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

The Seventh National Pay for Performance Summit

March 20, 2012

Presenters

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Overview

- Background and Vision for Change
- Payment System Reform
- Delivery System Reform
- Putting It All Together
- Q&A

The Current System

- **Greatest Acute Care in the World:** People come from around the world to be treated
- **But:** 46 Million Americans lack coverage
  - **Uncoordinated –** Fragmented delivery systems with highly variable quality
  - **Unsupportive –** of patients and physicians
  - **Unsustainable –** Costs rising at twice the inflation rate

A Future System

- **Affordable**
- **Accessible** – to care and to information
- **Seamless and Coordinated**
- **High Quality** – timely, equitable, safe
- **Person and Family-Centered**
- **Supportive of Clinicians** in serving their patients needs

Innovation Can Transform American Health Care

***Current State* –**
Producer-Centered

Current payments –
part of the problem…

- Fragmented payment systems (IPPS, OPPS, RBRVRS)
- Fee-for-service payment model
- Lack of Transparency

PRIVATE SECTOR

PUBLIC SECTOR

INNOVATION CENTER

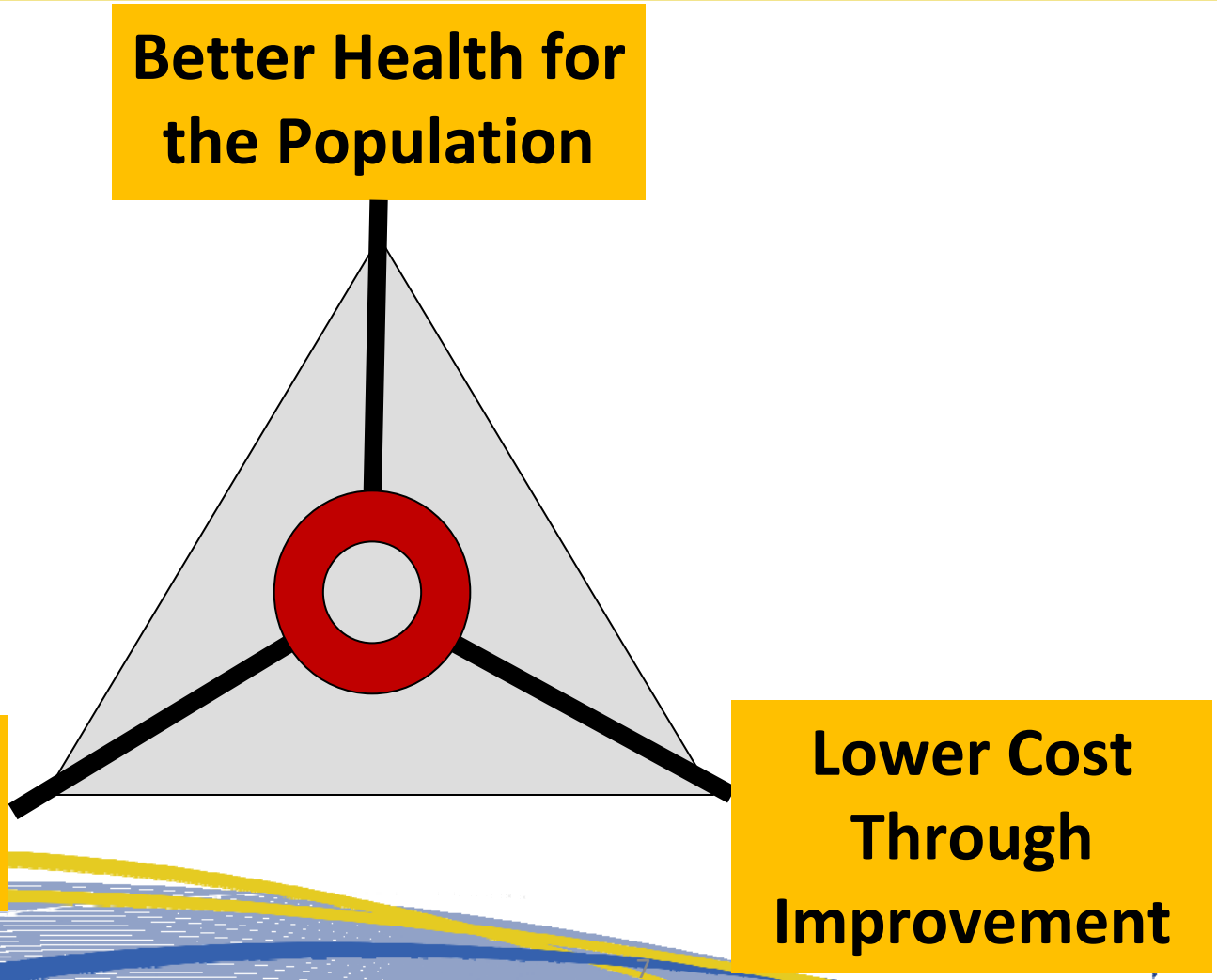
