Updates from CMS: Value-Based Purchasing, ACOs, and Other Initiatives

The Seventh National Pay for Performance Summit

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Presenters

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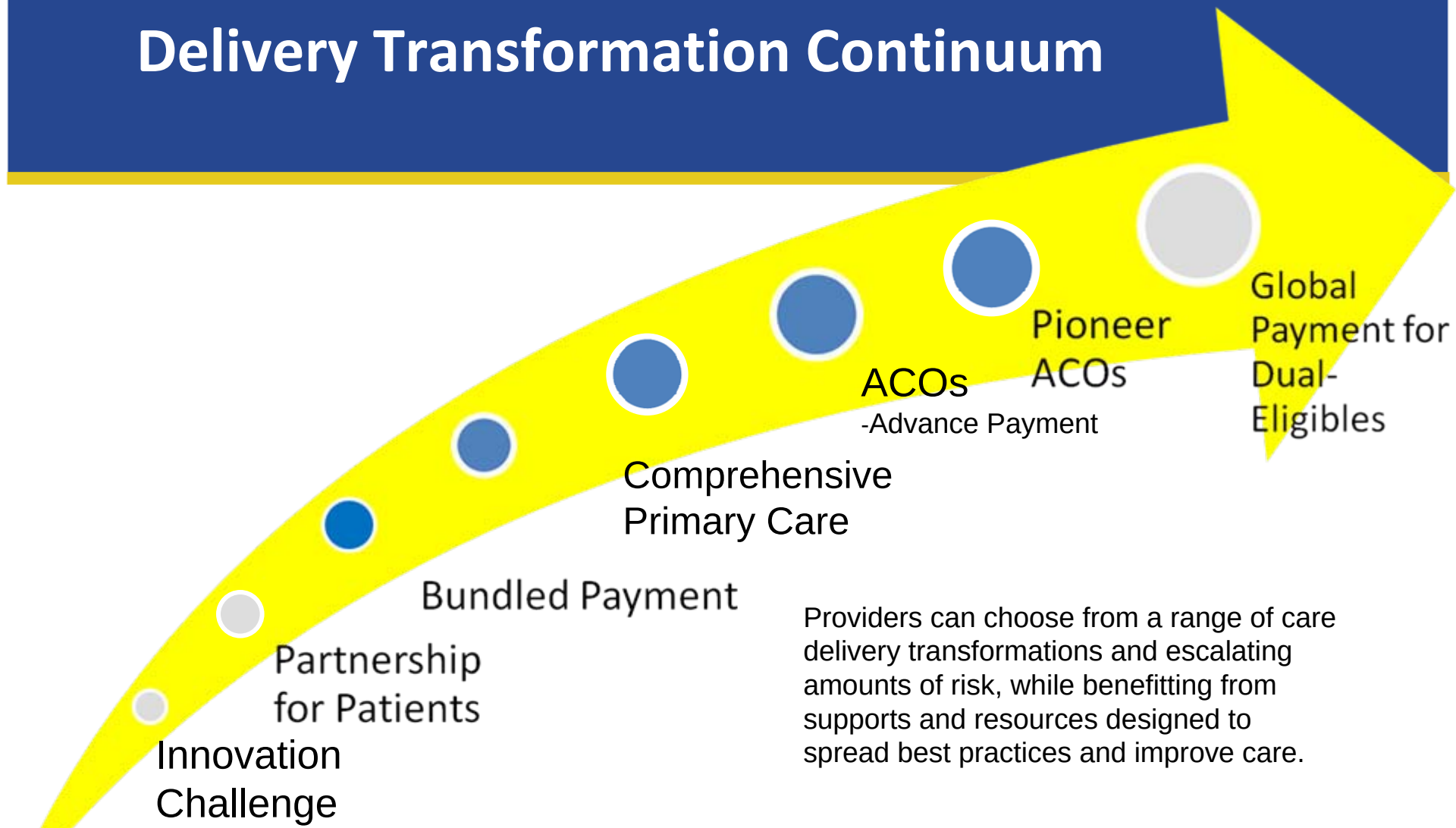
Delivery Transformation Continuum



Providers can choose from a range of care delivery transformations and escalating amounts of risk, while benefitting from supports and resources designed to spread best practices and improve care.

