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CENTER FOR MEDICARE & MEDICAID INNOVATION

Value Based Purchasing, Innovation and Health System Transformation

Health Watch USA; Healthcare Transparency & Patient Safety Conference; Lexington, KY.

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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)

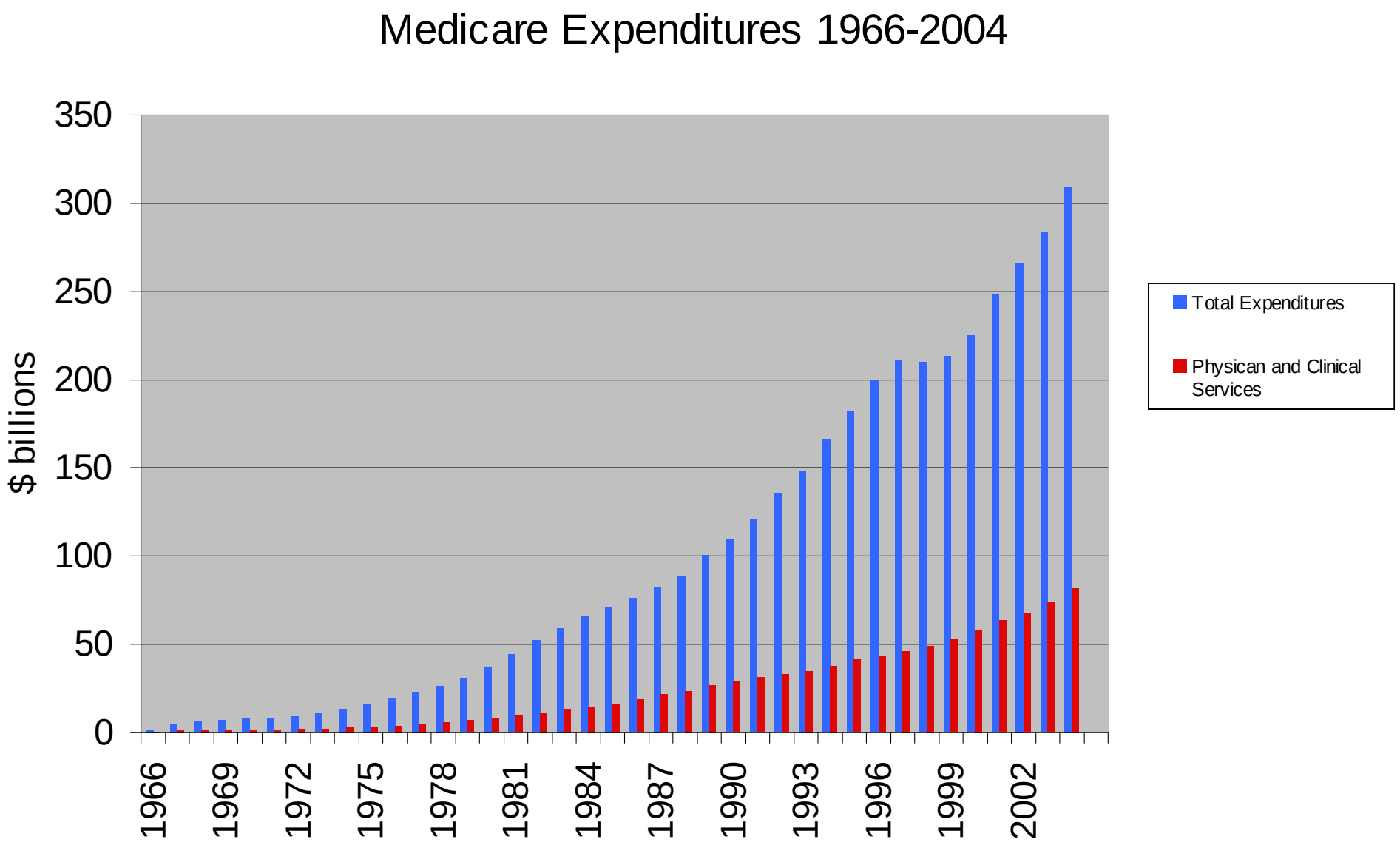
Poor information and data sharing and transfer?

Patient safety and quality ? (Compare to aviation industry?)

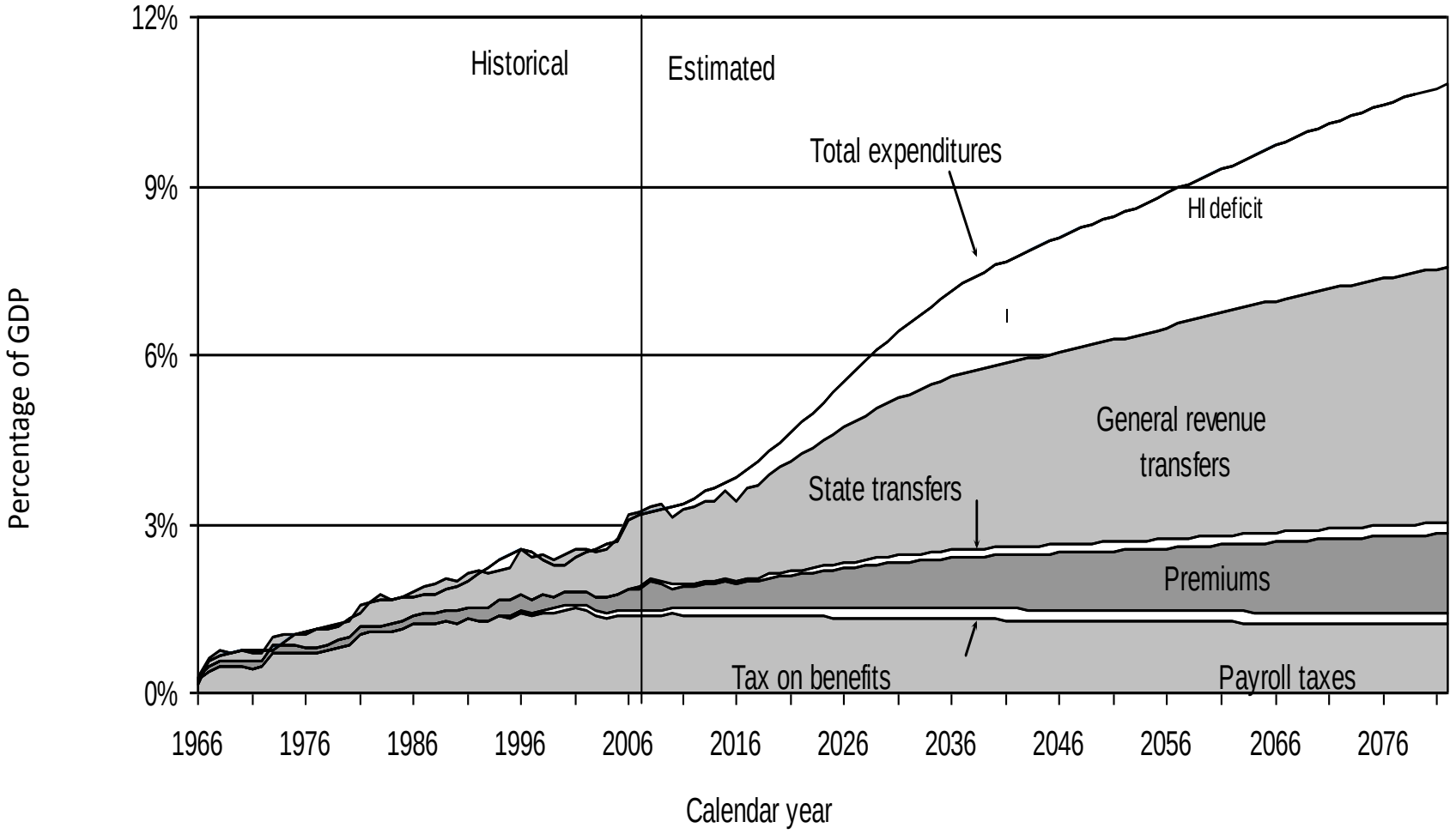
A payment system that rewards providing services rather than outcomes?

Coordinated, accountable or Uncoordinated, Unaccountable care?

