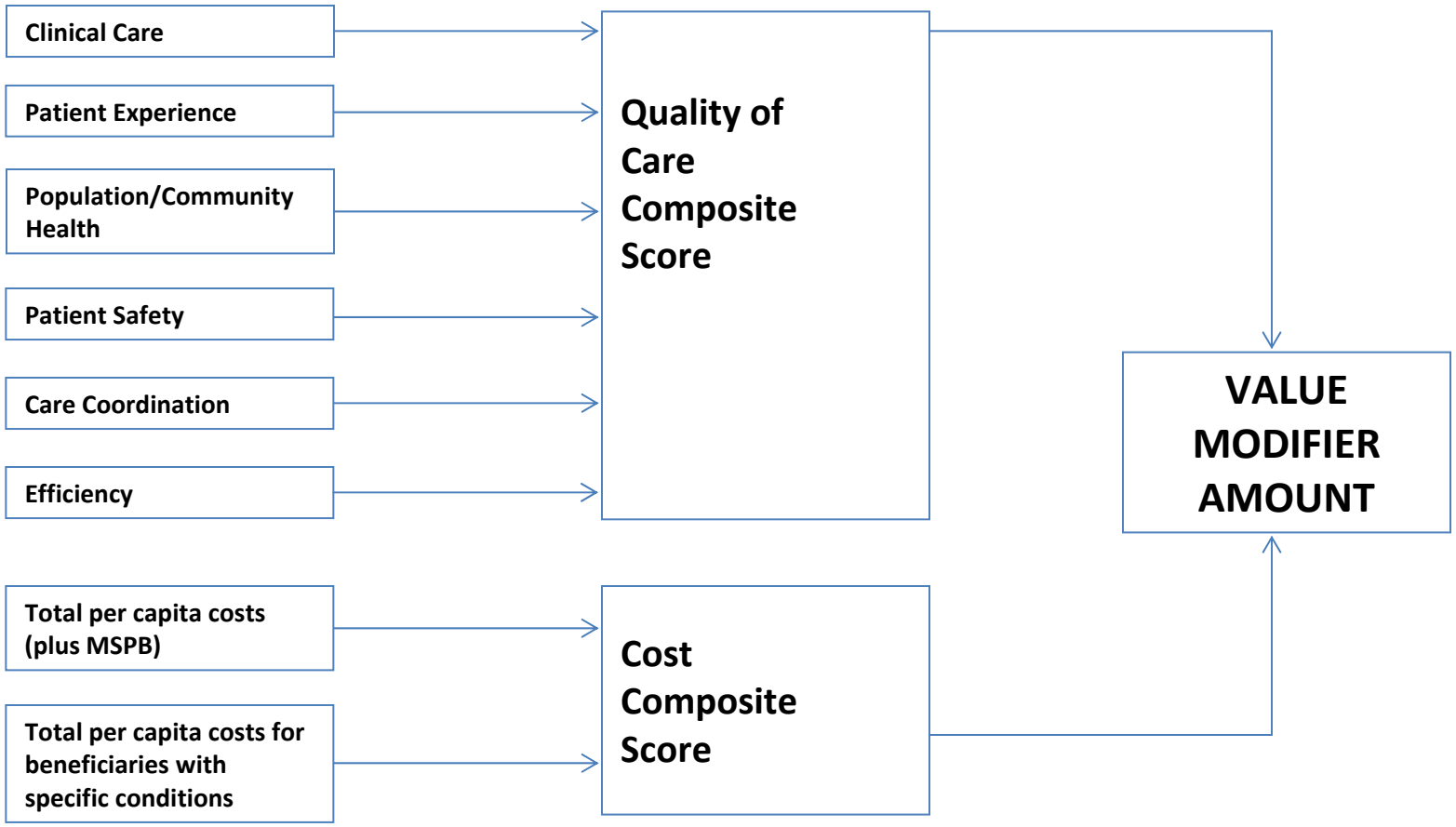
- **Measures reported through GPRO PQRS reporting mechanism selected by the group OR individual measures reported by at least 50% of the eligible professionals within the group**
- **Three outcome measures:**
  - **All Cause Readmission**
  - **Composite of Acute Prevention Quality Indicators (bacterial pneumonia, urinary tract infection, dehydration)**
  - **Composite of Chronic Prevention Quality Indicators (COPD, heart failure, diabetes)**
- **PQRS CAHPS Measures for 2014 (Optional)**
  - **Patient Experience of Care measures**
  - **For groups of 25 or more eligible professionals**

What Cost Measures will be used for Quality-Tiering?

- Total per capita costs measures (Parts A & B)
- Total per capita costs for beneficiaries with 4 chronic conditions:
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Heart Failure
  - Coronary Artery Disease
  - Diabetes
- Medicare Spending Per Beneficiary measure: 3 days prior and 30 days after an inpatient hospitalization (attributed to group providing plurality of Part B services during hospitalization)
- All cost measures are payment standardized and risk adjusted
- Each group's cost measures adjusted for specialty mix of EPs

Quality-Tiering Methodology

Use domains to combine each quality measure into a quality composite and each cost measure into a cost composite



Quality-Tiering Approach

- **Each group receives two composite scores (quality of care; cost of care)**
- **Score based on group's standardized performance (e.g., how far from national mean).**
- **Identifies statistically significant outliers and assigns them to their respective cost and quality tiers**

	Low cost	Average cost	High cost
High quality	**+2.0x***	**+1.0x***	**+0.0%**
Average quality	**+1.0x***	**+0.0%**	**-0.5%**
Low quality	**+0.0%**	**-0.5%**	**-1.0%**

* Eligible for an additional +1.0x if :

