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Value Based Purchasing, HAIs, HACs, Innovation and Health System Transformation

Health Watch USA;

Transparency & Patient Safety Conference

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Richard E. Wild, MD, JD, MBA, FACEP
Chief Medical Officer, Atlanta Region
Centers for Medicare and Medicaid

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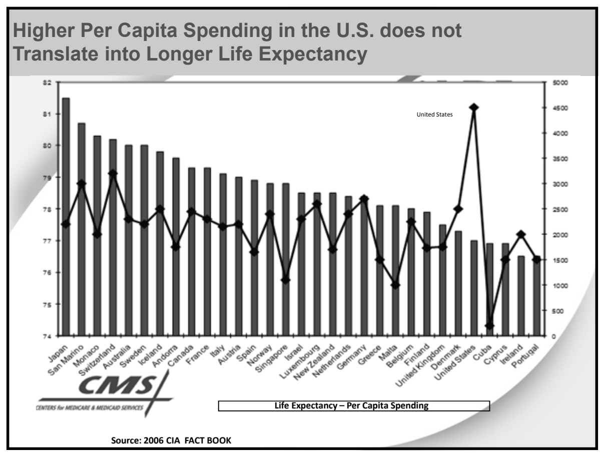
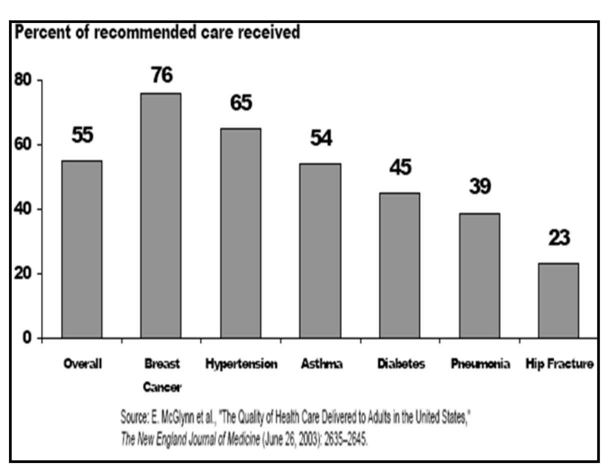
The Three Part Aim, Goals of CMS

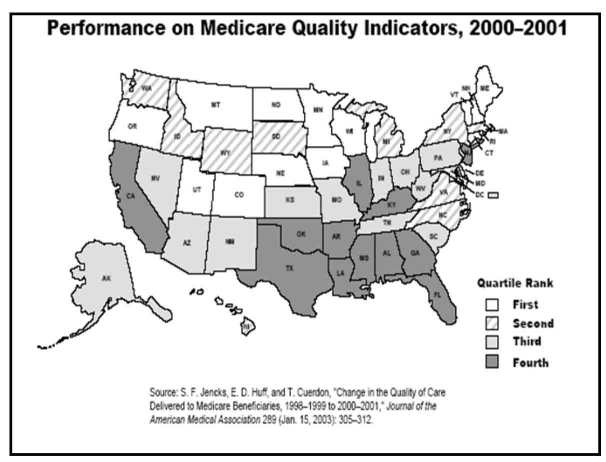
- Better Care
  - Patient Safety
  - Quality
  - Patient Experience
- Reduce Per Capita Cost
  - Reduce unnecessary and unjustified medical cost
  - Reduce administrative cost thru process simplification
- Improve Population Health
  - Decrease health disparities
  - Improve chronic care management and outcome
  - Improve community health status

What's Wrong with US Healthcare Today?

Too Costly?
Inefficient?
Disparities in Access and Quality?
Evidence Base foundation often lacking?
Lack of Prevention focus?
Fragmentation of care, between providers and sites of care? (Silos, care transitions)
Poor information and data sharing and transfer?
Patient safety and quality ? (Compare to aviation industry?)
A payment system that rewards providing services rather than outcomes?
Coordinated, accountable or Uncoordinated, Unaccountable care?