***Future State* –**
People-Centered

CMS –

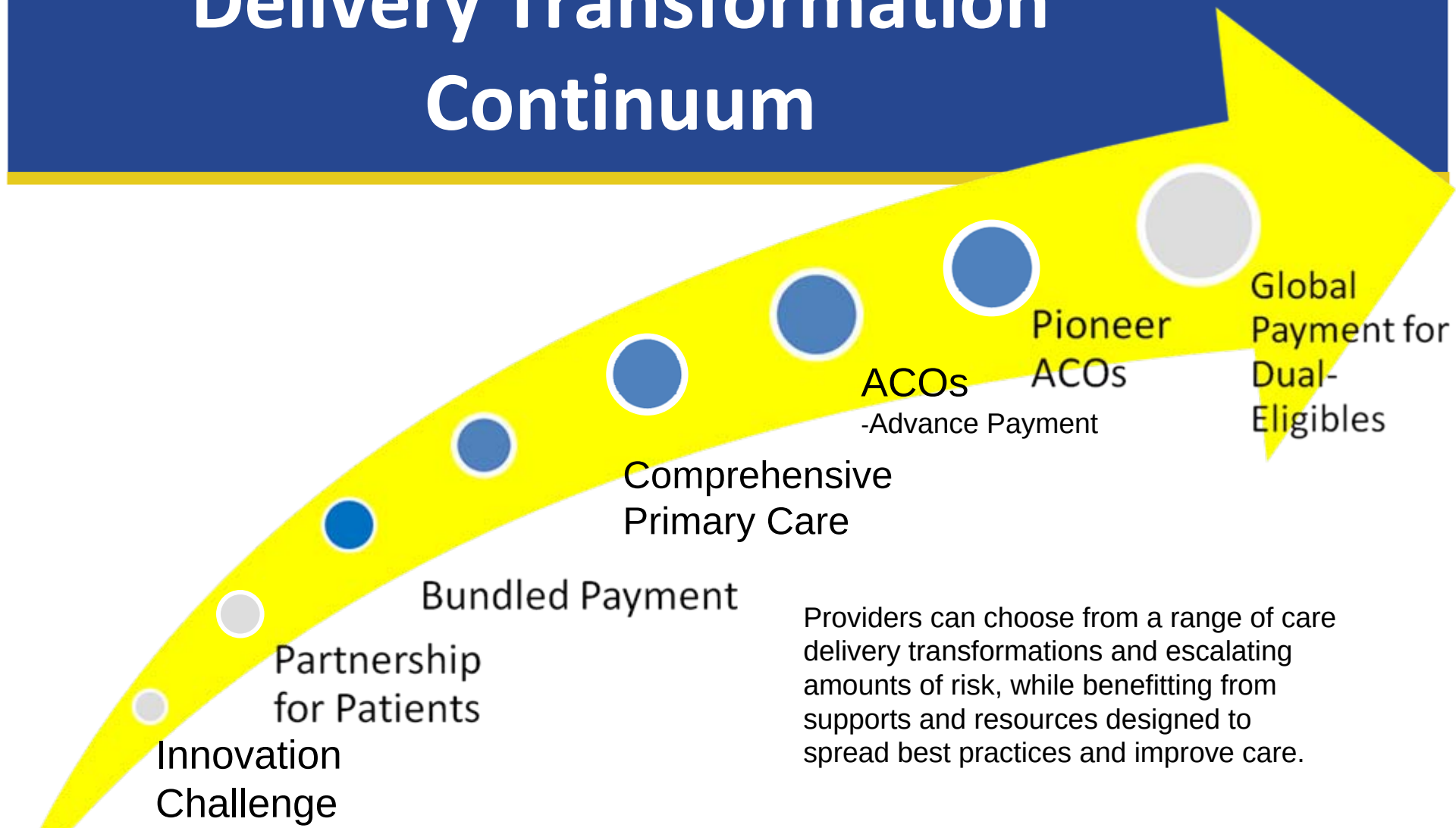
part of the solution…

- ACOs
- Episode-based payments
- Value-based purchasing
- Patient Centered Medical Homes
- Data Transparency

The "Three-Part Aim"



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

Payment System Reforms

- Accountable Care Organizations
- Hospital Value Based Purchasing
- Bundled Payment
- Comprehensive Primary Care Initiative
- Physician Value Based Modifier

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.

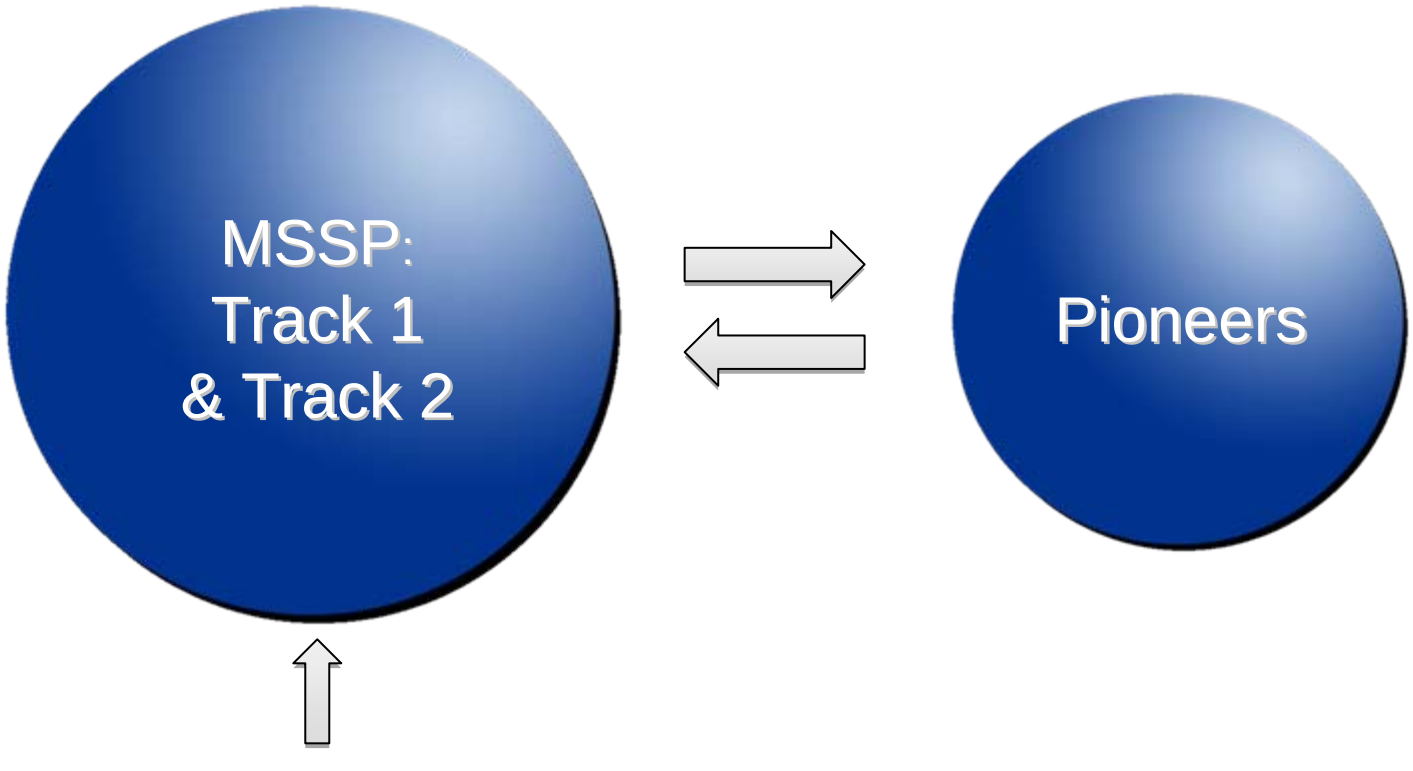
- Designed for health care organizations and providers that are already experienced in coordinating care
- Requires ACOs to create similar arrangements with other payers.
- Expected to improve the health and experience of care for individuals, improve population health, and reduce the rate of growth 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*

Physician Value-Based Payment Modifier

Delivery System Reforms

- Partnership for Patients
- Million Hearts Campaign
- Innovation Advisors Program
- Healthcare Innovation Challenge

Partnership for Patients: Better Care, Lower Costs

New nationwide public-private partnership to tackle all forms of harm to patients.