Increasing Expenditures

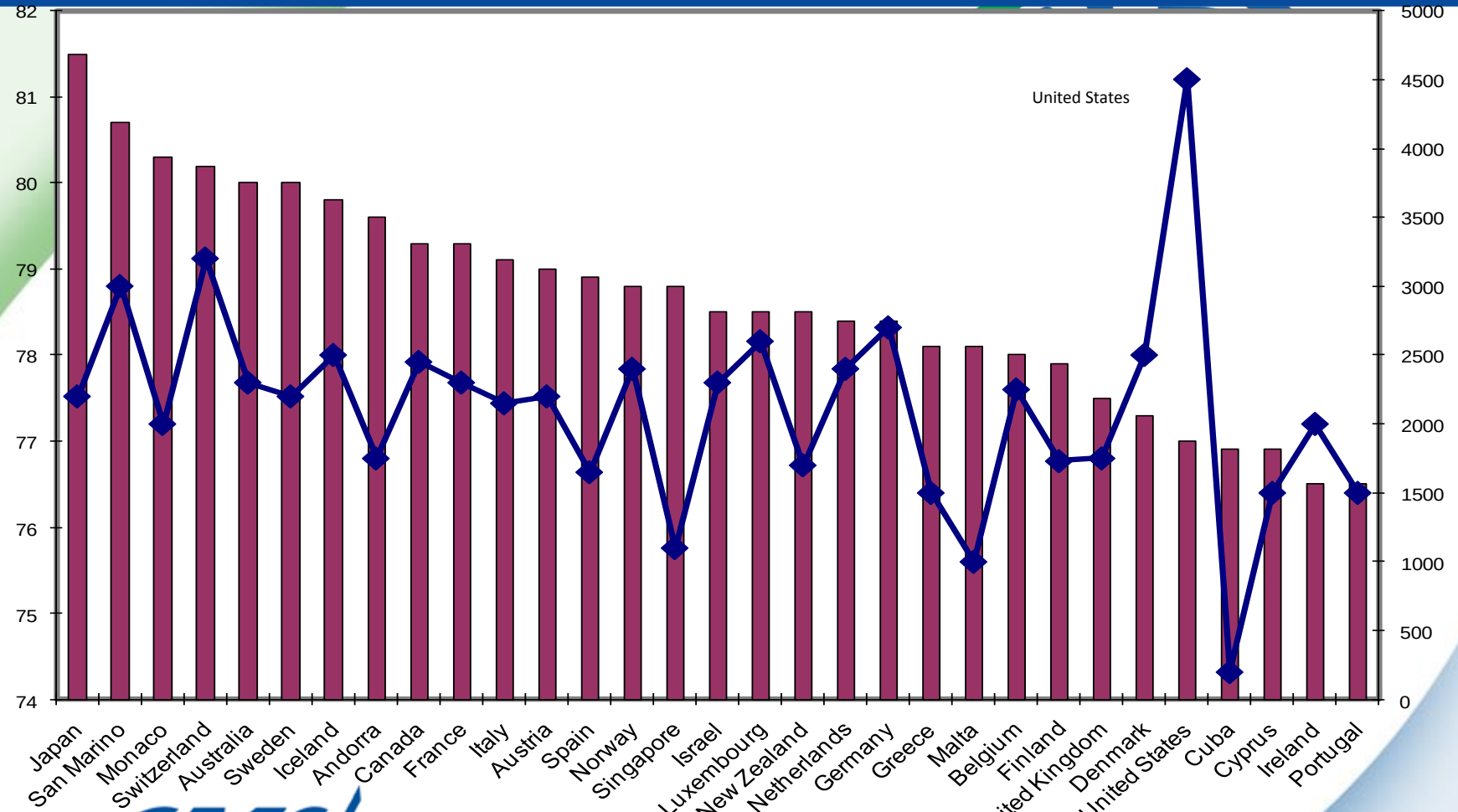


Medicare Will Place An Unprecedented Strain on the Federal Budget in the Future if Spending increases not slowed



Source: 2008 Trustees Report

Higher Per Capita Spending in the U.S. does not Translate into Longer Life Expectancy



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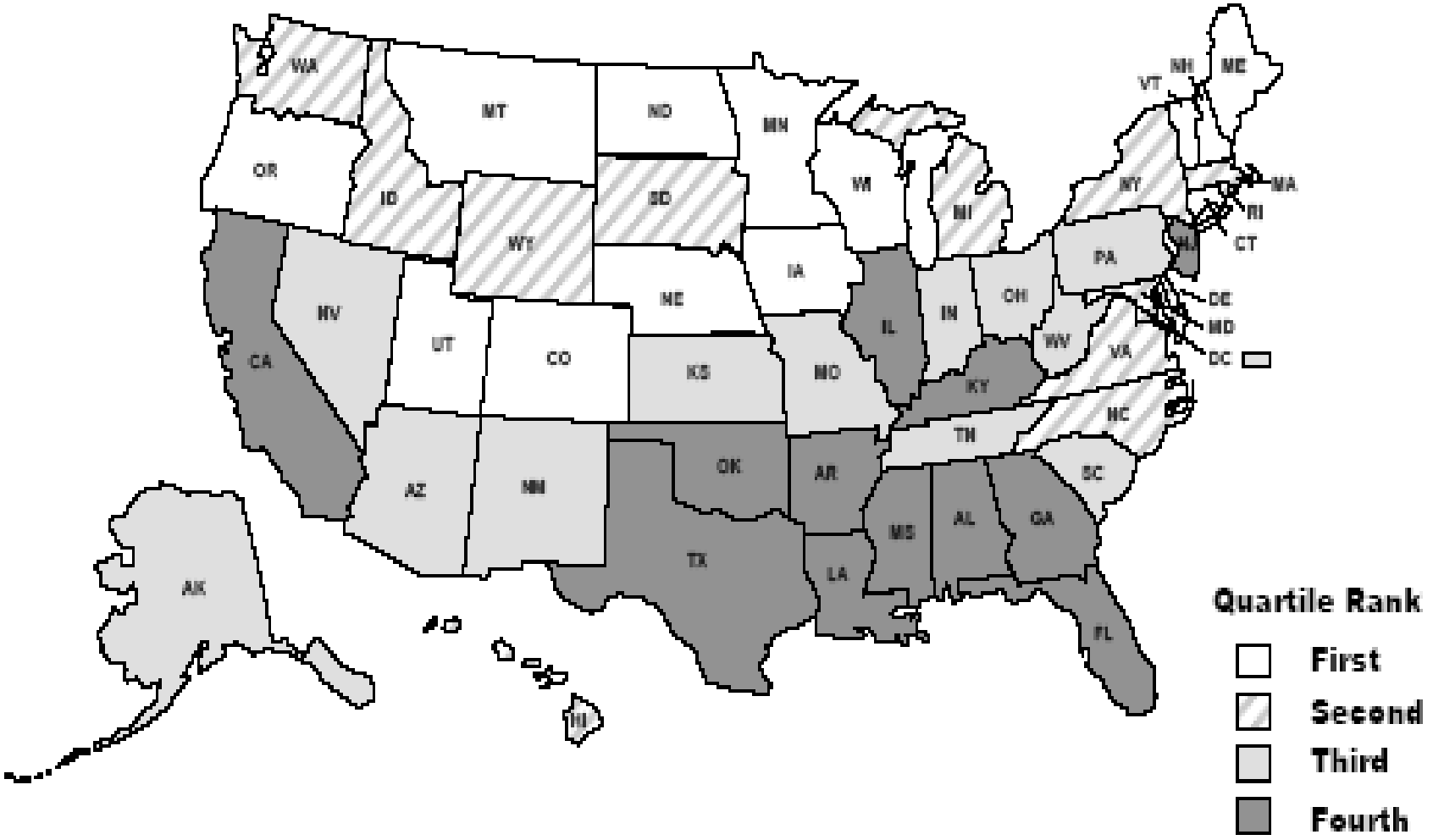
Life Expectancy – Per Capita Spending

