Value-Driven Healthcare: A Federal Priority

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The Healthcare Value Imperative

- We spend more per capita on healthcare than any other country in the world
- In spite of those expenditures, US Healthcare quality is often inferior to other nations and often doesn't meet expected evidence-based guidelines
- There are significant variations in quality and costs across the nation and there appears to often be an inverse relationship between quality and expenditures (cost)
- CMS is responsible for the healthcare of a growing number of persons
- CMS, in partnership and collaboration with other healthcare leaders, must demonstrate leadership in addressing these issues

Congressional & Employer Interests

- Many opportunities for improving the quality of healthcare services, outcomes and efficiency
- Increasing reimbursement for healthcare services leads to:
  - No uniform or widespread improvement in quality
  - Increased utilization of some services
  - Net increase in overall healthcare expenditures
- Congress & employers looking to CMS and healthcare providers to demonstrate ability to improve quality, avoid unnecessary complications and costs
  - Overall Medicare payment reform linked

Healthcare Transparency Initiative

- Administration's Transparency Initiative
  - Making available quality and price/cost information
  - Allowing consumers, employers, payers to choose & effect higher value healthcare
- Presidential Executive Order & Secretary's Value-Driven Health Care Initiative
  - Providing quality information
  - Providing price/cost information
  - Promote interoperable HIT systems
  - Implement incentives to promote higher quality & greater efficiency in healthcare

Value-Driven Healthcare Initiative

- Community Leaders (Tier 1)
  - Early-stage community collaboration efforts in healthcare quality
  - Recognized by the Secretary of HHS
- Value Exchanges (Tier 2)
  - Local collaboratives focused on transparency, quality improvement and use of aggregated quality, efficiency & cost/price data
  - Designated by the Secretary HHS
  - Learning Networks run by AHRQ
  - Chartered for Medicare data access by CMS

Value-Driven Healthcare Initiative

- Better Quality Information for Medicare Beneficiaries: BQI Pilots via AQA (Tier 3)
  - WI, MN, IN, MA, AZ, CA
- Testing of data aggregation & public reporting of commercial, Medicare, & other data
- Pilot site use of quality data for benefit of Medicare beneficiaries:
  - Quality improvement
  - Consumer & employer choice of providers
  - Pay-for-Performance and other incentives for higher quality and efficiency

CMS as a Public Health Agency

- Using CMS influence and financial leverage, in partnership with other healthcare stakeholders, to transform American healthcare system
- Focusing on not just Medicare & Medicaid, but also Commercial, uninsured, etc.
- Quality, Value, Efficiency, Cost-effectiveness
- Person-centeredness
- Assisting patients and providers in receiving evidence-based, technologically-advanced care while reducing avoidable complications & unnecessary costs

CMS Quality Roadmap

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

CMS Quality Roadmap: Strategies

1. Work through partnerships to achieve specific quality goals
2. Publish quality measurements and information as a basis for supporting more effective quality improvement efforts
3. Pay in a way that expresses our commitment to quality, efficiency & value
4. Promote health information technology adoption
5. Promote evidence development for coverage and clinical purposes

CMS P4P Initiatives

- Hospitals
- Nursing Homes
- Home Health Agencies
- Dialysis Facilities
- Physician Offices
- More to come…….
- Cross-setting quality & efficiency focus (care across the continuum) increasingly important

CMS P4P Initiatives (MMA & Before)

- Hospital Quality Initiative (MMA section 501b)
- Premier Hospital Quality Incentive Demo
- Physician Group Practice Demo (BIPA 2000)
- Medicare Care Management Performance Demo (MMA section 649)
- Medicare Health Care Quality Demo (MMA section 646)
- Chronic Care Improvement Program (MMA section 721)

CMS P4P Initiatives (MMA & Before)

- ESRD Disease Management Demo (MMA section 623)
- Disease Management Demo for Severely Chronically Ill Medicare Benficiaries (BIPA 2000)
- Disease Management Demo for Chronically Ill Dual-Eligible Beneficiaries
- Care Management for High-Cost Beneficiaries

Deficit Reduction Act of 2005

- Medicare Part A
  - Hospital Value-based purchasing plan
  - Demonstration projects in gainsharing
  - Post-acute care payment reform demonstration project
  - Hospital quality reporting: measure set expanded
  - Hospital-acquired infections: Non-payment for 2 conditions
- Medicare Part A and Part B
  - Home Health Agency quality reporting
- Prelude to wider P4P in Federal programs ?