GOALS:

40% Reduction in Preventable Hospital Acquired Conditions over three years.

- 1.8 Million Fewer Injuries
- 60,000 Lives Saved

20% Reduction in 30-Day Readmissions in Three Years.

- 1.6 Million Patients Recover Without Readmission
- $35 Billion Dollars Saved in Three Years

Over 3,100 hospitals have signed pledge.

Improving Patient Safety

GOAL: Testing intensive programs of support hospitals as they make care safer.

- Provide national-level content for anyone and everyone
- Support every facility to take part in cooperative learning
- Establish an Advanced Participants Network for ambitious organizations to tackle all-cause harm
- Engage patients and families in making care safer
- Improve measurement and data collection, without adding burdens to hospitals

$218 million awarded to 26 organizations to operate hospital networks across the country that will make patient care safer

Million Hearts Campaign

www.millionhearts.hhs.gov

GOAL: Prevent 1 million heart attacks and strokes over the next 5 years.

Clinical Prevention: improving care of the ABCS through

Focus	simplifying and aligning quality measures; emphasizing importance of improved care of the ABCS'
Health IT	using electronic health records to improve care and enable quality improvement through clinical decision support, patient reminders, registries, and technical assistance.
Care Innovations	team-based care, interventions to promote medication adherence.

Community prevention: reducing the need for treatment through

- Prevention of tobacco use.
- Improved nutrition: decreasing sodium and artificial trans-fat consumption.

Innovation Advisors Program

GOAL: Support the Innovation Center's development and testing of new models of payment and care delivery in their home organizations and communities.

•Opportunity to deepen key skill sets in:

- Health care economics and finance
- Population health
- Systems analysis
- Operations research and quality improvement

- 1 year commitment; 6 months of intensive training.
- Up to $20K Stipend available to home organizations.
- 73 Advisors selected in December 2011; up to 200 individuals will be selected within the first year.
- For further information, see: www.orise.orau.gov/IAP

Health Care Innovation Challenge

GOAL: To identify and support a broad range of innovative service delivery and payment models that achieve better care, better health and lower costs through improvement in communities across the nation.

Innovation Challenge projects will:

- Improve care and lower costs for Medicare, Medicaid, and CHIP beneficiaries.
- Reach populations with the greatest health care needs.
- Rapidly implement the proposed model.
- Develop, train, and deploy workforce in support of innovative health care payment and delivery models.

Challenge Award Information

Up to $1 billion committed to 3 award cycles, with individual awards ranging from approximately $1M to $30M.

Important Deadlines

December 19, 2011: Letter of Intent Due
January 27, 2012: Application Due
March 30, 2012: Anticipated Award Date

For more information please e-mail InnovationChallenge@cms.hhs.gov

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

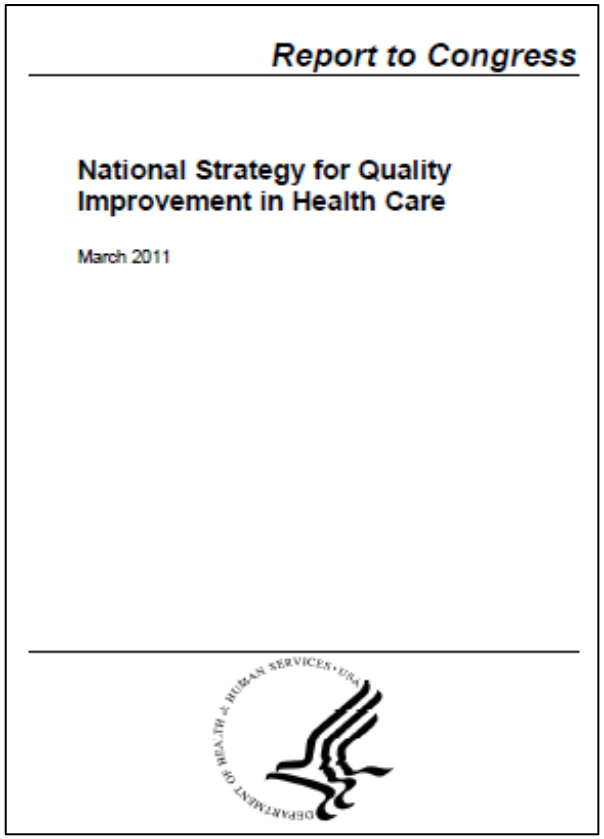
Aligned Incentives for wellness

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 promotes better health, healthcare, and lower cost



National Quality Strategy and CMS

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

CMS has a variety of quality reporting and performance programs, many led by OCSQ

Hospital Quality	Physician Quality Reporting	PAC and Other Setting Quality Reporting	Payment Model Reporting	"Population" Quality Reporting
•Medicare and Medicaid EHR Incentive Program	•Medicare and Medicaid EHR Incentive Program	•Inpatient Rehabilitation Facility	•Medicare Shared Savings Program	•Medicaid Adult Quality Reporting*
•PPS-Exempt Cancer Hospitals	•PQRS	•Nursing Home Compare Measures	•Hospital Value-based Purchasing	•CHIPRA Quality Reporting*
•Inpatient Psychiatric Facilities	•eRx quality reporting	•LTCH Quality Reporting	•Physician Feedback/Value-based Modifier*	•Health Insurance Exchange Quality Reporting*
•Inpatient Quality Reporting		•ESRD QIP		•Medicare Part C*
•HAC payment reduction program		•Hospice Quality Reporting		•Medicare Part D*
•Readmission reduction program		•Home Health Quality Reporting		
•Outpatient Quality Reporting				
•Ambulatory Surgical Centers				

* Denotes that the program did not meet the statutory inclusion criteria for pre-rulemaking, but was included to foster alignment of program measures.

