CMS Update on Value-Based Purchasing

Tenth National Pay for Performance Summit:
The Leading Forum on
Pay for Performance, Transparency, and
Value-Driven Healthcare

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

March 2, 2015

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.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

New Goals and Timeline for Moving Medicare from Rewarding Volume to Value

January 2015 Announcement

•HHS Secretary Sylvia M. Burwell announced **measurable goals and a timeline** to move the Medicare program, and the health care system at large, toward **paying providers based on the quality, rather than the quantity of care** they give patients

•**First time in the history of the program** that explicit goals for alternative payment models and value-based payments set for Medicare

•Creation of national **Health Care Payment Learning & Action Network** to accelerate the transition and foster collaboration between private payers, employers, providers, consumers, and state/federal partners

Goals

1.Alternative Payment Models:

1. **30%** of Medicare payments are tied to quality or value through **alternative payment models** by the end of 2016
2. **50%** by the end of 2018

2.Linking FFS Payments to Quality/Value:

1. **85%** of all Medicare fee-for-service payments are **tied to quality or value** by 2016
2. **90%** by the end of 2018

Better Care. Smarter Spending. Healthier People

In three words, our vision for improving health delivery is about **better, smarter, healthier**.

If we find better ways to pay providers, deliver care, and distribute information:

- ✓ We can receive better care.
- ✓ We can spend our health dollars more wisely.
- ✓ We can have healthier communities, a healthier economy, and a healthier country.

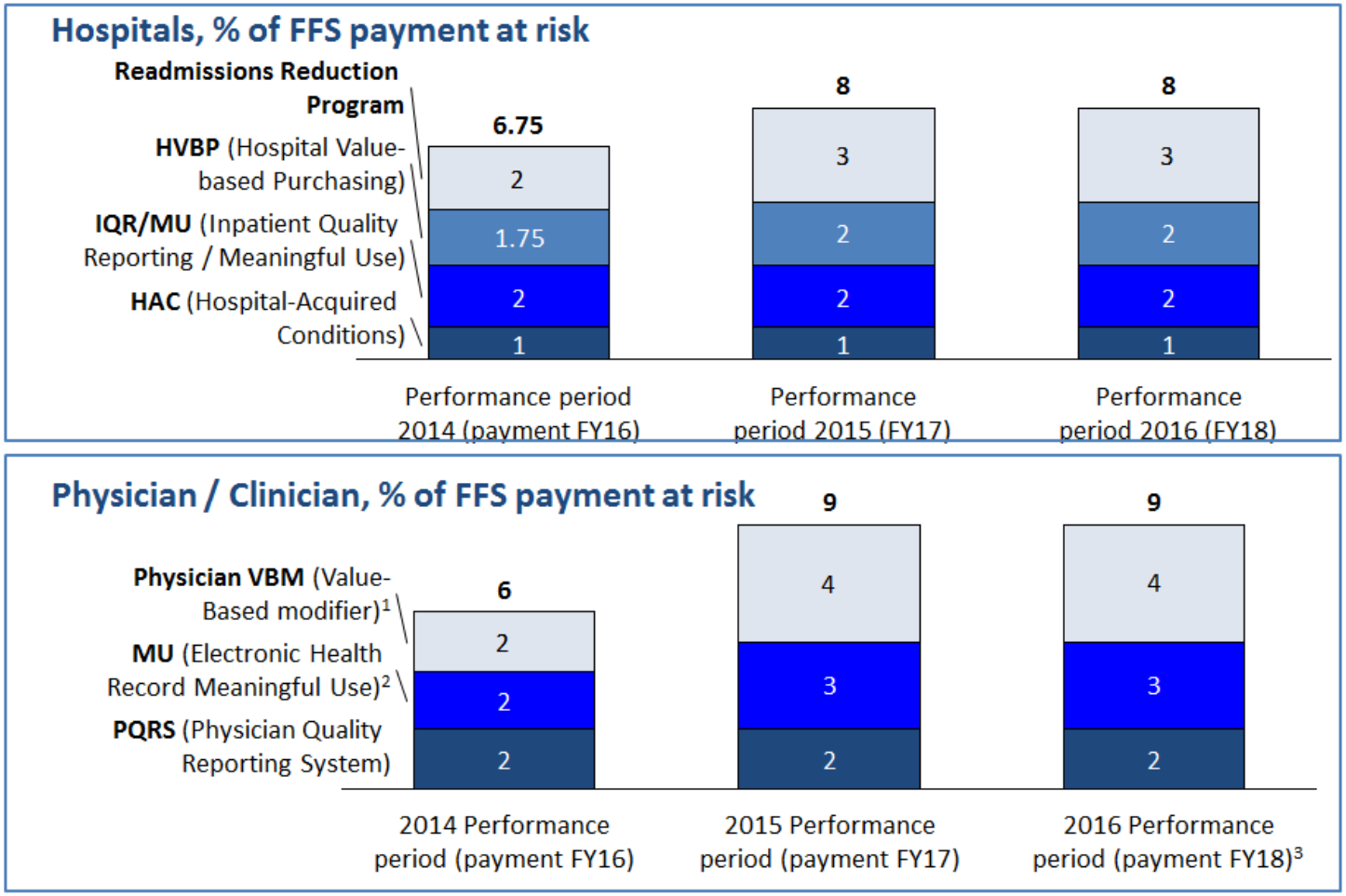
Focus Areas	Description
Incentives	▪ Promote value-based payment systems – Test new alternative payment models – Increase linkage of Medicaid, Medicare FFS, and other payments to value ▪ Bring proven payment models to scale
Care Delivery	▪ Encourage the integration and coordination of clinical care services ▪ Improve population health ▪ Promote patient engagement through shared decision making
Information	▪ Create transparency on cost and quality information ▪ Bring electronic health information to the point of care for meaningful use

Framework for Progression of Payment to Clinicians and Organizations in Payment Reform

	Category 1: Fee for Service – No Link to Quality	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models on Fee-for Service Architecture	Category 4: Population-Based Payment
Description	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	• Some payment is linked to the effective management of a population or an episode of care • Payments still triggered by delivery of services, but, opportunities for shared savings or 2-sided risk	• Payment is not directly triggered by service delivery so volume is not linked to payment • Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (eg, >1 yr)
Examples				
Medicare	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable Care Organizations • Medical Homes • Bundled Payments	• Eligible Pioneer accountable care organizations in years 3 – 5 • Some Medicare Advantage plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations
Medicaid	Varies by state	• Primary Care Case Management • Some managed care models	• Integrated care models under fee for service • Managed fee-for-service models for Medicare-Medicaid beneficiaries • Medicaid Health Homes • Medicaid shared savings models	• Some Medicaid managed care plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations

Rajkumar R, Conway PH, Tavenner M. The CMS—Engaging Multiple Payers in Risk-Sharing Models. JAMA. Doi:10.1001/jama.2014.3703

CMS is Increasingly Linking Fee-for-service Payment to Value



1 Physician VBM for 2014 Performance period is being phased in as follows: Physicians in groups of 10+ EPs only for 2014 performance period ; all physicians, groups and EPs starting in 2015 performance period. For the 2015 performance period, 4% is proposed maximum downward VBM adjustment. For 2016 performance period, amount at risk to be proposed in next year's rulemaking and will depend in part on the final value for 2015 performance period.

