

Centers for Medicare & Medicaid Services

CMS Value-Based Purchasing

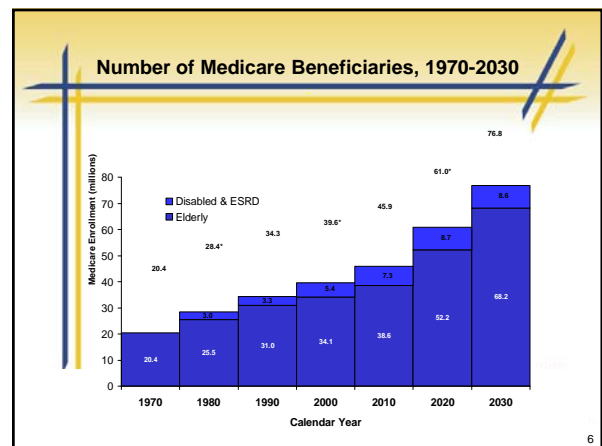
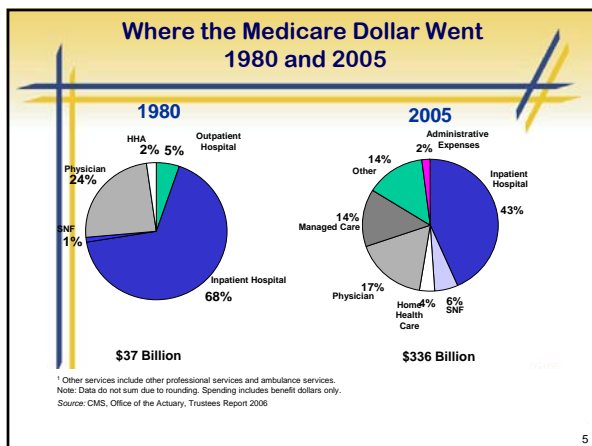
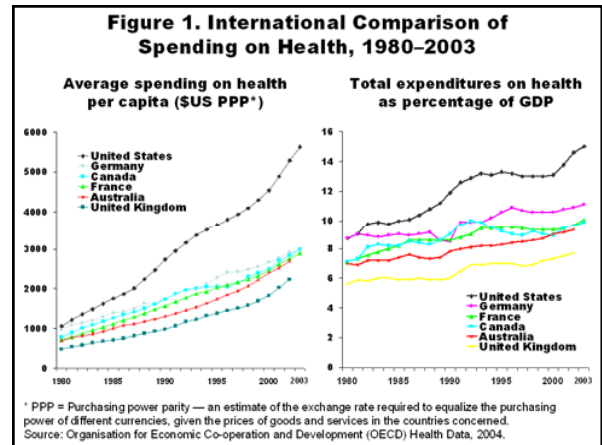
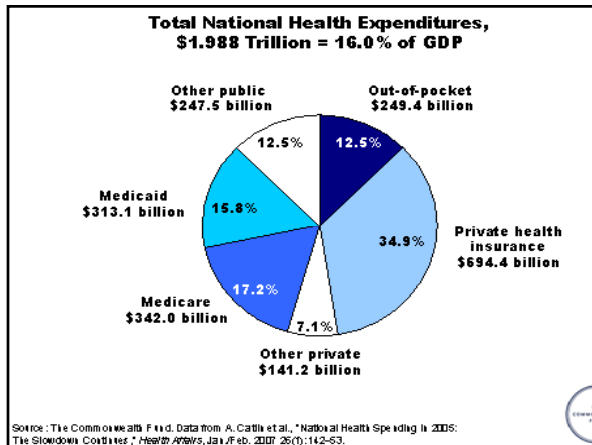
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Region III

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The Healthcare Quality Challenge

