Value Based Purchasing In the Traditional Medicare Fee-for-Service Program

The National Pay for Performance Summitt

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CMS, Department of HHS

Disclosures

I am speaking as an individual and not as a representative of the DHHS or CMS

All of the information contained in this talk is widely available on the CMS website

Presentation Overview

- Current State of Medicare Expenditures
- HHS Value Driven Healthcare
- CMS' Value-Based Purchasing (VBP) Principles
- Quality Measurement Roadmap
- Resource Use Measurement Plan
- VBP Roadmap and an inventory of its Programs
- Appreciation for Evidence Based Healthcare Policy reform

Centers for Medicare and Medicaid Management

Medicare Part A and B (CMM)

Medicaid (CMSO)

Medicare Advantage (MA- Part C)

Medicare Drug Program (Part D)

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Rising Healthcare Expenditures

Should Medicare be paying for care that promotes health, prevents complications, and that keeps health care costs down?

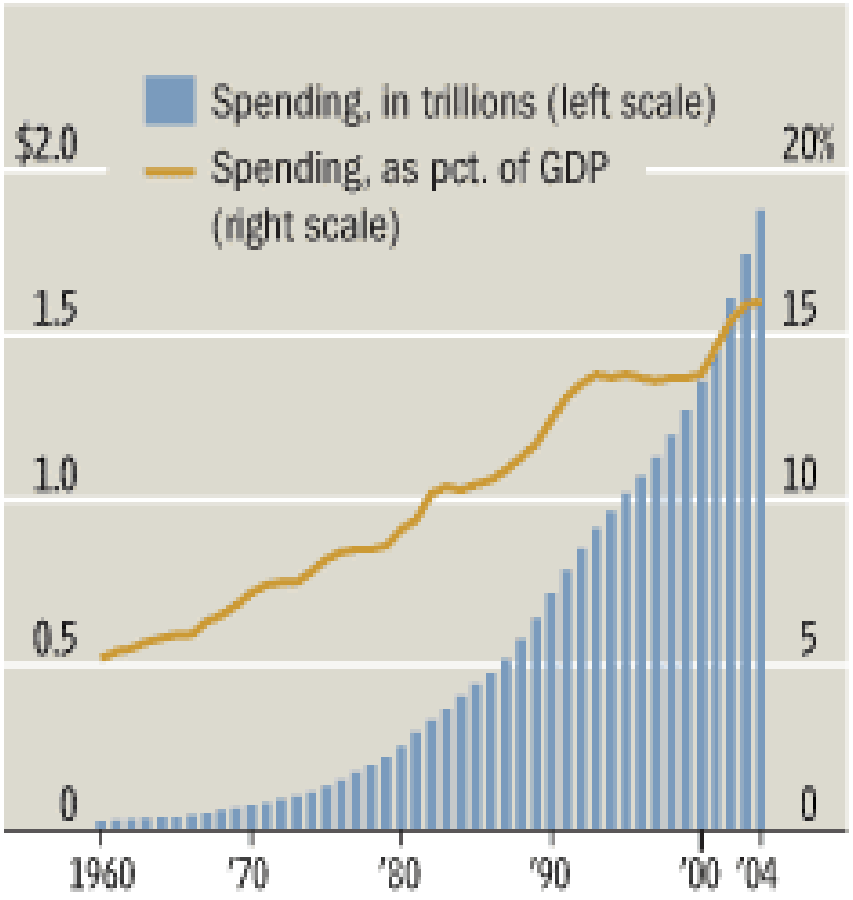
The Truth Is

- **Currently, Medicare pays for healthcare as follows:**
  - **Based on resource consumption and volume irrespective of the quality of care delivered.**
  - **In many cases paying too much.**
  - **Often paying for unnecessary care.**
  - **Paying for complications when things go wrong.**

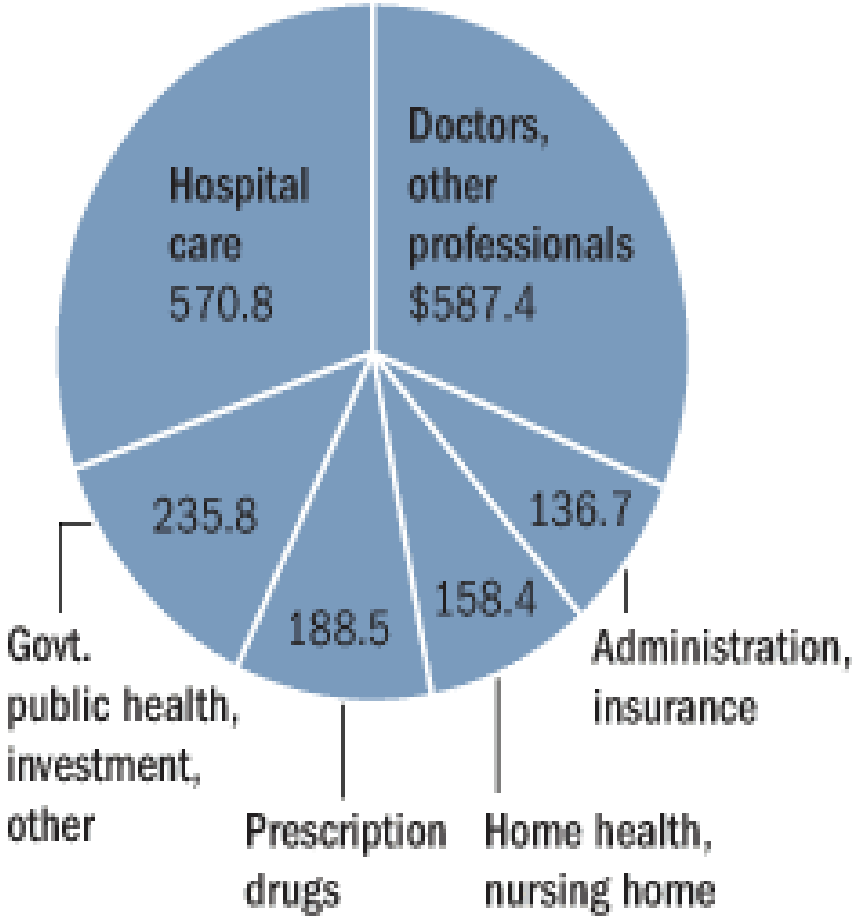
- **Between 2007 and 2017 our total health care bill, already $2.2 trillion, will double to an estimated $4.3 trillion, according to Medicare's actuaries.**