2 For 2018, if the Secretary finds that the proportion of eligible professionals who are meaningful EHR users is less than 75%, then the amount at risk would go up to 4%

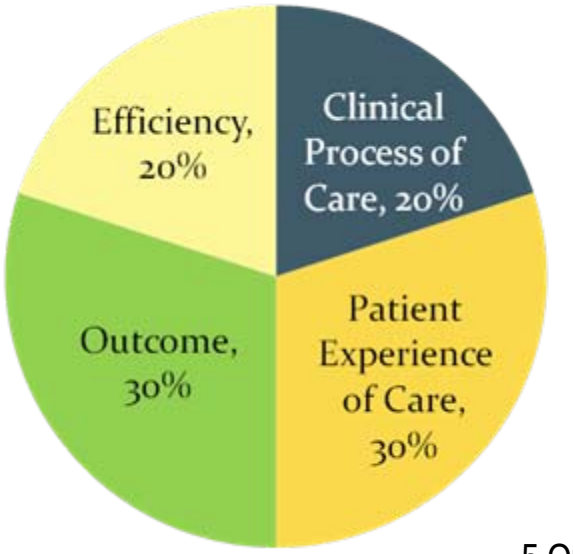
3 Proposed rule for 2016 performance year will be written in 2015. No cap on percent at risk for physician value-based modifier but unclear what the proposed rule will contain.

FY 2015 Finalized Domains and Measures/Dimensions

12 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 6AM Postoperative Serum Glucose
10. SCIP–Inf–9 Postoperative Urinary Catheter Removal on Post Operative 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-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 & 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

Physician 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

The CMS Innovation Center

http://innovation.cms.gov/

Identify, Test, Evaluate, Scale

"The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles.

- *The Affordable Care Act*

Providers are Driving Transformation

- More than 50,000 providers are or will be providing care to beneficiaries as part of the Innovation Center's current initiatives
- Over 400 organizations are participating in Medicare ACOs
- More than 7 million Medicare FFS beneficiaries are receiving care from ACOs
- More than 1 million Medicare FFS beneficiaries are participating in primary care initiatives

Transformation of Health Care on the Front Lines

AT LEAST SIX COMPONENTS

- Quality measurement
- Aligned payment incentives
- Comparative effectiveness and evidence available
- Health information technology
- Quality improvement collaboratives and learning networks
- Training of clinicians and multi-disciplinary teams

Source: P.H. Conway and Clancy C. Transformation of Health Care at the Front Line. JAMA 2009 Feb 18; 301(7): 763-5

CMS Innovations Portfolio

I. Accountable Care Organizations (ACOs)

- Medicare Shared Savings Program (Center for Medicare)
- Pioneer ACO Model
- Advance Payment ACO Model
- Comprehensive ERSD Care Initiative

II. Primary Care Transformation

- Comprehensive Primary Care Initiative (CPC)
- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home Demonstration
- Graduate Nurse Education Demonstration

III. Bundled Payment for Care Improvement

- Model 1: Retrospective Acute Care
- Model 2: Retrospective Acute Care Episode & Post Acute
- Model 3: Retrospective Post Acute Care
- Model 4: Prospective Acute Care

IV. Capacity to Spread Innovation

- Partnership for Patients
- Community-Based Care Transitions Program
- Million Hearts

V. Health Care Innovation Awards (Rounds 1 & 2)

VI. State Innovation Models Initiative

VII. Initiatives Focused on the Medicaid Population

- Medicaid Emergency Psychiatric Demonstration
- Medicaid Incentives for Prevention of Chronic Diseases
- Strong Start Initiative

VIII. Initiatives Focused on the Medicare Population

- Medicare Intravenous Immune Globulin Demo
- Medicare Acute Care Episode Demonstration
- Medicare Imaging Demo

IX. Medicare-Medicaid Enrollees

- Financial Alignment Initiative
- Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents

Accountable Care Organizations Moving Ahead

"Today, we at CMS are excited to announce that 89 new Accountable Care Organizations (ACOs) will be joining the Medicare Shared Savings Program (Shared Savings Program). With today's announcement, we will have a total of **405 ACOs participating in the Shared Savings Program** next year, serving more than 7.2 million beneficiaries. When combined with the Innovation Center's **19 Pioneer ACOs**, we will have a total of 424 ACOs serving over 7.8 million beneficiaries."

-- Sean Cavanaugh, Deputy Administrator and Director
Center for Medicare, December 22, 2014

ACO Goals

An ACO promotes seamless coordinated care that:

- Puts the beneficiary and family at the center of all its activities
- Remembers patients over time and place
- Attends carefully to care transitions
- Manages resources carefully and respectfully
- Proactively reaches out to patients with reminders and advice
- Evaluates data to improve care and patient outcomes
- Innovates around better health, better care and lower growth in expenditures through improvement
- Invests in team-based care and workforce

Lessons Learned

- Importance of strong clinical leadership
- Communication and transparency
- Practice redesign
- Innovative care coordination
- The value of data and dashboards
- Pick a few things to improve and build on success

Comprehensive Primary Care Initiative

GOAL: Test a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care.

- **Practice redesign** involves provision of "comprehensive primary care" characterized by 5 core functions, better use of data and HIT by practices, and learning opportunities to support practice transformation.
- **Payment redesign** involves multi-payer investment in selected primary care practices, with Medicare paying an average $20 per beneficiary per month (PBPM) in first 2 years, moving to a $15 PBPM in years 3 and 4, and a shared savings opportunity in years 2-4 of the program.
- **The 7 regions selected:** New York (Hudson Valley), Ohio/Kentucky (Cincinnati region), Oklahoma (Tulsa), statewide in Arkansas, Colorado, New Jersey, Oregon

Bundled Payments for Care Improvement

GOAL: Test payment models that link payments for multiple services patients receive during an episode of care for effectiveness in promoting coordination across services and reducing the cost of care.

