HealthWatch USA Meeting

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July 31, 2013

Discussion

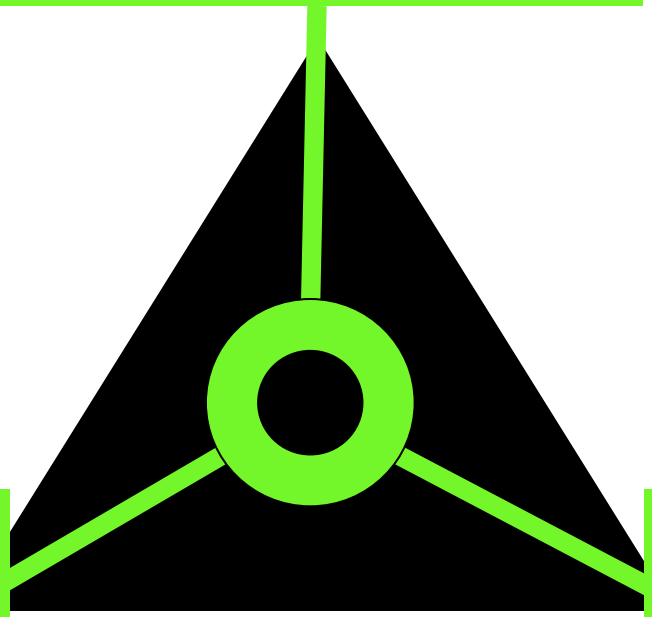
- **Our Goals and Early Results**
- **Value-based purchasing and quality improvement programs**
- **2014 Physician Fee Schedule Quality Proposals**
- **Quality Measurement to Drive Improvement**
- **Future and Opportunities for collaboration**

Size and Scope of CMS Responsibilities

- CMS is the largest purchaser of health care in the world (approx $900B per year)
- Combined, Medicare and Medicaid pay approximately one-third of national health expenditures.
- CMS programs currently provide health care coverage to roughly 105 million beneficiaries in Medicare, Medicaid and CHIP (Children's Health Insurance Program); or roughly 1 in every 3 Americans.
- The Medicare program alone pays out over $1.5 billion in benefit payments per day.
- CMS answers about 75 million inquiries annually.
- Millions of consumers will receive health care coverage through new health insurance programs authorized in the Affordable Care Act.

Our Aims

Better Health for the Population



Better Care for Individuals

Lower Cost Through Improvement

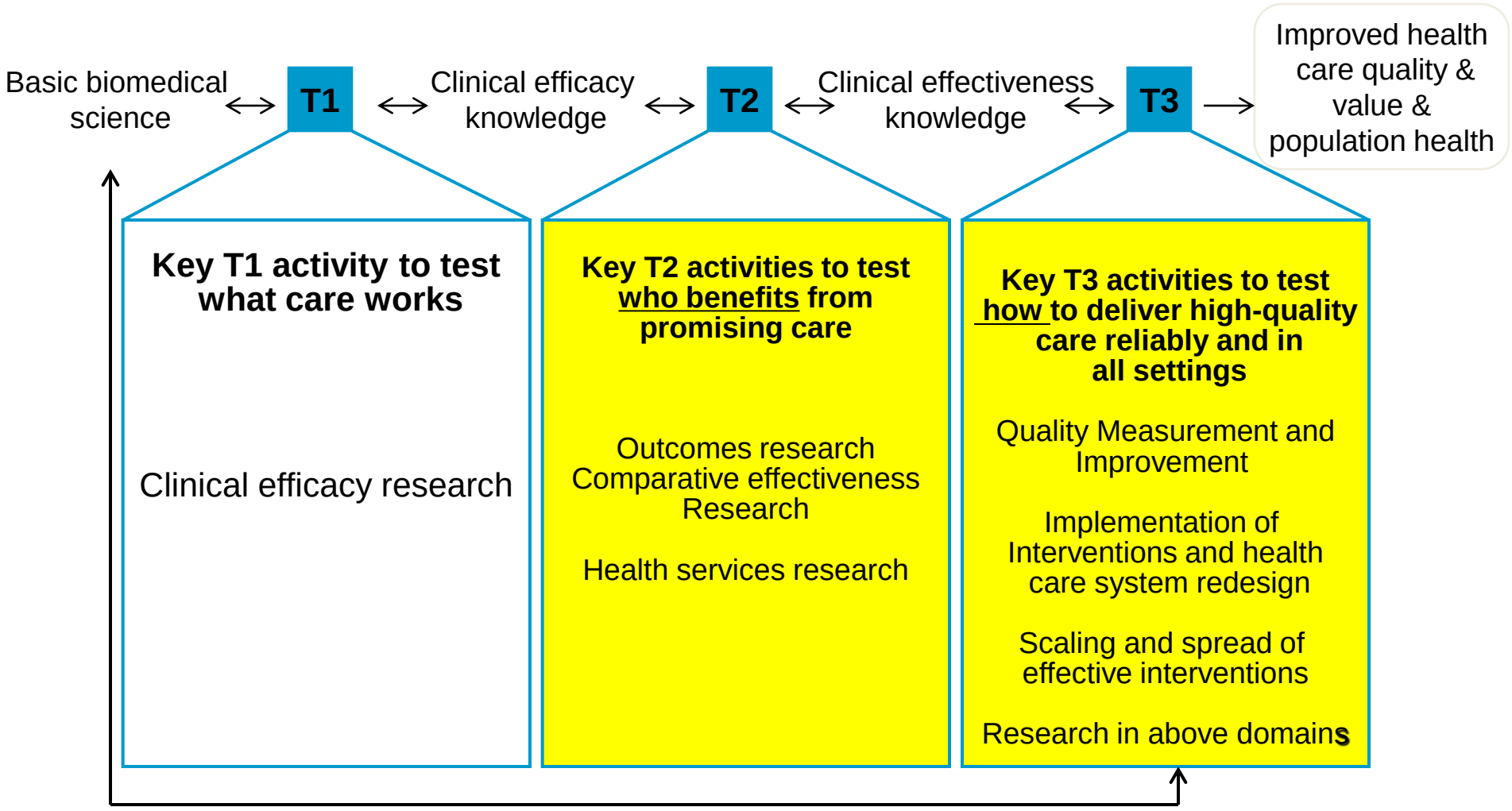
How do we ensure quality care?