Health-Care Spending, American-Style

Up, up and still up



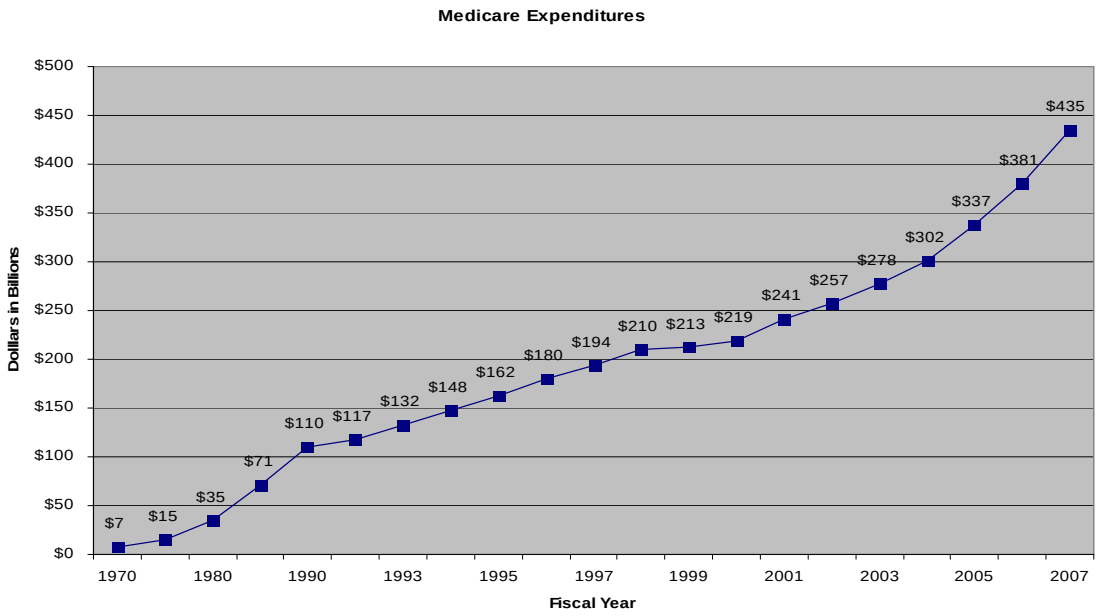
Where the money goes, in billions



Source: Centers for Medicare & Medicaid Services

Medicare Spending

Overall Medicare spending grew from $3.3 billion in 1967 to nearly $435 billion in 2007.



Note: Overall spending includes benefit dollars, administrative costs, and program integrity costs. Represents Federal spending only.

Source: CMS, Office of the Actuary.

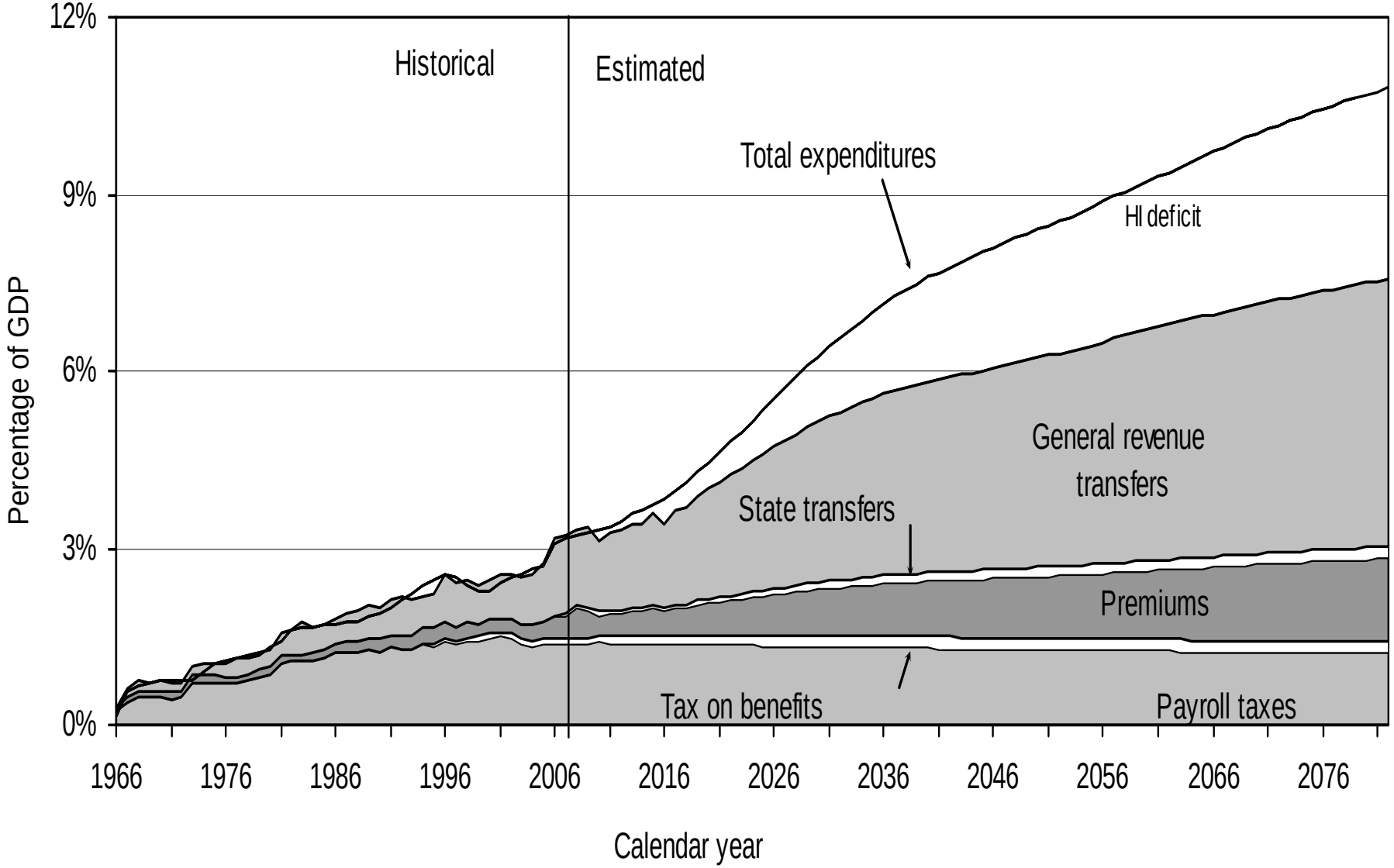
How is Medicare financed?