Four models:

1. Acute care hospital stay only
2. Acute care hospital stay plus post-acute care
3. Post-acute care only
4. Prospective payment of all services during inpatient stay

Bundled Payments: 4 Models

	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	1 representing 24 health care facilities	51 representing 192 health care organizations	14 representing 164 health care organizations	37 representing 76 health care facilities

Partnership for Patients
Focused on 2 Breakthrough Aims

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

partnershipforpatients.cms.gov

Community-based Care Transitions Program (CCTP)

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

CCTP Evaluation

by Econometrica, Inc. , May 30, 2014

Challenges and Lessons Learned:

-hiring personnel with appropriate skills and experience

-identifying at-risk patients

-developing systems to manage information

-learning about the qualities needed to be an effective coach through experience

-revising hiring criteria to include personal qualities, such as ability to work at a fast pace that were effective in reaching and motivating patients

-having direct access to the hospitals' electronic health record (EHR) system and case management data to support the identification of at-risk patients

Planned Changes Going Forward:

-adding new hospital partners

-expanding eligibility criteria for patients

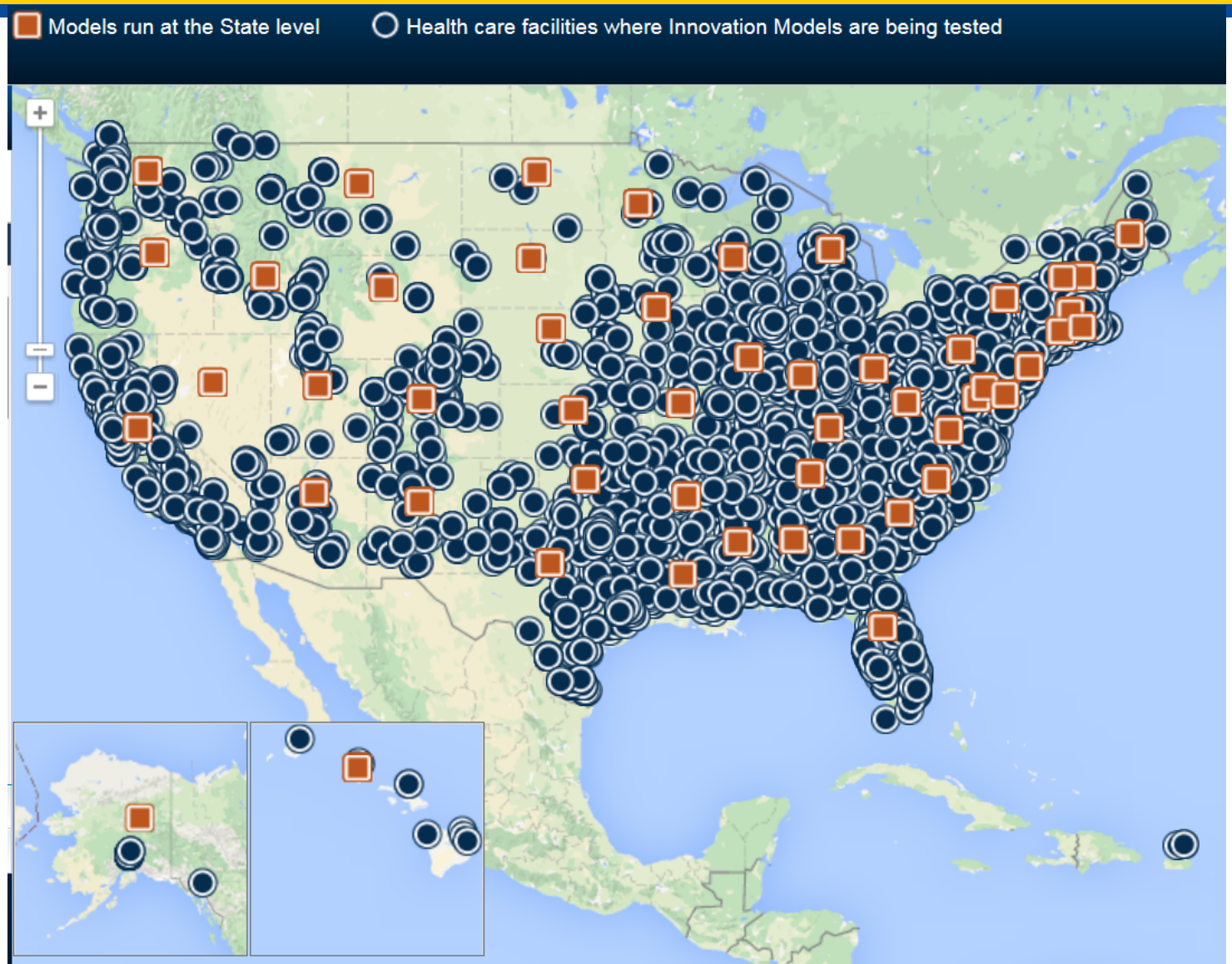
-expanding reach and footprint to have a greater impact on readmission rates

-broadening eligibility criteria may help achieve higher enrollment numbers, but increasing client pool could make lower readmission rates more difficult to achieve since it would require serving more beneficiaries