Tools to Empower Learning and Redesign:
Data Sharing, Learning Networks, RECs, PCORI, Aligned Quality Standards

Medicare Shared Savings Program Goals

- The Shared Savings Program is a new approach to the delivery of health care aimed at reducing fragmentation, improving population health, and lowering overall growth in expenditures by:
  - Promoting accountability for the care of Medicare fee-for-service beneficiaries
  - Improving coordination of care for services provided under Medicare Parts A and B
  - Encouraging investment in infrastructure and redesigned care processes

The Pioneer ACO Model

GOAL: Test the transition from a shared-savings payment model to a population-based payment.

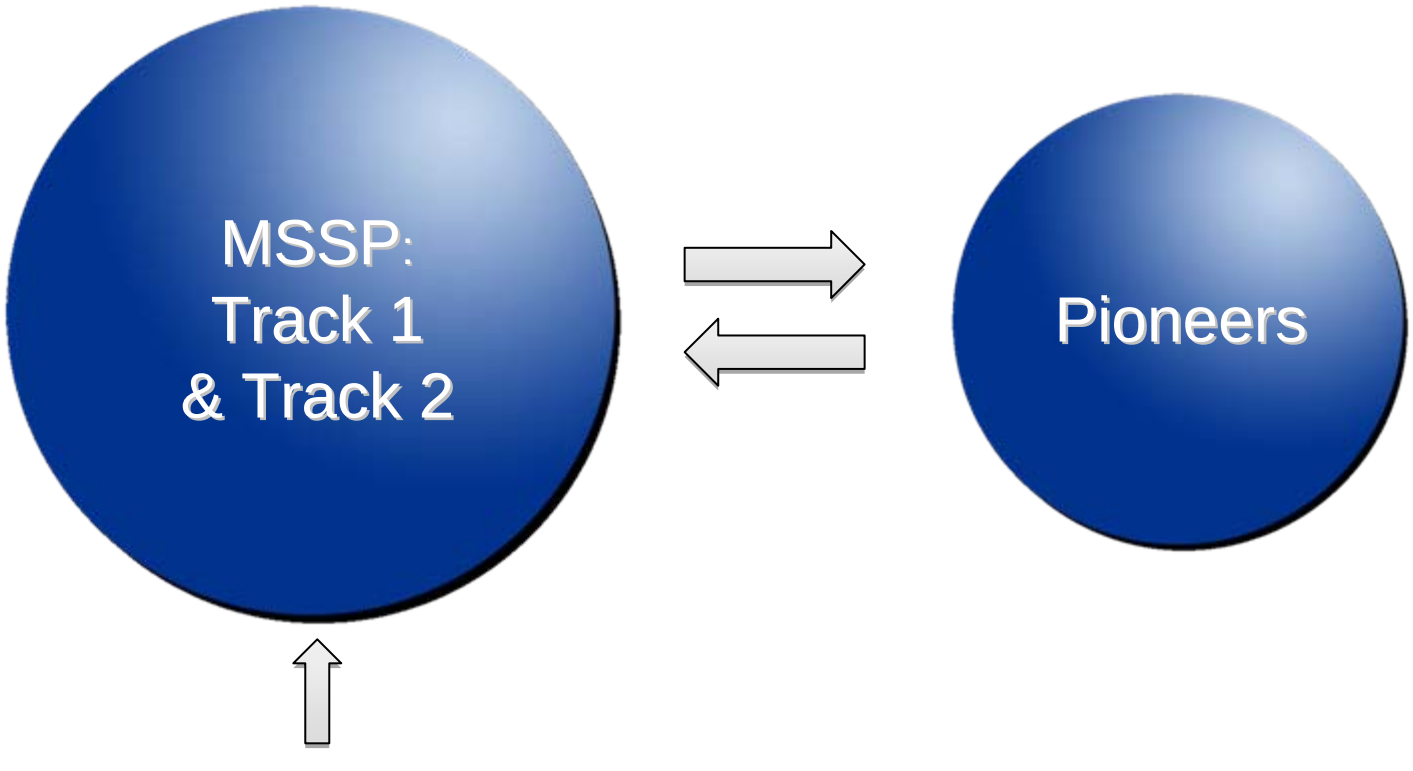
- Designed for health care organizations and providers that are already experienced in coordinating care
- Requires ACOs to create similar arrangements with other payers.
- Expected to improve the health and experience of care for individuals, improve population health, and reduce the rate of growth in health care spending
- CMS will publicly report the performance of Pioneer ACOs on quality metrics
- 32 Participating ACOs announced in December 2011
- First performance period scheduled to began in January 2012.