- Improvement as a Strategy
- Customer-Mindedness
- Outcomes Focus
- Statistical Thinking
- Continual Improvement (PDSA)
- Leadership

How Will Change Actually Happen?

- There is no “silver bullet”
- We must apply many incentives
- We must show successful alternatives
- We must offer intensive supports
  - Help providers with the painstaking work of improvement
- We must learn how to scale and spread successful interventions

The "3T's" Road Map to Transforming U.S. Health Care



Source: JAMA, May 21, 2008: D. Dougherty and P.H. Conway, pp. 2319-2321. The "3T's Roadmap to Transform U.S. Health Care: The 'How' of High-Quality Care."

Transformation of Health Care at the Front Line

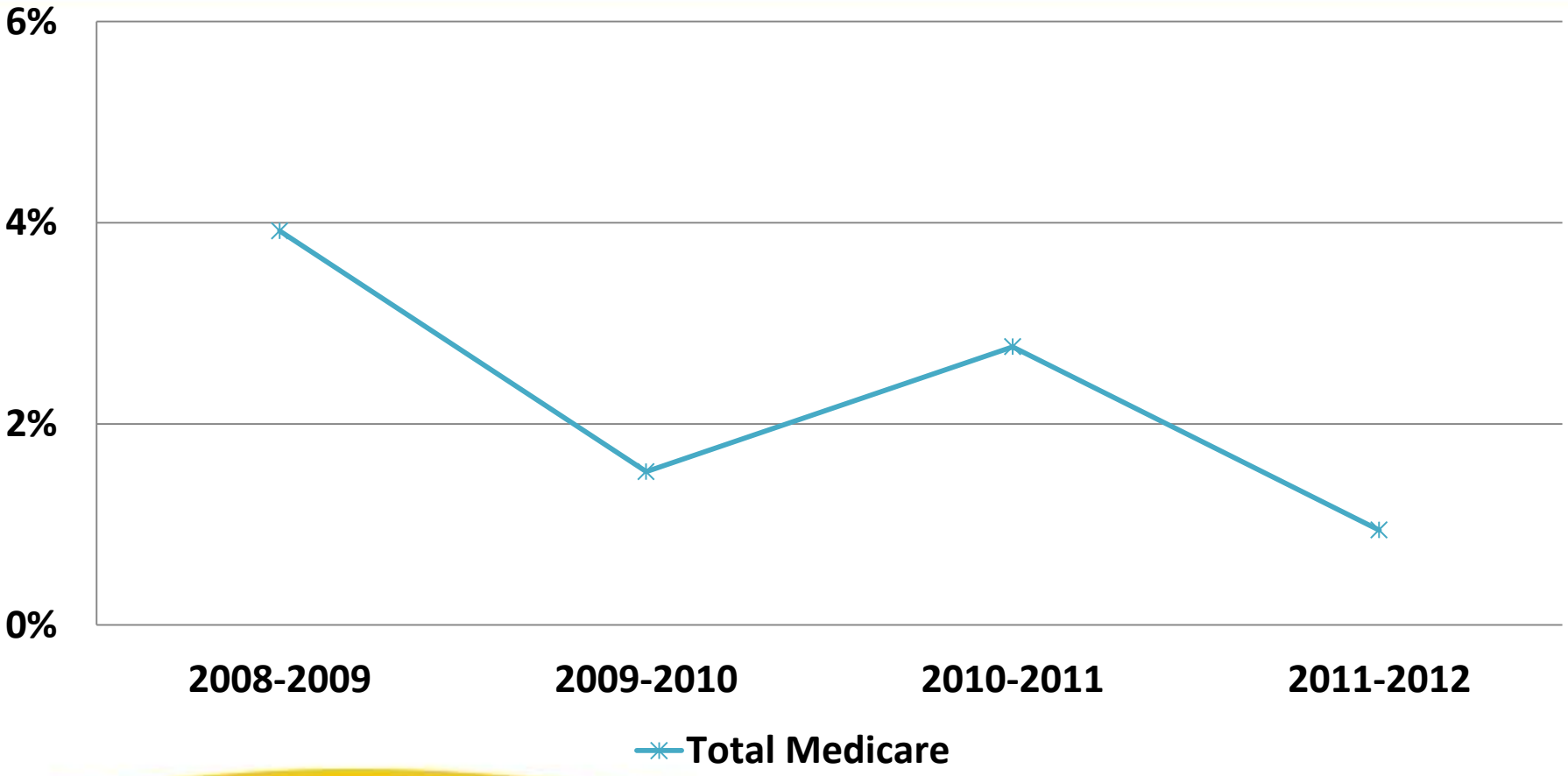
- At least six components
  - Quality measurement
  - Aligned payment incentives
  - Comparative effectiveness and evidence available
  - Health information technology
  - Quality improvement collaboratives and learning networks
  - Training of clinicians and multi-disciplinary teams

Source: P.H. Conway and Clancy C. Transformation of Health Care at the Front Line. JAMA 2009 Feb 18; 301(7): 763-5

Early Example Results

- Cost growth leveling off - actuaries and multiple studies indicated partially due to “delivery system changes”
- But cost and quality still variable
- Moving the needle on some national metrics, e.g.,
  - Readmissions
  - Line Infections
- Increasing value-based payment and accountable care models
- Expanding coverage with insurance marketplaces gearing up for 2014