- **Hospital Insurance Program (Part A)**
  - **Payroll taxes**
- **Supplemental Insurance Program (Part B)**
  - **General Tax Revenues**
  - **Beneficiary Premiums**

2008 Medicare Trustees' Report

- **Medicare Solvency and Beneficiary Impact**
  - **Expenditures up from $219 billion in 2000 to a projected $486 billion in 2009**
  - **Part A Trust Fund**
    - **Excess of expenditures over tax income in 2008**
    - **Projected to be depleted by 2018**
  - **Part B Trust Fund**
    - **Expenditures increasing 11% per year over the last 6 years**
  - **Medicare premiums, deductibles, and cost-sharing are projected to consume 28% of the average beneficiaries' Social Security check in 2010**

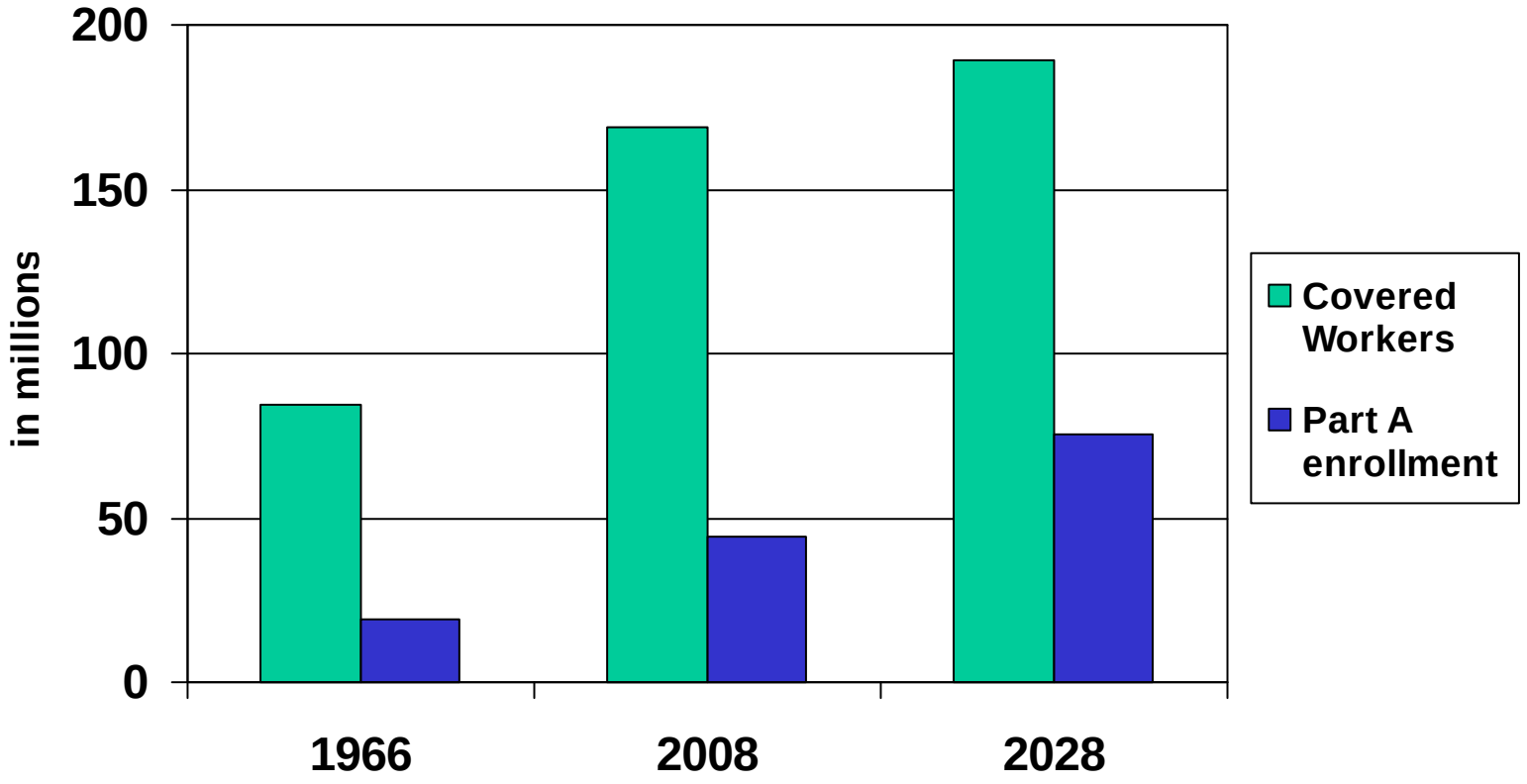
Under Current Law, Medicare Will Place An Unprecedented Strain on the Federal Budget