- Reporting quality measures via the web based interface or registries

AND

- Average beneficiary risk score in the top 25% of all beneficiary risk scores

44

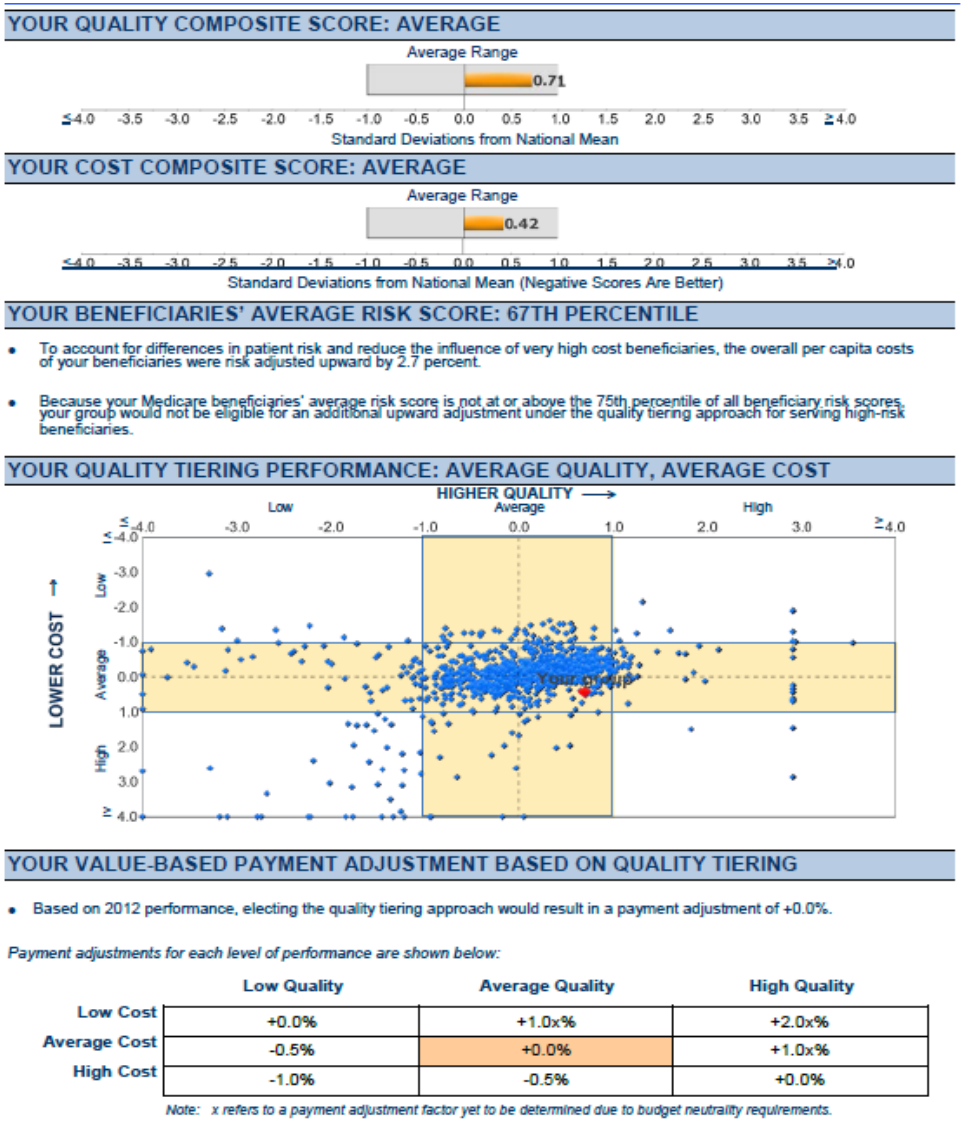
Physician Feedback Reports

- **Late Summer 2014: QRURs for Groups and Solo Practitioners**

- **Drill down tables include beneficiaries attributed to the group, resource use, specific chronic diseases**
  - **All hospitalizations for attributed beneficiaries**
  - **Individual EP PQRS reporting (December 2014)**

What Information Is Included on the Performance Highlights Page?

1. Your Quality Composite Score
2. Your Cost Composite Score
3. Your Beneficiaries' Average Risk Score
4. Your Quality Tiering Performance Graph
5. Your Payment Adjustment Based on Quality Tiering



YOUR QUALITY COMPOSITE SCORE: AVERAGE

Average Range

0.71

≤-4.0 -3.5 -3.0 -2.5 -2.0 -1.5 -1.0 -0.5 0.0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 ≥4.0

Standard Deviations from National Mean

YOUR COST COMPOSITE SCORE: AVERAGE

Average Range

0.42

≤-4.0 -3.5 -3.0 -2.5 -2.0 -1.5 -1.0 -0.5 0.0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 ≥4.0

Standard Deviations from National Mean (Negative Scores Are Better)

YOUR BENEFICIARIES' AVERAGE RISK SCORE: 67TH PERCENTILE

- To account for differences in patient risk and reduce the influence of very high cost beneficiaries, the overall per capita costs of your beneficiaries were risk adjusted upward by 2.7 percent.
- Because your Medicare beneficiaries' average risk score is not at or above the 75th percentile of all beneficiary risk scores, your group would not be eligible for an additional upward adjustment under the quality tiering approach for serving high-risk beneficiaries.

YOUR QUALITY TIERING PERFORMANCE: AVERAGE QUALITY, AVERAGE COST

HIGHER QUALITY →

Low Average High

≤-4.0 -3.0 -2.0 -1.0 0.0 1.0 2.0 3.0 ≥4.0

LOWER COST ↑

Low Average High

≤-4.0 -3.0 -2.0 -1.0 0.0 1.0 2.0 3.0 ≥4.0

Your group

YOUR VALUE-BASED PAYMENT ADJUSTMENT BASED ON QUALITY TIERING

- Based on 2012 performance, electing the quality tiering approach would result in a payment adjustment of +0.0%.

Payment adjustments for each level of performance are shown below:

	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0x%	+2.0x%
Average Cost	-0.5%	+0.0%	+1.0x%
High Cost	-1.0%	-0.5%	+0.0%

Note: x refers to a payment adjustment factor yet to be determined due to budget neutrality requirements.

(payment adjustments in example based on 2015 VM implementation)