Tax Relief & Healthcare Act of 2006

- Establishes a 1.5% bonus payment for physician office submission of quality measures between July 1, 2007 and December 31, 2007 (PQRI)
- Will use PVRP measures initially, but CMS must develop an expanded group of consensus-based measures via NQF or AQA or similar groups
  - By August 15, 2007: Publish proposed measures in FR
  - By November 15, 2007: Publish final list of measures
- Allows for measures reported in registries
- Sets stage for further Congressional action in 2008 re: physician payment structure and P4P

Hospital Quality Initiative

- National Voluntary Hospital Reporting Initiative (NVHRI) public-private initiative
  - Federation of American Hospitals
  - AHA
  - AAMC
  - CMS , JCAHO, others
- Hospital Quality Alliance
- Medicare Modernization Act of 2003: Section 501b – Financial incentive of 0.4%

Hospital Quality Initiative

- “Voluntary” participation went from 10% of hospitals reporting some of 10 measures to over 95%
- Incentive increased from 0.4% to 2% of APU under DRA
- Now 21 hospital quality measures required to qualify for Annual Payment Update
- Current year 95% of hospitals qualified
- Pay-for-Reporting works

Premier Hospital Quality Demonstration

- 260 participating hospitals
  - Wide variation in demographics, funding
- 34 Quality Metrics
  - Acute myocardial infarction (9)
  - Coronary artery bypass graft (8)
  - Heart failure (4)
  - Community acquired pneumonia (7)
  - Hip and knee replacement (6)

Premier Demonstration

- Hospital scores
  - "Rolling up" individual measures into one score for each disease category
  - Each disease category will be categorized by hospital scores by decile
- Public reporting of all data will be available
- Financial awards
  - Hospitals in top 20% will be given bonuses: 2% for top decile, 1% for second decile
  - Top 50% recognized on CMS website