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**

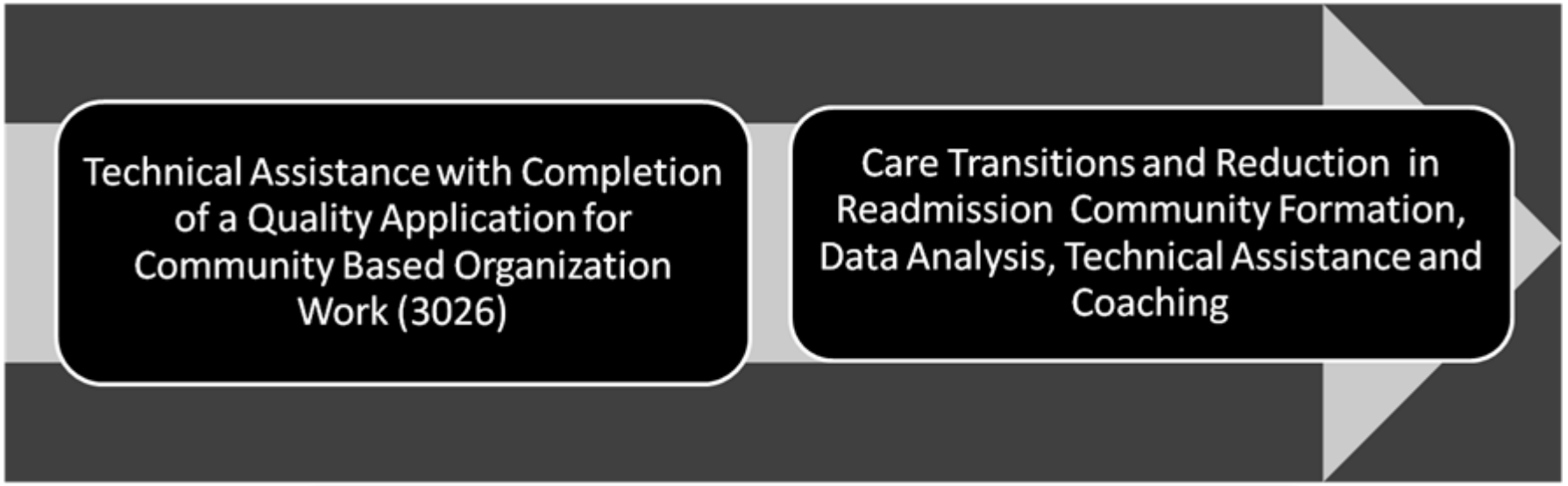
Learning and Action Networks, Onsite Technical Assistance, Spread Strategies

Aligned for Action – For Patient Safety

Partner Benefits

Active Learning and Teaching, Consumer Health Engagement Networks, Input into program development, Shaping system requirements with partners (e.g. NHSN development with CDC), High Performance leading to Payment Updates and Incentive Payments

Aligned for Action-Readmissions



Partner Benefits

Active Learning and Teaching, Improving Consumer Health, Input into program development, Reduction in Readmissions, Savings related to payment penalties, Connecting with Community Partners

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

- Measurement Development and Selection

OCSQ framework for measurement maps to the six national priorities

Clinical care

- Acute care
- Chronic care
- Prevention
- Clinical efficiency and utilization

Care coordination

- Transition of care measures
- Admission and readmission measures
- Provider communication

Population/ community health

- Health behaviors
- Access to care
- Social and economic factors
- Physical environment
- Disparities in care (across all domains)

Person- and Caregiver-centered experience and outcomes

- Patient experience
- Caregiver experience
- Patient –reported and functional outcomes

Safety

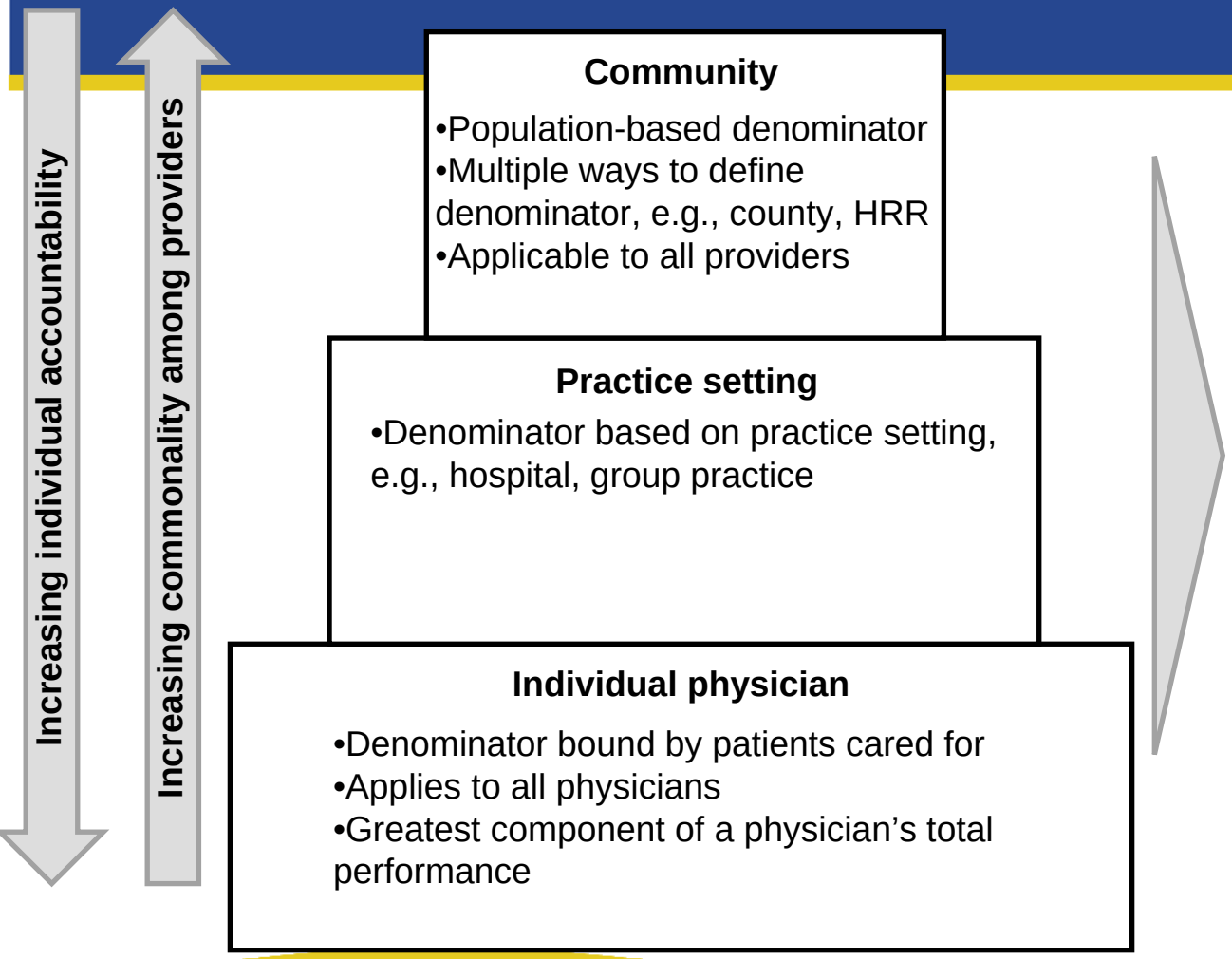
- Patient Safety
- Provider Safety

Efficiency and cost reduction

- Annual spend measures (e.g., per capita spend)
- Episode cost measures
- Quality to cost measures