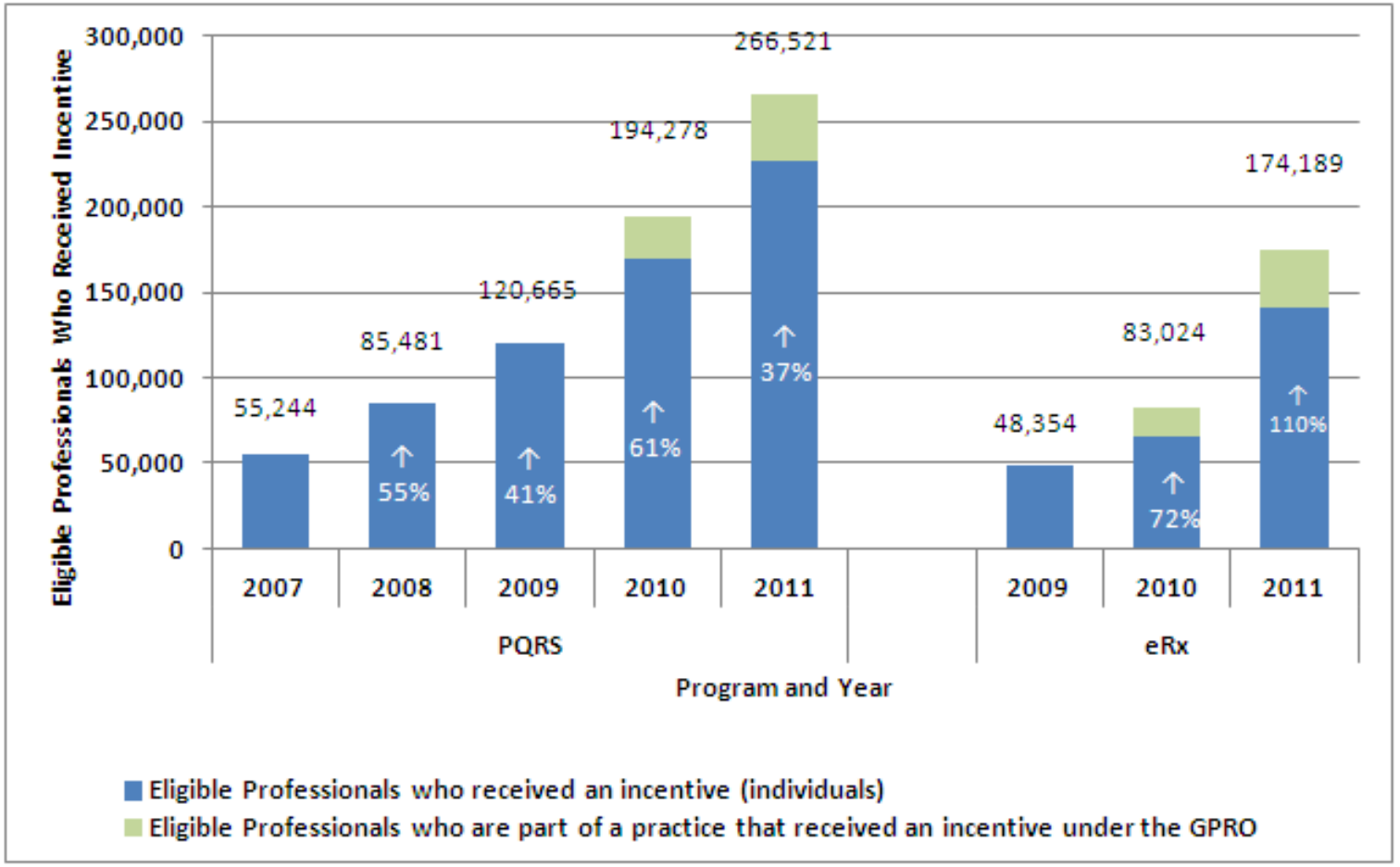
ePrescribing bt

eRx Overview

- What is the Medicare eRx Incentive Program?
  - Established by MIPPA in 2009 to encourage EPs to adopt electronic prescribing systems
- 2014 eRx Incentive Program
  - 2% payment adjustment

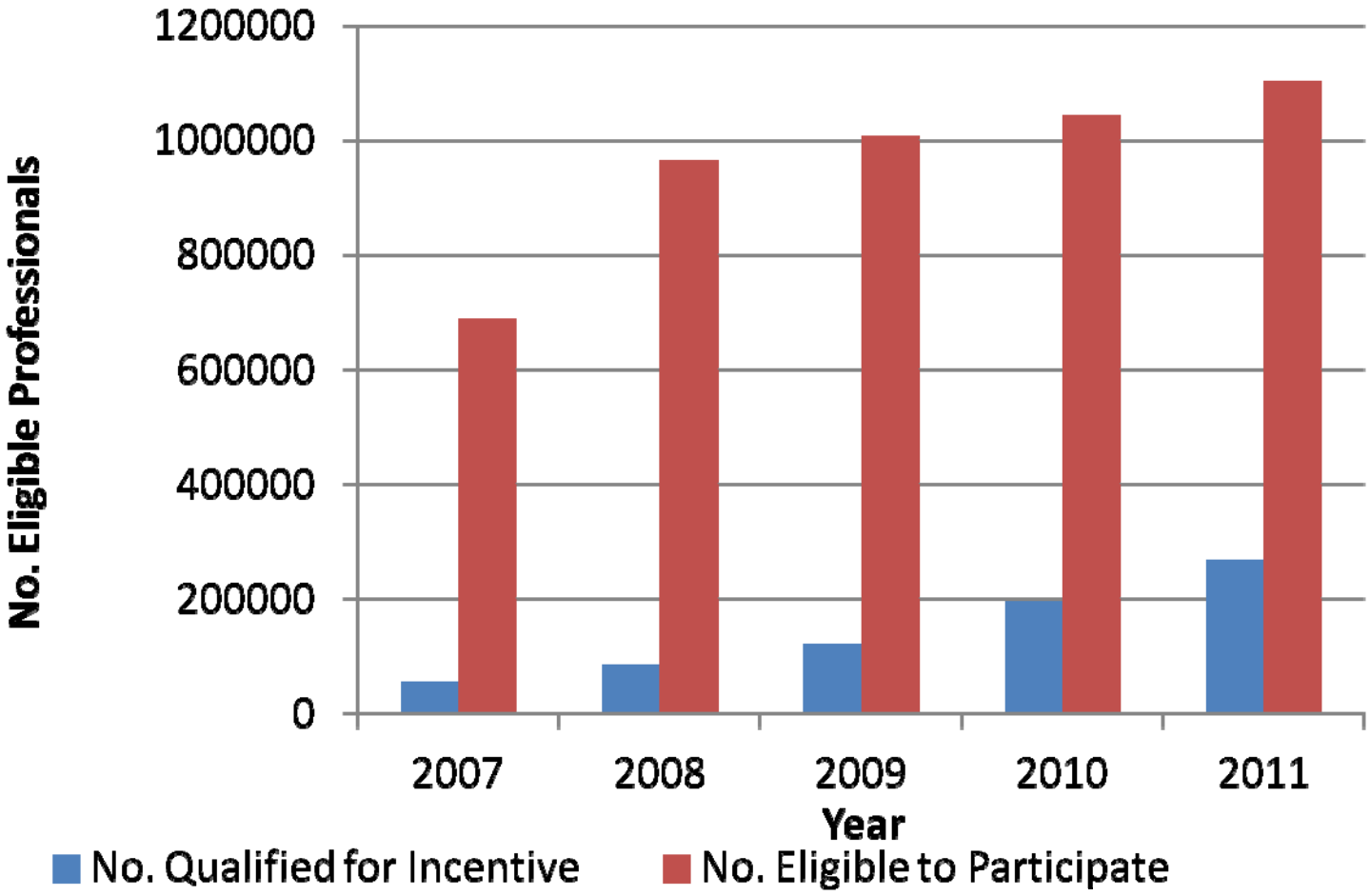
PQRS and eRx Experience to Date – Take 1

Number of Eligible Professionals Who Qualified for an Incentive: PQRS (2007-2011) and eRx (2009-2011)



PQRS Experience to Date – Take 2

Number of EPs who Qualified for Incentive vs. Number Eligible to Participate, 2007-2011



EHR Incentive Programs ds

What is Your Meaningful Use Path?

For Medicare EPs:

Maximum Payment by Start Year	Annual Incentive Payment by Stage of Meaningful Use					
	2011	2012	2013	2014	2015	2016
2011	1	1	1	2	2	3
$44,000	$18,000	$12,000	$8,000	$4,000	$2,000	
2012		1	1	2	2	3
$44,000		$18,000	$12,000	$8,000	$4,000	$2,000
2013			1	1	2	2
$39,000			$15,000	$12,000	$8,000	$4,000
2014				1	1	2
$24,000				$12,000	$8,000	$4,000

What is Your Meaningful Use Path?