Source: 2008 Trustees Report

Workers per Medicare Beneficiary

Selected Years



Worker to Beneficiary Ratio	**4.46**	**3.39**	**2.49**

Source: OACT CMS and SSA

Potential Solutions

Value Based Purchasing

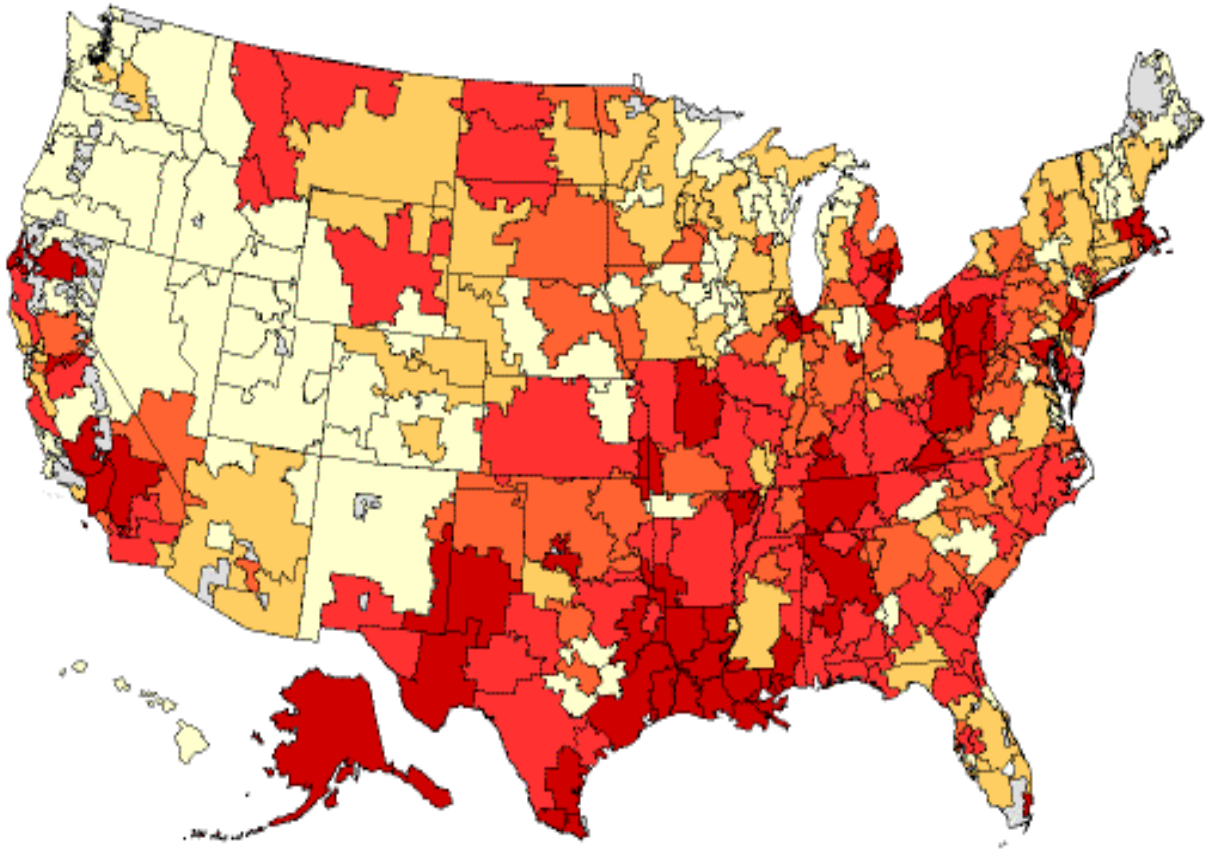
What Does This Mean to CMS?

Transforming Medicare from a passive payer to an active purchaser of higher quality, more efficient health care

Why?

- 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
    - Payment systems' incentives are not aligned

Practice Variation

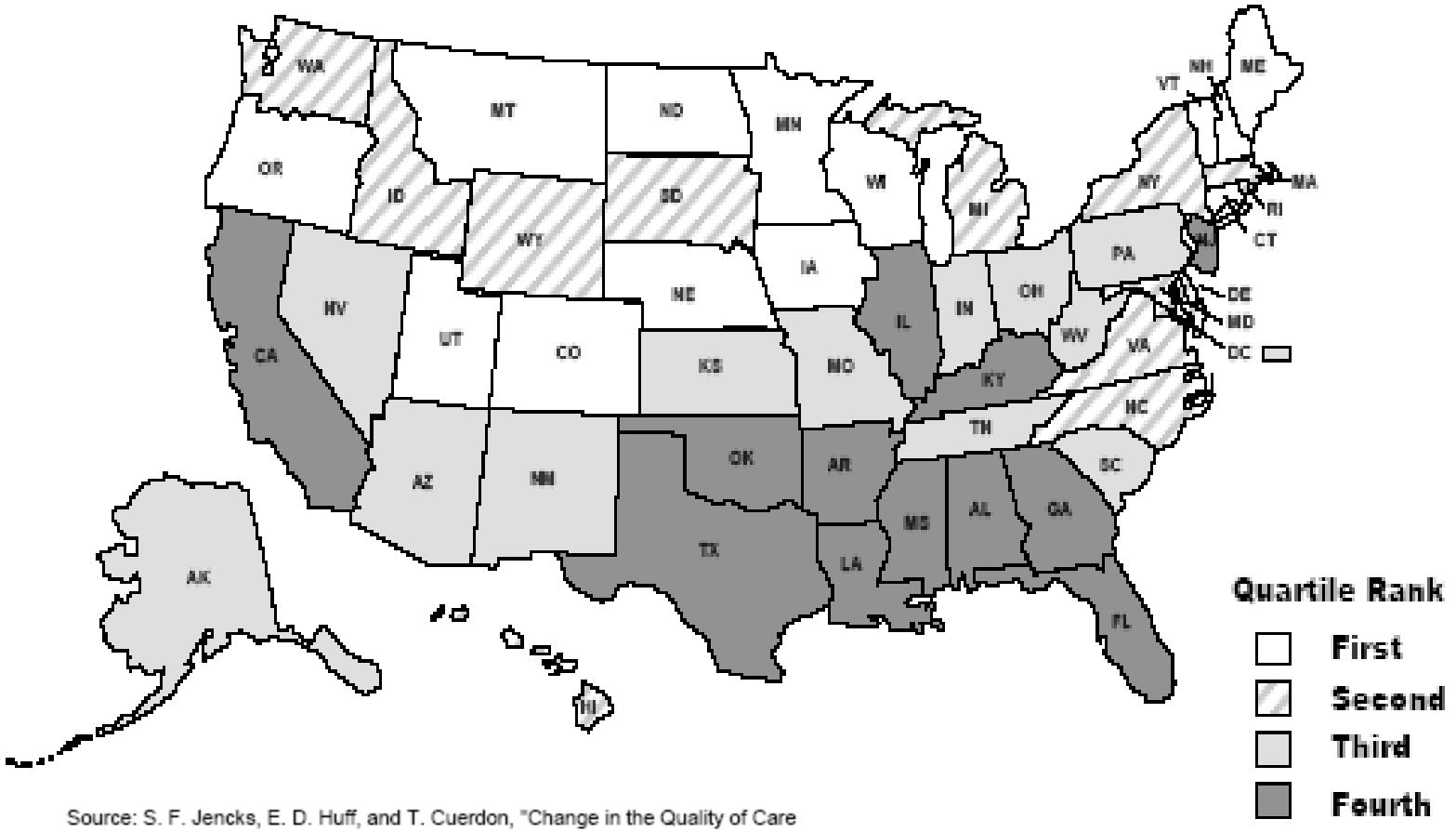


Map 2.5. Inpatient Hospital Services per Medicare Enrollee
by Hospital Referral Region (1995)

- $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.