Source: 2006 CIA FACT BOOK

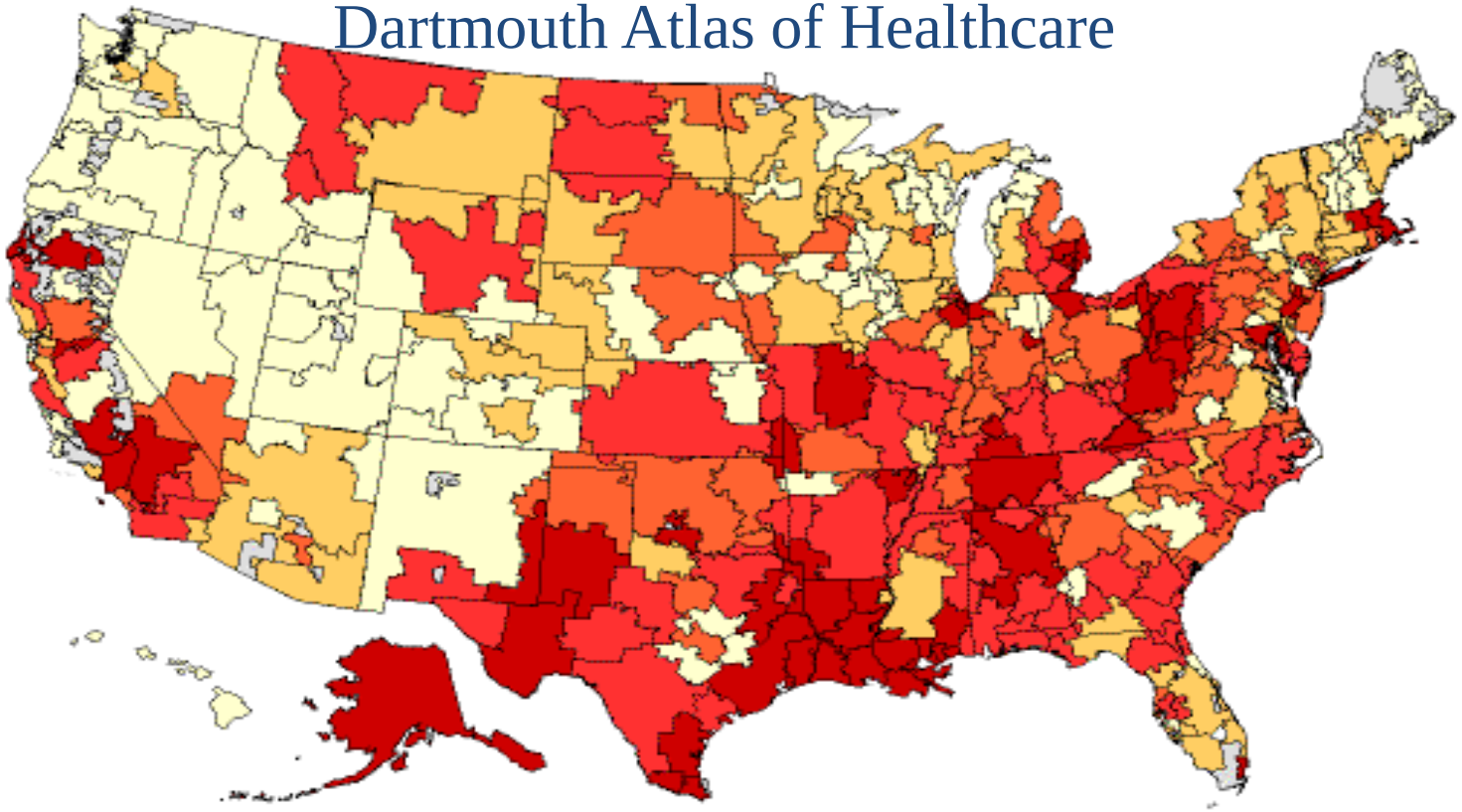
Performance on Medicare Quality Indicators, 2000–2001



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.

A Variation Problem

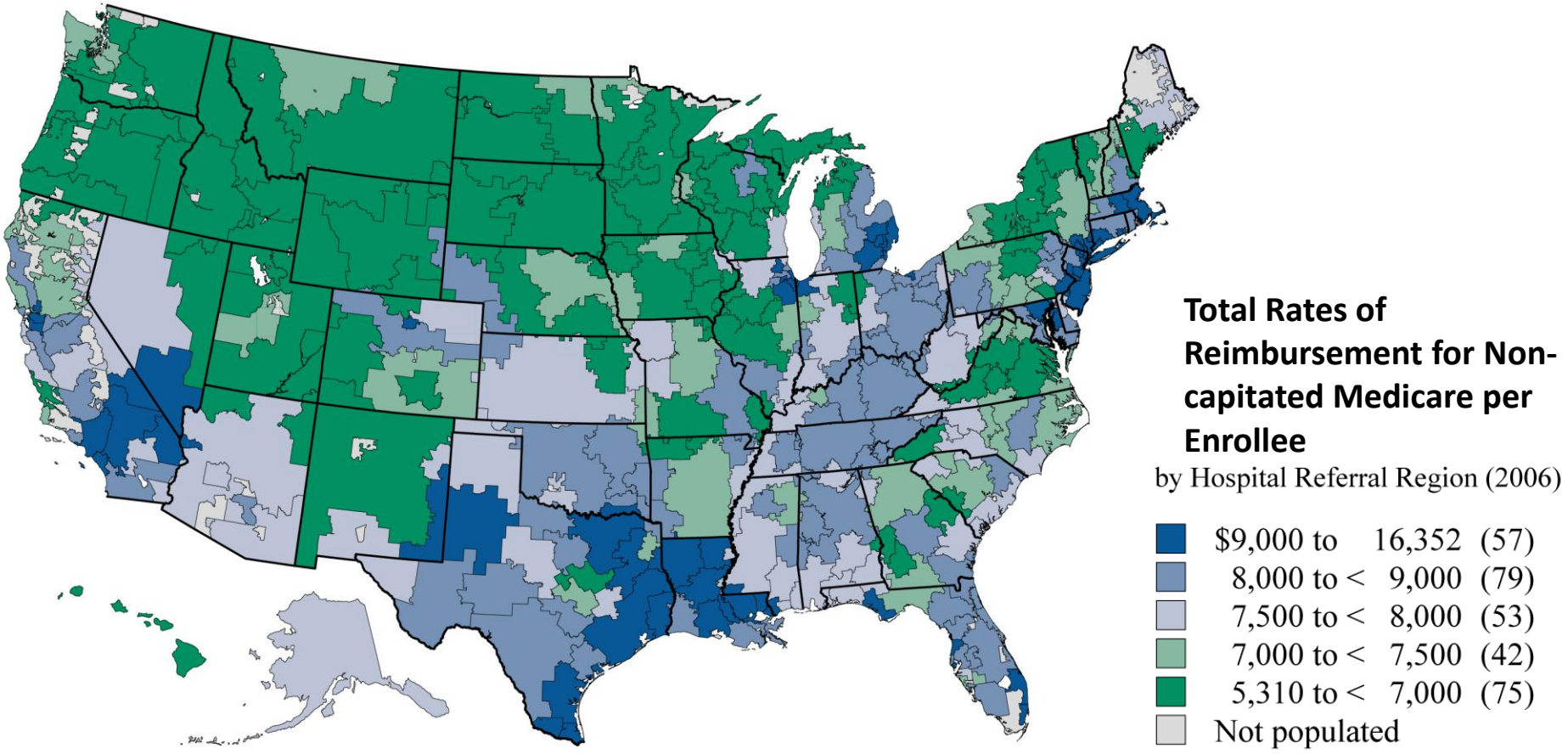
Dartmouth Atlas of Healthcare



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

Challenge 2: Unwarranted Variation in Costs (and Quality)



Source: E. Fisher, D. Goodman, J. Skinner, and K. Bronner, *Health Care Spending, Quality, and Outcomes*, (Hanover: The Dartmouth Institute for Health Policy and Clinical Practice, Feb. 2009).

Perverse Incentives

Senator Charles E. Grassley
(R) Iowa
Senate Finance Committee

"Today, Medicare pays the same amount regardless of quality of care.

Some people would argue that in fact, the current Medicare payment system rewards poor quality," Grassley said.

This situation just doesn't make sense to me, nor should it to beneficiaries."

CQ HEALTHBEAT, JUNE 30, 2005

What Does VBP Mean to CMS?