Value Based Purchasing Incentives

- Incentivize the best care and improve transparency for Beneficiaries
- Transform CMS from a passive payer to an active purchaser of care
- Link payment to quality outcomes and stimulate efficiencies in care

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Delivery system and payment transformation

Current State –		***Future State –***
Producer-Centered	PRIVATE SECTOR	People-Centered
Volume Driven		Outcomes Driven
Unsustainable		Sustainable
Fragmented Care	PUBLIC SECTOR	Coordinated Care
FFS Payment Systems		New Payment Systems (and many more)

- Value-based purchasing
- ACOs, Shared Savings
- Episode-based payments
- Medical Homes and care mgmt
- Data Transparency

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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

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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
  - Vascular Line Infections
- Increasing value-based payment and accountable care models
- Expanding coverage with insurance marketplaces (ACA)

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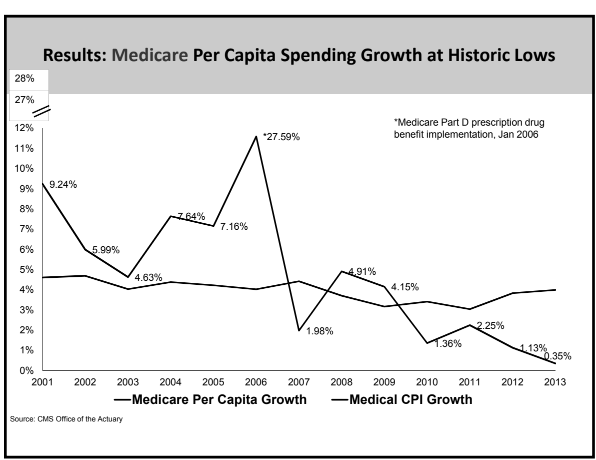
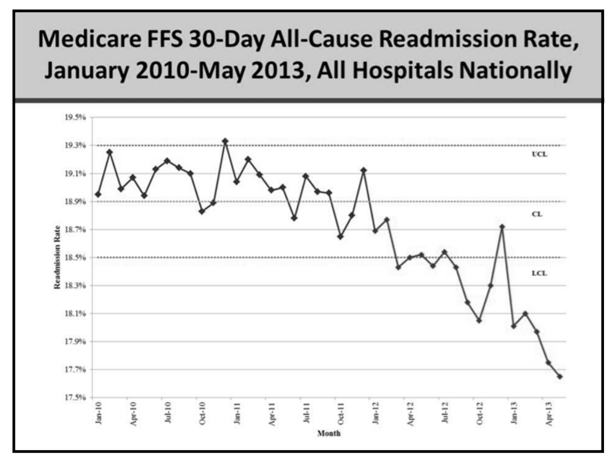
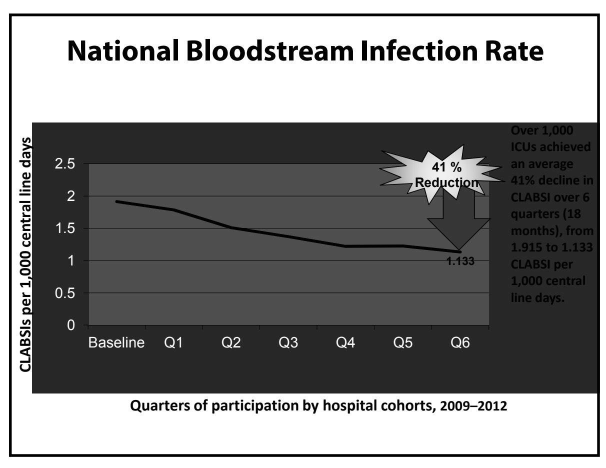
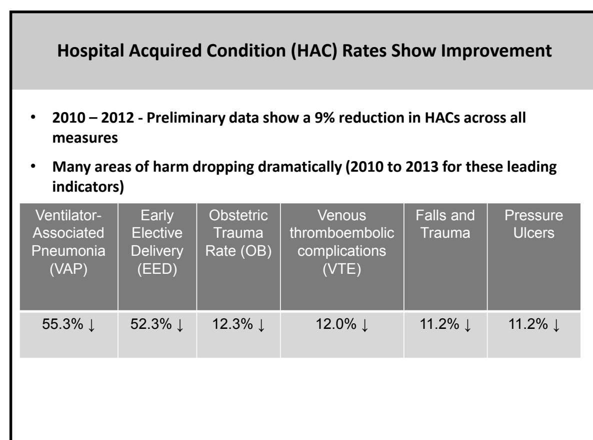