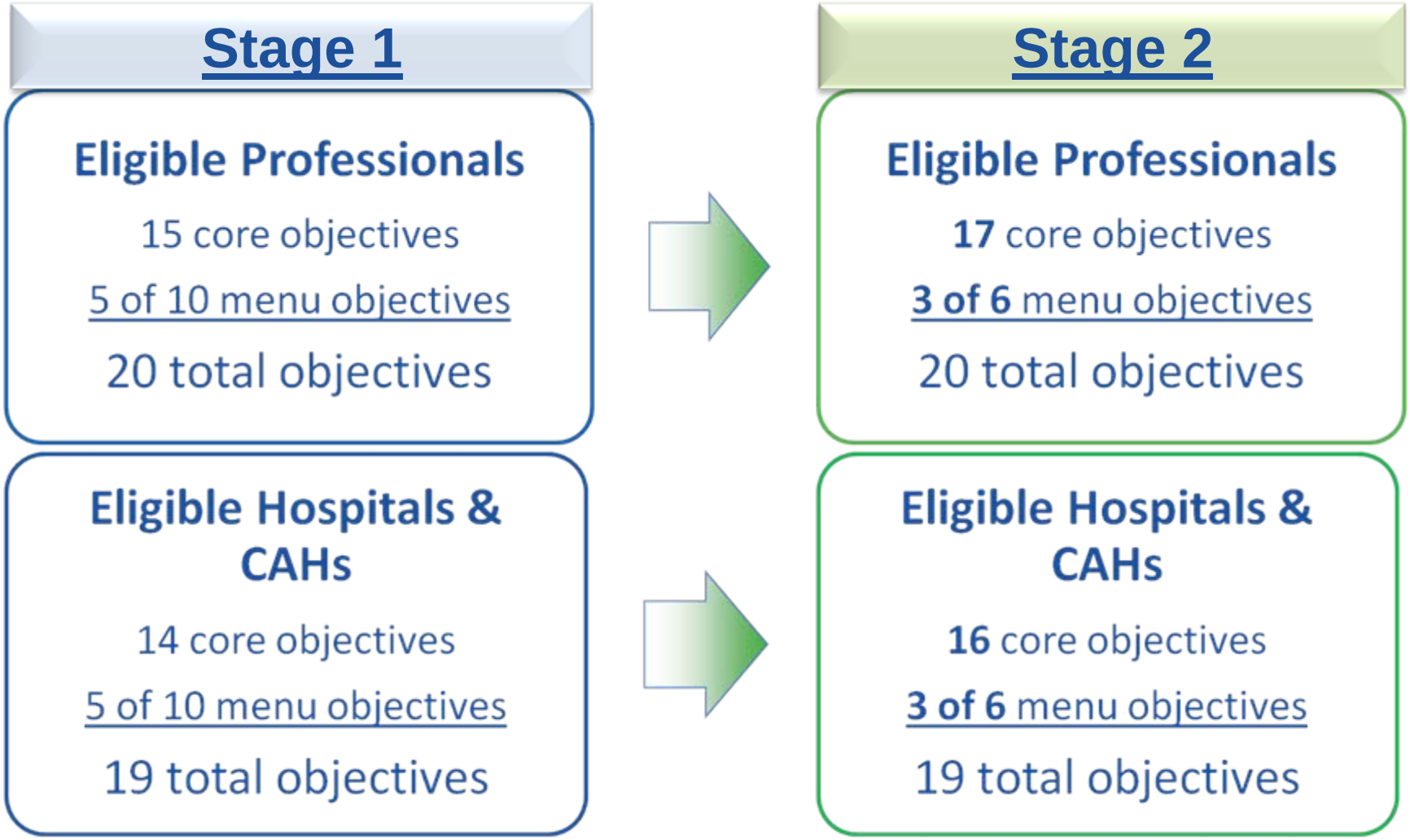
For Medicaid EPs:

Annual Incentive Payment by Stage of Meaningful Use					
YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6
(AIU)	1	1	2	2	3
$21,250	$8,500	$8,500	$8,500	$8,500	$8,500

Maximum incentive amount is $63,750. Payments are made over 6 years and do not have to be consecutive.

*2016 is the last year that Medicaid EPs can begin participation in the program.

Meaningful Use: Changes from Stage 1 to Stage 2



EP EHR Payment Adjustments

% Adjustment shown below assumes less than 75% of EPs are meaningful users for CY 2018 and subsequent years

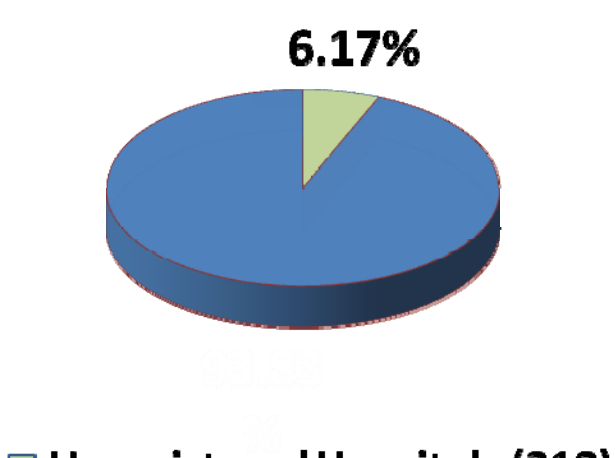
	2015	2016	2017	2018	2019	2020+
EP is not subject to the payment adjustment for e-Rx in 2014	99%	98%	97%	96%	95%	95%
EP is subject to the payment adjustment for e-Rx in 2014	98%	98%	97%	96%	95%	95%

% Adjustment shown below assumes more than 75% of EPs are meaningful users for CY 2018 and subsequent years

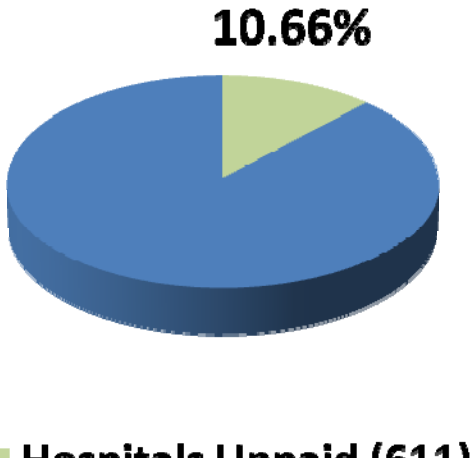
	2015	2016	2017	2018	2019	2020+
EP is not subject to the payment adjustment for e-Rx in 2014	99%	98%	97%	97%	97%	97%
EP is subject to the payment adjustment for e-Rx in 2014	98%	98%	97%	97%	97%	97%