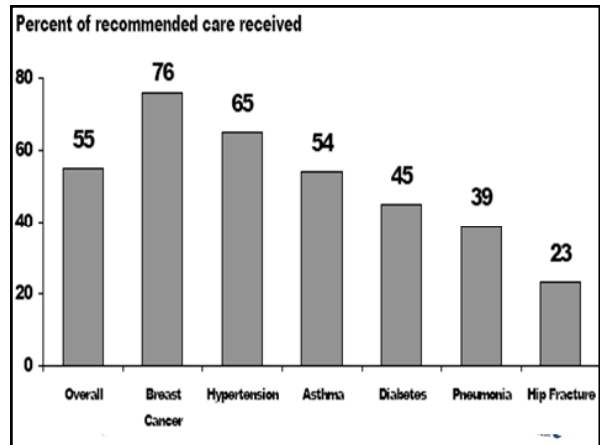
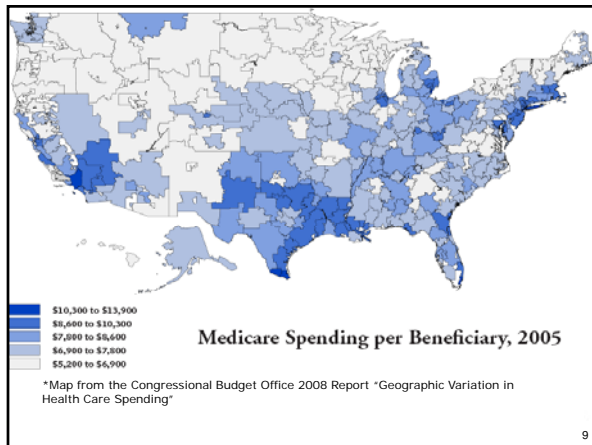
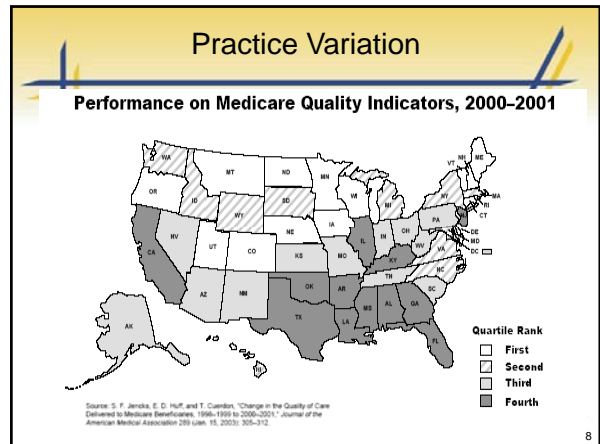
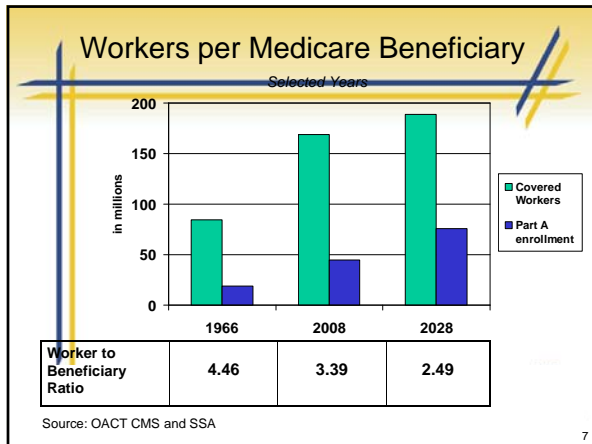
- We spend more per capita on healthcare than any other country in the world
- US Healthcare quality is often inferior to other nations and often doesn't meet expected evidence-based guidelines
- There are significant variations in quality and costs across the nation

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Slide 1

C1 CMS_DU, 10/1/2008



- ### Climate Supporting Pay for Performance
- President's Budget
 - FYs 2006-09
 - Congressional Interest in P4P and Other Value-Based Purchasing Tools
 - BIPA, MMA, DRA, TRCHA, MMSEA, MIPPA
 - MedPAC Reports to Congress
 - P4P recommendations related to quality, efficiency, health information technology, and payment reform
 - IOM Reports
 - P4P recommendations in *To Err Is Human* and *Crossing the Quality Chasm*
 - Report, *Rewarding Provider Performance: Aligning Incentives in Medicare*
 - Private Sector
 - Private health plans
 - Employer coalitions