- Transforming Medicare from a passive payer to an active purchaser of higher quality, more efficient health care
- Tools and initiatives for promoting better quality, while avoiding unnecessary costs
  - Tools: measurement, payment incentives, public reporting, conditions of participation, coverage policy, QIO program
  - Initiatives: pay for reporting, pay for performance, gain sharing, competitive bidding, bundled payment, coverage decisions, direct provider support (i.e. E.HR incentive etc)

Delivery system and payment transformation

Current State –

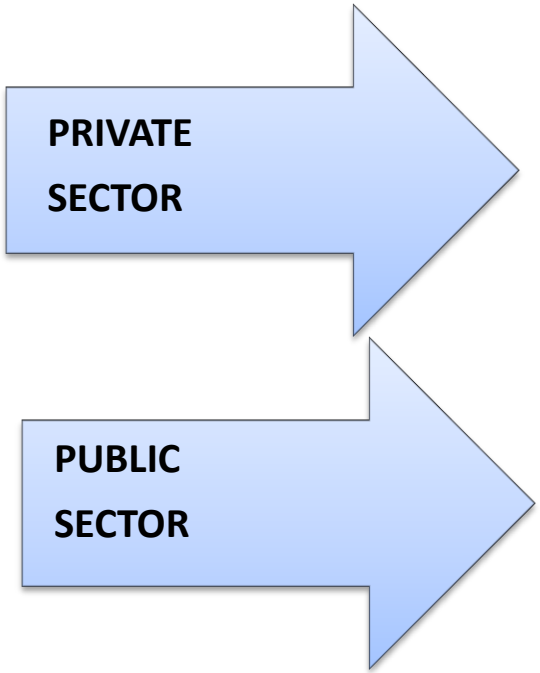
Producer-Centered

Volume Driven

Unsustainable

Fragmented Care

FFS Payment Systems



Future State –

People-Centered

Outcomes Driven

Sustainable

Coordinated Care

New Payment Systems (and many more)

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

Better. **Smarter.** ***Healthier.***

We will continue to work across sectors and across the aisle for the goals we share: ***better care, smarter spending, and healthier people***.

The Six Goals of the National Quality Strategy

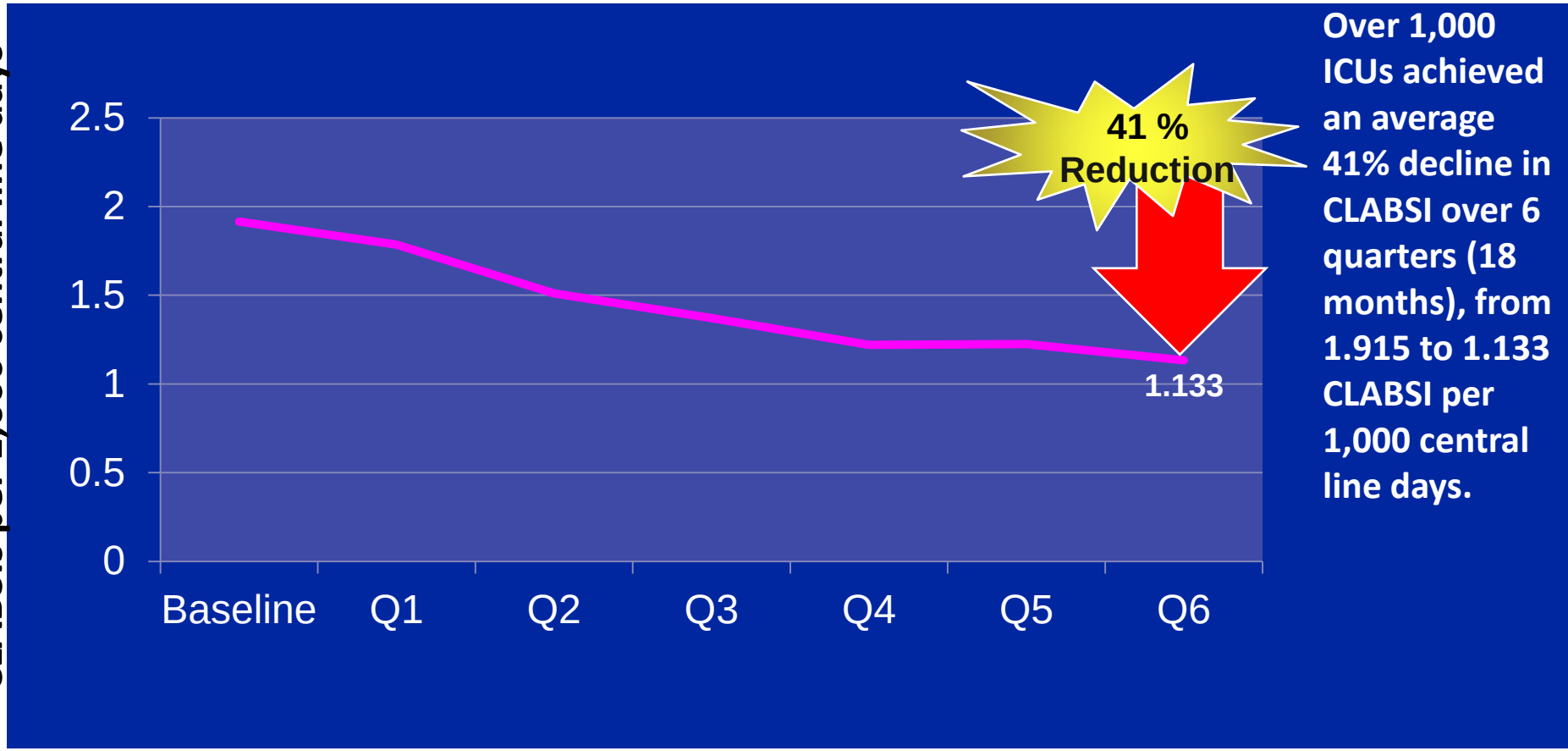
1. Make care safer by reducing harm caused in the delivery of care
2. Strengthen person and family engagement as partners in their care
3. Promote effective communication and coordination of care
4. Promote effective prevention and treatment of chronic disease
5. Work with communities to promote healthy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

Hospital Acquired Condition (HAC) Rates Show Improvement

- 2010 to 2013: Data show a 17% reduction in HACs across all measures
- Estimated 50,000 lives saved, 1.3M injuries, infections, and adverse events avoided, and almost $12B billion in cost savings
- Many areas of harm dropping dramatically (2010 to 2013 for these leading indicators)

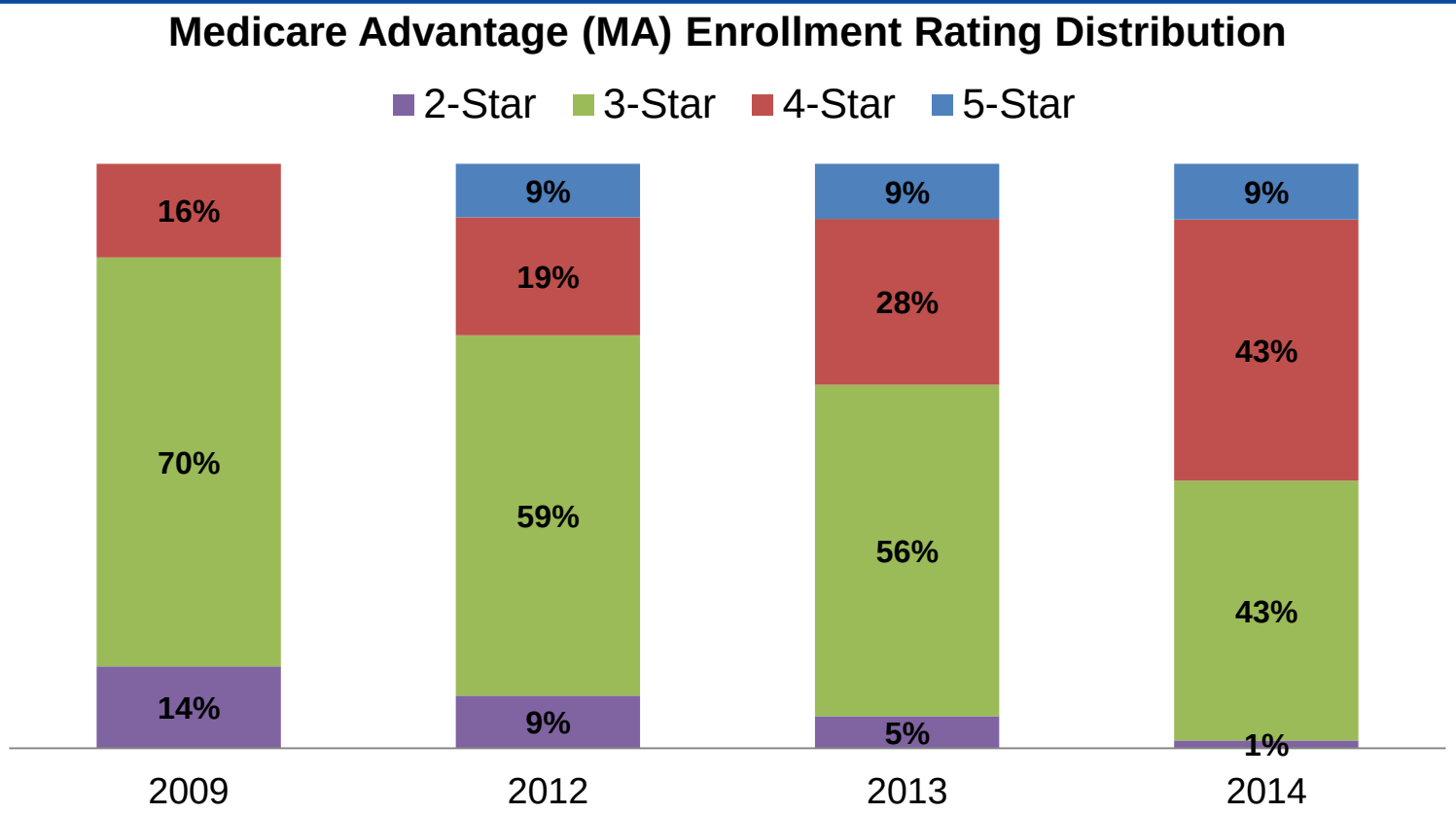
Hospital Acquired Condition	Ventilator-Associated Pneumonia (VAP)	Early Elective Delivery (EED)	Obstetric Trauma Rate (OB)	Venous thromboembolic complications (VTE)	Falls and Trauma	Pressure Ulcers
Percent Decrease	55.3%	52.3%	12.3%	12.0%	11.2%	11.2%