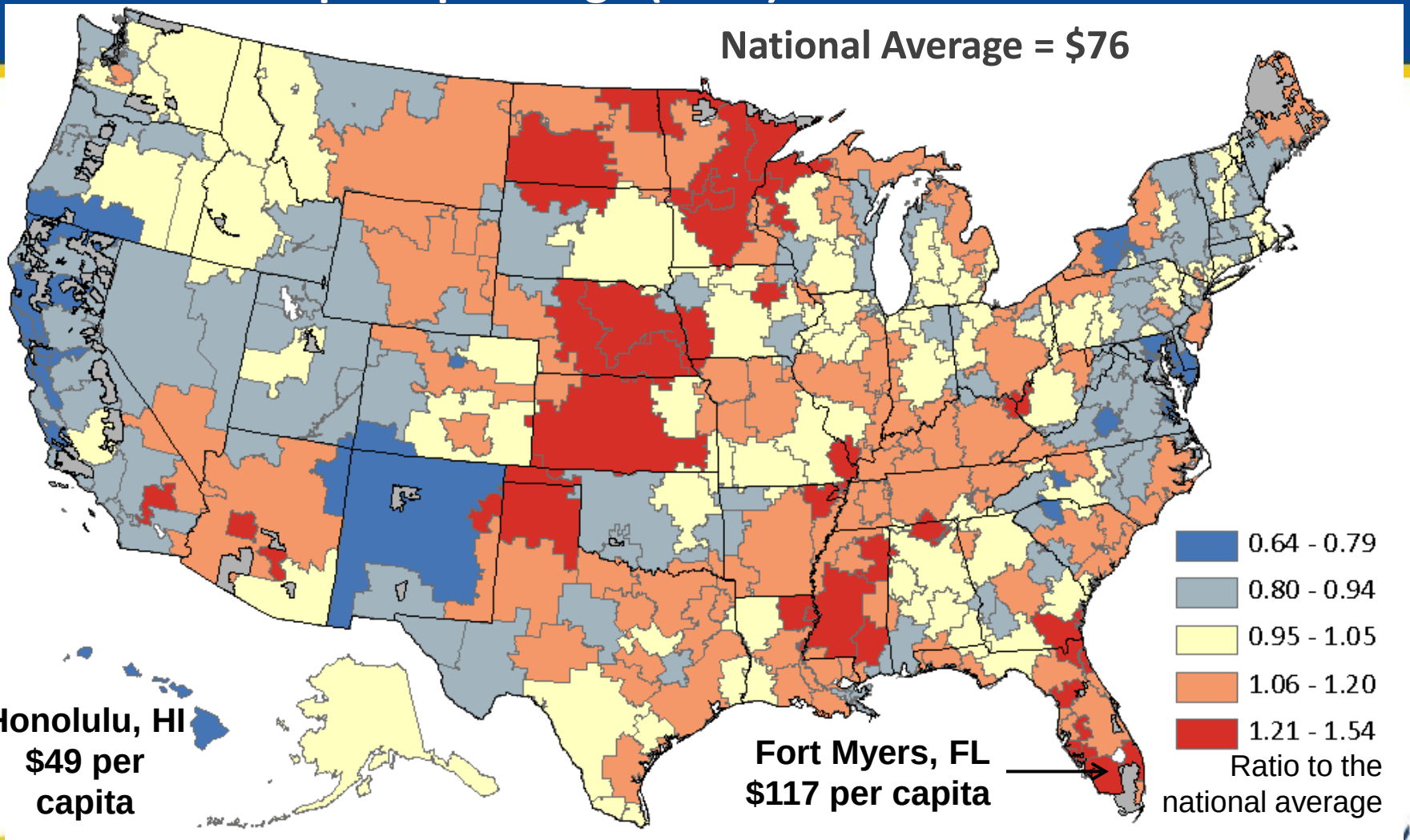
Results: Medicare Per-Capita Spending Growth at Historic Low



Source: CMS Office of the Actuary, Midsession Review – FY 2013 Budget

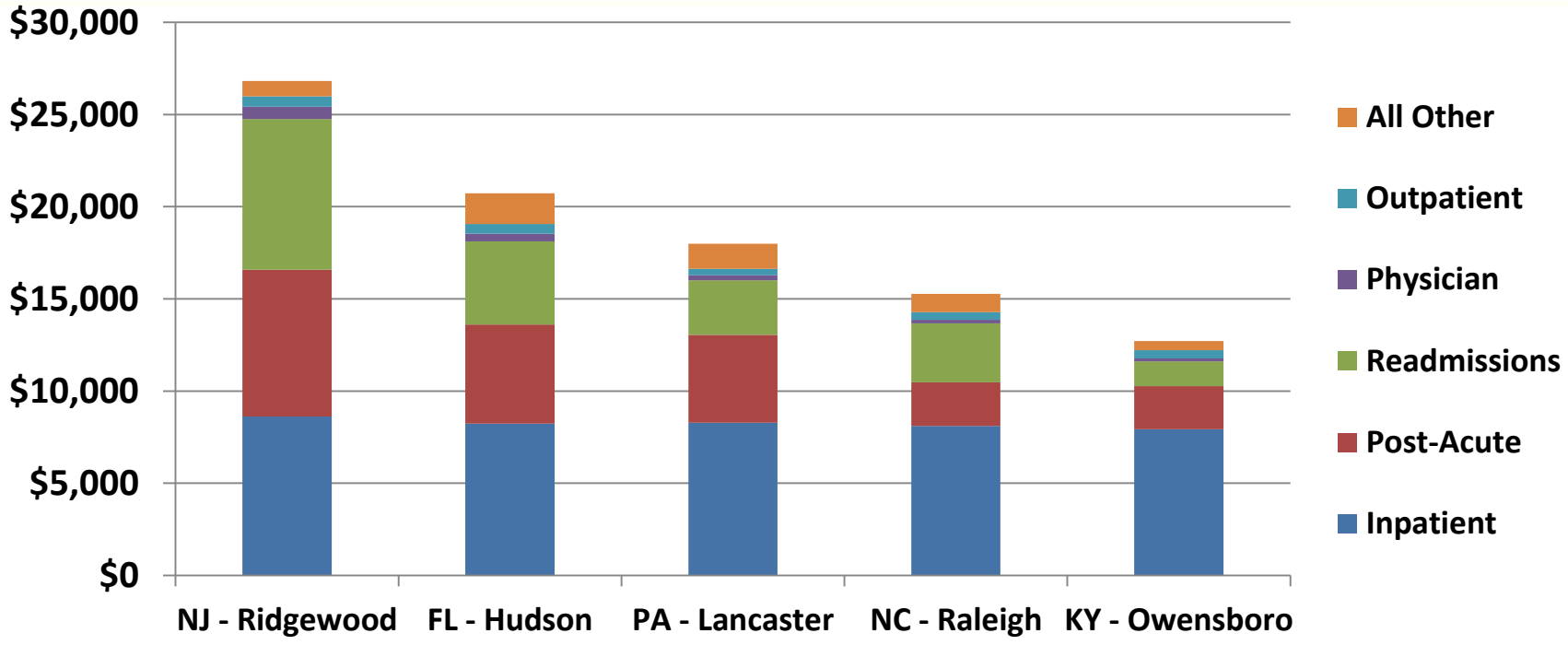
Wide Variation in Spending Across the Country