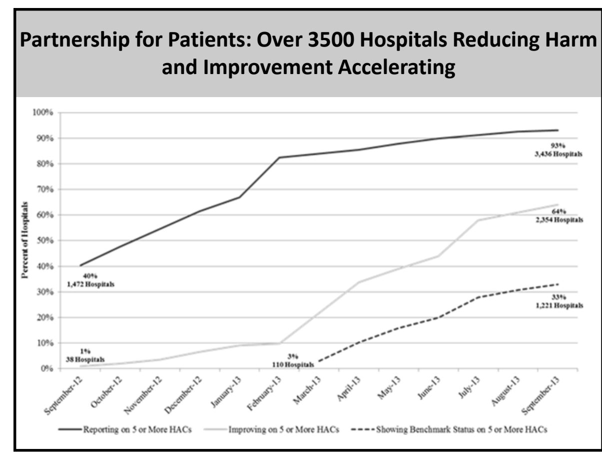


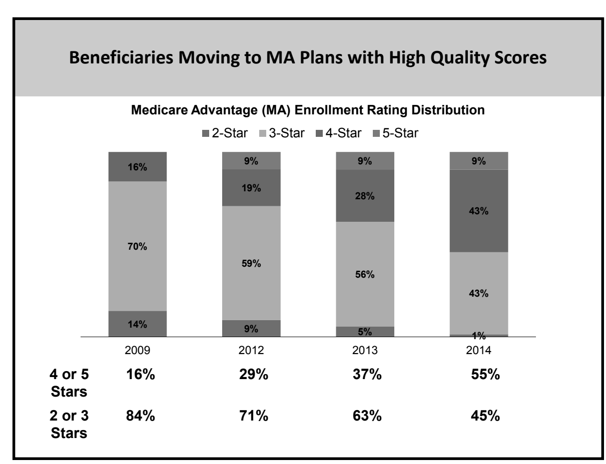


Hospital Acquired Condition (HAC) Rates Show Improvement

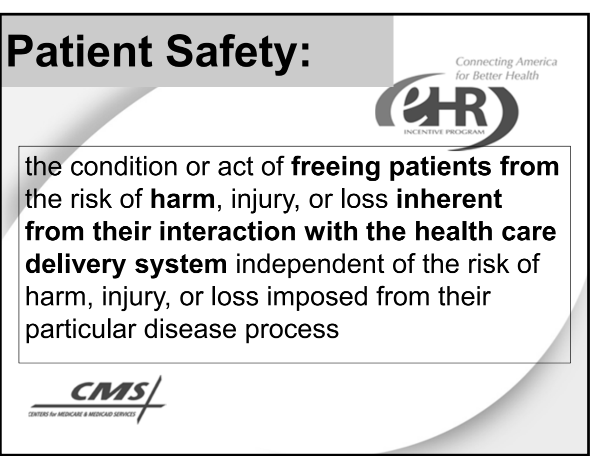
- 2010 – 2012 - Preliminary data show a 9% reduction in HACs across all measures
- Many areas of harm dropping dramatically (2010 to 2013 for these leading indicators)

Ventilator-Associated Pneumonia (VAP)	Early Elective Delivery (EED)	Obstetric Trauma Rate (OB)	Venous thromboembolic complications (VTE)	Falls and Trauma	Pressure Ulcers
55.3% ↓	52.3% ↓	12.3% ↓	12.0% ↓	11.2% ↓	11.2% ↓





	2009	2012	2013	2014
4 or 5 Stars	16%	29%	37%	55%
2 or 3 Stars	84%	71%	63%	45%



Making the Case for Safety

- **Medical harm is the fourth leading cause of death in the U.S. Each year, 100,000 Americans die from preventable medical errors in hospitals– more than auto accidents, AIDS, and breast cancer combined.**
- On any given day, 1 out of every 20 patients in American hospitals is affected by a hospital-acquired infection.
- Among chronically ill adults, 22 percent report a "serious error" in their care.
- About 1,800 people living in nursing homes die each year from falls.
- Nearly 1 in 5 Medicare hospital patients readmitted within 30 days