National Bloodstream Infection Rate



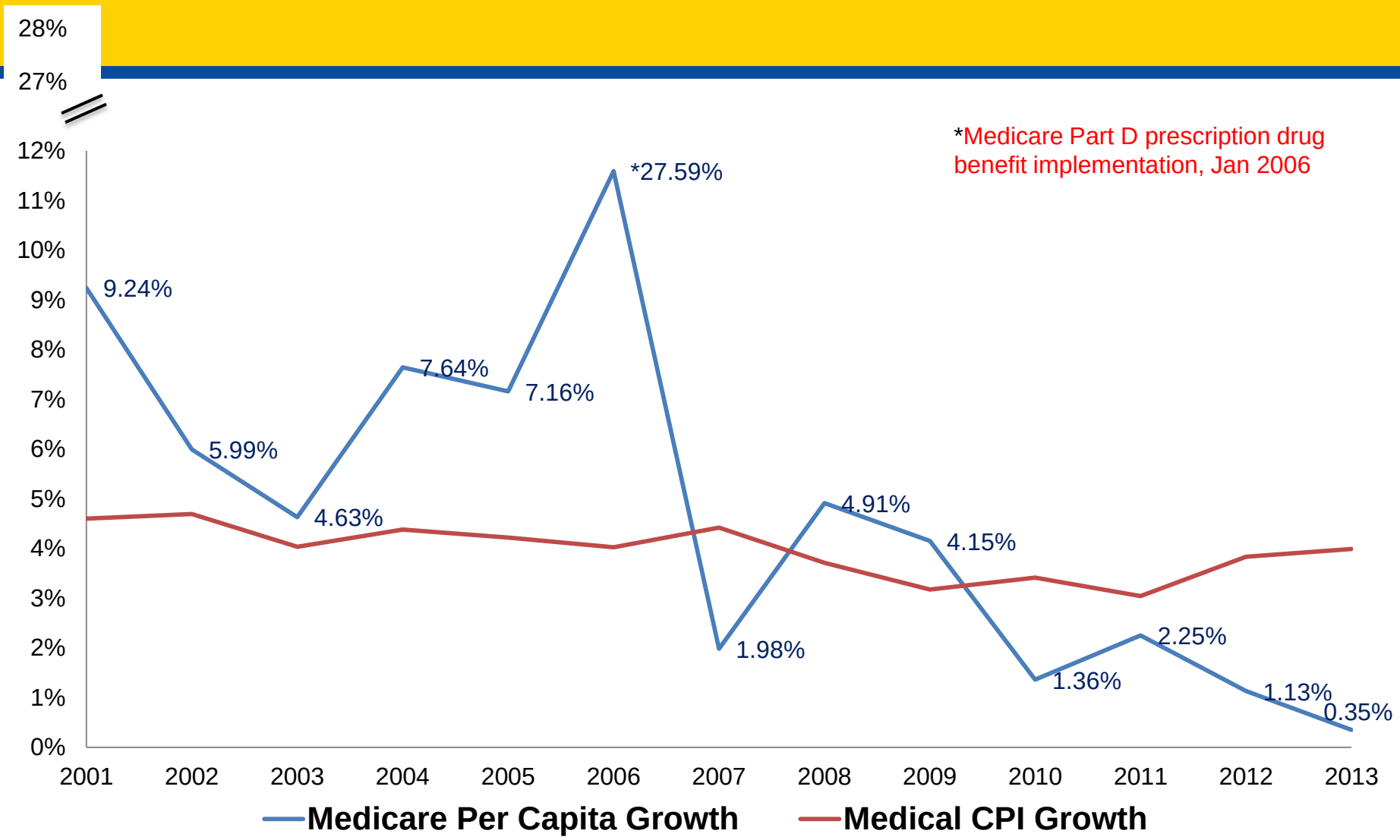
Quarters of participation by hospital cohorts, 2009–2012

Beneficiaries Moving to MA Plans with High Quality Scores



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

Results: Medicare Per Capita Spending Growth at Historic Lows



Source: CMS Office of the Actuary

Medicare FFS 30-Day All-Cause Readmission Rate, January 2010-May 2013 (all hospitals)

What's the re-admission problem?

- **High re-admission rates could indicate breakdowns in care delivery systems.**
  - Payment systems incentivized fragmentation.
  - More complicated cases = more "hands in the pot."
  - Expectation of patients to self-manage is great.
- **Medicare patients said they were more dissatisfied with their preparation for discharge than any other patient satisfaction measure.**
  - Only 80% received discharge information.
  - Only 59% received medication information.

Why are patients readmitted?

Provider-Patient interface

Unmanaged condition worsening
Use of suboptimal medication regimens
Return to an emergency department/lack of primary care