CT Scans Per Capita Spending* (2011)



*includes institutional and professional spending

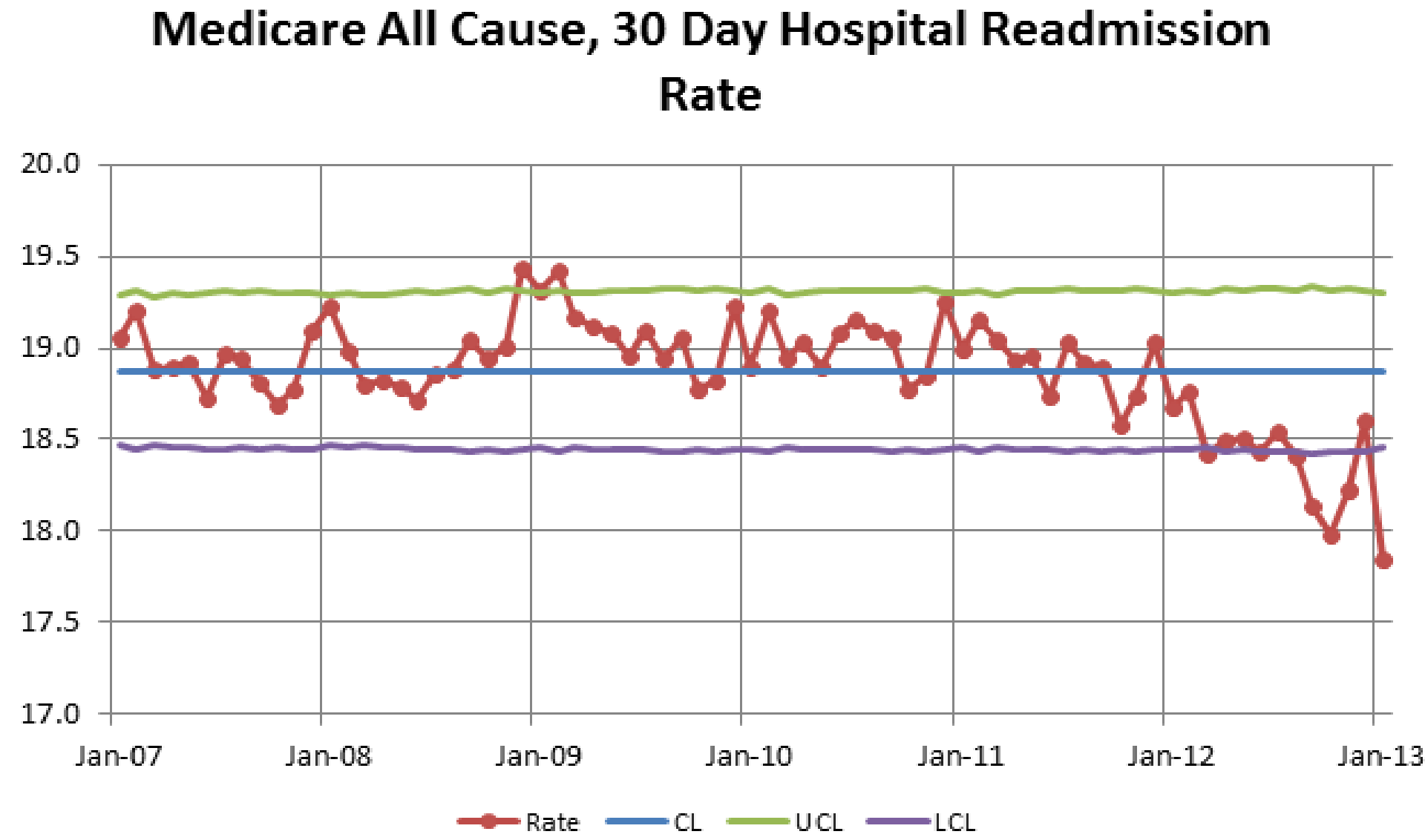
Wide Variation in Spending Across the Country
Heart Failure and Shock with Complications MS-DRG 291