MEDICAL ERRORS EVERY DAY

• Number of patients who have an operation on the wrong side	5 +
• Number of hospitalized patients who have something go wrong	40,000 +
• Number of people who have a complication from a medication	10,000

Healthcare Associated Infections (HAIs)

- What are they?
  - **Bloodstream infections, urinary tract infections, pneumonia, surgical site infections**
- The Problem
  - **1.7 million HAIs** in hospitals—unknown burden in other healthcare settings
  - **99,000 deaths** per year
  - **$26-33 billion** in added healthcare costs
- HAI Prevention
  - Implementing what we know for prevention can lead to up to a **70%** or more reduction in HAIs

ACA Provisions: Quality and Efficiency of Care

- Emphasize Prevention and Promote Primary Care
- Expand quality measurement including outcomes and efficiency
- Expand settings covered by quality reporting and public reporting programs
- **Value Based Purchasing**
  - **Base payment in part on quality**
    - **Hospital Value Based Purchasing**
    - Physician Value Modifier
- **Address specific quality issues**
  - **Hospital readmissions**
  - **Health disparities**
  - **Health Care Associated Conditions**
- Introduce New Care Models
  - ACO – program
  - Multiple Demonstrations and pilots (CMMI)
    - Bundled payment
    - Medical Home
  - **Pays for care that rewards better value, patient outcomes, and innovations, instead of just volume of services**

P4P Ten Areas of Focus

Hospital Engagement Networks are required to address ten areas of focus and Adverse Drug Events:

- **Catheter-Associated Urinary Tract Infections**
- **Central Line Associated Blood Stream Infections**
- **Injuries from Falls and Immobility**
- **Obstetrical Adverse Events**
- **Pressure Ulcers**
- **Surgical Site Infections**
- **Venous Thromboembolism**
- **Ventilator-Associated Pneumonia**
- **Preventable readmissions**

Hospital Inpatient Quality Reporting (IQR) Program

- Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
- Initial reduction of 0.4 % of market basket update for FY 2005. Deficit Reduction Act extended and changed reduction to 2.0% for FY 2007 onward. In FY2015 this increases to one-quarter of APU.
- Measures displayed on the Hospital Compare website
- Part of Medicare QIO contract work
- 99% of hospitals successfully participate

Hospital VBP Program

- Required by the Affordable Care Act
- Built on the Hospital Inpatient Quality Reporting measure reporting infrastructure (IQR)
- Next step in promoting higher quality care for Medicare beneficiaries
- Rewards better value, patient outcomes, and innovations, instead of just volume of services
- Funded by a 1.25% withhold from participating hospitals' Diagnosis-Related Group payments (FY2014)(-->2.0% by FY2017)

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Hospital VBP in FY 2016

Hospital VBP Program Domain Weighing

Domain	FY 2013	FY 2014	FY 2015	FY 2016
Clinical Process of Care	70%	45%	20%	10%
Patient Experience of Care	30%	30%	30%	25%
Outcome	N/A	25%	30%	40%
Efficiency	N/A	N/A	20%	25%

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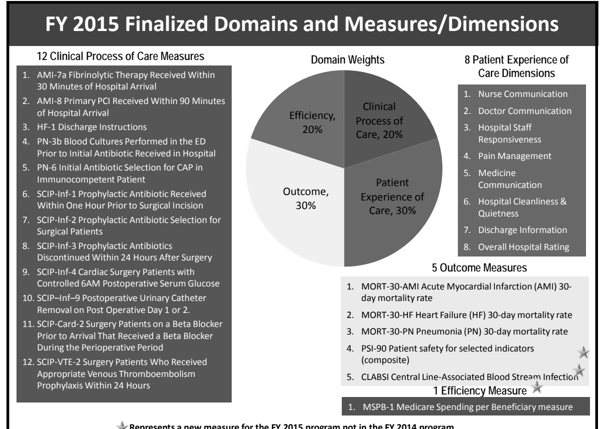
FY 2015 Finalized Domains and Measures/Dimensions