Support for Value Driven Healthcare

- President's Budget
  - FYs 2006-09
- Congressional Interest in P4P and Other Value-Based Purchasing Tools
  - BIPA, MMA, DRA, TRCHA, MMSEA, MIPPA
- 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

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

HHS Program Goals

- Improve clinical quality
- Reduce adverse events and improve patient safety
- Encourage 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
- **Create joint clinical and financial accountability**

Requirements for Implementing VBP

- Quality/efficiency measures and other implementation tools,
- Payment system redesign through:
  - Demonstration projects and/or
  - Statutory and regulatory authority
- Resources to develop and implement VBP based payments, and
- Data infrastructure (such as HER, PHR, and interoperable systems between payment and quality data).

Other Program Needs

- Payment incentives, public reporting, conditions of participation, coverage policy, QIO program

- Initiatives: **pay for reporting**, pay for performance, gainsharing, **competitive bidding**, **bundled payment**, coverage decisions, direct provider support

CMS Roadmaps for Value Driven Healthcare

Quality Measurement

Resource Use Measurement Plan

Value Based Purchasing

www.cms.hhs.gov

CMS Quality Measurement

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

CMS Quality Measurement

- **Strategies**
  - Work through partnerships
  - Develop and endorse quality measures
  - Measure quality and report comparative results
  - Establish benchmarks for performance
  - Share best practices
  - Encourage adoption of effective health information technology and participation in registries
  - Identify gaps in quality measurement domains and work with measure developers/providers to establish areas of vulnerability and high risk/cost

CMS Quality Measurement

- **Identify gaps and promote measure development**
  - Chronic conditions
  - Coordination of care
  - Continuum of care
  - Beyond episodes of care to allow insight into costs of care for a chronic condition (CAD)

CMS Resource Use Measurement Plan

- Measure resource consumption
- Develop effective tools – groupers
- Create efficiency measures
- Report to providers
  - MIPPA: physician feedbeck reports beginning Jan, 2009

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

Issues for Episode Measurement

- Attribution of episodes to physicians,
- Defining appropriate comparison group for benchmarking,
- Impact of different benchmarking strategies, including how to create composites using different episode types.
- Relatively small number of physicians for whom scores are feasible,
- Appropriate risk adjustment.

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

CMS VBP Roadmap

- Work through currently established payment systems.
- Identify and promote the use of quality measures through **pay for reporting**.
- **Pay for quality performance**.
- Develop measures of physician and provider resource use,
- **Pay for value** — pay for efficiency in resource use while providing high quality care,
- Promote better alignment of financial incentives among providers, and
- Transparency and public reporting.

Goals for Value Based Purchasing

- Financial viability
- Payment incentives
- Joint accountability
- Effectiveness
- Ensuring access
- Safety and transparency
- Smooth transitions
- Promote adoption of HER/HIT

Work Through the Current Payment Systems

Medicare Part A and B (CMM)

Medicaid (CMSO)

Medicare Advantage (MA- Part C)

Medicare Drug Program (Part D)

Major Medicare FFS Payment Systems

- **PROSPECTIVE PAYMENT SYSTEMS (Part A)**:
  - Inpatient PPS
  - Outpatient PPS
  - Inpatient Rehab
  - Long-term Care Hospital
  - Inpatient Psych
  - Skilled Nursing Facility
  - Home Health
- **FEE SCHEDULES (Part B)**:
  - Physicians (SGR)
  - Ambulatory Surgical Centers
  - Clinical Labs
  - Durable Medical Equipment, Prosthetics & Orthotics
  - Ambulance
  - ESRD

Fee For Service Payment Systems Part A

Payment System	Number of Providers	Total Annual Payments
Inpatient Hospital	4,000	$121 Billion
Outpatient Hospital	4,300	$ 28.7 Billion
Skilled Nursing Facility	15,105	$ 20 Billion
Home Health	8,090	$ 13.5 Billion
End Stage Renal Disease Facility	4,538	$ 8.2 Billion
Hospice	2,872	$ 9.2 Billion
Inpatient Rehabilitation	1,250	$ 6.3 Billion
Inpatient Psychiatric	1,800	$ 4.3 Billion
Long-Term Care Hospital	390	$ 4.6 Billion
Critical Access Hospital	1,200	$ 2.3 Billion

Fee For Service Payment Systems
Part B

Payment Area	Number of Providers/Suppliers	Total Annual Payments
Physician/ Non-Physician Practitioner Services	900,000	$ 61.5 Billion
Part B Drugs - Paid to Physicians		$ 9 Billion
Durable Medical Equipment	107,000	$ 12 Billion
Clinical Laboratory	196,000	$ 6 Billion
Ambulance	10,000	$ 4 Billion
Ambulatory Surgical Center	4,500	$ 3 Billion
FQHCs **RHCs**	2,544 3,404	$ 1 Billion

CMS Roadmap for VBP

- Work through currently established payment systems.
- **Identify and promote the use of quality measures through pay for reporting**.
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Implementing VBP

- **Identify and promote the use of quality measures through pay for reporting**
  - Hospital IPPS
  - Physicians (PQRI)
  - Home Health

Pay For Reporting 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

Pay For Reporting 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

Pay For Reporting

Physician Quality Reporting Initiative (PQRI)