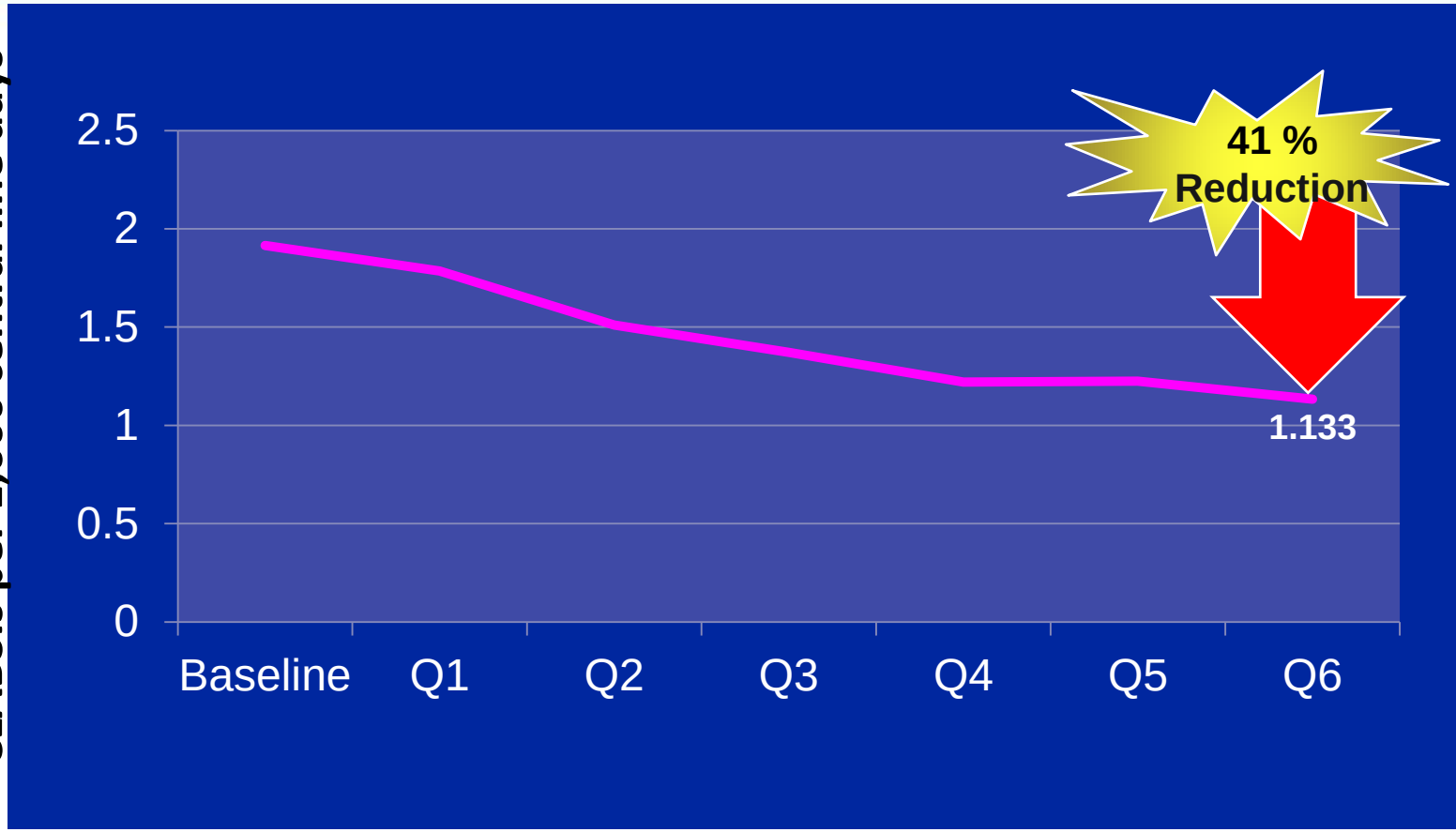
Ratio to Nat'l Avg	1.49	1.15	1.00	0.85	0.71

Source: CMS Office of Information Products and Data Analysis, Medicare Claims Analysis - 2010

National Medicare 30 Day Readmissions



CLABSI Rate in CUSP National Project



Over 1,000 ICUs achieved an average 41% decline in CLABSI over 6 quarters (18 months), from 1.915 to 1.133 CLABSI per 1,000 central line days.

Quarters of participation by hospital cohorts, 2009–2012

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The Six Goals of the CMS Quality Strategy

1. Make care safer by reducing harm caused in the delivery of care
2. Strengthen person and family engagement as partners in their care
3. Promote effective communication and coordination of care
4. Promote effective prevention and treatment of chronic disease
5. Work with communities to promote healthy living
6. Make care affordable

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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.***
- **Hospital value-based purchasing program shifts approximately $1 billion based on performance**

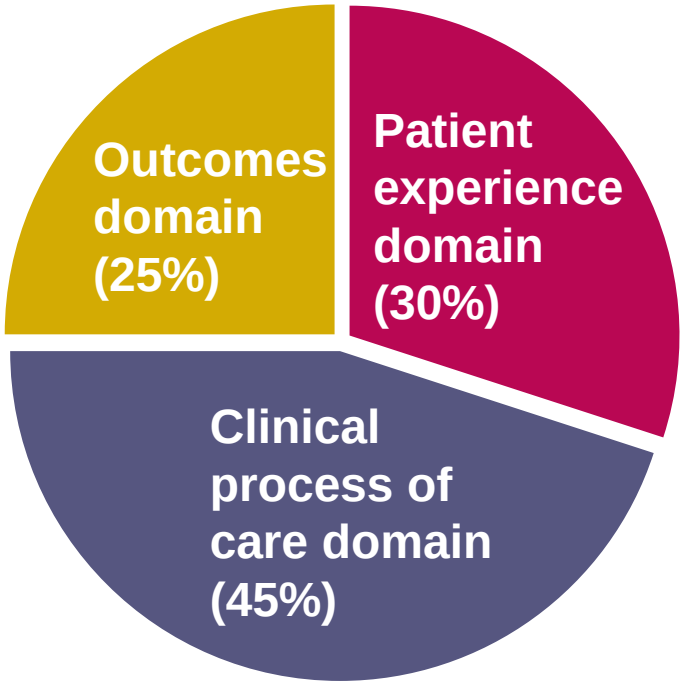
Value-Based Purchasing

- **Five Principles**
  - **Define the end goal, not the process for achieving it**
  - **All providers' incentives must be aligned**
  - **Right measure must be developed and implemented in rapid cycle**
  - **CMS must actively support quality improvement**
  - **Clinical community and patients must be actively engaged**

VanLare JM, Conway PH. Value-Based Purchasing – National Programs to Move from Volume to Value. NEJM July 26, 2012