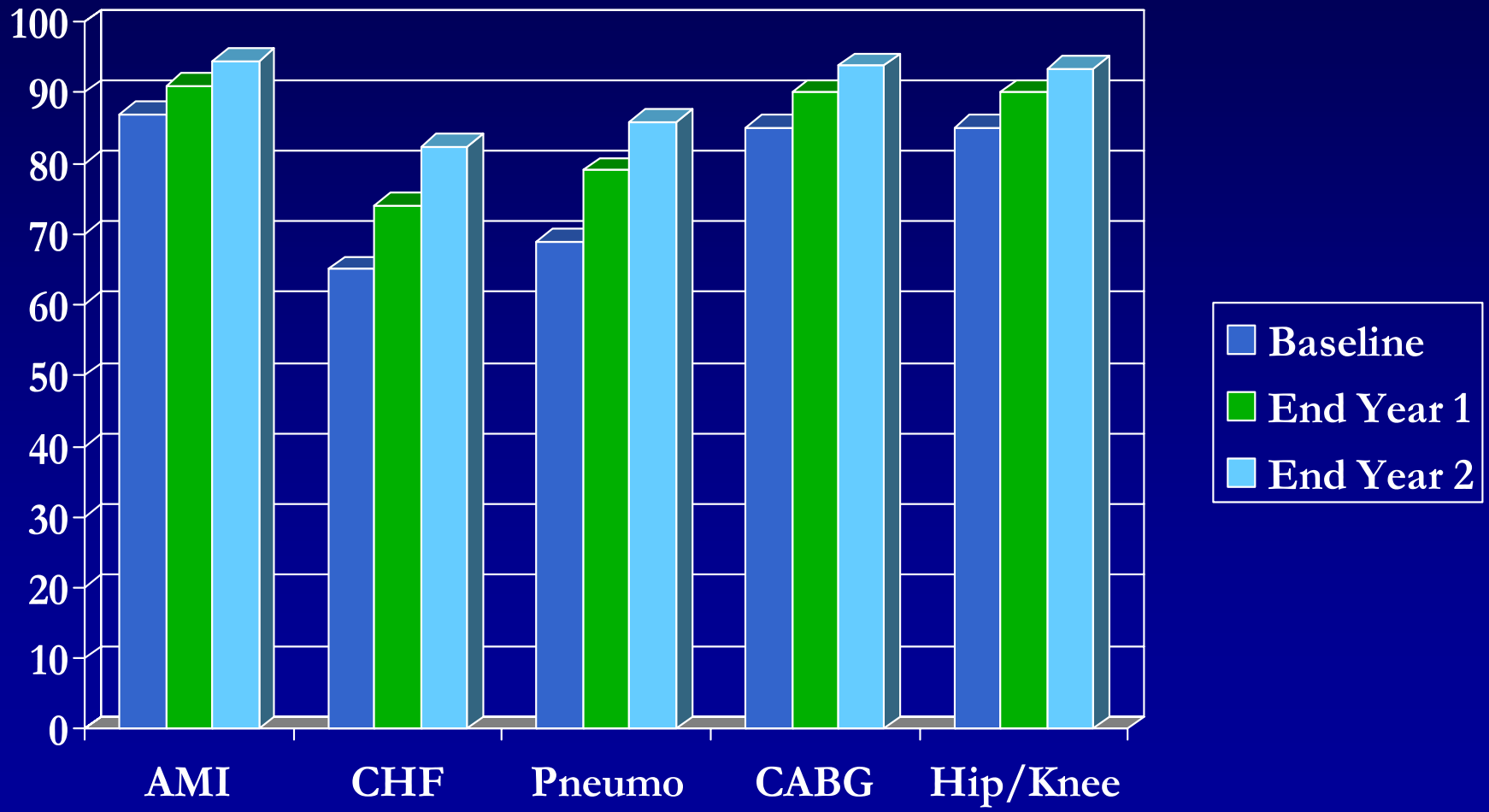
Premier Hospital Demonstration

- Improvement over baseline
  - Hospitals that do not improve over demonstration baseline will have adjusted payments
  - Demonstration baseline cut-off will be at level of the 9th and 10th deciles of base year
  - Hospitals below baseline 9th decile will have 1% reduction in DRG reimbursement
  - Hospitals below baseline 10th decile will have 2% reduction in DRG reimbursement

Premier Hospital Demo: 1st Year P4P Payouts

- $8.85 million paid in first year
  - AMI – $1.756 million to 49 hospitals
  - CHF – $1.818 million to 57 hospitals
  - Pneumonia – $1.139 million to 52 hospitals
  - CABG – $2.078 million to 27 hospitals
  - Hip & Knee Replacement -$2.061 million to 43 hospitals
- 49 out of 260 participating hospitals received bonuses
- Awards received by all hospital types

Premier Hospital Demo: 1st & 2nd Year Results



Premier Hospital Demo: The Business Case for P4P

- Hospitals achieving >75% percentile quality scores
  - Fewer complications
  - Fewer readmissions
  - Significantly lower hospital costs
  - Significantly shorter length of stay
- For coronary artery bypass graft patients
  - Significantly lower mortality rates
- Demonstration extension under discussion
  - May examine P4P incentives v.s. business case