Advance Payment Model

GOAL: Test whether pre-paying a portion of future shared savings will increase the participation and success of physician-based and rural ACO's in the Medicare Shared Savings Program

- Payments recouped through shared savings earned by ACO
- Open to ACOs participating in Shared Savings Program
  - Only available for April 1, 2012 and July 1, 2012 start dates
- Application Deadlines:
  - April 1 start date: applications accepted Jan 3 – Feb 1, 2012
  - July 1 start date: applications accepted Mar 1 – Mar 30, 2012 (consistent with Shared Savings Program)
- **E-mail questions to advpayaco@cms.hhs.gov.**

CMS's ACO Strategy:
Creating Multiple Pathways with Constant Learning and Improving



Bundled Payments for Care Improvement

GOAL: Testing the effect of "bundling" payments for multiple services that a patient receives during a single episode of care.
Fostering better care coordination and improved care quality through payment innovation.

Four patient-centered approaches:

- Acute care hospital stay only
- Acute care hospital stay plus post-acute care associated with the stay
- Post-acute care only
- Prospective payment of all services during inpatient stay

Comprehensive Primary Care Initiative

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

- Requires investment across multiple payers, because individual health plans, covering only their members, cannot provide enough resources to transform primary care delivery.

•CMS is inviting public and private insurers to collaborate in purchasing high value primary care in communities they serve.

- Medicare will pay approximately $20 per beneficiary per month (PBPM) then move towards smaller PBPM to be combined with shared savings opportunity.
- Will select 5-7 markets where majority of payers commit to investing in comprehensive primary care; approximately 75 practices per market.

Practice and Payment Redesign through the CPC initiative

SUPPORTIVE MULTIPAYER 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*

Health Care Delivery System Transformation

Healthcare Delivery System 1.0

Episodic Non Integrated Care

- Episodic Health Care
  - Sick care focus
  - Uncoordinated care
  - High Use of Emergency Care
  - Multiple clinical records
  - Fragmentation of care
- Lack integrated care networks
- Lack quality & cost performance transparency
- Poorly Coordinate Chronic Care Management

Healthcare Delivery System 2.0

Accountable Care

- Transparent Cost and Quality Performance
  - Results oriented
  - Access and coverage
- Accountable Provider Networks Designed Around the patient
- Focus on care management and preventive care
  - Primary Care Medical Homes
  - Utilization management
  - Medical Management

Healthcare Delivery System 3.0

Integrated Health

Patient/Person Care Centered
- Patient/Person centered Health Care
- Productive and informed interactions between Family and Provider
- Cost and Quality Transparency
- Accessible Health Care Choices