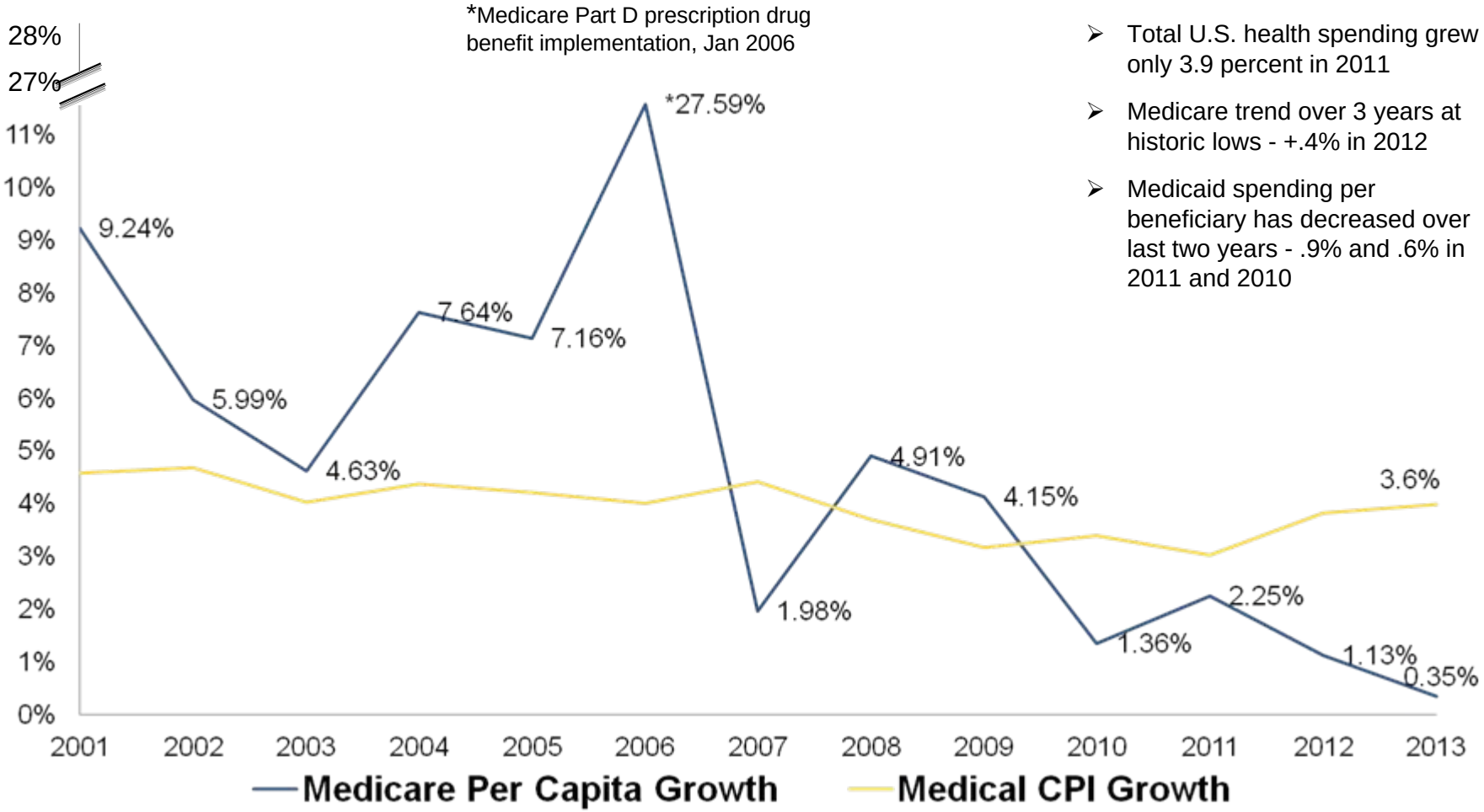
-adding new hospitals as partners may still be a worthwhile goal, but it may not have the impact of increasing a CBO's footprint

-changing services offered and strategies used to meet the needs of beneficiaries

Innovation is happening broadly across the country



Results: Medicare Per Capita Spending Growth at Historic Lows

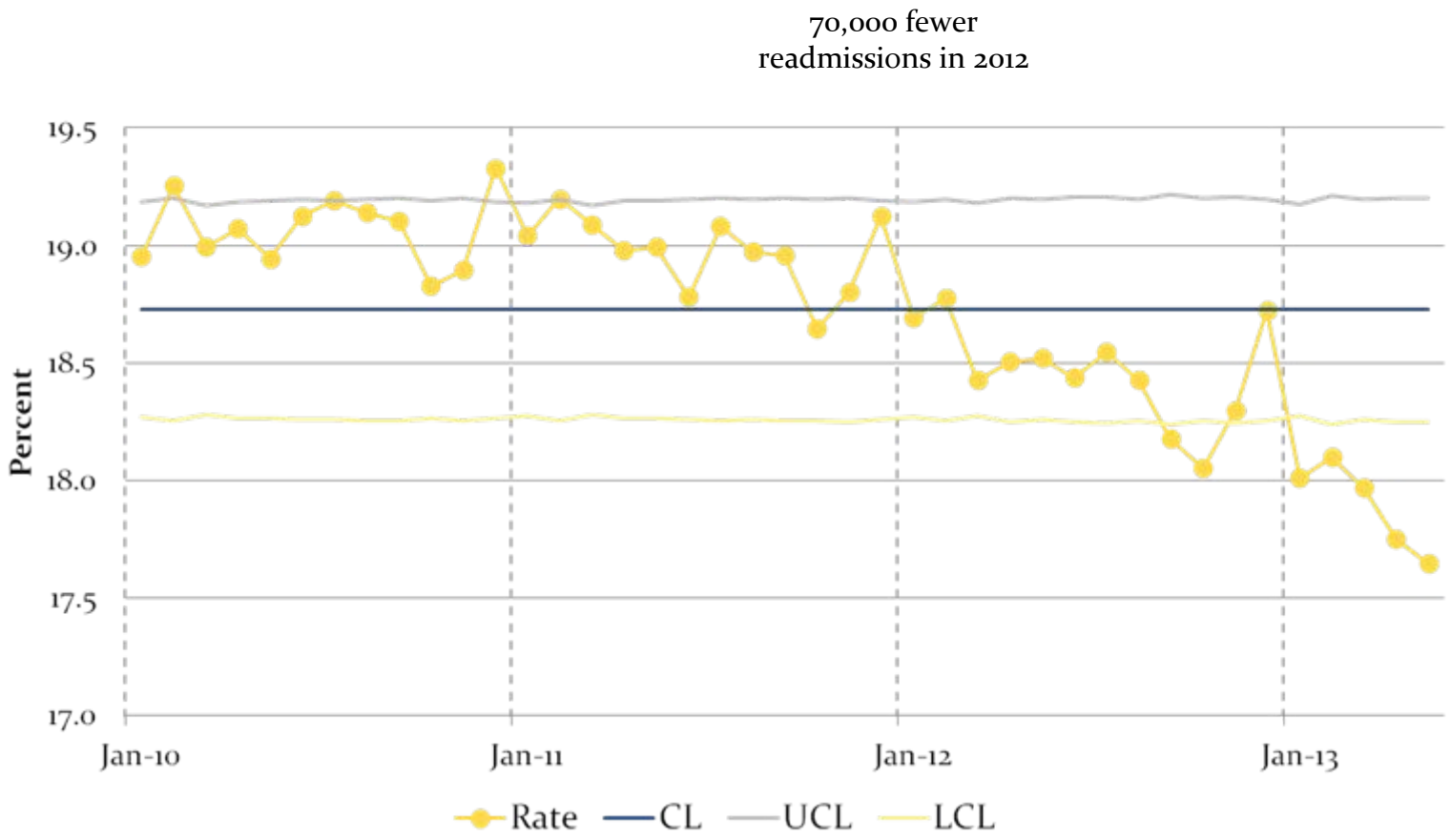


- Total U.S. health spending grew only 3.9 percent in 2011
- Medicare trend over 3 years at historic lows - +.4% in 2012
- Medicaid spending per beneficiary has decreased over last two years - .9% and .6% in 2011 and 2010