EHR Incentive Program Status: Eligible Hospitals

Registered Eligible Hospitals

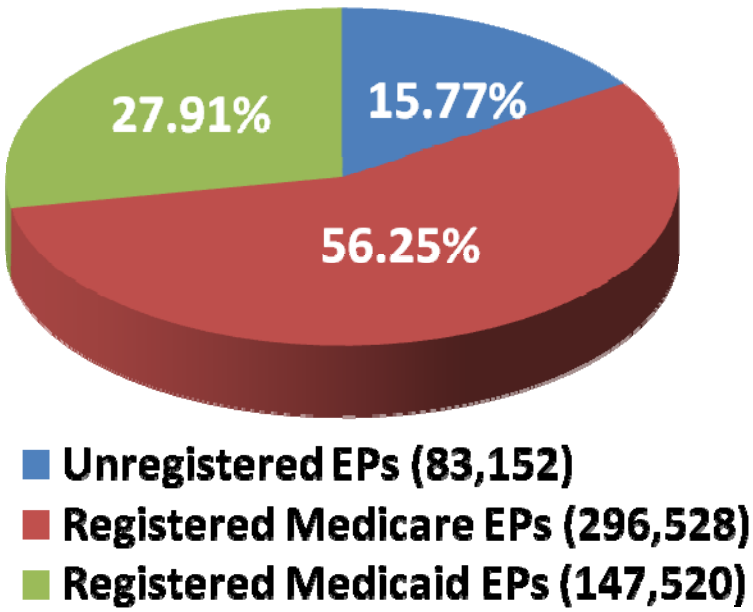


Paid Eligible Hospitals

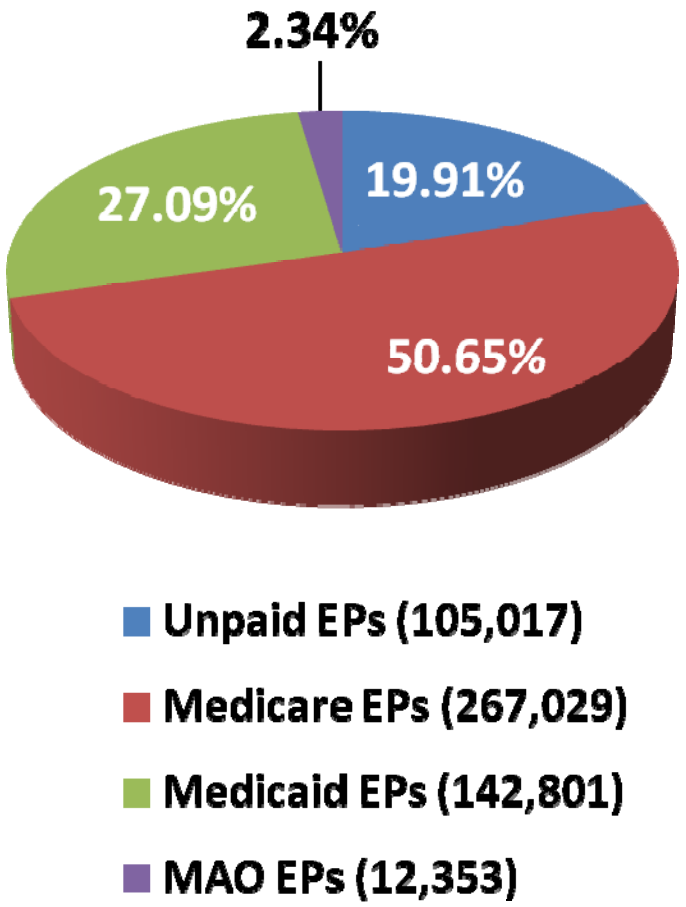


EHR Incentive Program Status: Eligible Professionals

Registered Eligible Professionals



Paid Eligible Professionals



EHR Incentive Program Trends

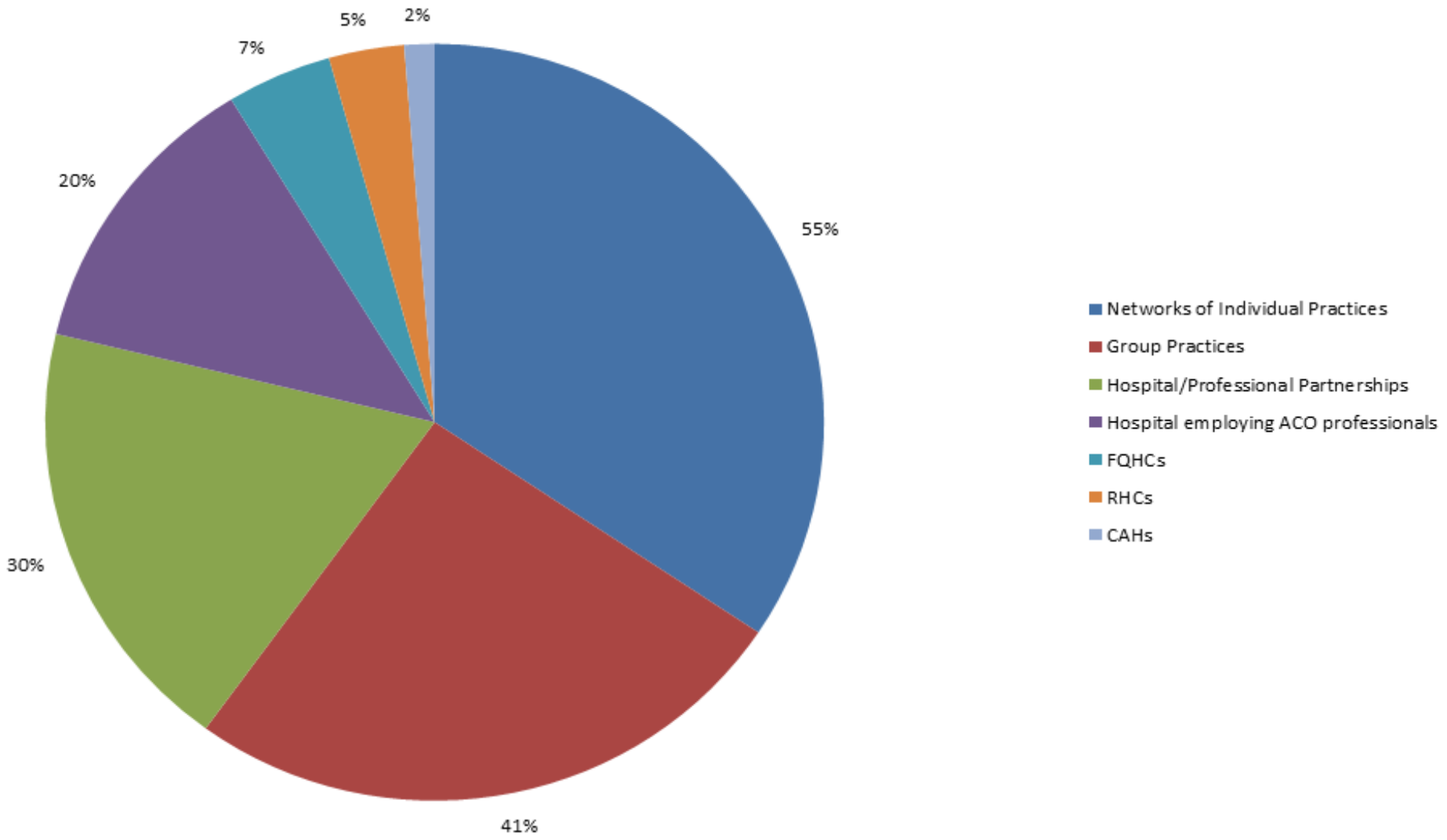
- Approximately **88% of all eligible hospitals** have received an EHR incentive payment
- Approximately **3 out of 5 Medicare EPs** are meaningful users of EHRs
- Approximately **4 out of 5 Medicaid EPs** have received an EHR incentive payment
- Almost 63% or **3 out of every 5 Medicare and Medicaid EPs** have made a financial commitment to an EHR
- **Over 340,000 Medicare and Medicaid EPs** have received an EHR incentive payment