FY 2014 HVBP domains

Weighted value of each domain



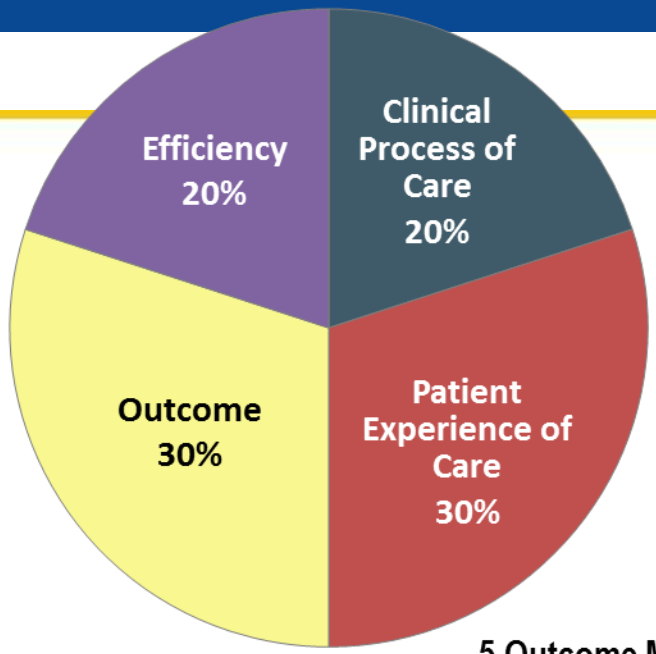
- FY 15 adding efficiency domain (20%) with total cost per beneficiary for admissions; increase outcomes to 30%, decrease process to 20%
- FY16 and 17 – more outcomes weighting and safety measures, align with NQS domains

FY 2015 Finalized Domains and Measures/Dimensions

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 6 a.m. Postoperative Serum Glucose
10. SCIP–Inf–9 Postoperative Urinary Catheter Removal on Postoperative Day 1 or 2
11. SCIP-Card-2 Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
12. SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis within 24 Hours

Domain Weights



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

5 Outcome Measures

1. MORT-30-AMI – Acute Myocardial Infarction (AMI) 30-day mortality rate
2. MORT-30-HF – Heart Failure (HF) 30-day mortality rate
3. MORT-30-PN – Pneumonia (PN) 30-day mortality rate
4. **PSI-90 – Patient safety for selected indicators (composite)** ★
5. **CLABSI – Central Line-Associated Bloodstream Infection** ★

1 Efficiency Measure

1. MSPB-1 Medicare Spending per Beneficiary measure ★

★ **Represents a new measure for the FY 2015 program that was not in the FY 2014 program.**

FY 2016 Hospital VBP Program
Healthcare Associated Infection Proposals

- Proposed two additional HAI measures
  - Catheter Associated Urinary Tract Infection (CAUTI)
  - Surgical Site Infection (SSI)
- Proposed performance period is 2014 calendar year
- CMS intends to post final rule by August 1, 2013
- HAI's are part of Outcomes domain in FY 2016 (40% total domain weight)

Other Payment adjustment programs

- **Starting in Oct 2012, hospitals with excess risk adjusted Medicare readmissions had payments reduced (5 conditions proposed for FY15)**
- **Payment reductions for hospitals in bottom quartile of healthcare acquired conditions starting Oct 2014**
  - **Proposed to start with 2 domains weighted 50% each: healthcare acquired infections and healthcare acquired conditions**
  - **Need to move beyond claims-based HAC measures over time**

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Physician Reporting Programs

- **Principle of report once and receive credit for all programs: Physician Quality Reporting System, Physician Value-Based Modifier, EHR Incentive Meaningful Use, and ACO if applicable**
- **Focus on registry reporting and EHR based reporting, both of which can be all payer**
- **Group reporting growth, including for ACOs**
- **Physician value modifier starts in 2013 (groups of 100 or more), proposed down to groups of 10 or more for 2014 and by 2017 adjusting all Medicare payments to physicians based on quality and cost**

Physician Quality Reporting System

- Adding 47 new measures and 3 measures groups to fill existing gaps
- Doubling the number of outcome measures and reduced the number of process measures
- Removing a number of claims-based measures that were duplicative or infrequently reported
- Eliminating claims based measure groups (all are available via registries)
- Encouraging registry and EHR reporting and proposed decreasing claims-based measures more over time

Physician Quality Reporting System

- PQRS Incentive: 9 measures across 3 domains (aligns with MU reporting requirements)
- PQRS Payment Adjustment: 3 measures
- Physicians that meet the Incentive criteria automatically avoid the Payment Adjustment
- Groups that report on CG-CAHPS can use those measures towards meeting satisfactory reporting criteria

Clinical Data Registries

- ATRA of 2012 allows physicians who submit quality measures to a CDR to meet PQRS criteria
- Proposed PFS rule lays out the criteria for an entity to be a CDR
- Only applies to individual physician reporting in statute but will allow group batch reporting
- Physicians may report on all patients, regardless of payer source
- To meet PQRS incentive criteria, must report on 9 measures across 3 domains
- Must report on at least 1 outcome measure
- Measures do not need to be part of current PQRS measure set

Physician Compare

- Outlines a phased plan for publicly reporting physician performance on quality measures
- In 2014, CMS will publicly report measures reported by large groups and ACOs
  - Physicians will have a 30 day preview period of measure results
- In 2014, CMS will publicly report CG-CAHPS measures
- As early as 2015, CMS will publicly report measures for individual physicians
- CMS will work with specialty societies to identify vetted measures for public reporting
- Website redesign is now live

Physician Value Modifier

- 2014 is the 2nd year of the program; by 2015 measurement year, law requires all physicians to be assessed for payment in 2017
- Decrease group size to 10 or more eligible professionals (will affect 60% of EPs)
- Category 1: Groups that participate in the PQRS Group Practice Reporting Option (GPRO) by any method (EHR, Registry, Web Interface)
  - If a group doesn't participate in GPRO, then if 70% of the group's EPs report individually, they will be assessed as a group
- Category 2: Groups that do not participate in reporting