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

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Implementing VBP

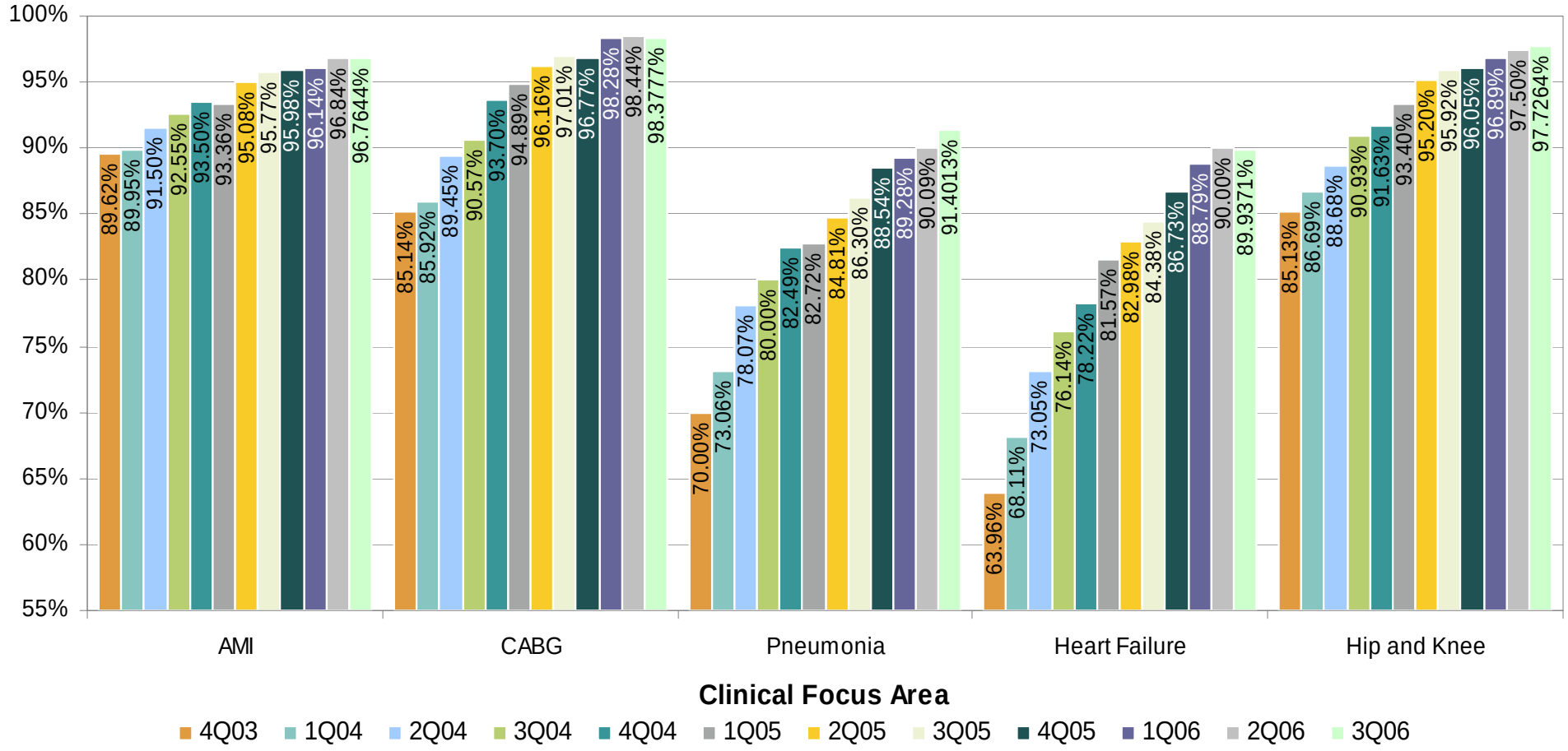
- **Pay for quality performance**
  - Hospitals: Premier Demonstration

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)



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Implementing VBP

- **Develop measures of physicians and provider resource use**
  - Formed internal workgroup
  - Post Acute Care (PAC) Payment Reform Initiative

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
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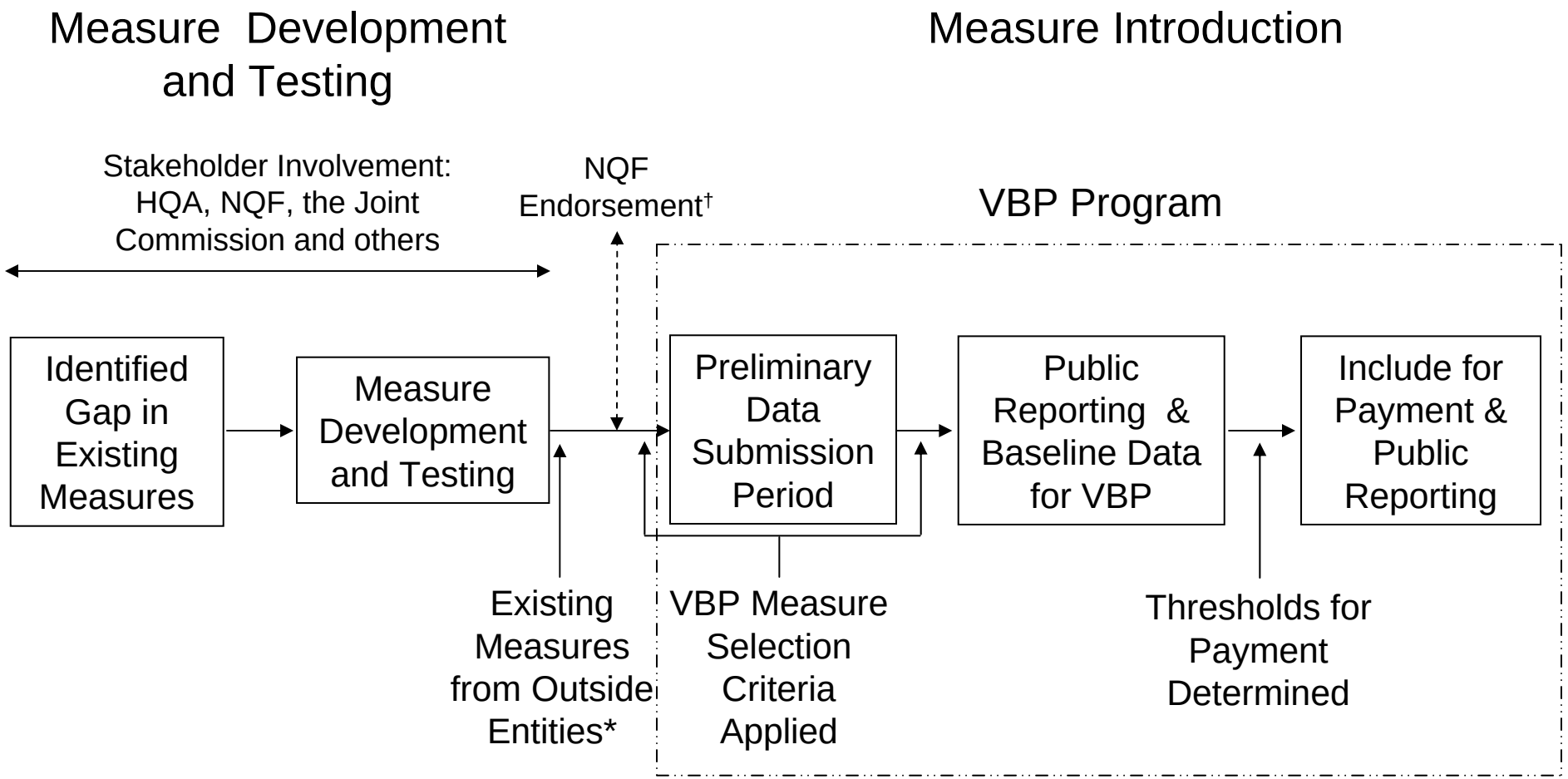
Implementing VBP