Accountable Care Organizations ds

360 ACOs serving over 5.3 million Americans with Medicare

"Accountable Care Organizations are delivering higher-quality care to Medicare beneficiaries and are using Medicare dollars more efficiently," **Secretary Sebelius said. "*This is a great example of the Affordable Care Act rewarding hospitals and doctors that work together to help our beneficiaries get the best possible care." (December 23, 2013)***

ACO Reported Composition
(includes multiple responses per ACO, in 2013)



Goals of the Pioneer ACO Model

- **To engage experienced provider organizations in demonstrating what is possible in reducing Medicare spending through care improvement**
- **To complement and inform the Medicare Shared Savings Program**

Patient Population

- ACO accepts responsibility for an “assigned” patient population
- Assigned patient population is the basis for establishing and updating the financial benchmark, quality measurement and performance, and focus of the ACO’s efforts to improve care and reduce costs
- Assignment will not affect beneficiaries’ guaranteed benefits or choice of doctor or any other provider
- Shared Savings Program performs preliminary prospective assignment with a retrospective reconciliation
- Pioneer relies on prospective alignment only

PY1 Quality Performance

- **All Pioneers successfully reported quality measures and earned PQRS incentives**
- **Pioneers performed better than national average for all 15 clinical quality measures with comparable data (7 measures had no comparable data)**
  - **25 of 32 Pioneer ACOs generated lower risk-adjusted readmission rates than the rate for Medicare fee-for-service**
  - **Compared to 10 managed care plans across 7 states from 2000 to 2001, the median rate among Pioneer ACOs on BP control among diabetics was 68% vs. 55%, and on LDL control was 57% vs. 48%**
  - **The majority of Pioneers also had higher CAHPS scores than reported rates in Medicare fee-for-service**

Common Priorities in PY1

- **Integrating Medicare claims with clinical information and other existing data systems**
- **Risk stratifying populations**
- **Identifying savings opportunities**
- **Refining staffing strategies and hiring**
- **Beneficiary outreach**
- **Beginning to implement interventions**

Comprehensive Primary Care Initiative ds

Practice and Payment Redesign through the CPC initiative

Supportive Multi-payer Environment

Enhanced, accountable payment
Continuous improvement driven by data
Optimal use of health IT

Comprehensive primary care functions:

- Risk-stratified care management
- Access and continuity
- Planned care for chronic conditions and preventive care.
- Patient and caregiver engagement
- Coordination of care across the medical neighborhood

COMPREHENSIVE PRIMARY CARE

Aims:

- Better health
- Better care
- Lower cost

CPC initiative: What is CMS trying to support?

1. **Risk-stratified care management**
2. **Access and continuity**
3. **Planned care for chronic conditions and preventive care**
4. **Patient and caregiver engagement**
5. **Coordination of care across the medical neighborhood**

Web Resources

CMS eHealth Webpage

http://www.cms.gov/ehealth/

- **PQRS Website**
  - **–http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/**
- **eRx Incentive Program Website**
  - **–http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/**
- **Medicare and Medicaid EHR Incentive Programs**
  - **–http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/**
- **Value Based Modifier (VBM)**
  - **–http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html**
- **Frequently Asked Questions (FAQs)**
  - **–https://questions.cms.gov/**

Summary

Overview

- CMS Strategy and Challenges
- Hospitals and Value Based Purchasing
- Physicians and Value Based Purchasing
- Other Initiatives and Programs bt
- Next Steps
- Questions and Comments

Other Initiatives and Programs

- End-Stage Renal Disease Initiative
- ICD-10
- Health Insurance Marketplace
- Next Steps
- Questions and Comments

Comprehensive ESRD Care Initiative

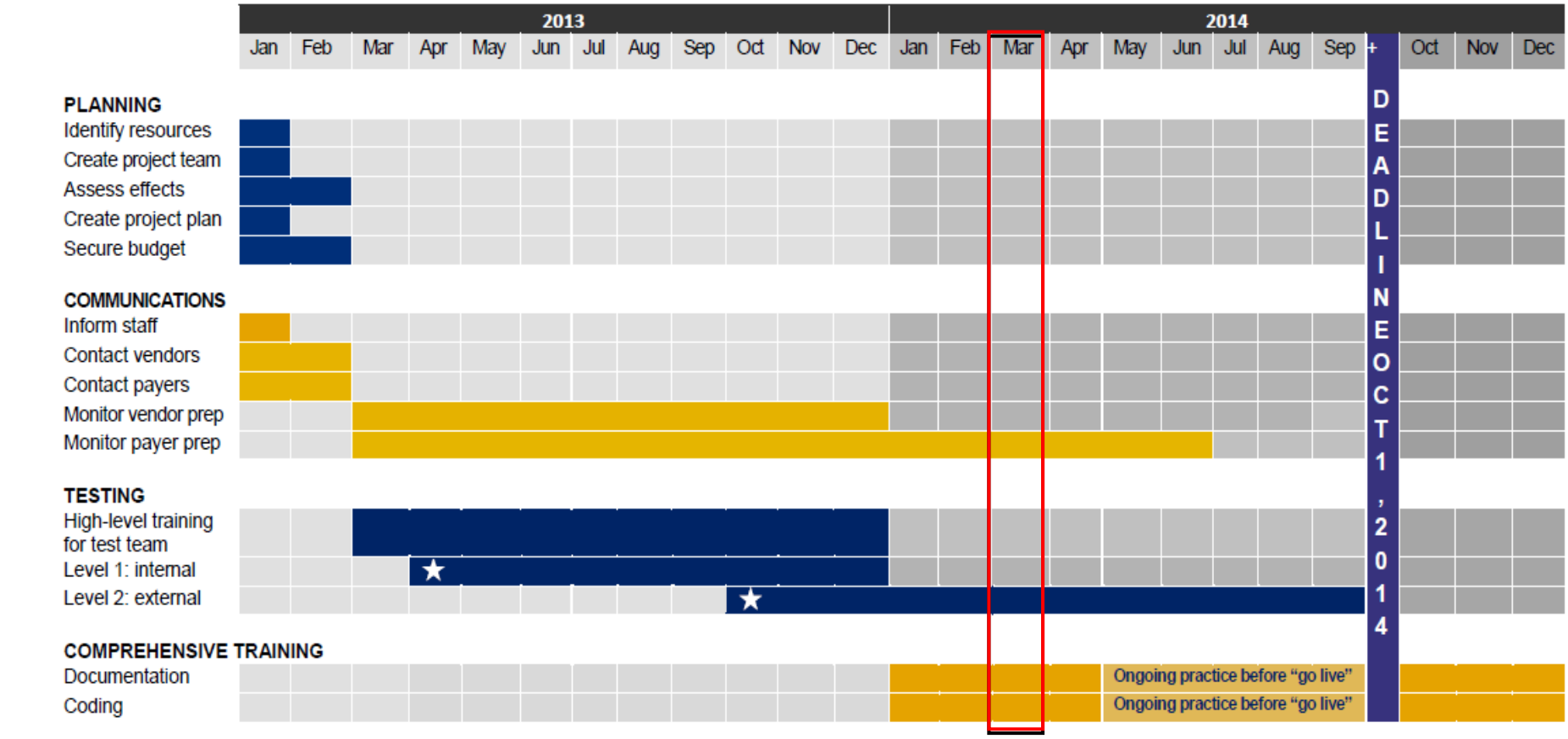
GOAL: To test a new model of payment and care delivery specific to Medicare beneficiaries with ESRD.