Physician Value Modifier

Category 1 groups:

- **Quality Tiering (up, down or no adjustment) will be mandatory for groups of 10 or more**
  - **Groups of 10-99 will not be subject to a downward adjustment**
  - **Groups of 100 or more will be subject to upward, downward or neutral adjustment**
- **Max downward is -2% (low quality/high cost) and -1% for low quality/avg cost or avg quality/high cost**
- **Upward adjustment +1x and +2x to maintain budget neutrality**
- **Greater upward adjustment for EPs with high complexity patients**

Category 2 groups

- **Subject to an automatic downward adjustment of -2%**

Feedback Reports

- **In September of 2013, we anticipate making available feedback reports to all groups of physicians of 25 or more based on 2012 data**
- **In 2014 we anticipate providing feedback reports to all physicians**
- **We continue to seek ways to provide more frequent and timely feedback reports**
  - **Challenging with claims-based measures**
  - **Registries and EHRs can provide more frequent feedback; proposing quarterly feedback at minimum for CDRs**

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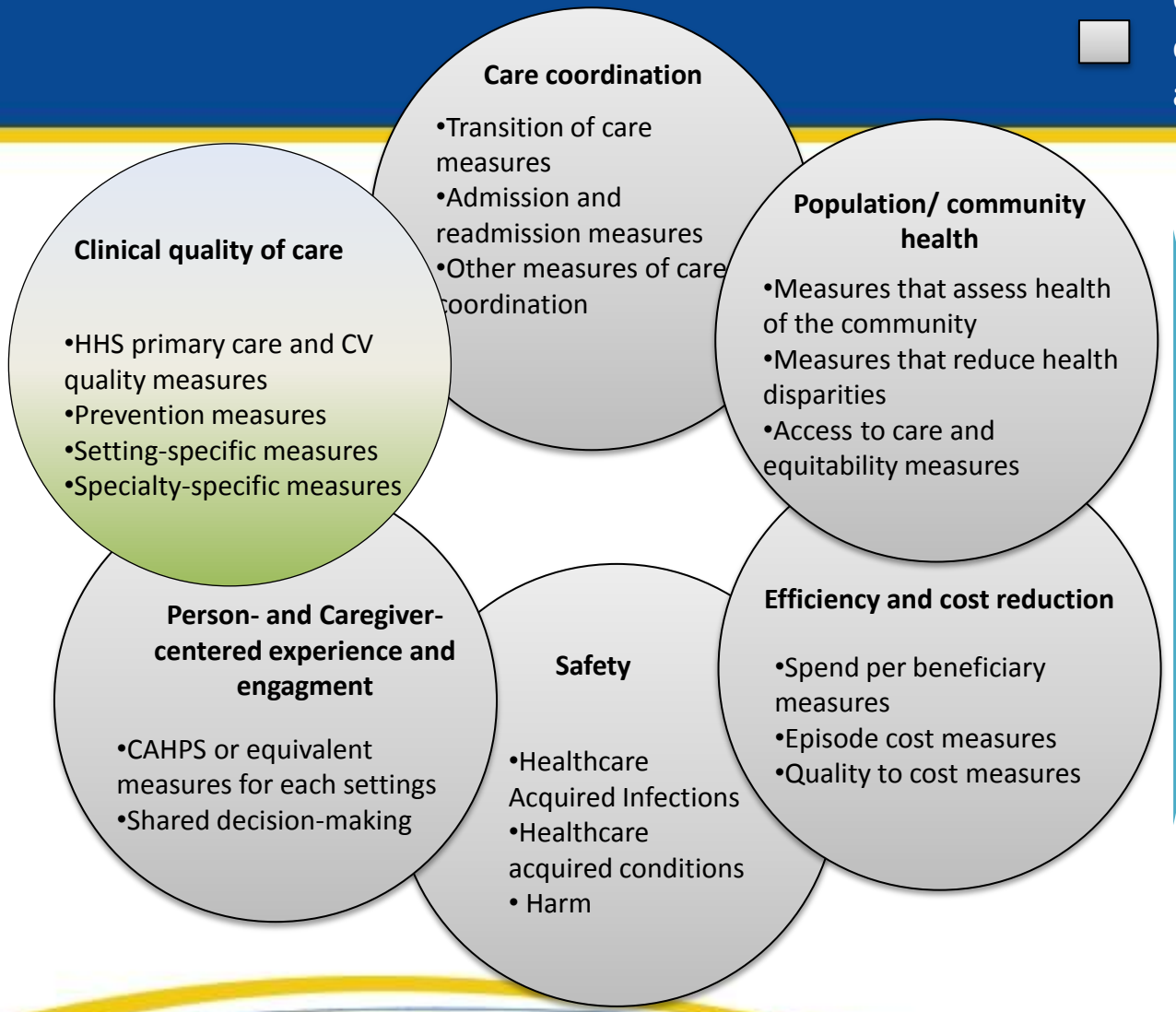
CMS has a variety of quality reporting and performance programs, many led by CCSQ