- **Pay for value**
  - Hospital-acquired conditions and present on admission indicator reporting
  - Hospital VBP Plan
  - Physician VBP Plan
  - VBP for End Stage Renal Disease (ESRD) facilities
  - Physician: Physician Group Practice Demonstration
  - Home Health Pay for Performance Demonstration
  - Nursing Home Pay for Performance Demonstration
  - Medical home Demonstration

Pay For Value
Hospital VBP

- Moving from pay for reporting to pay for performance
- 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

Proposed Process for Introducing Measures into Hospital VBP

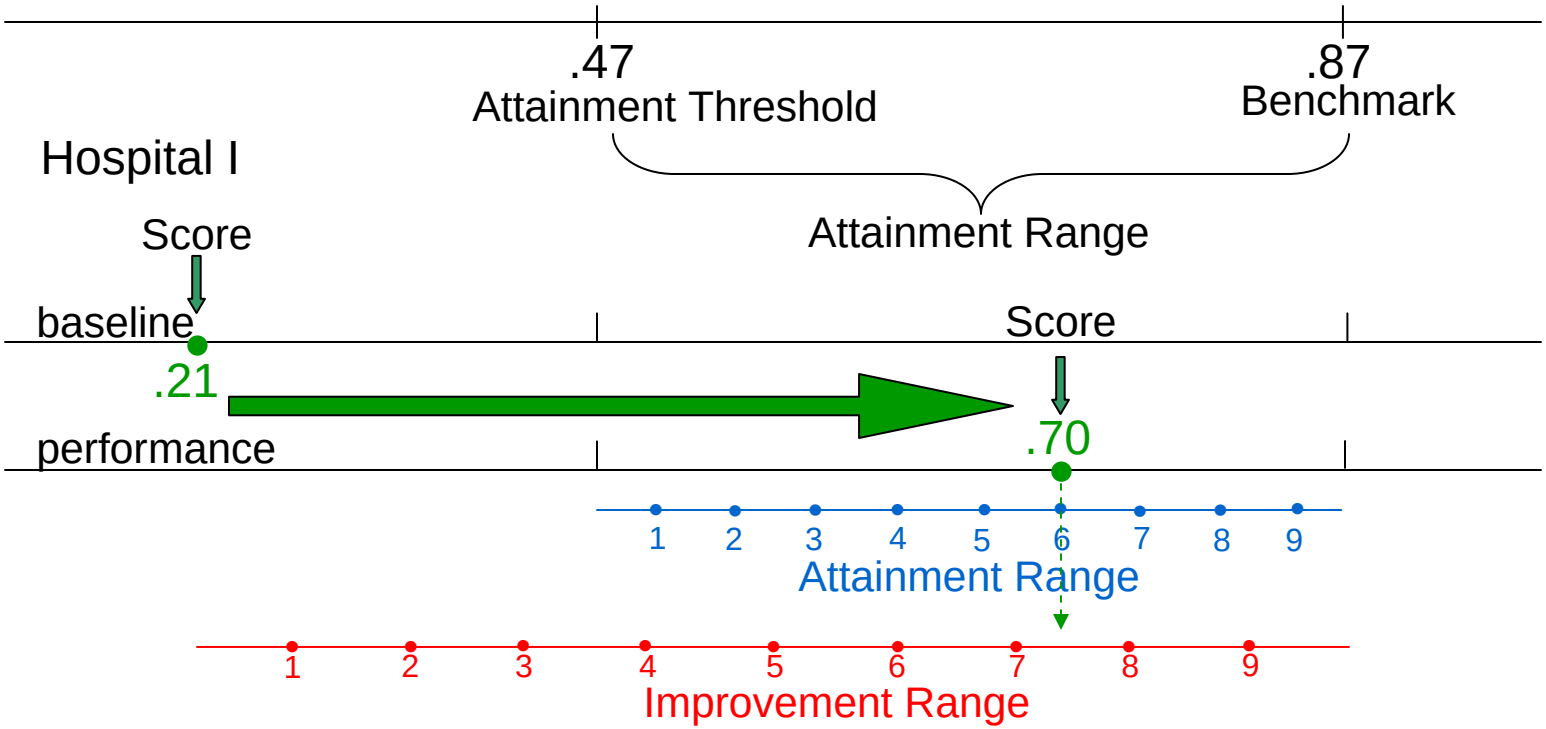


*Measures without substantial field experience will be tested as needed

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

Earning Quality Points Example

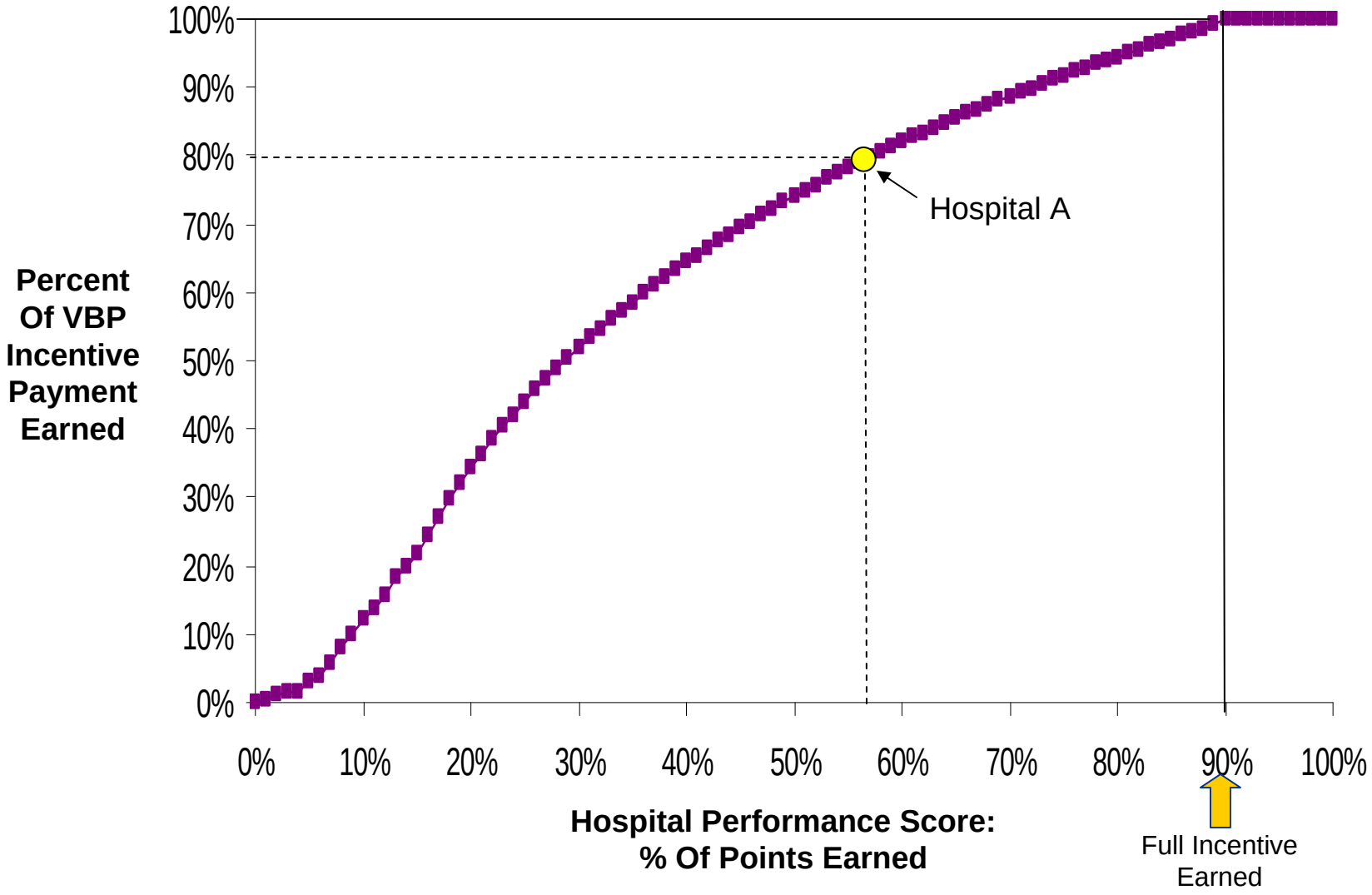
Measure: PN Pneumococcal Vaccination



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

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

Translating Performance Score into Incentive Payment: Example



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

Pay For Value
Physician VBP Plan

- Section 131(d) MIPPA mandated a Physician VBP Report to Congress due May 1, 2010
- Internal workgroup developed
- Policy Lead
- Issues paper written
- Listening session Dec 9, 2008
- Interim report Jan, 2009

Physician VBP Plan Objectives

- Promote the practice of evidence-based medicine
- Reduce fragmentation and duplication
- Align measures and incentives across providers and settings of care
- Encourage effective management of chronic disease
- Accelerate adoption of HIT including registries
- Disseminate transparent & useful information

Physician VBP Design Principles

- Measures
  - Measure key dimensions of quality with emphasis on outcomes, cost of care, care coordination
  - Risk adjustment
  - Minimize data burden, provide validation & feedback
- Incentives
  - Reward attainment of thresholds as well as improvement
  - Provide large enough incentives to drive QI