- **Measures should be patient-centered and outcome-oriented whenever possible**
- **Measure concepts in each of the six domains that are common across providers and settings can form a core set of measures**

Quality can be measured and improved at multiple levels

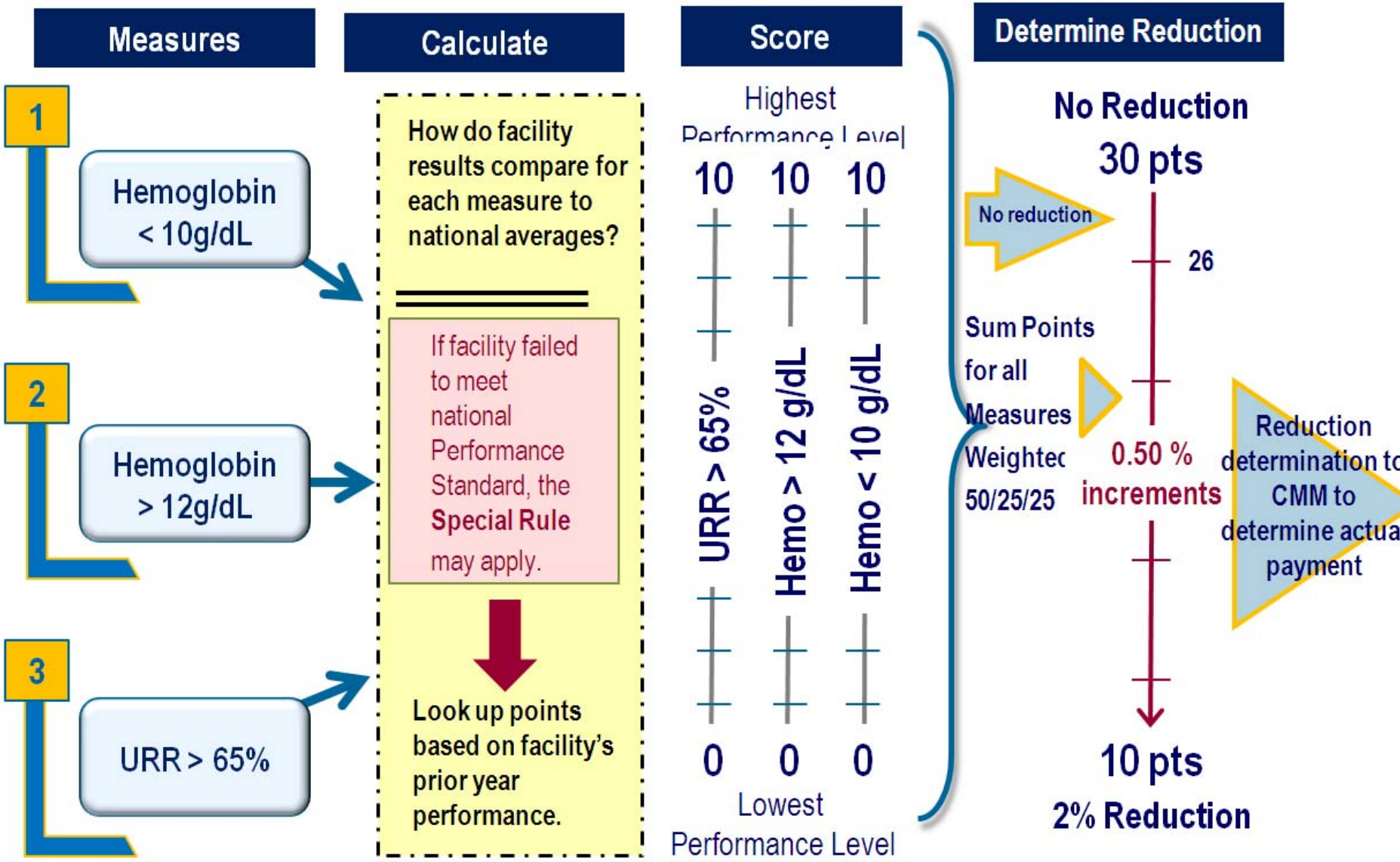


- Three levels of measurement critical to achieving three aims of National Quality Strategy
- Measure concepts should "roll up" to align quality improvement objectives at all levels
- Patient-centric, outcomes oriented measures preferred at all three levels
- The "five domains" can be measured at each of the three levels

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

PY 2013 Measures

- **Two measures have been adopted for the PY 2013 ESRD QIP:**
  - Percentage of patients with hemoglobin levels greater than 12 g/dL (Hemoglobin Greater Than 12 g/dL)
    - Lower percentage indicates better care
  - Percentage of patients with a Urea Reduction Ratio (URR) of 65% or greater (Hemodialysis Adequacy)
    - Higher percentage indicates better care
- **Facilities must have at least 11 patients eligible for each measure to receive a Total Performance Score**

PY 2013: Payment Reductions

- **A facility's Total Performance Score determines whether a payment reduction applies:**

PY 2013 Payment Reduction Scale	
Total Performance Score	**Percentage of Payment Reduction**
30 points	No Reduction
26-29 points	1.0%
21-25 points	1.5%
20 points or less	2.0%

PY 2014: Overview

- **The PY 2014 Final Rule broadens the scope of the ESRD QIP measures:**
  - Total of three clinical measures:
    - **Addition of one new clinical measure**
    - Clinical measures comprise 90% of the Total Performance Score
  - Total of three reporting measures:
    - **All reporting measures are new**
    - Reporting measures comprise 10% of the Total Performance Score
- **Scoring on clinical measures is based upon a facility's achievement or improvement on a measure**
- **The facility receives the higher of its achievement score or improvement score for each clinical measure**

Introduction: Hospital VBP Program

- Initially required in the Affordable Care Act and further defined in Section 1886(o) of the Social Security Act
- Quality incentive program built on the Hospital Inpatient Quality Reporting (IQR) measure reporting infrastructure
- Next step in promoting higher quality care for Medicare beneficiaries
- Pays for care that rewards better value, patient outcomes, and innovations, instead of just volume of services