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Domain 1: AHRQ Patient Safety Indicators (FY 2015 onward)

PSI-90 (Composite of 8 Measures)
Pressure ulcer rate (PSI 3);
Iatrogenic Pneumothorax rate (PSI 6);
Central venous catheter-related blood stream infection rate (PSI 7);
Postoperative hip fracture rate (PSI 8);
Postoperative pulmonary embolism (PE) or deep vein thrombosis rate (DVT)(PSI 12);
Postoperative sepsis rate (PSI 13);
Wound dehiscence rate (PSI 14); and
Accidental puncture and laceration rate (PSI 15)

For FY 2015, CMS will use the 24-month period from July 1, 2011 through June 30, 2013 as the applicable time period for the AHRQ measures.

Domain 2: CDC HAI Measures

Finalized Measures
Central Line-associated Blood Stream Infection (CLABSI) (FY 2015 onward)
Catheter-associated Urinary Tract Infection (CAUTI) (FY 2015 onward)
Surgical Site Infection (SSI):
SSI Following Colon Surgery (FY 2016 onward)
SSI Following Abdominal Hysterectomy (FY 2016 onward)
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia (FY 2017 onward)
Clostridium difficile (FY 2017 onward)

For FY 2015, CMS will use calendar years 2012 and 2013 for the CDC measures in the HAC Reduction Program.

Hospital-Acquired Condition (HAC) Reduction Program

- Public reporting of each hospital's HAC rates in Hospital Compare by 2015
- Adjustment to payments for HAC, FY 2015
  - Section 3008 of the Affordable Care Act
  - 1% decrease for high rates (risk adjusted)
  - top quartile compared to national average
- Methodology in FY2014 IPPS Final Rule
  - (**CMS-1599-F ,** Federal Register 08/19/2013)

Hospital Readmissions Reduction Program

Section 3025 of the 2010 Affordable Care Act (Public Law 111-148) requires the Secretary of Health and Human Services to establish a Hospital Readmissions Reduction Program whereby the Secretary would reduce Inpatient Prospective Payment System (IPPS) payments to hospitals for excess readmissions beginning on or after October 1, 2012 (Fiscal Year [FY] 2013).

The ACA required the Secretary to adopt the three National Quality Forum (NQF)-endorsed 30-day Risk-Standardized Readmission measures beginning October 2012 for:

- acute myocardial infarction (AMI),
- heart failure (HF),
- pneumonia (PN)

Payment Adjustment

- **Based on readmissions for AMI, HF and Pneumonia**
- **In FY2015, 2 conditions will be added (COPD, Total Hip/Knee Arthroplasty)**
- **Applies to hospital's base DRG payments for Medicare discharges starting October 1, 2012**
  - **FY 2013 no more than 1% reduction**
  - **FY 2014 no more than 2% reduction**
  - **FY 2015 no more than 3% reduction**
  - **Calculation methodology finalized in rule-making**

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Why are people readmitted?

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Provider-Patient interface

Unmanaged condition worsening
Use of suboptimal medication regimens
Return to an emergency department

Unreliable system support

Lack of standard and known processes
Unreliable information transfer
Unsupported patient activation during transfers

No Community infrastructure for achieving common goals

Transitional Care Coordination Handoffs/Handovers

Care transitions = **handovers** in care.

- Significant patient safety issue
- Information often acquired and transmitted without determining comprehension
- Should imply transfer of patient information as well as professional responsibility to both deliver the information and assure it is understood.

Key Messages About Value Based Purchasing

A major, overarching theme in the Affordable Care Act is one of measurement, transparency, and altering payment to reinforce, not simply volume of services, but the quality of those services.

Instead of payment that asks "How much did you do?" the Affordable Care Act clearly moves us toward payment that asks, "How well did you do?" and more importantly, "How well did the patient do?"

-- Don Berwick, April 11, 2011

The CMS Innovation Center

Identify, Test, Evaluate, Scale

The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles.

