CMS’ Progress Toward Implementing Value-Based Purchasing

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Presentation Overview

- CMS’ Value-Based Purchasing (VBP) Principles
- CMS’ VBP Demonstrations and Pilots
- CMS’ VBP Programs
- Value-Driven Health Care
- Horizon Scanning and Opportunities for Participation
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
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

Health-Care Spending, American-Style

Up, up and still up

- Spending, in trillions (left scale)
- Spending, as pct. of GDP (right scale)

$2.0
$1.5
$1.0
$0.5
$0.0

1960 '70 '80 '90 '00 '04

Where the money goes, in billions

- Hospital care: 570.8
- Doctors, other professionals: $587.4
- Administration, insurance: 136.7
- Home health, nursing home: 158.4
- Prescription drugs: 188.5
- Govt. public health, investment, other: 235.8

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
CMS’ VBP Programs

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

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

Benchmark: .87
Attainment Threshold: .47

Baseline: .21
Performance: .70

Score: maximum of attainment or improvement

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

Hospital I Score: 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% HCAHPS

- As new domains are added (e.g., outcomes), weights will be adjusted.
Translating Performance Score into Incentive Payment: Example

Hospital Performance Score: % Of Points Earned

Hospital A

Percent Of VBP Incentive Payment Earned

Full Incentive Earned
Proposed Process for Introducing Measures into Hospital VBP

Measure Development and Testing

- Identified Gap in Existing Measures
- Measure Development and Testing
- Stakeholder Involvement: HQA, NQF, the Joint Commission and others

Measure Introduction

- Preliminary Data Submission Period
- VBP Measure Selection Criteria Applied
- Public Reporting & Baseline Data for VBP
- Thresholds for Payment Determined
- Include for Payment & Public Reporting

VBP Program

- NQF Endorsement†

Existing Measures from Outside Entities*

*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
VBP Initiatives

Hospital-Acquired Conditions and Present on Admission Indicator Reporting
Statutory Authority: DRA Section 5001(c)

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

- Ventilator Associated Pneumonia (VAP)
- Staphylococcus Aureus Septicemia
- Deep Vein Thrombosis (DVT)/ Pulmonary Embolism (PE)
- Methicillin Resistant Staphylococcus Aureus (MRSA)
- Clostridium Difficile-Associated Disease (CDAD)
- Wrong Surgery
# POA Indicator Reporting Options

## POA Indicator Options and Definitions

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<thead>
<tr>
<th>Code</th>
<th>Reason for Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Diagnosis was present at time of inpatient admission.</td>
</tr>
<tr>
<td>N</td>
<td>Diagnosis was not present at time of inpatient admission.</td>
</tr>
<tr>
<td>U</td>
<td>Documentation insufficient to determine if condition was present at the time of inpatient admission.</td>
</tr>
<tr>
<td>W</td>
<td>Clinically undetermined. Provider unable to clinically determine whether or not the condition was present at the time of inpatient admission or not.</td>
</tr>
<tr>
<td>1</td>
<td>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.</td>
</tr>
</tbody>
</table>
Successful Documentation of POA

“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/
VBP Initiatives

Physician Quality Reporting Initiative (PQRI)
Quality and PQRI

- PQRI reporting has focused attention on measuring quality of physician practice
  - Foundation is evidence-based measures developed by professionals
  - Reporting data for quality measurement is rewarded with financial incentive
  - Measurement enables improvements in care
  - Reporting is the first step toward pay for performance
Oral Anti-platelet Therapy Prescribed for Patients with Coronary Artery Disease*

• **Performance Description:**
  Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease who were prescribed anti-platelet therapy

• **Reporting Description:**
  Percentage of patients aged 18 years and older seen by the clinician and an applicable CPT Category II code reported once per reporting period for patients seen during the reporting period

*Anti-platelet therapy consists of aspirin, clopidogrel/Plavix or a combination of aspirin and dipyridamole/Aggrenox
PQRI: Reporting Scenario
Oral Antiplatelet Therapy Prescribed for Patients with CAD

Mr. Jones presents for office visit with Dr. Thomas

Mr. Jones has diagnosis of CAD

Situation 1:
Dr. Thomas documents that Mr. Jones is receiving antiplatelet therapy.
CPT II code 4011F

Situation 2:
Dr. Thomas documents that antiplatelet therapy is contraindicated for Mr. Jones because he has a bleeding disorder.
CPT II code 4011F-1P modifier

Situation 3:
There is no documentation that Dr. Thomas or other eligible professional addressed antiplatelet therapy for Mr. Jones.
CPT II code 4011F-8P modifier

All of these situations represent successful PQRI reporting
PQRI Quality Data Reporting

Visit Documented in the Medical Record → Encounter Form → Coding & Billing

Analysis Contractor → National Claims History File → Carrier/MAC

Confidential Report → Bonus Payment
PQRI 2007: Review of Accomplishments

• Launch of PQRI—overcoming inertia
• Partnership with physicians and their organizations
• Implementation of measures across specialties and the continuum of care
• Developed new model for education and outreach
  - Reached critical stakeholders
  - Comprehensive website
  - Tool kit, including AMA worksheets
• Moving IT agenda forward
PQRI Future

• Additional Channels for Reporting
  – Registry-based reporting
  – EHR-based reporting
  – Reporting on groups of measures for consecutive patients
  – Group practice reporting

• Public reporting of participation and performance rates
PQRI Resources

- PQRI information and educational materials are available at:
  www.cms.hhs.gov/PQRI
VBP Initiatives

Physician Resource Use
Efficiency in the Quality Context

- **Efficiency** is one of the Institute of Medicine's key dimensions of **Quality**
  1. Safety
  2. Effectiveness
  3. Patient-Centeredness
  4. Timeliness
  5. **Efficiency**: absence of waste, overuse, misuse, and errors
  6. Equity