Hospital VBP Program

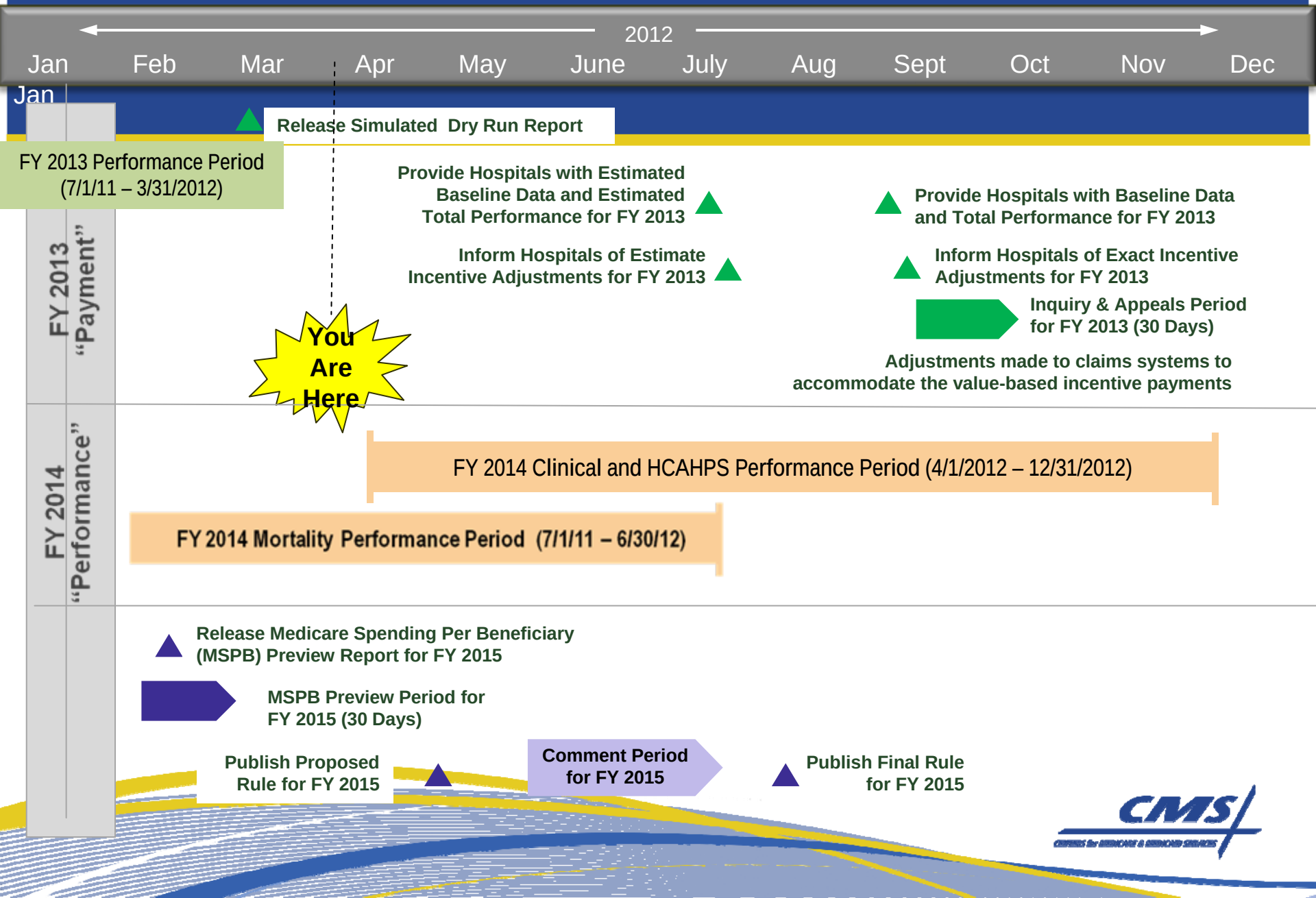
- For the first time, 3,500 hospitals across the country will be paid for inpatient acute care services based on care quality.

- 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

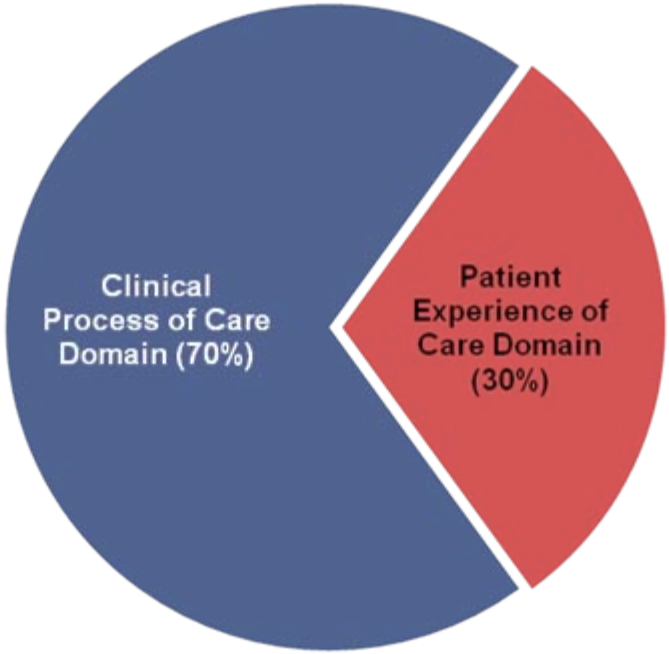


FY2013 HVBP measures

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-Card-2 Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
11. SCIP-VTE-1 Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
12. SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours

Weighted Value of Each Domain



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

How Will Hospitals Be Evaluated?
FY 2013 Program Summary

- **Two domains: Clinical Process of Care (12 measures) and Patient Experience of Care (8 HCAHPS dimensions)**
- **Hospitals are given points for Achievement and Improvement** for each measure or dimension, with the greater set of points used
- **Points are added across all measures** to reach the Clinical Process of Care domain score
- **Points are added across all dimensions** and are added to the Consistency Points to reach the Patient Experience of Care domain score
- **70% of Total Performance Score based on Clinical Process of Care measures**
- **30% of Total Performance Score based on Patient Experience of Care dimensions**