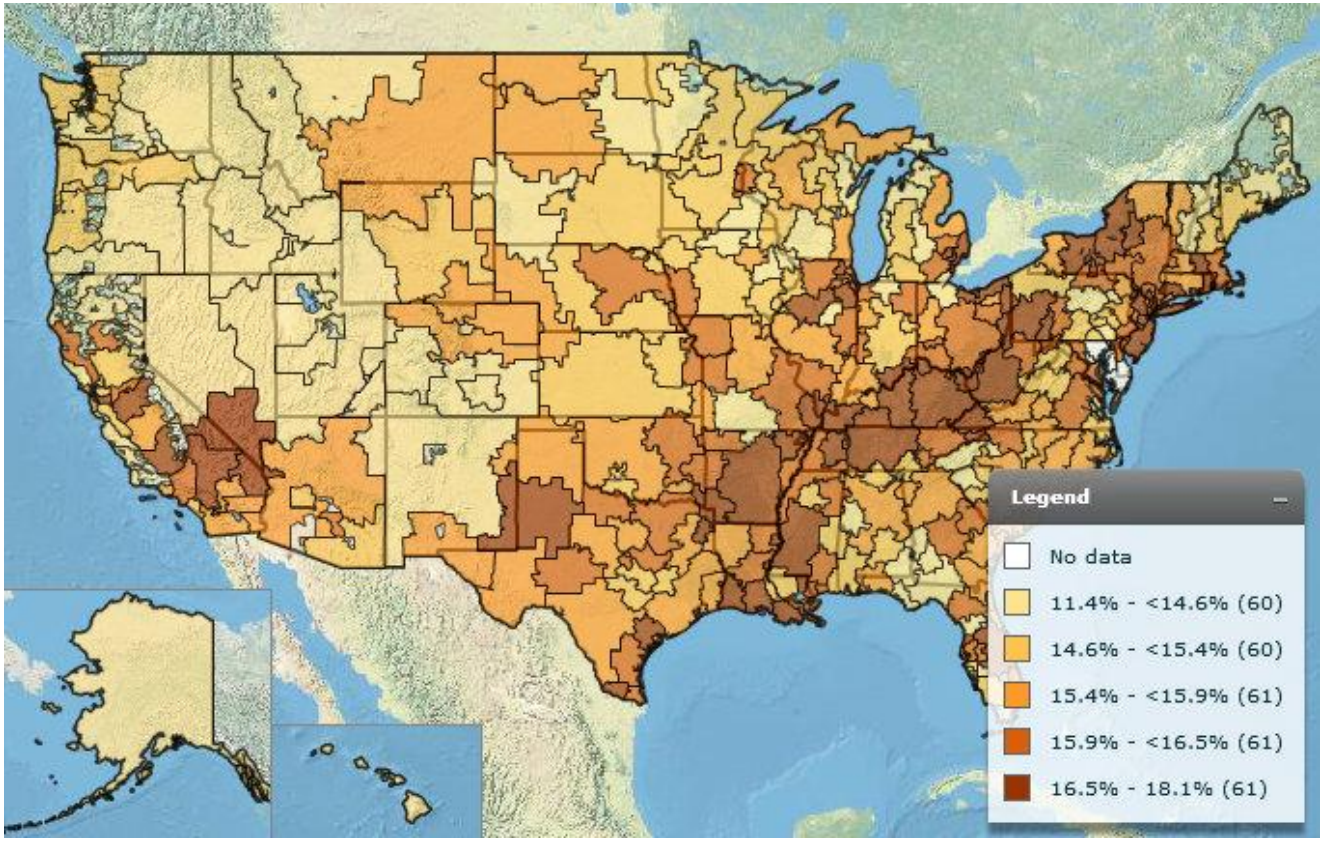
Unreliable system support

Lack of standard and known processes between providers
Unreliable information transfer
Unsupported patient & family engagement during transfers

No Community infrastructure for achieving common goals

30-Day Readmission Rates, 2010

(Fee-for-service Medicare Beneficiaries)



Source: http://www.dartmouthatlas.org/data/map.aspx?ind=192&loct=3&ch=201

What's all of this costing us?

- Re-admissions cost Medicare $17.4 billion in 2004.[1]
  - 30-day re-admission rate: 19.6%.
  - Of them, 50.2% didn't see a doctor before re-hospitalization.
  - Re-hospitalized patients stayed 0.6 days longer on average.
- We could have saved $12 billion if we prevented 30-day "potentially preventable" readmissions in 2005.[2]
  - "Potentially preventable" per MedPAC estimates.
  - 13.3% of all hospitalizations or 3 out of 4 ***re-admissions***!
- First NEJM article published November 1984.[3]
  - Rate was 22% after 60 days.
  - Re-admissions comprised 25¢ of every inpatient claim dollar.

[1]Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. N Engl J Med 2009;360:1418-1428.

[2]Anderson GF, Steinberg EP. Hospital readmissions in the Medicare population. N Engl J Med 1984;311:1349-1353.

[3]Medicare Payment Advisory Commission (MedPAC). Report to the Congress: Promoting greater efficiency in Medicare. Washington, DC: June 2007.

What's CMS doing about it?

- **Hospital Compare**
  - 30-day re-admission rates for heart attack, pneumonia, and heart failure.
  - Complements other outcomes information already on the site.
  - Is your local hospital "better than" "no different than" or "worse than" the U.S. national rate for re-admissions?

But wait, there's more. . . .

What's CMS doing about it? (Part 2)

- **Patient/Caregiver Activation**
  - Goal: Equip beneficiaries and their families to be their own advocates for well-coordinated care.

✓Ask Medicare Caregiving Initiative

✓"Planning for Your Discharge" (CMS-11376)

✓**Care Transitions Program . . .**

But wait, there's more. . . .

Hospital Readmissions Reduction Program

- Required by Section 3025 of the 2010 Affordable Care Act
- Requires Secretary to establish a Hospital Readmissions Reduction Program which
  - Reduces Inpatient Prospective Payment System (IPPS) payments to hospitals for excess readmissions
  - For discharges on or after October 1, 2012 (Fiscal Year [FY] 2013)
- Required initial adoption of the National Quality Forum-endorsed 30-day Risk-Standardized Readmission measures:
  - acute myocardial infarction (AMI),
  - heart failure (HF),
  - pneumonia

Payment Adjustment

- FY 2014, Based on readmissions for AMI, HF and Pneumonia
  - Algorithm introduced to account for planned readmissions
- In FY2015, adding 3 conditions
  - Acute exacerbation of chronic obstructive pulmonary disease
  - Elective total hip arthroplasty
  - Total knee arthroplasty
- Applies to hospital's base DRG payments for Medicare discharges started October 1, 2012
  - FY 2014 no more than 2% reduction
  - FY 2015 no more than 3% reduction
  - Calculation methodology finalized in rule-making

Aims for Readmission Measures

Promote broadest possible efforts to lower readmission rates:

- **Assume all patients are at risk of readmission and their risk can be lowered**
- **Opportunity to focus efforts on patients most at risk of readmission**
- **CMS is targeting funding support to hospitals and communities with greatest need for improvement**
- **Goal is not zero readmissions, but to lower readmission rates overall**

Risk-Adjusted Readmission Rate

- **Relative measure of hospital performance**
- **Allows comparison of hospital's performance given its case-mix to average hospital's performance with same case-mix**
- **"observed" to "expected" ratio**

Public Reporting

- Measures reported yearly based on 3 years of data
- Reported on Hospital Compare as:
  - Better than the U.S. national rate;
  - Worse than the U.S. national rate;
  - No different than the U.S. national rate; or
  - Difference is uncertain
- Will not classify performance for hospitals with <25 cases in 3 year period

Hospital Compare

- **Hospital Compare**
- **www.hospitalcompare.hhs.gov**
- **Select the Patient Safety Measures tab during your hospital search to get information on Healthcare Associated Infections from the Centers for Disease Control and Prevention's National Healthcare Safety Network.**

Hospital Compare

- **EMORY UNIVERSITY HOSPITAL**
  ATLANTA,GA 30322
  Hospital Type: Acute Care Hospitals
  Healthcare Associated Infections (HAIs)
- **Measure Description EMORY UNIVERSITY HOSPITAL GEORGIA Central Line Associated Blood Stream Infections (CLABSI) 0.28 Standardized infection Ratio Better than the U.S. National Benchmark 0.55**

- **Central Line Associated Blood Stream Infections (CLABSI)**
  The Central Line Associated Blood Stream Infections (CLABSI) Score is reported using a Standardized Infection Ratio (SIR). This calculation compares the number of central line infections in a hospital's intensive care unit to a national benchmark based on data reported to NHSN from 2006 – 2008. The result is adjusted based on certain factors such as the type and size of a hospital or ICU.
-

Hospital Compare: 3 Houston Hospitals

METHODIST HOSPITAL,THE
6565 FANNIN
HOUSTON, TX 77030
(713) 790-2221
Distance : 4.8 miles

Add METHODIST HOSPITAL,THE to My Favorites
Map and Directions for METHODIST HOSPITAL,THE - Opens in a new window

*HOUSTON VA MEDICAL CENTER *
2002 HOLCOMBE BLVD.
HOUSTON, TX 77030
(713) 794-7100
Distance : 5.4 miles
Add HOUSTON VA MEDICAL CENTER to My Favorites
Map and Directions for HOUSTON VA MEDICAL CENTER - Opens in a new window

UNIVERSITY GENERAL HOSPITAL
7501 FANNIN
HOUSTON, TX 77054
(713) 652-3800
Distance : 6.3 miles

Add UNIVERSITY GENERAL HOSPITAL to My Favorites
Map and Directions

Hospital Compare Readmission & Death Rates, AMI

	Methodist	Houston VAMC	University	
Rate of unplanned readmission for heart attack patients	No different than the National Rate	No different than the National Rate	Number of Cases Too Small footNote [1]	17.8%
Death rate for heart attack patients	No different than the National Rate	No different than the National Rate	Number of Cases Too Small footNote [1]	14.9%

Hospital Compare: Readmission & Death Rates CHF

	METHODIST	HOUSTON VAMC	UNIVERSITY	
Rate of unplanned readmission for heart failure patients	Better than the National Rate	Worse than the National Rate	No different than the National Rate	22.7%
Death rate for heart failure patients	Better than the National Rate	No different than the National Rate	No different than the National Rate	11.9%

Hospital Compare: CLABSI & CAUTI

	METHODIST	HOUSTON VAMC	UNIVERSITY
Central line-associated bloodstream infections (CLABSI)	Better than the U.S. National Benchmark	Not Available	No Different than U.S. National Benchmark footNote [8]
Catheter-associated urinary tract infections (CAUTI)	Worse than the U.S. National Benchmark	Not Available	No Different than U.S. National Benchmark footNote [8]