Aligned Incentives for wellness

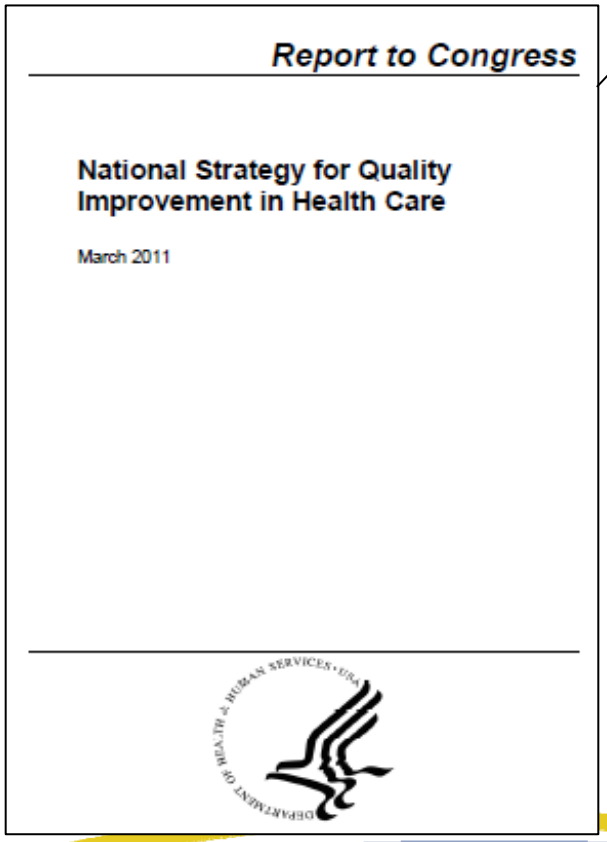
Integrated networks with community resources wrap around

Aligned reimbursement/cost Rapid deployment of best practices

Patient and provider interaction
- Aligned care management
- E-health capable
- E-Learning resources

National Quality Strategy and CMS

National Quality Strategy and CMS



Three-part aim:

- **Better Care: Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.**
- **Healthy People and Communities: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.**
- **Affordable Care: Reduce the cost of quality health care for individuals, families, employers, and government.**

Six priorities:

- **Making care safer by reducing harm caused in the delivery of care.**
- **Ensuring that each person and family are engaged as partners in their care.**
- **Promoting effective communication and coordination of care.**
- **Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.**
- **Working with communities to promote wide use of best practices to enable healthy living.**
- **Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.**

OCSQ has a wide variety of tools to achieve the three-part aim of the National Quality Strategy

OCSQ tool kit

- National coverage determinations
- Setting clinical standard for providers
- Survey and certification
- Technical assistance for quality improvement
- Public reporting of providers' quality performance
- Value-based purchasing

These tools allow OCSQ to define the kind of care CMS pays for and to ensure it furthers the national quality strategy

Technical Assistance

Quality Improvement Organizations Strategic Aims

Beneficiary-Centered Care
- **Case Review**
- **Patient and Family Engagement**

Improve Individual Patient Care
- **Patient Safety –Reduce HACs by 40%**
- ***Improving Quality through Value Based Purchasing***

Integrate Care for Populations
- **Care Transitions that Reduce Readmissions by 20%**
- **Using Data to Drive Dramatic Improvement in Communities**

Improve Health for Populations and Communities
- **Prevention through screening and immunizations**
- **Prevention in Cardiovascular Disease**

Learning and Action Networks, Onsite Technical Assistance, Spread Strategies

Purpose statement for Value-Based Purchasing

Value-based purchasing is a tool that allows CMS to link the National Quality Strategy with fee-for-service payments at a national scale. It is an important driver in revamping how services are paid for, moving increasingly toward rewarding providers and health systems that deliver better outcomes in health and health care at lower cost to the beneficiaries and communities they serve.