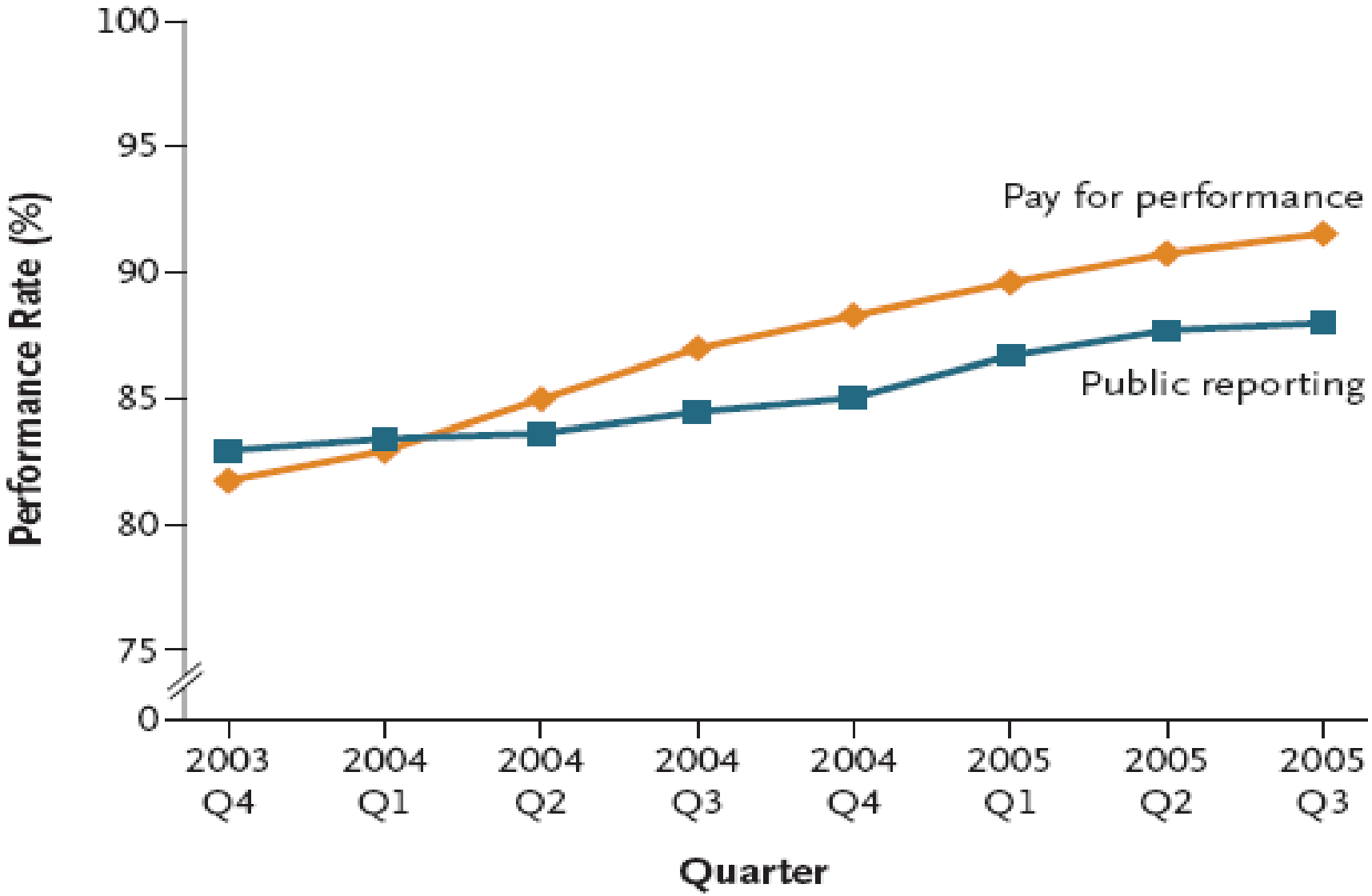
The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