- Public reporting

Physician VBP Plan

- Much more complicated
- Cuts across sites of care
- Must account for variability in practices (multi-specialty,single specialty,small & institution based practices)
- Multiple models vs single model with sites of service payment domain

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- **Promote better alignment of financial incentives among providers,** and
- Transparency and public reporting.

Implementing VBP

- **Promote better alignment of financial incentives among providers**
  - Proposed exception to the physician self-referral rules
  - Announcement of Acute Care Episode (ACE) Demonstration
  - Medicare Hospital Gainsharing Demonstration
  - Physician Hospital Collaboration Demonstration

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- **Transparency and public reporting.**

Implementing VBP

- **Transparency and public reporting**
  - Compare site reporting upgrades/star rating systems
  - Chartered Value Exchanges (CVEs)
- **Implementation and adoption of electronic health records and health information technology**
  - E-prescribing incentive program
  - Electronic Health Records Demonstration
  - Personal Health Record Choice (pilot)

Summary
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

Summary
VBP Demonstrations and Pilots

- Medical Home demonstration
- Gainsharing Demonstrations
- Accountable Care Episode (ACE) Demonstration
- Electronic Health Records (EHR) Demonstration
- Medical Home Demonstration
- Chartered Value Exchange Initiative

Summary
VBP Programs

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

Summary

- CMS has reacted to legislation to create new payments
- CMS has developed many demos and pilots with broad stakeholder input to test new health delivery models and payment systems
- Feedback/results from those programs will hopefully be used in creating new evidence based health policy

Thank You

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