Value-Based Purchasing

- **Hospital:**
  - **Value-based purchasing, readmissions reduction program, healthcare acquired conditions, EHR Incentive Program and Inpatient Quality Reporting**
- **Physician/clinician**
  - **Physician value-based modifier, physician quality reporting system, EHR incentive program**
- **End stage renal disease bundle and quality incentive program**

Medicare Hospital Value Payments 2011-2017

Policy	2011	2012	2013	2014	2015	2016	2017
Hospital Inpatient Quality Reporting Program /a	-2.0%	-2.0%	-2.0%	-2.0%	-1.0%	-1.0%	-1.0%
Meaningful Use + Incentive Payments /b -	.5%	1.7%	1.7%	1.3%	1.4% -1.0%	-2.0%	-3.0%
Hospital Acquired Conditions (ACA) /d					-1.0%	-1.0%	-1.0%
Readmissions /e			-1.0%	-2.0%	-3.0%	-3.0%	-3.0%
Hospital Value-Based + Purchasing /f -			1.0% - 1.0%	1.25% - 1.25%	1.5% - 1.5%	1.75% - 1.75%	2.0% - 2.0%

New Goals and Timeline for Moving Medicare from Rewarding Volume to Value ***

January 2015 Announcement

- HHS Secretary Sylvia M. Burwell announced **measurable goals and a timeline** to move the Medicare program, and the health care system at large, toward **paying providers based on the quality, rather than the quantity of care** they give patients
- **First time in the history of the program** that explicit goals for alternative payment models and value-based payments set for Medicare
- Creation of national **Health Care Payment Learning & Action Network** to accelerate the transition and foster collaboration between private payers, employers, providers, consumers, and state/federal partners

Goals

1. ***Linking FFS Payments to Quality/Value: (Category 2 on following chart)***
    1. **85% of all Medicare fee-for-service payments** to be **tied to quality or value** by 2016
    2. **90%** by the end of 2018
2. ***Alternative Payment Models (APMs): (Category 3 on following chart)***
    1. **30%** of Medicare payments to tied to quality or value through **alternative payment models** by the end of 2016
    2. **50%** by the end of 2018

Framework for Progression of Payment to Clinicians and Organizations in Payment Reform

	Category 1: Fee for Service – No Link to Quality	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models on Fee-for Service Architecture	Category 4: Population-Based Payment
Description	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	• Some payment is linked to the effective management of a population or an episode of care • Payments still triggered by delivery of services, but, opportunities for shared savings or 2-sided risk	• Payment is not directly triggered by service delivery so volume is not linked to payment • Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (eg, >1 yr)
Examples				
Medicare	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable Care Organizations • Medical Homes • Bundled Payments	• Eligible Pioneer accountable care organizations in years 3 – 5 • Some Medicare Advantage plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations
Medicaid	Varies by state	• Primary Care Case Management • Some managed care models	• Integrated care models under fee for service • Managed fee-for-service models for Medicare-Medicaid beneficiaries • Medicaid Health Homes • Medicaid shared savings models	• Some Medicaid managed care plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations

Rajkumar R, Conway PH, Tavenner M. The CMS—Engaging Multiple Payers in Risk-Sharing Models. JAMA. Doi:10.1001/jama.2014.3703

CMS Innovations Portfolio, CMMI: Testing New Models (APMs) 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

Accountable Care Organizations
Year 2 results

- **Pioneer and Medicare Shared Savings ACO Programs** program savings of $372 million
- Majority of ACOs in both programs generated savings
- Improved quality and patient experience on almost all measures
  - **Pioneer ACOs** improved in 28 out of 33 quality measures with mean improvement from 70.8% to 84.0%[1]
  - Improved patient experience in 6 out of 7 measures
  - **Medicare shared savings ACOs** also improved quality and patient experience for almost all measures

[1] Pham H, Cohen M, Conway PH. The Pioneer Accountable Care organization Model: Improving quality and lowering costs. JAMA 2014 Sept 17.

What is the Value-Based Payment Modifier (VM) for Physicians?

- Section 3007 of the Affordable Care Act mandated that, by 2015, CMS begin applying a value modifier under the Medicare Physician Fee Schedule (MPFS)
- VM assesses both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule
- For CY 2015, CMS will apply the VM to groups of physicians with 100 or more eligible professionals (EPs)
- For CY 2016, CMS will apply the VM to groups of physicians with 10 or more EPs
- Phase-in to be completed for all physicians by 2017
- Implementation of the VM is based on participation in Physician Quality Reporting System

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Quality-Tiering Approach for 2016 (Based on 2014 PQRS Performance)

- **Each group receives two composite scores (quality of care; cost of care), based on the group's standardized performance (e.g., how far away from the national mean).**
- **Group cost measures are adjusted for specialty composition of the group. This approach identifies statistically significant outliers and assigns them to their respective cost and quality tiers.**

	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Average quality	+1.0x*	+0.0%	-1.0%
Low quality	+0.0%	-1.0%	-2.0%

* Eligible for an additional +1.0x if reporting clinical data for quality measures and average beneficiary risk score in the top 25% of all beneficiary risk scores

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What Quality Measures will be Used for Quality Tiering?

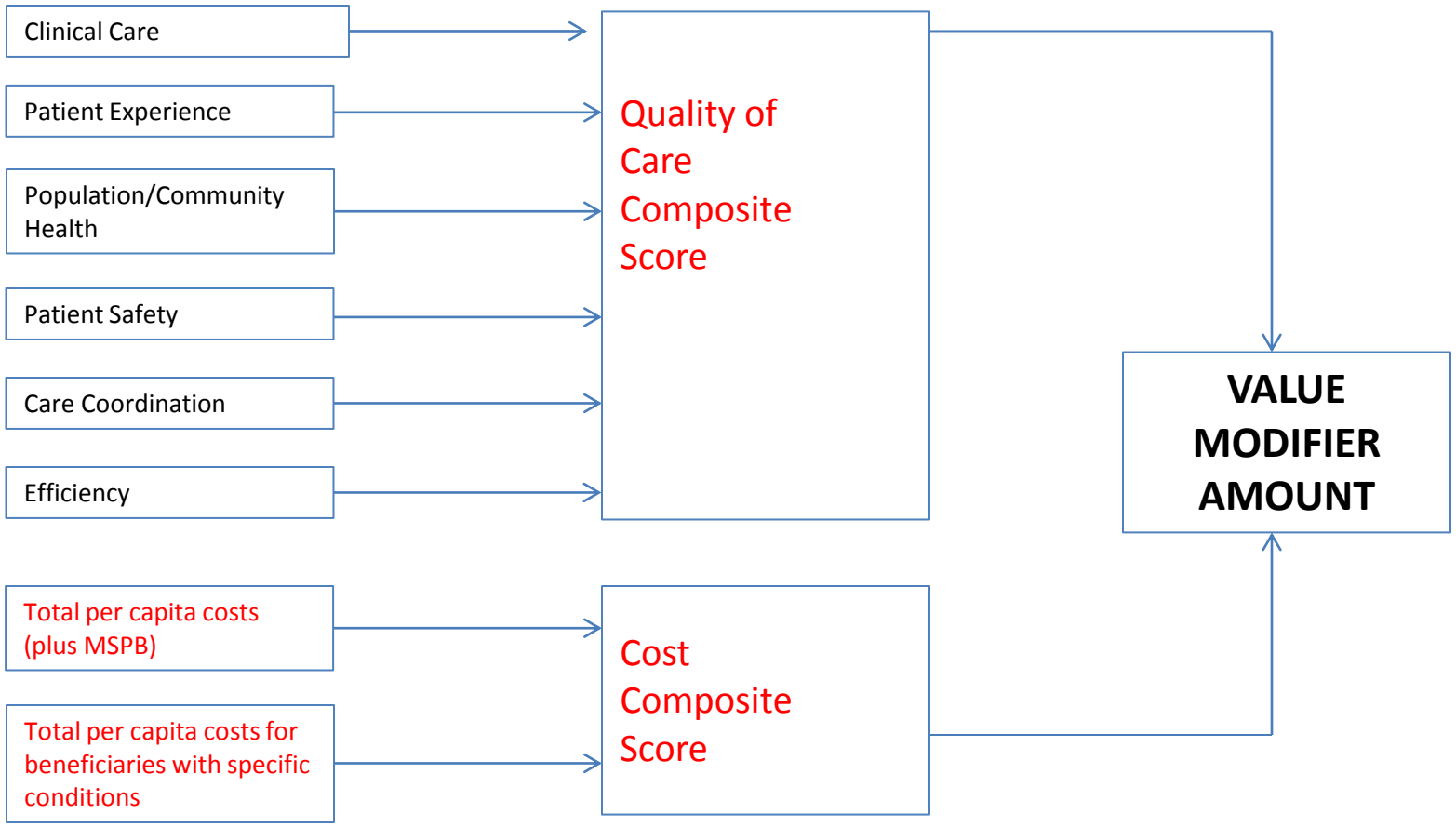
- Measures reported through the GPRO PQRS reporting mechanism selected by the group **OR** individual measures reported by at least 50% of the eligible professionals within the group (50% threshold option)
- Three outcome measures:
  - All Cause Readmissions
  - Composite of Acute Prevention Quality Indicators (bacterial pneumonia, urinary tract infection, dehydration)
  - Composite of Chronic Prevention Quality Indicators (COPD, heart failure, diabetes)
- PQRS CAHPS Measures for 2014 (Optional)
  - Patient Experience of Care measures
  - For groups of 25 or more eligible professionals

What Cost Measures will be used for Quality-Tiering?