Source: CMS Office of the Actuary

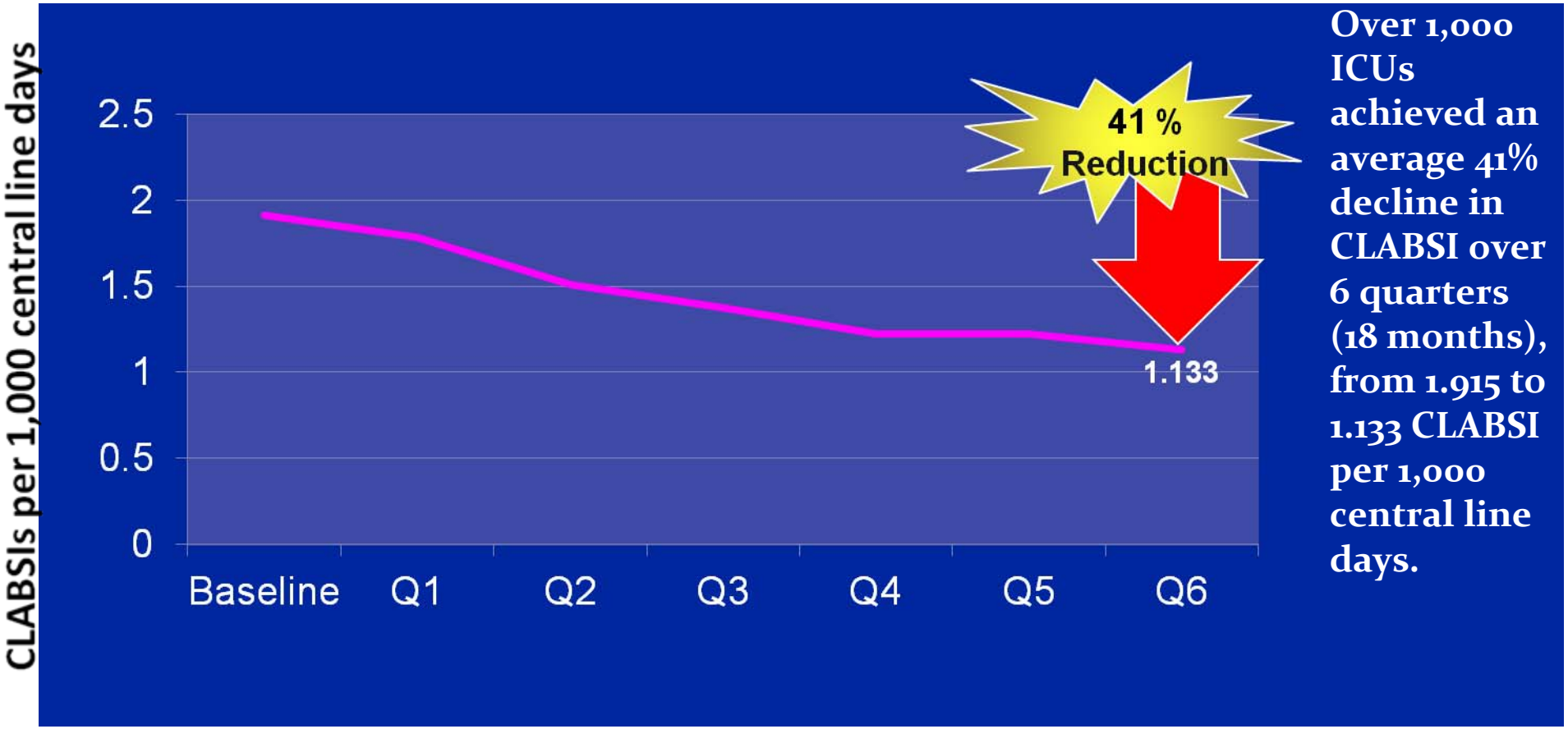
Medicare All Cause, 30 Day Hospital Readmission Rate

Medicare 30-day, all-cause readmission rate is estimated to have dropped 1 percent after being at 19 percent for five years