Cost of Care Measurement

- CMS’ Cost of Care Measurement Goals
  - To develop meaningful, actionable, and fair cost of care measures of actual to expected physician resource use
  - To link cost of care measures to quality of care measures for a comprehensive assessment of physician performance
Cost of Care Measurement

- Typical cost of care measure is the ratio of actual resource use (numerator) to expected resource use (denominator), given equivalent high quality of care.
Physician Resource Use: The Challenges

- Attribution
- Benchmarking
- Risk adjustment
- Small numbers
- Peculiarities of Medicare claims
Cost of Care Measure Development

- Physician Resource Use Reports for Highly Utilized Imaging Services
  - Phase I: Echocardiograms for Heart Failure
  - Phase II: MRs/CTs for Neck Pain
- Episode Grouper Evaluation
Medicare Physician Echocardiogram Resource Use Report - For CHF* Patients with an E/M Service

Physician Information

**Metropolitan Sample**
UPIN: X22222
Specialty: Cardiology
Wisconsin
Location Type: Metropolitan
Reporting Period: 1/1/2004-12/31/2004

CHF Report Highlights

* For your CHF* patients, you ordered 39% fewer echocardiograms than your peer group.
* In total, 97% of your CHF* patients had an echocardiogram ordered. 81% had an echocardiogram ordered by another provider.

CHF Basic Statistics

- Number of CHF Patients with an E/M Service You Provided: 70
- Number of Echocardiograms You Ordered for These CHF Patients: 11
- Number of Doppler Imaging Add-On Services You Ordered for These CHF Patients: 20
- Number of These CHF Patients Who Received an Echocardiogram You Ordered: 11
- Number of These CHF Patients with an Echocardiogram Ordered only by Another Provider**: 57

Averages

<table>
<thead>
<tr>
<th>Rate of Echocardiograms Ordered per 100 CHF* Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Rate:</td>
</tr>
<tr>
<td>Metropolitan Cardiology Rate: 16</td>
</tr>
<tr>
<td>State Cardiology Rate: 26</td>
</tr>
<tr>
<td>Metropolitan Peer Rate: 27</td>
</tr>
</tbody>
</table>

CHF Rates and Rankings

- Echocardiogram Referrals per 100 CHF Patients
  - % of CHF Patients with at Least One Echocardiogram You Ordered: 16, 26, 27
  - % of CHF Patients with Echocardiograms Ordered only by Another Provider**: 81, 59, 57
  - % of Your CHF Echocardiogram Recipients with a Doppler Imaging Add-On Service: 91, 95, 96

Comparison

- Your Percentile Rank to Metropolitan Peer Group
  - Your Rate: 47%
  - Metropolitan Cardiology Rate: 47%
  - State Cardiology Rate: 50%

Note: Data Represents all your Provider Locations Summarized at the UPIN Level
*CHF Diagnosis = 402.x1, 404.x1, 404.x3, 428.xx, 398.91
**Excludes Patients for Whom you Ordered an Echocardiogram

Echocardiogram Code Range: 93303-93318, 93350
Echocardiogram Doppler Imaging Add-On Code Range: 93320-93325
Imaging Resource Use Reports

- What We Learned
  - Physicians understand their practices from a patient-by-patient perspective, not from an aggregate statistics perspective
  - Claims data for a specific procedure or service alone limits the ability to generate resource use reports that are meaningful or actionable for physicians
  - The cost of widespread dissemination of these imaging resource use reports would likely outweigh the benefits
  - These resource use reports could be used as a screening tool to identify outliers for educational intervention
Episode Grouper Evaluation

- Face Validity
- Clinical Logic
- Phased pilot dissemination of physician resource use reports
Physician Resource Use Reports

Phased Pilot Approach

- Phase I tasks
  - Use both ETG and MEG episode groupers
  - Risk adjust for patient severity of illness
  - Develop several attribution options
  - Develop several benchmarking options
  - Populate and produce RURs for several medical specialties
  - Recruit and pilot RURs with focus groups of physicians
  - Submit all documentation and production logic to allow for a national dissemination of RURs
Value-Driven Health Care

- Executive Order
- CMS’ Posting of Quality and Cost Information
- Better Quality Information for Medicare Beneficiaries Pilots (BQI) & Chartered Value Exchanges (CVEs)
Value-Driven Health Care

- Executive Order 13410
  - Promoting Quality and Efficient Health Care in Government Administered or Sponsored Health Care Programs
  - Directs Federal Agencies to:
    - Encourage adoption of health information technology standards for interoperability
    - Increase transparency in healthcare quality measurements
    - Increase transparency in healthcare pricing information
    - Promote quality and efficiency of care, which may include pay for performance
Horizon Scanning and Opportunities for Participation

- IOM Payment Incentives Report
  - Three-part series: *Pathways to Quality Health Care*
- MedPAC
  - Ongoing studies and recommendations regarding value-based purchasing tools
- Congress
  - VBP legislation in new Congress?
- CMS Proposed Regulations
  - Seeking public comment on the VBP building blocks
- CMS Demonstrations and Pilots
  - Periodic evaluations and opportunities to participate
Horizon Scanning and Opportunities for Participation

- CMS Implementation of BI PA, MMA, DRA, and TRHCA, and MMSEA provisions
  - Demos, P4R programs, VBP planning
- Measure Development
  - Foundation of VBP
- Value-Driven Health Care Initiative
  - Expanding nationwide
- Quality Alliances and Quality Alliance Steering Committee
  - AQA Alliance and HQA adoption of measure sets and oversight of transparency initiative
Thank You

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