- Total per capita costs measures (Parts A & B)
- Total per capita costs for beneficiaries with 4 chronic conditions:
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Heart Failure
  - Coronary Artery Disease
  - Diabetes
- Medicare Spending Per Beneficiary (MSPB) measure (3 days prior and 30 days after an inpatient hospitalization) attributed to the group providing the plurality of Part B services during the hospitalization
- All cost measures are payment standardized and risk adjusted.
- Each group's cost measures adjusted for specialty mix of the EPs in the group.

Quality-Tiering Methodology

- Use domains to combine each quality measure into a quality composite and each cost measure into a cost composite



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	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Average quality	+1.0x*	+0.0%	-1.0%
Low quality	+0.0%	-1.0%	-2.0%

* Eligible for an additional +1.0x if reporting clinical data for quality measures and average beneficiary risk score in the top 25% of all beneficiary risk scores

Quality and Resource Use Reports (QRURs)

- **The QRURs are annual reports that provide groups of physicians with:**
  - **Comparative information about the quality of care furnished, and the cost of that care, to their Medicare fee-for-service (FFS) patients**
  - **Beneficiary-specific information to help coordinate and improve the quality and efficiency of care furnished**
  - **Information on how the provider group would fare under the value-based payment modifier (VBM)**

- **2012 QRURs are produced and made available to all groups of physicians with 25 or more eligible professionals (EP)**

- Late Summer 2014: QRURs for all Groups and Solo Practitioners

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Overview:

- Signed into Law **4/16/2015**
- Repeals 1997 Sustainable Growth Rate Physician Fee Schedule (PFS) Update
- Changes Medicare PFS Payment:
  - **Merit-Based Incentive Payment System** (MIPS)
  - **Incentives** for participation in **Alternate Payment Models** (APM)

Physician Fee Schedule Updates:

- PFS 0.5% update 7/1/15-12/31/15
- PFS 0.5% update CY2016 - CY2019

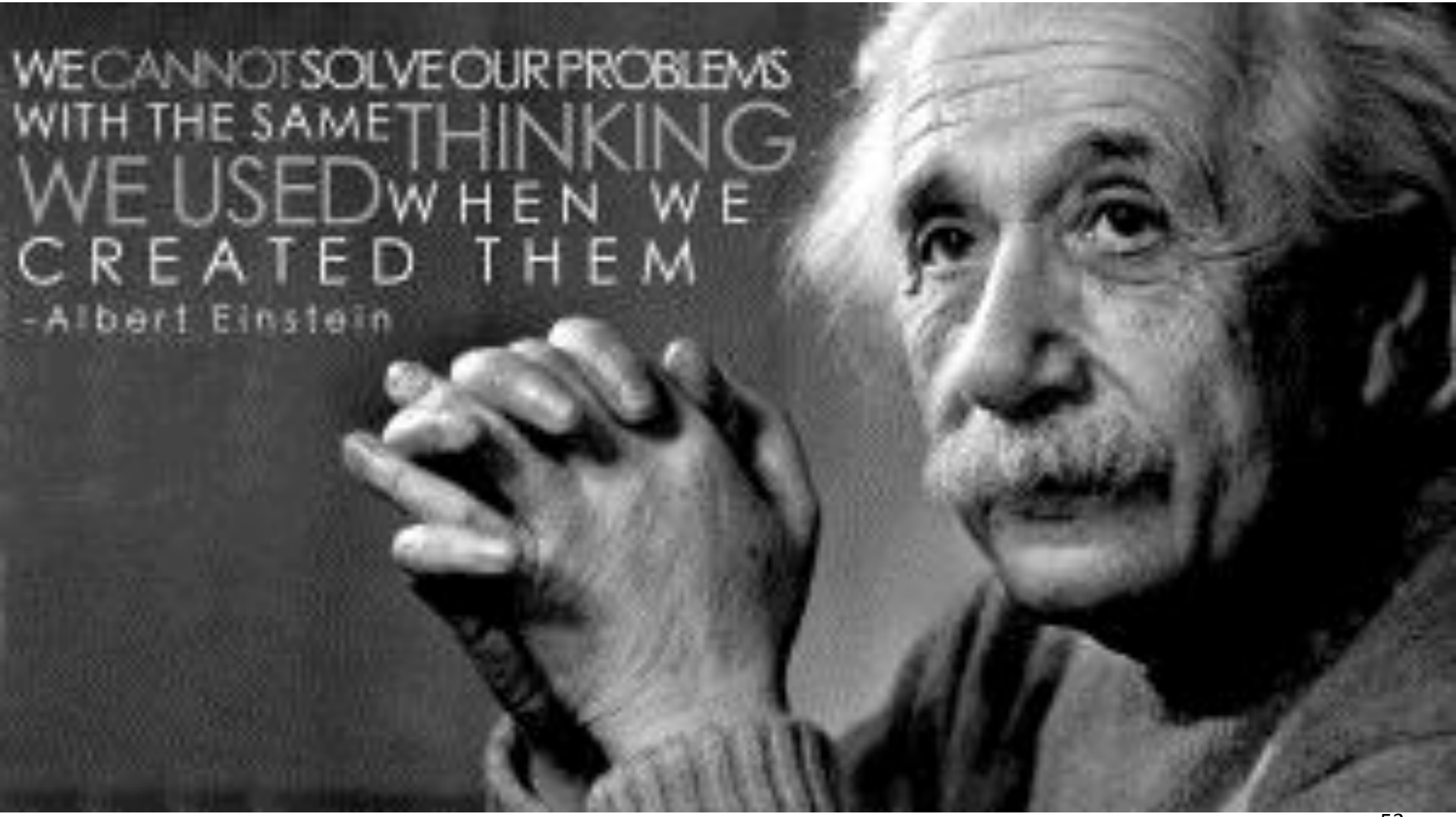
- **PFS 0.0% update CY 2020-2025**
- **MIPS & APMs will drive payment 2019 onward**
- **(i.e. payment updates based on performance)**

- Beginning with CY 2026 - **0.75% APM update**
- Beginning with CY 2026 - 0.25% update for other PFS services

MIPS & APM Incentives:

- Separate application of payment adjustments under PQRS, VM, and EHR-MU will sunset Dec. 31, 2018
- January 1, 2019 – MIPS and APM incentive payments begin
- EPs can participate in **MIPS** or meet requirements to be qualifying **APM participant**
- **MIPS** – Can receive **positive, negative or zero** payment adjustment
- **APM Participant** – If criteria are met, **can receive 5 percent incentive payment for 6 years**

Continuous Improvement and Innovation



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

What can you do?

- **Eliminate patient harm**
- **Focus on better health, better care, and lower costs for the patient population you serve**
- **Engage in accountable care and other alternative contracts that move away from fee-for-service to model based on achieving better outcomes at lower cost**
- **Invest in the quality infrastructure necessary to improve**
- **Test innovative models to better coordinate care for people with multiple chronic conditions**
- **Test new innovations and scale successes rapidly**
- **Relentless pursuit of improving health outcomes**

Learn. Act. Improve. Spread.

More information:

- **http://www.cms.gov/pqrs**
- **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html**
- **www.cms.gov/ehrincentiveprograms**
- **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

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Thank You

Questions?