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				

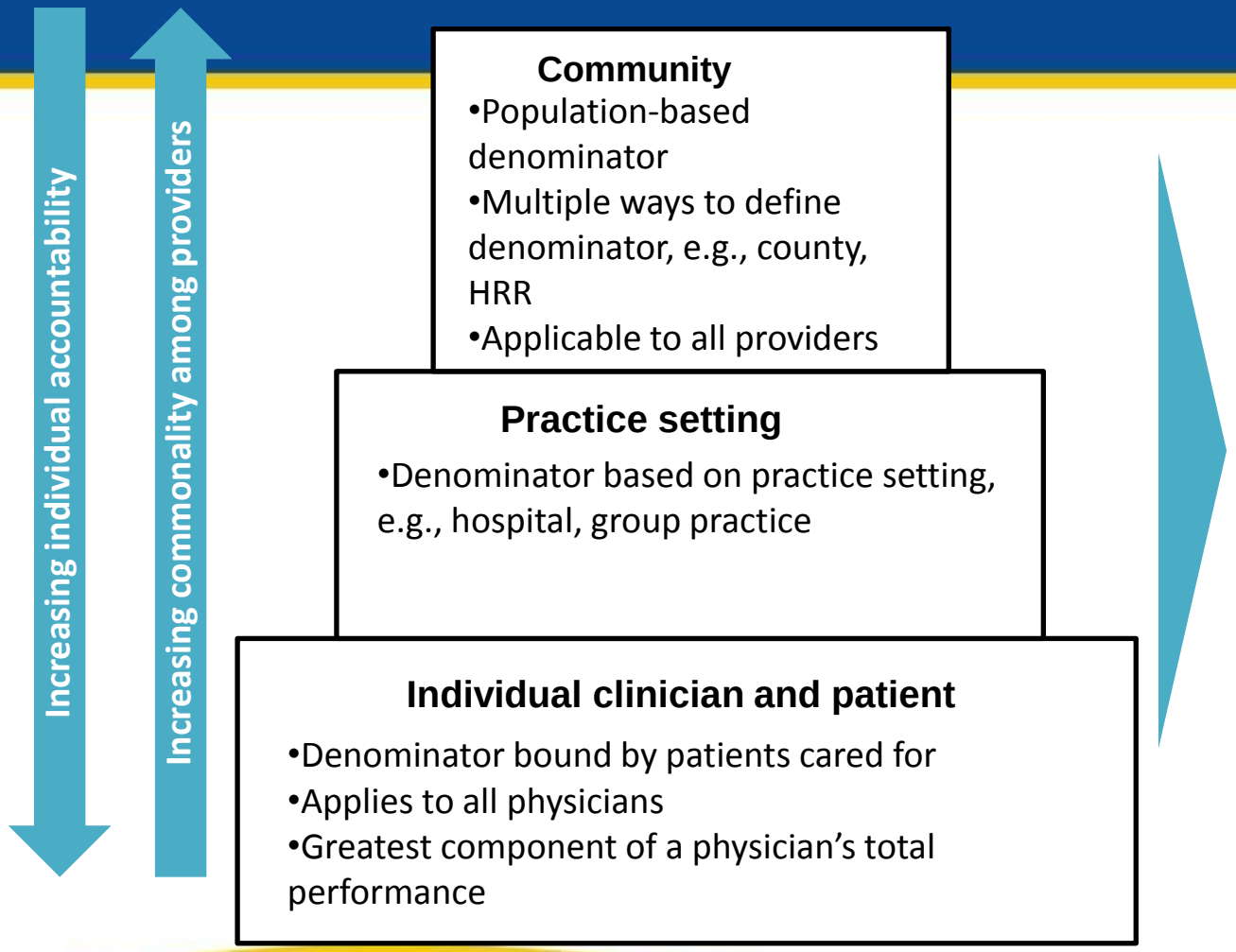
CMS framework for measurement maps to the six national priorities

Greatest commonality of measure concepts across domains



- **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



- **Measure concepts should "roll up" to align quality improvement objectives at all levels**
- **Patient-centric, outcomes oriented measures preferred at all three levels**
- **The six NQS domains can be measured at each of the three levels**

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Vision for the Future

- Measures Drive Improvement
  - –Real-time
  - –Local ownership with benchmarking
  - –Linked to decision support and patient dashboards
- Measures Drive Value-Based Purchasing
  - –Reliable
  - –Accurate
  - –Outcomes-based
- Measures Inform Consumers
  - –Meaningful
  - –Transparent

The Future of Quality Measurement for Improvement and Accountability

- Meaningful quality measures increasingly need to transition away from setting-specific, narrow snapshots
- Reorient and align measures around patient-centered outcomes that span across settings
- Measures based on patient-centered episodes of care
- Capture measurement at 3 main levels (i.e., individual clinician, group/facility, population/community)
- Why do we measure?
  - Improvement

Source: Conway PH, Mostashari F, Clancy C. The Future of Quality Measurement for Improvement and Accountability. JAMA 2013 June 5; Vol 309, No. 21 2215 - 2216

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Opportunities and Challenges of a Lifelong Health System

- Payers, including Medicare and Medicaid, increasingly responsible for care for longer periods of time
- Goal of system to optimize health outcomes and lower costs over much longer time horizons
- Health trajectories modifiable and compounded over time
- Importance of early years of life

Source: Halfon N, Conway PH. The Opportunities and Challenges of a Lifelong Health System. NEJM 2013 Apr 25; 368, 17: 1569-1571

Financial Instruments and models that might incentivize lifelong health management

- Horizontally integrated health, education, and social services that promote health in all policies, places, and daily activities
- Consumer incentives (value-based insurance design)
- “Warranties” on specific services
- Bundled payment for suite of services over longer period
- Measuring health outcomes and rewarding plans for improvement in health over time
- Community health investments
- ACOs could evolve toward community accountable health systems that have a greater stake in long-term population health outcomes

What can you do?

- **Delivery system transformation happens at the state and community level**
- **Clinicians are key to transformation**
- **Need to focus on better care, better health, and lower costs**
- **Need to continuously test and improve**
- **Will need to engage front line clinicians, consumers, employers, and others in driving change**
- **Support the testing of new accountable care models, care coordination models, and models to purchase value, instead of volume**
- **So much more….**

What can you do?

- **Eliminate patient harm**
- **Engage patients and families in transformation**
- **Teach others and continuously learn**
- **Test new ideas**
- **Strive to be the best possible quality improvement infrastructure**
- **Relentless pursuit of improving health outcomes**
- ***Major* Force in Delivery System Transformation**

Contact Information

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Questions and Comments

- How can we work together to accelerate the pace of improvement in the health system?
- How can CMS support your efforts?
- How can we drive improvement in all settings and shift towards payment based on value and accountable, coordinated care?
- How do we scale and spread success?
- How can we work together to reduce and attempt to eliminate patient harm in all settings?
- How can you best lead transformation of the delivery system?