- Partnering with groups of health care providers and suppliers - ESRD Seamless Care Organizations (ESCOs)
  - Must include dialysis provider and nephrologist
- ESCOs must have minimum of 350 “matched” beneficiaries
  - Beneficiaries with ESRD “matched” to ESCO based on where they receive dialysis
  - Fee for service Medicare beneficiaries with ESRD
- ESCOs evaluated on performance on quality measures
- ESCOs successful in lowering total Part A and B costs can share in savings
- Application period will open this winter with a revised RFA

http://innovation.cms.gov/initiatives/comprehensive-ESRD-care/

ICD-10 Implementation bt

Where Should Practices Be?



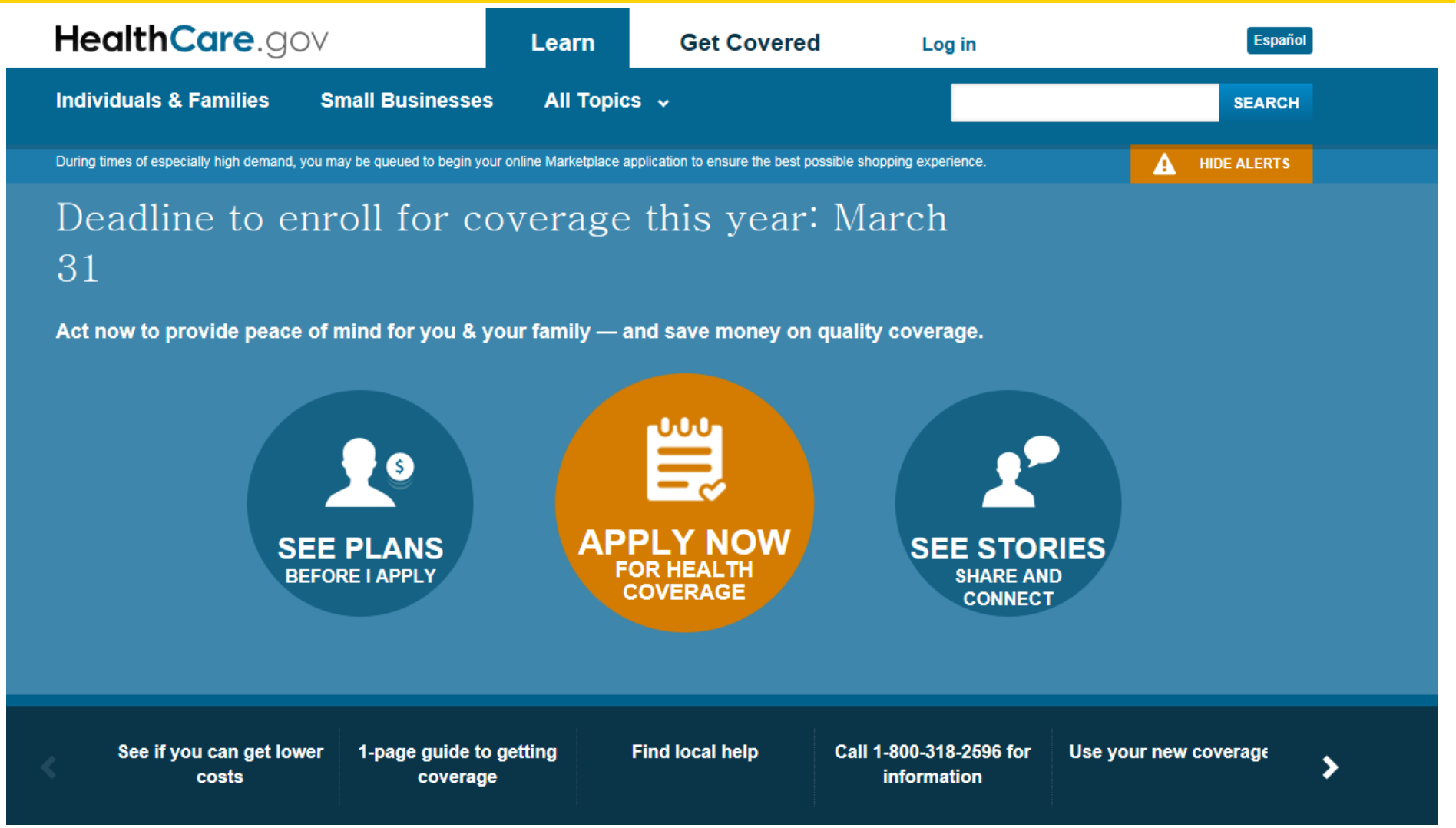
Resources

CMS website:

www.cms.gov/icd10

- **Fact sheets**
- **FAQs**
- **Implementation guides**
- **Timelines**
- **Checklists**

Marketplace ds



A WEEKEND WAVE OF ENROLLMENT

MARKETPLACE ENROLLMENT HAS TOPPED

5,000,000

YOU HAVE JUST

14 days

TO ENROLL IN COVERAGE **BY MARCH 31** OR

spread the word

#GetCoveredNow

HealthCare.gov

From Coverage to Care

Sponsored by the Centers for Medicare & Medicaid Services, Office of Minority Health (CMS OMH), to help the newly insured understand:

- **What** it means to have health insurance;
- **How** to find a provider and;
- **When** and **Where** to seek health services;
- **Why** prevention and partnering with a provider is important for achieving optimal health

Your ROADMAP to health

1 Start here

Put your health first.

- Staying healthy is important for you and your family.
- Get a regular check-up.
- Keep all of your health information in one place.

2

Understand your insurance plan.

- Check with your insurance plan to see what services are covered by your plan.
- Be familiar with your copayments, deductibles, and coinsurance.
- Know the difference between in-network and out-of-network.

3

Find a provider.

- Ask people you trust.
- Check your plan's provider network.
- If you are assigned a provider, contact your plan if you want to change.
- Do research on the internet.

4

Make an appointment.

- Mention that you are a new patient.
- Provide the name of your insurance plan.
- Tell them the name of the provider you want to see and why you want an appointment.
- Ask for days or times that work for you.