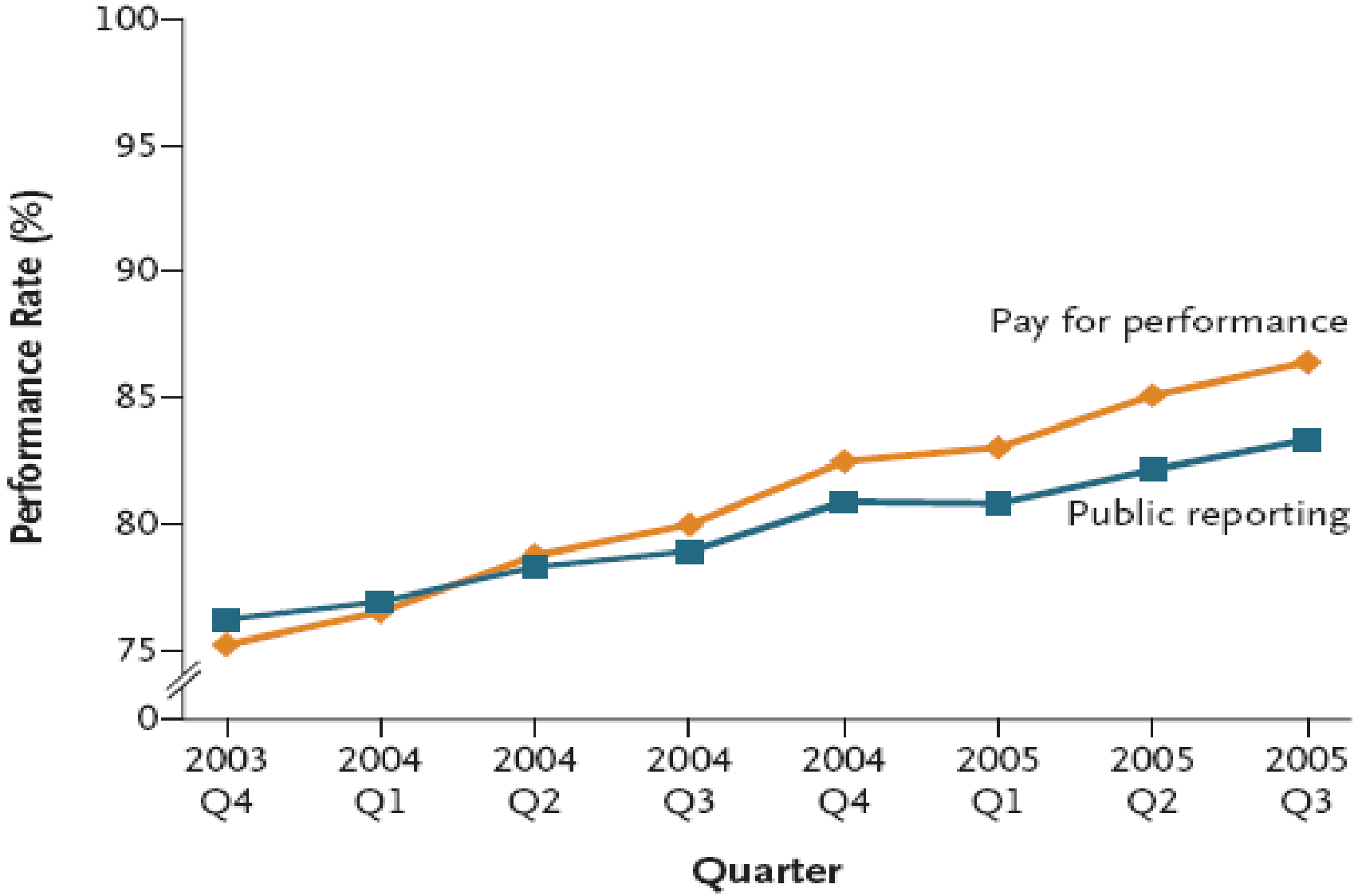
Public Reporting and Pay for Performance in Hospital Quality Improvement