- ### Value Based Purchasing
- Define quality, access and efficiency locally
 - Shift payment policy from volume
 - Pay for quality care for a specific beneficiary
 - Reward systems and providers who efficiently provide service (quality and process management)

Value-Based Purchasing- What it is really about:

It is about defining/rewarding providers for the value of their contribution to quality and efficient care that leads to better health outcomes.

Transforming Medicare from a passive payer to an active purchaser of higher quality, more efficient health care

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Why VBP?

- Medicare Solvency and Beneficiary Impact
 - Expenditures up from \$219 billion in 2000 to a projected \$486 billion in 2009
 - Part A Trust Fund
 - Excess of expenditures over tax income in 2007
 - Projected to be depleted by 2019
 - Part B Trust Fund
 - Expenditures increasing 11% per year over the last 6 years
- Medicare premiums, deductibles, and cost-sharing are projected to consume 28% of the average beneficiaries' Social Security check in 2010

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Why VBP?

- Improve Quality
 - Quality improvement opportunity
 - Wennberg's Dartmouth Atlas on variation in care
 - McGlynn's NEJM findings on lack of evidence-based care
 - IOM's Crossing the Quality Chasm findings
- Avoid Unnecessary Costs
 - Medicare's various fee-for-service fee schedules and prospective payment systems are based on resource consumption and quantity of care, NOT quality or unnecessary costs avoided
 - Payment systems' incentives are not aligned

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VBP: Payment Methodologies

- Pay for Participation
- Pay for Reporting
- Pay for Care Coordination
- Pay for Process
- Pay for Outcomes

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VBP Programs

- Hospital Quality Initiative: Inpatient & Outpatient Pay for Reporting
- Hospital VBP Plan & Report to Congress
- Hospital-Acquired Conditions & Present on Admission Indicator Reporting
- Physician Quality Reporting Initiative
- Physician Resource Use Reporting
- Home Health Care Pay for Reporting
- ESRD Pay for Performance

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VBP Demonstrations and Pilots

- Medical Adult Day Care
- Medicare Medical Home Demonstration
- Care Management for High-Cost Beneficiaries
- Medicare Healthcare Quality Demonstration
- Gainsharing Demonstrations
- Accountable Care Episode (ACE) Demonstration
- Better Quality Information (BQI) Pilots
- Electronic Health Records (EHR) Demonstration
- Nursing Home P4P
- PAC Payment Reform Demonstration

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Hospital Quality Initiative

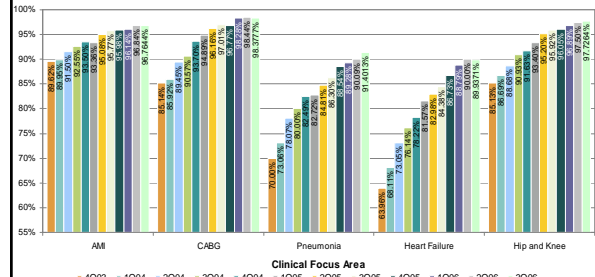
- MMA Section 501(b)
 - Payment differential of 0.4% for reporting (hospital pay for reporting)
 - FYs 2005-07
 - Starter set of 10 measures
 - High participation rate (>98%) for small incentive
 - Public reporting through CMS' Hospital Compare website

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Premier Hospital Quality Incentive Demonstration

CMS/Premier HQID Project Participants Composite Quality Score:

Trend of Quarterly Median (5th Decile) by Clinical Focus Area
October 1, 2003 - September 30, 2006 (Year 1 and Year 2 Final Data, and Yr 3 Preliminary)