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

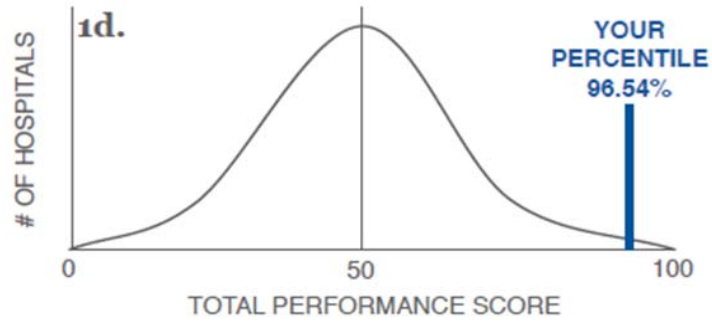
REPORT GENERATED:
07 Dec. 2012

Estimated Total Performance Score (TPS) Summary

1a. FACILITY
72.35/100
earned/available

1b. STATE
49.15/100

1c. NATIONAL
46.83/100



Simulated Hospital Report Estimated Value-Based Incentive Payment Percentage

Hospital Value-Based Purchasing

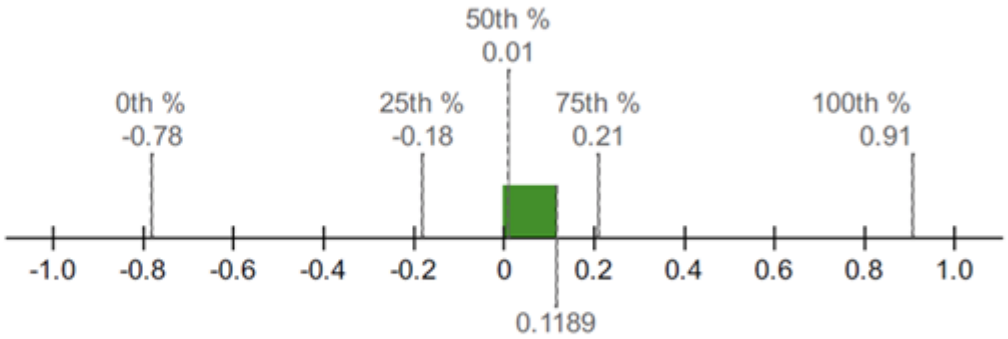
Simulated Hospital Report

Estimated Value-Based Incentive Payment Percentage

2a. ESTIMATED NET CHANGE IN BASE-OPERATING DRG PAYMENT

0.119%

2b. NATIONAL DISTRIBUTION OF NET CHANGE IN BASE-OPERATING DRG PAYMENT



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

Simulated Hospital Report
Unweighted Clinical Process of Care

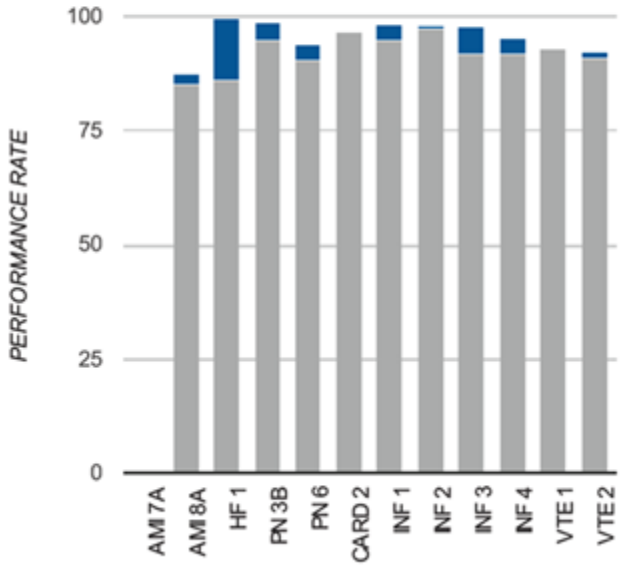
Hospital Value-Based Purchasing

Simulated Hospital Report

3d. UNWEIGHTED CLINICAL PROCESS OF CARE DIMENSION SCORE (70% of TPS)

69.00 /100

3e. CLINICAL PROCESS OF CARE MEASURE RATES



Simulated Hospital Report
Unweighted Patient Experience of Care

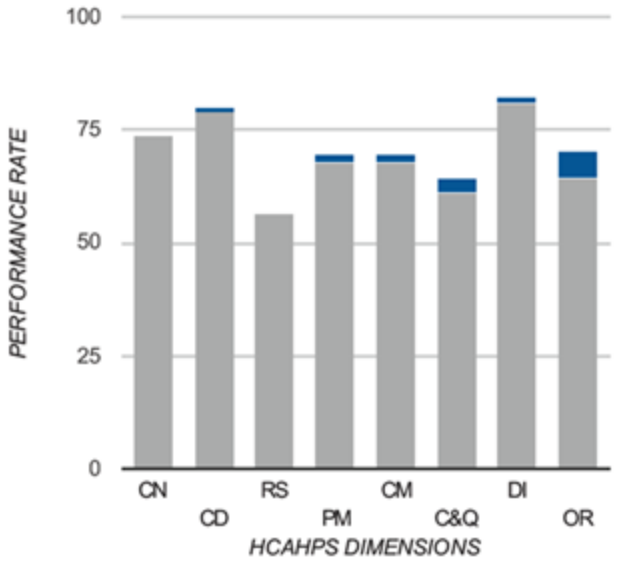
Hospital Value-Based Purchasing

Simulated Hospital Report

3f. UNWEIGHTED PATIENT EXPERIENCE OF CARE DIMENSION SCORES (30% of TPS)