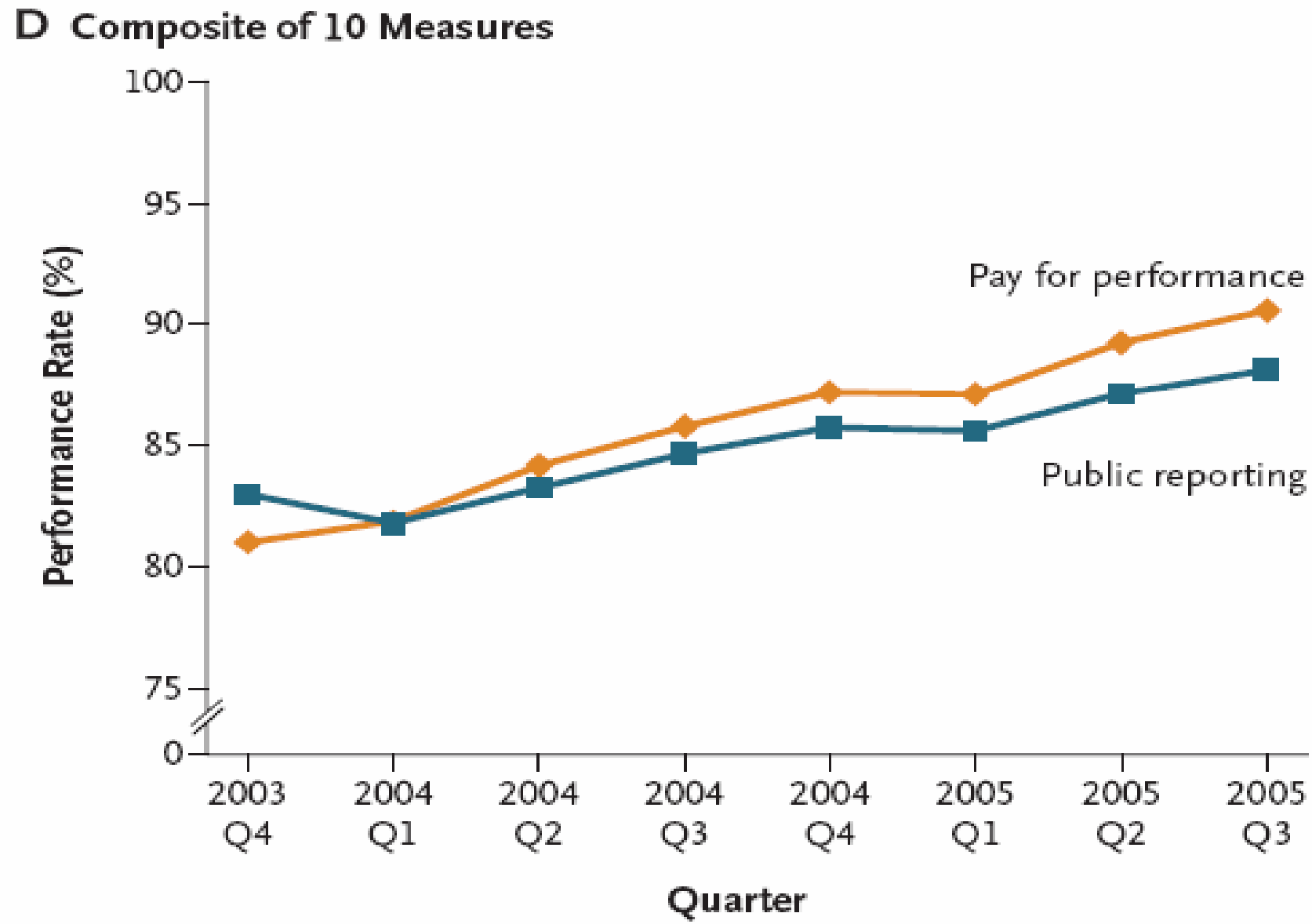
Peter K. Lindenauer, M.D., M.Sc., Denise Remus, Ph.D., R.N.,
Sheila Roman, M.D., M.P.H., Michael B. Rothberg, M.D., M.P.H.,
Evan M. Benjamin, M.D., Allen Ma, Ph.D., and Dale W. Bratzler, D.O., M.P.H.