Source: Office of Information Products and Data Analytics, CMS

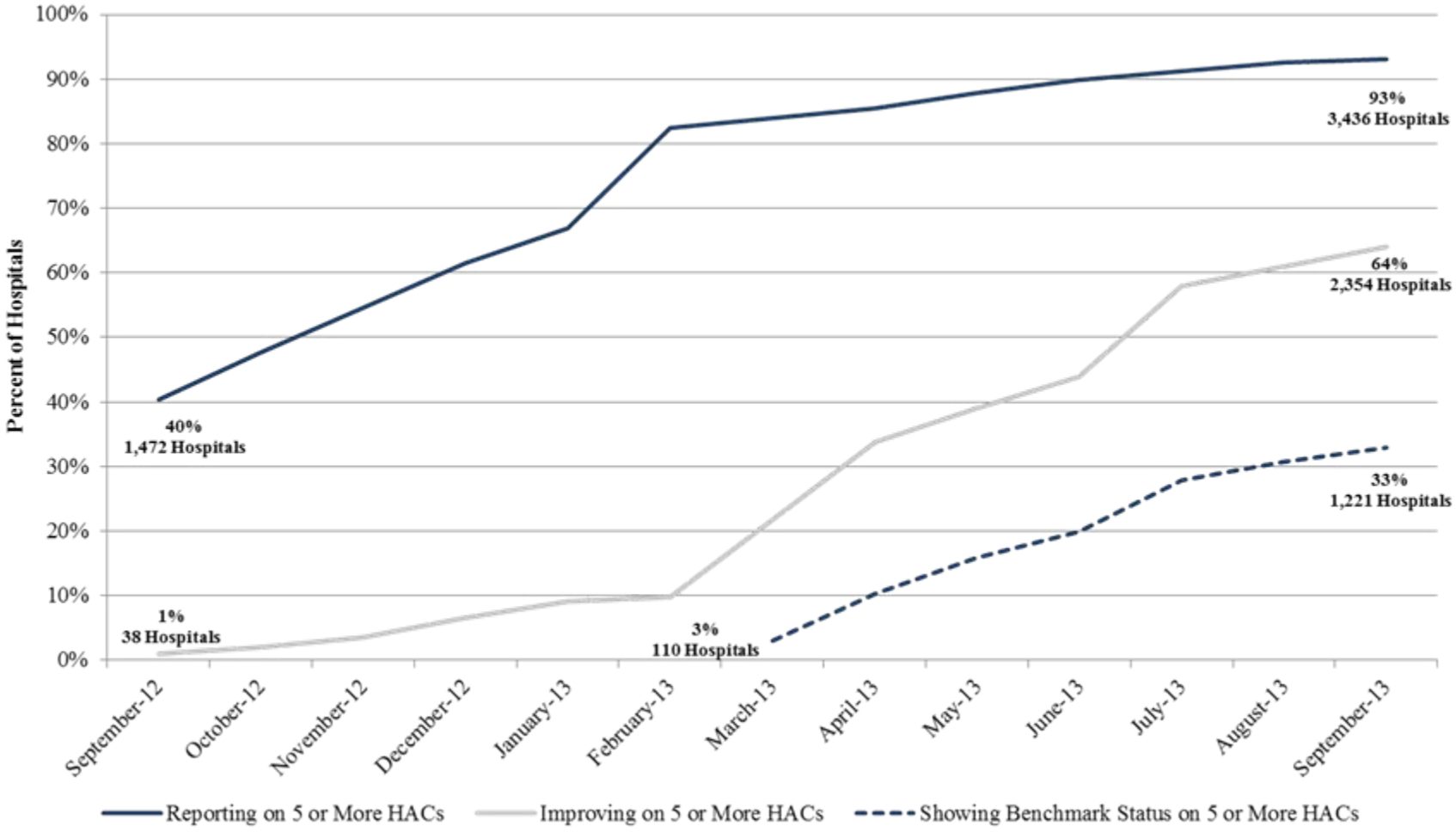
National Bloodstream Infection Rate



Over 1,000 ICUs achieved an average 41% decline in CLABSI over 6 quarters (18 months), from 1.915 to 1.133 CLABSI per 1,000 central line days.

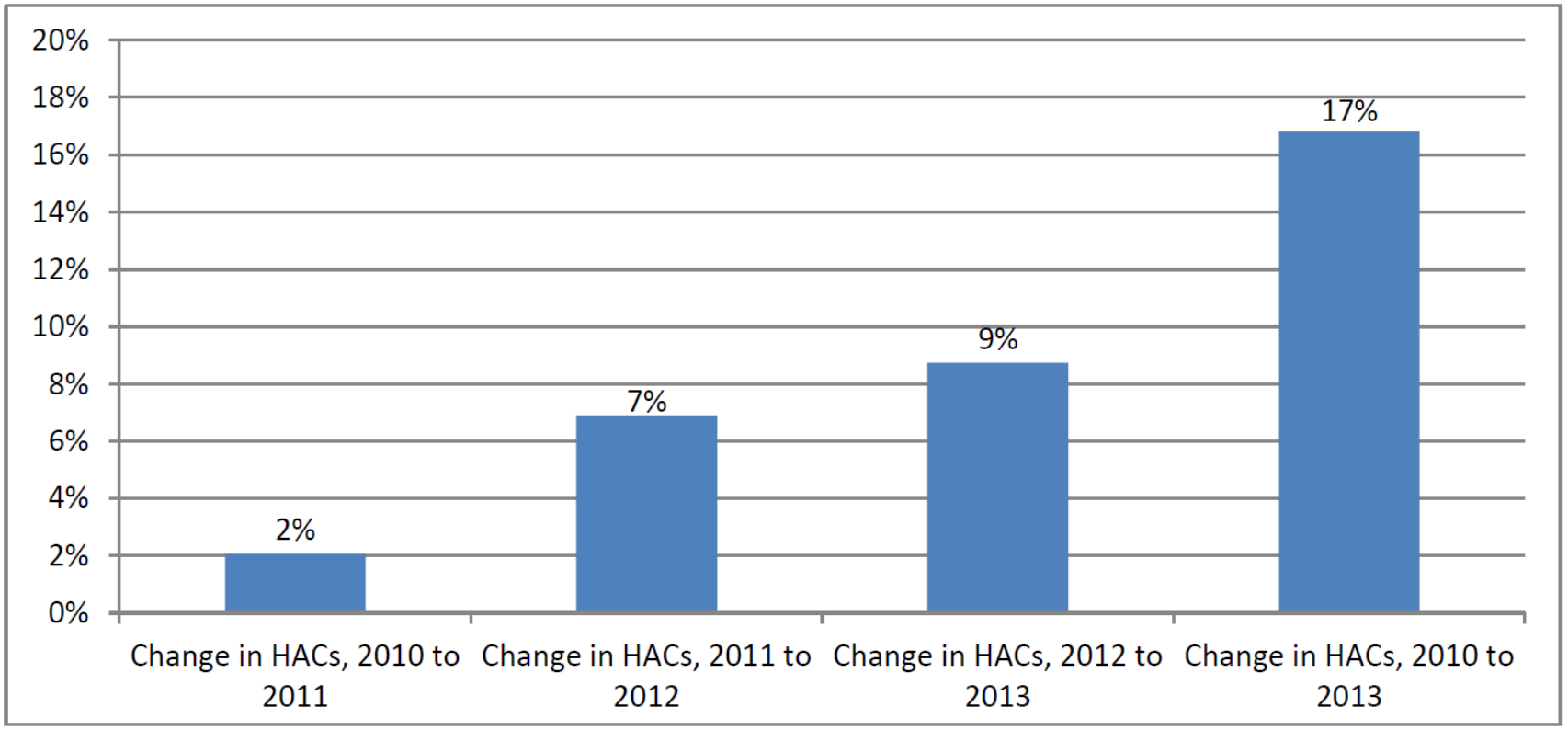
Quarters of participation by hospital cohorts, 2009–2012