5

Be prepared for the first visit.

- Have your insurance card with you.
- Make a list of any medicines you are currently taking.
- Bring a list of questions and things to discuss with the provider and write notes during your visit.
- Bring someone with you to help if you need.

6

No

Yes

Decide if you like the provider.

- You should feel comfortable with who you see.
- You should understand and be able to communicate with your provider.
- Remember: It is okay to change to a different provider!

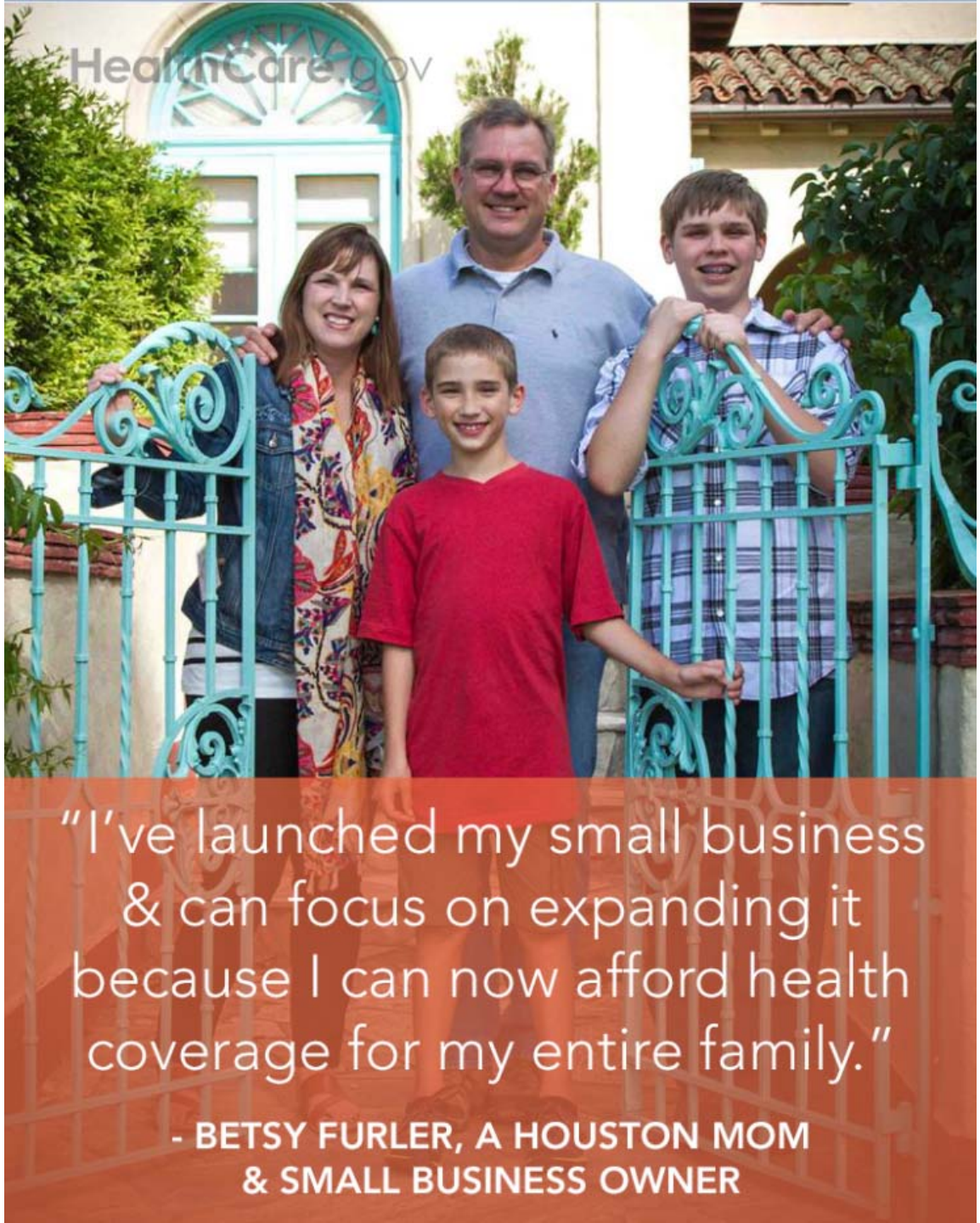
7

Next steps after your appointment.

- Follow your provider's instructions.
- Fill any prescriptions you were given.
- Schedule a follow-up visit if necessary.
- Contact your insurance plan or provider with any questions.

Developed by the MITRE Corporation and the RAND Corporation for CMS.

CMS


HealthCare.gov
"I've launched my small business & can focus on expanding it because I can now afford health coverage for my entire family."
- BETSY FURLER, A HOUSTON MOM & SMALL BUSINESS OWNER

Overview

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Delivery system and payment transformation

Current State –

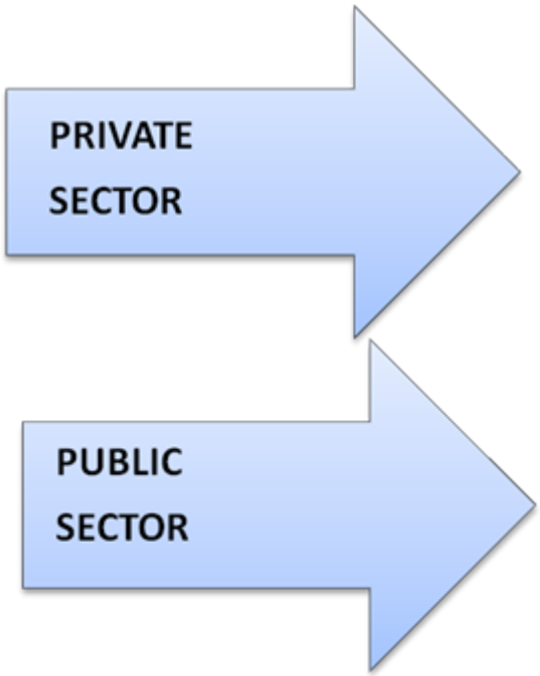
Producer-Centered

Volume Driven

Unsustainable

Fragmented Care

FFS Payment Systems



Future State –

People-Centered

Outcomes Driven

Sustainable

Coordinated Care

New Payment Systems (and many more)

- Value-based purchasing
- ACOs, Shared Savings
- Episode-based payments
- Medical Homes and care mgmt.
- Data Transparency

Going Forward: What Can You Do?

- **Continue improving quality and patient safety**
- **Push your organizations to support the transition to a sustainable patient centered healthcare system**
- **Chose your pathways to participate in alternative payment models:**
  - **ACOs, Bundled Payments for Care Improvement, State Innovation Models, etc.**
- **Make your personal commitment to transformation**

Contact Information: San Francisco Regional Office Centers for Medicare & Medicaid Services

David W. Saÿen
Regional Administrator
415-744-3501
David.Sayen@cms.hhs.gov

Betsy L. Thompson, MD, DrPH
Regional Chief Medical Officer
415-744-3631
Betsy. Thompson@cms.hhs.gov