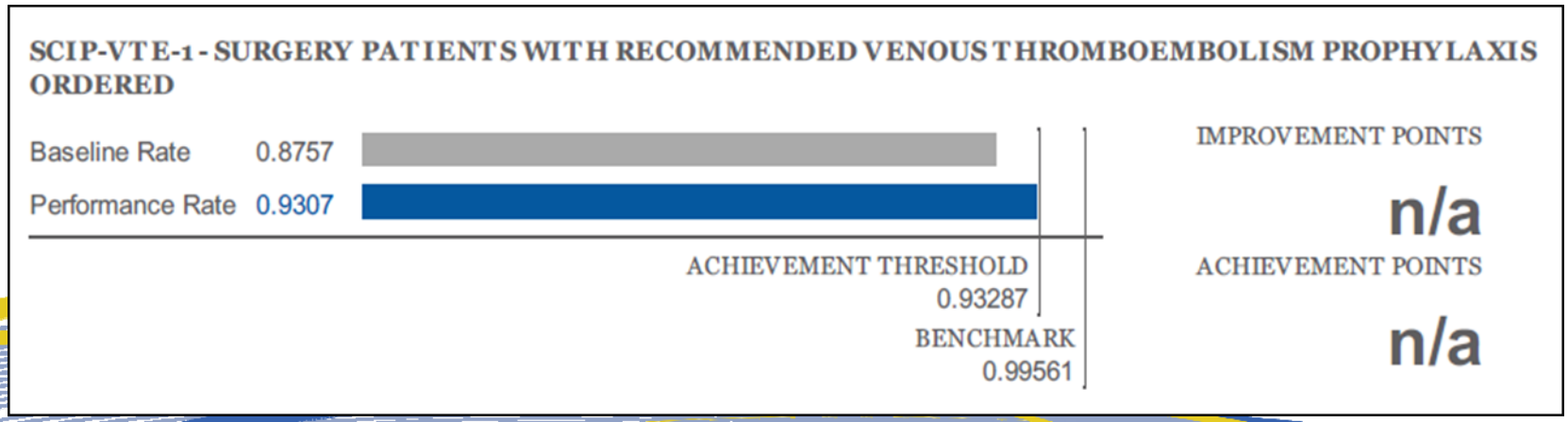
31.00 /100

3g. PATIENT EXPERIENCE OF CARE DIMENSION RATES

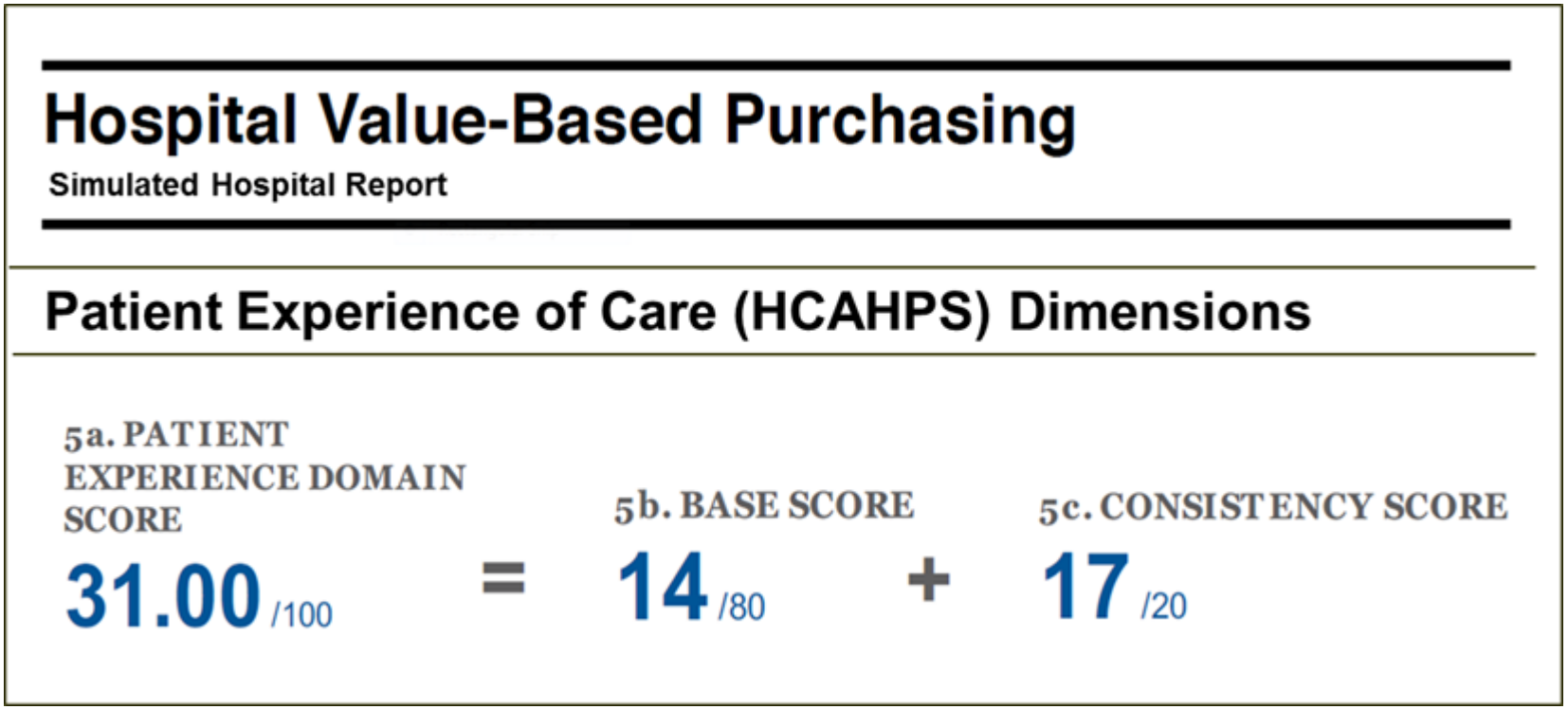


Clarification of Criteria for Clinical Scores in the Dry Run

- For the Simulated Performance Report, hospitals that do not report at least 10 cases for at least 4 measures will not be given:
  - A Total Clinical Domain Score
  - A Total Performance Score
  - An Incentive Adjustment
- For measures that do not meet the minimum 10 cases, hospitals will see "n/a" instead of a score for the Improvement and Achievement points.



Simulated Hospital Report
Patient Experience Domain Score



Simulated Hospital Report Consistency Points Details

Hospital Value-Based Purchasing

Simulated Hospital Report

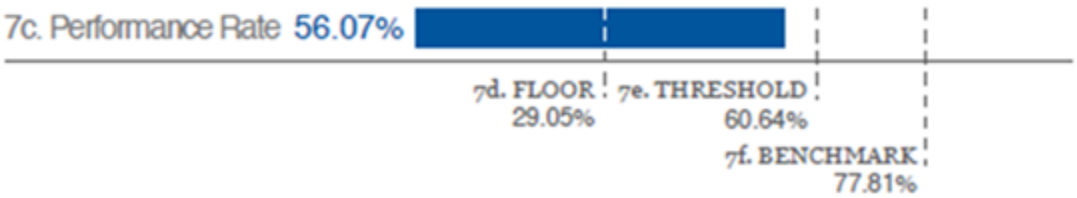
Consistency Points Details

7a. CONSISTENCY SCORE

17 /20 POINTS

7a. Your Hospital's Consistency Score is shown based on a maximum of 20 points.

7b. LOWEST HCAHPS DIMENSION:
RS - RESPONSIVENESS OF HOSPITAL STAFF



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?

- 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 when 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?

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?

When all is Said and Done

When all is Said and Done

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
- Million Hearts Campaign: www.millionhearts.hhs.gov
- Partnership for Patients: http://www.healthcare.gov/center/programs/partnership/join/index.html
- http://partnershippledge.healthcare.gov/
- Department of Health and Human Services' health care reform web site: http://www.healthcare.gov

Thank you for listening!