Early Results Partnership for Patients: Over 3000 Hospitals Reducing Harm and Improvement Accelerating



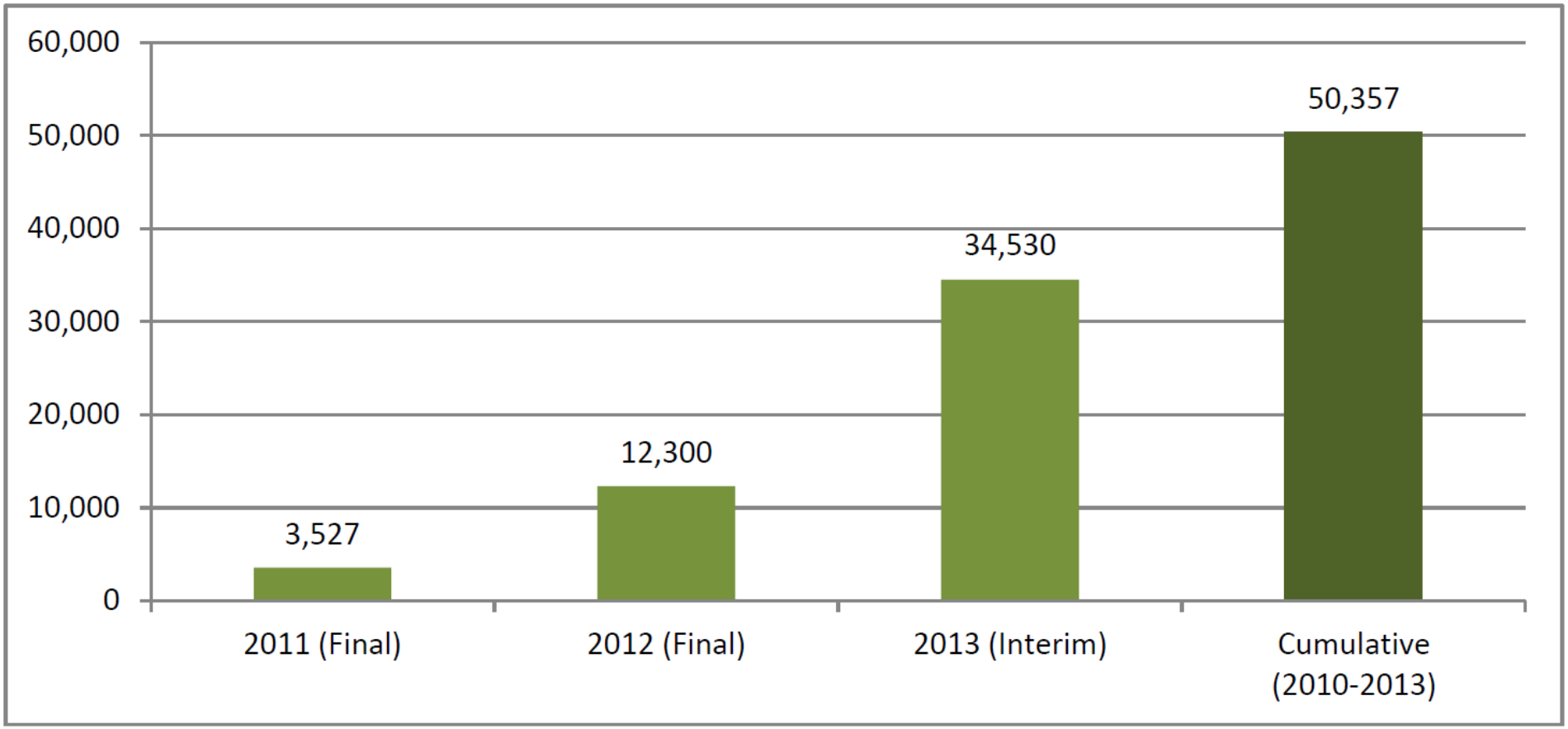
Hospital Acquired Condition (HAC) Rates Show Improvement

- **2010 – 2013 - Preliminary data show a 17% reduction in HACs across all measures**