Value Based Purchasing Cycle

Measure development and selection

Data collection

Data analysis and validation

Incentive calculation and disbursement

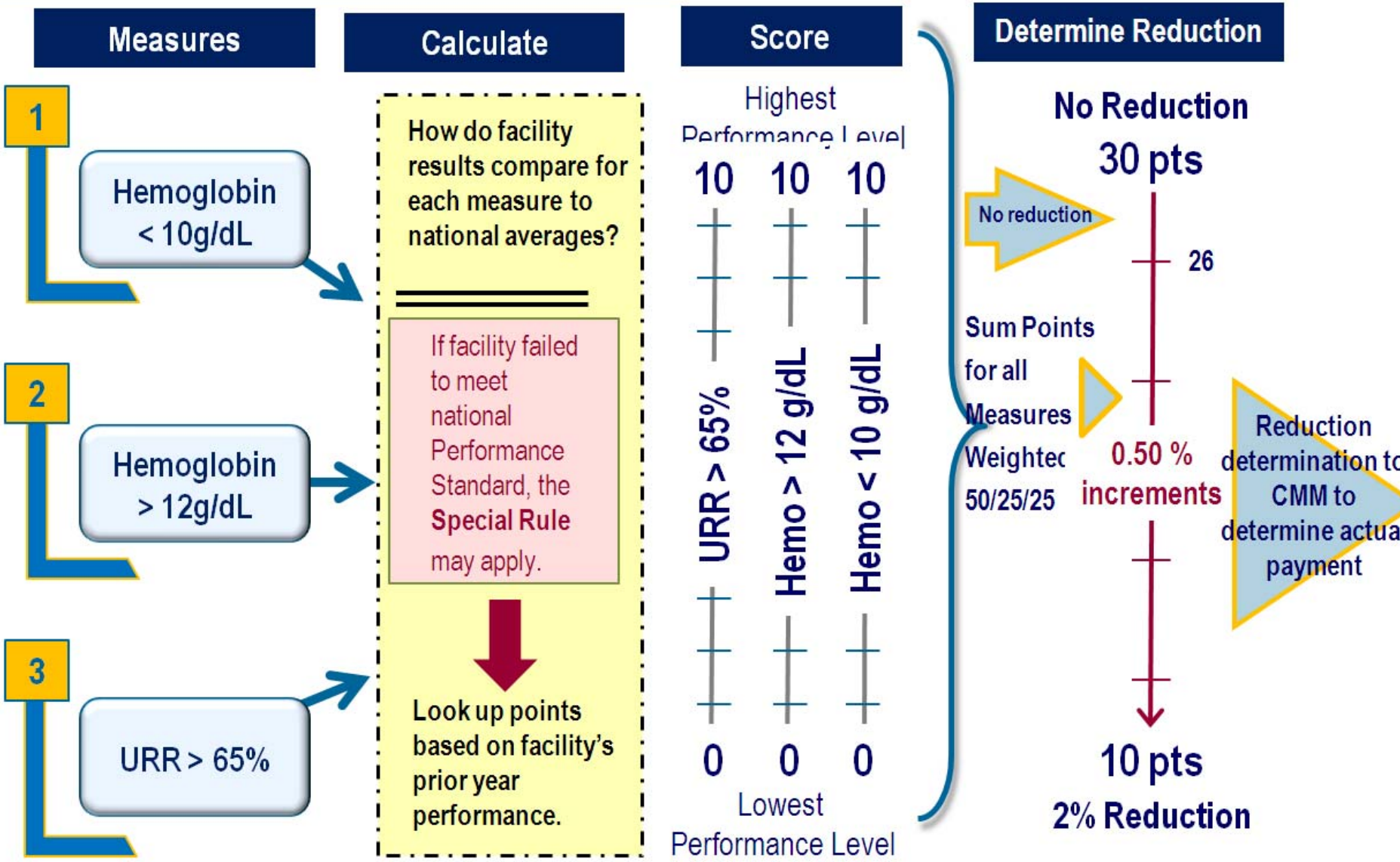
Monitoring and evaluation of process, measures, and quality improvement

- Supportive policy and rule-making
- Integrated IT infrastructure
- Seamless communication with providers
- Public engagement and input
- Support of quality improvement
- Person-centeredness