B Heart Failure



C Pneumonia


Performance Rate (%)
100
95
90
85
80
75
0
Pay for performance
Public reporting
2003 Q4
2004 Q1
2004 Q2
2004 Q3
2004 Q4
2005 Q1
2005 Q2
2005 Q3
Quarter


D Composite of 10 Measures
Performance Rate (%)
100
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Pay for performance
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2003 Q4
2004 Q1
2004 Q2
2004 Q3
2004 Q4
2005 Q1
2005 Q2
2005 Q3
Quarter

Hospital Value Based Purchasing: Legislative Background

- Deficit Reduction Act (DRA) Section 5001(b) authorized CMS to develop a Medicare Hospital Value-Based Purchasing (VBP) Plan
  - Plan based on assumption of implementation in FY 2009; implementation will require additional statutory authority
  - Must consult relevant stakeholders and consider experience with relevant P4P demonstrations and private-sector programs

Hospital 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 the quality of care

Plan Design Considerations

- The Medicare Hospital VBP Program will
  - Be budget neutral
  - Build upon the measurement and reporting infrastructure of the Reporting Hospital Quality Data for Annual Payment Update Program (RHQDAPU)
  - Include measures that address at least three performance domains
    - Clinical quality
    - Patient-centered care
    - Efficiency

Plan Design Considerations

- CMS will work collaboratively through consensus processes
- Program design will seek to reduce healthcare disparities
- As recommended by the Institute of Medicine, CMS will develop and implement ongoing evaluation processes to
  - Assess impact
  - Examine continued utility of measures
  - Monitor for unintended consequences
- Will include the hospital outpatient setting

VBP Plan Development Process

- Issues Paper approach with public comment
- Focus/priority Issues
  - Measures
  - Data Infrastructure and Validation
  - Incentive Structure
  - Public Reporting

CMS Hospital VBP Workgroup Tasks and Expected Timeline

2006 Oct	• Conduct Environmental Scan
Dec	• Develop Issues Paper
2007 Jan 17	• Conduct Listening Session #1 for Stakeholder Input on Issues Paper
	• Develop Draft Hospital VBP Plan
Apr 12	• Conduct Listening Session #2 for Input on Draft Hospital VBP Plan
June	• Complete Final Plan
July	• Prepare Final Report, Including Plan, Process, and Environmental Scan

Physician Voluntary Reporting Program (PVRP)

- Program implementation began January 2006
- Claims-based, G-code appended for relevant measures
- Distilled down to a starter set of 16 measures
- Need for progressive additional measures development, migration to clinical/electronic
- Burden analysis, health disparities focus
- Feedback to clinicians for QI, No public reporting
- Conversion to Physician Quality Reporting Initiative (PQRI) July 1, 2007

Physician P4P: A Potential Timeline

- 2006: Voluntary reporting and performance feedback (PVRP)
- 2007: Pay-for-reporting (PQRI)
- 2008: P4P for quality?
- 2009: P4P for efficiency?
- Timetable not fixed
  - Congressional actions would modify

Medicaid P4P

- Over half of states operate 1 or more Medicaid P4P Programs
  - 85% projected to do so over next 5 years
- Focus on children, adolescents, women
  - Chronic disease management focus growing
- Activities across provider settings
- Incentive amounts small, but sometimes not insignificant to safety-net provider setting

IOM: Rewarding Provider Performance Recommendations

- Implement phased approach P4P in Medicare
- Congress should initially derive funding from existing funds
- Congress should authorize aggregation of funding “pools” from different settings of care
- Reward health care that is high-quality, patient-centered, efficient
- Reward both providers who improve significantly as well as highest performers

IOM: Rewarding Provider Performance Recommendations

- Offer incentives for providers to submit data which is then publicly reported
- Implement a strategy to require all providers to submit data & participate in P4P ASAP
- CMS should develop P4P that promotes coordination across providers and through complete episodes of care
- Promote adoption of HIT to enhance performance measurement
- Implement a monitoring program of P4P

Contact Information

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