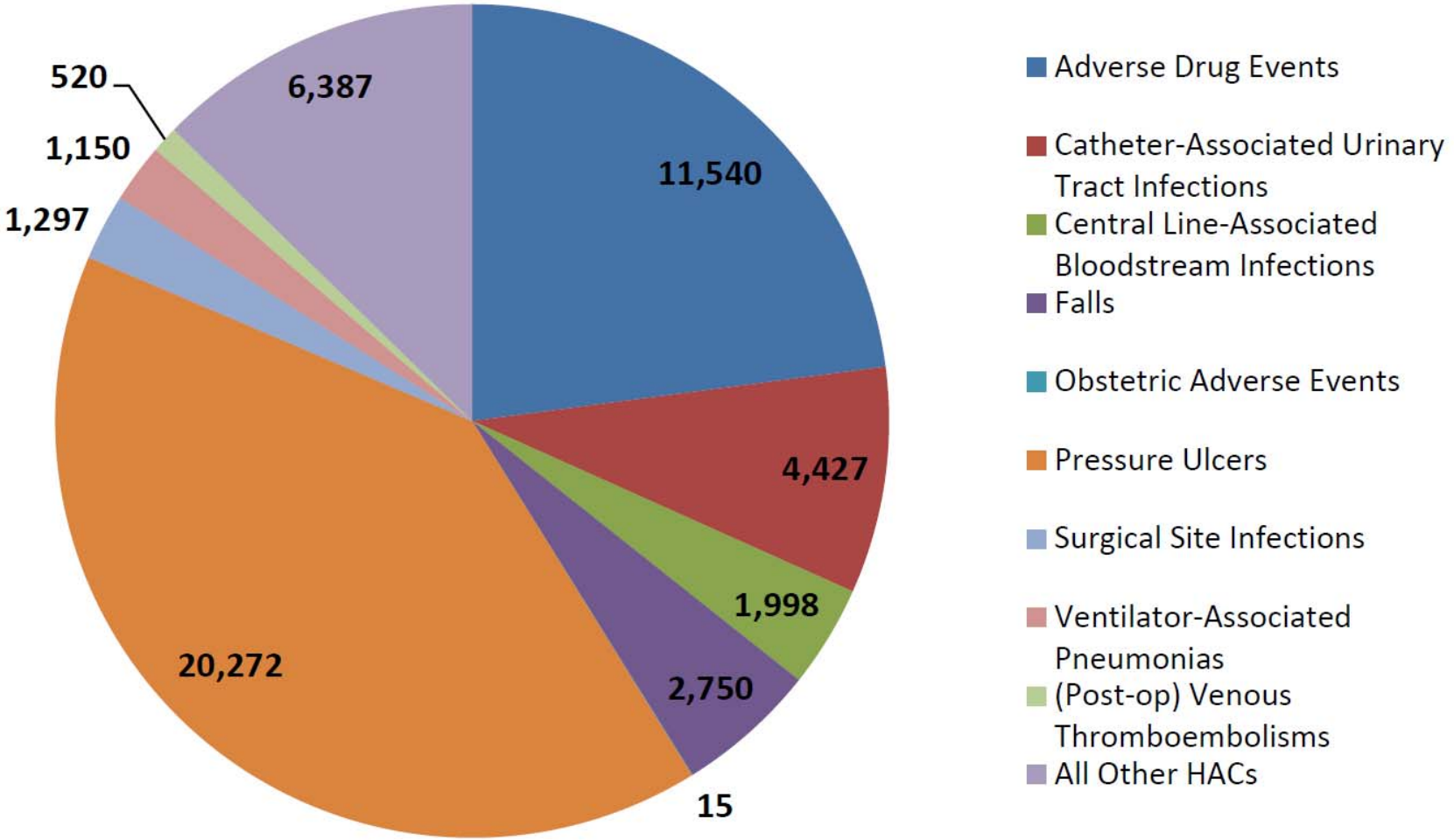


Source: AHRQ National Scorecard Estimates from Medicare Patient Safety Monitoring System, National Healthcare Safety Network, and Healthcare Cost and Utilization Project.
Note: The 17 percent change from 2010 to 2013 is not the sum of 2 percent, 7 percent, and 9 percent due to different total HAC rates in 2010, 2011, and 2012.

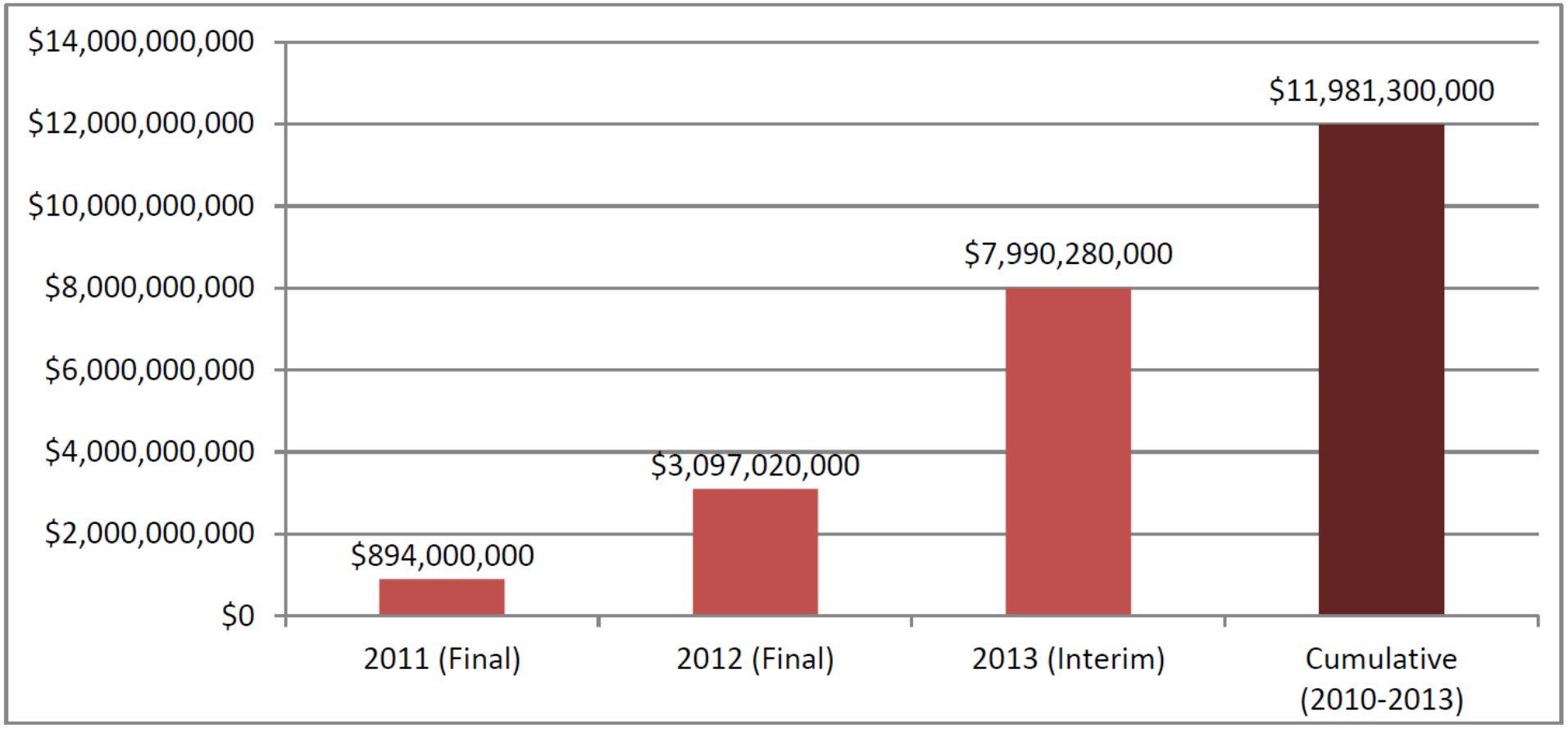
Total Annual and Cumulative Deaths Averted (Compared to 2010 Baseline)



Estimated Deaths Averted, by Hospital-Acquired Condition (HAC), 2011-2013



Total Annual and Cumulative Cost Savings (Compared to 2010 Baseline)



Possible New Model Concepts

- Outpatient specialty models
- Practice Transformation Support
- ACOs version 2.0
- Health Plan Innovation
- Consumer Incentives
- Home Health
- SNF
- More…..

Contact Information
CMS San Francisco

DAVID W. SAŸEN
Regional Administrator

(415) 744-3501
david.sayen@cms.hhs.gov
www.cms.gov
@davidsayen