Background on the Payment Year 2012 ESRD QIP

- **Section 153(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) mandates the establishment of a QIP, which requires CMS to:**
  - Assess the quality of dialysis care by selecting quality measures, establishing performance standards and a performance period, and evaluating performance with respect to the standards.
  - Starting January 1, 2012, apply payment reductions of up to 2% for providers that do not meet standards (*based on scoring methodology published in the ESRD QIP Final Rule on January 5, 2011*).
  - Publicly report provider performance through a website and provide a Performance Score Certificate for each facility to post in their patient area.
- **The ESRD QIP is intended to complement the Prospective Payment System (PPS) by establishing a financial incentive for providing high-quality dialysis care.**

2012 ESRD QIP Model



2012 QIP Results

For the PY 2012 ESRD QIP, 4,939 facilities received a Total Performance Score. Of these facilities:

- 69.1 percent will receive no payment reduction as a result of meeting or exceeding the performance expectations.

- **The payment reductions for the remaining facilities are as follows:**
  - 16.6 percent will receive a 0.5 percent reduction
  - 6.0 percent will receive a 1.0 percent reduction
  - 7.7 percent will receive a 1.5 percent reduction
  - 0.6 percent will receive a 2.0 percent reduction

Hospital Value Based Purchasing Program

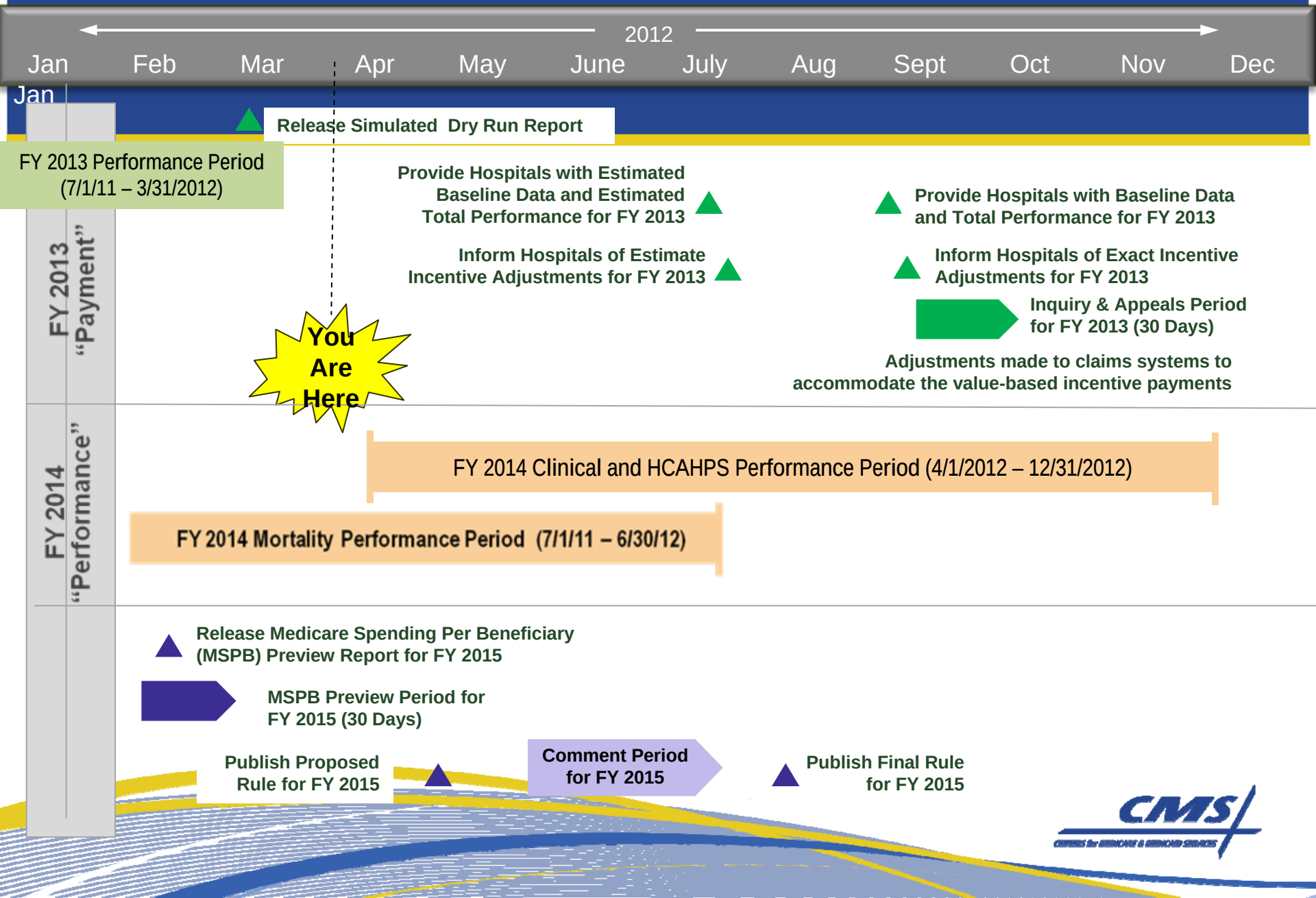
- For the first time, 3,500 hospitals across the country will have payment more closely aligned with quality.