- *The Affordable Care Act*

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CMS Innovations Portfolio: Testing New Models to Improve Quality

Accountable Care Organizations (ACOs)
- Medicare Shared Savings Program (Center for Medicare)
- Pioneer ACO Model
- Advance Payment ACO Model
- Comprehensive ERSD Care Initiative

Primary Care Transformation
- Comprehensive Primary Care Initiative (CPC)
- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home Demonstration
- Graduate Nurse Education Demonstration

Bundled Payment for Care Improvement
- Model 1: Retrospective Acute Care
- Model 2: Retrospective Acute Care Episode & Post Acute
- Model 3: Retrospective Post Acute Care
- Model 4: Prospective Acute Care

Capacity to Spread Innovation
- Partnership for Patients
- Community-Based Care Transitions
- Million Hearts

Health Care Innovation Awards

State Innovation Models Initiative

Initiatives Focused on the Medicaid Population
- Medicaid Emergency Psychiatric Demonstration
- Medicaid Incentives for Prevention of Chronic Diseases
- Strong Start Initiative

Medicare-Medicaid Enrollees
- Financial Alignment Initiative
- Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents

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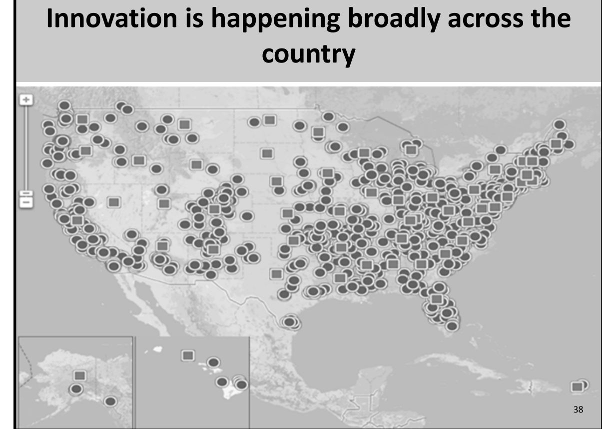
Innovation is happening broadly across the country



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Accountable Care Organizations

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Accountable Care Organizations (ACOs) are a new approach to health care delivery aimed at providing better care, improving population health, and lowering growth in expenditures by:

- Promoting accountability for the care of Medicare Fee-For-Service beneficiaries
- Requiring coordination of care for services provided under Medicare Parts A and B
- Encouraging investment in infrastructure and redesigned care processes

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Different Paths Toward ACOs

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- Many organizations are at different stages in their ability to move toward participating in Medicare Accountable Care Organization initiatives.
- We have created several different programs ,or models of participation to encourage organizations across the spectrum of readiness to get started.

ACO Initiatives at CMS:

- Medicare Shared Savings Program
- Advance Payment Initiative
- Pioneer ACO Model
- ACO Accelerated Development Learning Sessions

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Accountable Care Organization Goals

- **Improve the safety and quality of patient care while lowering costs**
- **Promote shared accountability across providers**
- **Increase coordination of care**
- **Invest in infrastructure and redesigned care services**
- **Achieve better health and better care at lower costs**
- **Medicaid and private payers increasingly launching both Accountable Care Organizations and "alternative" contracts**

Accountable Care Organizations (ACOs) Preliminary Results/Success

- An ACO promotes coordinated care and population management
- **Over 350 ACOs serving over 5 million Medicare beneficiaries**
- **Over $380 million of savings combined year 1 of MSSP and Pioneers**
- Pioneer model with early promising results
  - Generated shared savings and low cost growth (0.3%)
  - Outperformed published benchmarks on 15/15 clinical quality measures and 4/4 patient experience measures

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More information:

- **http://www.cms.gov**
- **www.hospitalcompare.hhs.gov**
- **http://www.cms.gov/HospitalAcqCond/**
- **http://www.cms.gov/Hospital-Value-Based-Purchasing/**
- http://www.innovations.cms.gov/
- www.healthcare.gov/center/programs/partnership
- www.healthcare.gov/partnershipforpatients
- Questions?

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