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Hospital Quality Initiative

- DRA Section 5001(a)
 - Payment differential of 2% for reporting (hospital P4R)
 - FYs 2007- "subsequent years"
 - Expanded measure set, based on IOM's December 2005 *Performance Measures* Report
 - Expanded measures publicly reported through CMS' Hospital Compare website

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Hospital VBP Plan Legislative Background

- Deficit Reduction Act (DRA) Section 5001(b) authorized CMS to develop a Medicare Hospital VBP Plan
 - IPPS hospitals
 - Assumption of FY 2009 start date
 - Must consider
 - Measures
 - Data infrastructure and validation
 - Incentive structure
 - Public reporting
 - Must consult stakeholders and consider experience with relevant demonstrations and private-sector programs

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FY 2009 Candidate Measures for VBP Financial Incentive

Clinical Quality Process-of-Care Measures

Acute Myocardial Infarction (AMI)
Heart Failure (HF)
Pneumonia (PN)

Surgical Care Improvement/Surgical Infection Prevention (SCIP/SIP)

Clinical Quality – Outcome Measures

Patient-Centered Care Measures - HCAHPS

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FY 2009 Candidate Measures for VBP Financial Incentive

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Clinical Quality – Outcome Measures

Patient-Centered Care Measures - HCAHPS

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FY 2009 Candidate Measures: HCAHPS Dimensions

- Communication with Doctors
- Communication with Nurses
- Responsiveness of Hospital Staff
- Cleanliness and Quiet of Hospital Environment
- Pain Management
- Communication about Medicines
- Discharge Information
- Overall Rating

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Hospital VBP Report to Congress

- The Hospital Value-Based Purchasing Report Congress can be downloaded from the CMS website at:

<http://www.cms.hhs.gov/center/hospital.asp>

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VBP Initiatives

Hospital-Acquired Conditions
and Present on Admission
Indicator Reporting

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The HAC Problem

- The IOM estimated in 1999 that as many as 98,000 Americans die each year as a result of medical errors
- Total national costs of these errors estimated at \$17-29 billion

IOM: To Err is Human: Building a Safer Health System, November 1999.
Available at: <http://www.iom.edu/Object.File/Master/4/117/ToErr-8pager.pdf>.

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The HAC Problem

- In 2000, CDC estimated that hospital-acquired infections add nearly \$5 billion to U.S. health care costs annually
- A 2007 study found that, in 2002, 1.7 million hospital-acquired infections were associated with 99,000 deaths

Centers for Disease Control and Prevention: Press Release, March 2000.
Available at: <http://www.cdc.gov/od/oc/media/pressrel/r2k0306b.htm>.

Klevens et al. Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002. *Public Health Reports*. March-April 2007. Volume 122.

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The HAC Problem

- A 2007 Leapfrog Group survey of 1,256 hospitals found that 87% of those hospitals do not consistently follow recommendations to prevent many of the most common hospital-acquired infections

2007 Leapfrog Group Hospital Survey. The Leapfrog Group 2007.
Available at:
http://www.leapfroggroup.org/media/file/Leapfrog_hospital_acquired_infections_release.pdf

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Statutory Authority: DRA Section 5001(c)

- Beginning October 1, 2007, IPPS hospitals were required to submit data on their claims for payment indicating whether diagnoses were present on admission (POA)
- Beginning October 1, 2008, CMS cannot assign a case to a higher DRG based on the occurrence of one of the selected conditions, if that condition was acquired during the hospitalization

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Present on Admission (POA) Indicator General Requirements

- Present on admission is defined as *present at the time the order for inpatient admission occurs*
 - Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered present on admission
- Phased implementation

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Selected HACs Categories for Implementation

1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility
4. Pressure ulcers
 - Stages III & IV
5. Falls
 - Fracture
 - Dislocation
 - Intracranial injury
 - Crushing injury
 - Burn
 - Electric shock

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Selected HACs Categories for Implementation