- In FY 2013, an estimated $850 million will be allocated to hospitals based on their overall performance on a set of quality measures that have been shown to improve clinical processes of care and patient satisfaction.

- This funding will be taken from what Medicare otherwise would have spent, and the size of the fund will gradually increase over time, resulting in a shift from payments based on volume to payments based on performance.

- Funded by a 1% withhold from participating hospitals' Diagnosis-Related Group (DRG) payments raising to 2% by 2017.

Hospital VBP Program for CY 2012 Critical Dates and Milestones



Simulated Hospital Report Estimated TPS Summary

Hospital Value-Based Purchasing

Simulated Hospital Report

ABC Hospital

Provider ID: 123456

123 Main St.
Anytown, MD 12345
(555) 555-1234

BASELINE PERIOD:
1 Apr. 2008 - 31 Dec. 2008

PERFORMANCE PERIOD:
1 Apr. 2010 - 31 Dec. 2010

REPORT GENERATED:
07 Dec. 2012

Estimated Total Performance Score (TPS) Summary

1a. FACILITY

72.35/100
earned/available

1b. STATE

49.15/100

1c. NATIONAL

46.83/100

What are your best ideas?

- This dramatic shift in payment policy may cause a commensurate change in how care is delivered in this country

- The intent is to ensure that care improves; however, often changes in payment of this nature can have unintended consequences

- As the program continues to develop several policy areas must continue to be explored including:

What are your best ideas?

- How will policy decisions impact the patient, family and caregivers?
- How will practice patterns change as a result of the model?
- How do we ensure that we do not unnecessarily disproportionately impact facilities based on its characteristics?
- How do we allow for the greatest level of participation in the programs and what are the trade offs?

What are your best ideas?

- Are the measurements of performance accurate, fair, feasible and reflective of systematic difference?
- What are the proper domains of care and how should each be weighted in the payment formula?
- Is the program overly burdensome?
- What is the right model for the payment adjustment?
- How do we ensure that we have heard from the people most impacted by the decisions in the field and in their homes and how do we ensure we have considered the multiple and varied view points?

Questions?
Suggestions?

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For Additional Information:

- Accountable Care Organizations: https://www.cms.gov/ACO/
- Hospital Value Based Purchasing: https://www.cms.gov/Hospital-Value-Based-Purchasing/
- End Stage Renal Disease (ESRD) Center: https://www.cms.gov/center/esrd.asp
- Department of Health and Human Services' health care reform web site: http://www.healthcare.gov

Thank you for listening!