6. Manifestations of poor glycemic control
 - Hypoglycemic coma
 - Diabetic ketoacidosis
 - Nonketotic hyperosmolar coma
 - Secondary diabetes with ketoacidosis
 - Secondary diabetes with hyperosmolarity
7. Catheter-associated urinary tract infection
8. Vascular catheter-associated infection
9. Deep vein thrombosis (DVT)/pulmonary embolism (PE)
 - Total knee replacement
 - Hip replacement

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Selected HACs Categories for Implementation

10. Surgical site infection
 - Mediastinitis after coronary artery bypass graft (CABG)
 - Certain orthopedic procedures
 - Spine
 - Neck
 - Shoulder
 - Elbow
 - Bariatric surgery for obesity
 - Laparoscopic gastric bypass
 - Gastroenterostomy
 - Laparoscopic gastric restrictive surgery

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CMS' Authority to Address the NQF's "Never Events"

- National Coverage Determinations (NCDs)
 - CMS is evaluating evidence regarding three surgical "never events:"
 - Surgery performed on the wrong body part
 - Surgery performed on the wrong patient
 - Wrong surgery performed on a patient
 - NCD tracking sheets are available at:
http://www.cms.hhs.gov/mcd/index_list.asp?list_type=nca

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CMS' Authority to Address the NQF's "Never Events"

- State Medicaid Director Letter (SMD)
 - Advises States about how to coordinate State Medicaid Agency policy with Medicare HAC policy to preclude Medicaid payment for HACs when Medicare does not pay
 - <http://www.cms.hhs.gov/SMDL/downloads/SMD073108.pdf>

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President's FY 2009 Budget Addresses NQF's "Never Events"

- The President's FY 2009 Budget outlined another option for addressing "never events" through a legislative proposal to:
 - Require hospitals to report occurrences of these events or receive a reduced annual payment update
 - Prohibit Medicare payment for these events

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POA Indicator General Requirements

- Present on admission (POA) is defined as present at the time the order for inpatient admission occurs
 - Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered POA
- POA indicator is assigned to
 - Principal diagnosis
 - Secondary diagnoses
 - External cause of injury codes (Medicare requires reporting only if E-code is reported as an additional diagnosis)

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POA Indicator Reporting Options

POA Indicator Options and Definitions	
Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
I	Unreported/Not used. Exempt from POA reporting. This code is equivalent code of a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.

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POA Indicator Reporting Requires Accurate Documentation

"A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures."

ICD-9-CM Official Guidelines for Coding and Reporting

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HAC & POA Enhancement & Future Issues

- Future Enhancements to HAC payment provision
 - Risk adjustment
 - Individual and population level
 - Rates of HACs for VBP
 - Appropriate for some HACs
 - Uses of POA information
 - Public reporting
 - Adoption of ICD-10
 - Example: 125 codes capturing size, depth, and location of pressure ulcer
 - Expansion of the IPPS HAC payment provision to other settings
 - Discussion in the IRF, OPPTS/ASC, SNF, LTCH regulations

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Opportunities for HAC & POA Involvement

- Updates to the CMS HAC & POA website: www.cms.hhs.gov/HospitalAcqCond/
- FY 2010 Rulemaking
- Hospital Open Door Forums
- Hospital Listserv Messages

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Demonstration Projects

- CMS currently pays for quality through a series of demonstration (all must be budget neutral)
- Several Demonstrations are mandated through Congressional Legislation

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Demonstration Purpose

- Test the development and implementation of Medicare policy changes prior to legislation enacting such changes on a national basis
 - Whether it works...
 - What refinements...
- Generally look at payment, new benefit, new organization of care delivery

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Nursing Home P4P

- 4-5 states will be selected
- About 100 nursing homes in each state
- 50 in study, 50 control
- Quality is assessed in four domains: staffing, appropriate hospitalizations, MDS outcomes and survey deficiencies
- Those facilities in the top 20% and those facilities with 20% of improvement will be eligible for a share of that states savings pool

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Design of NH Demo

- Nursing homes interested in participating must fill out a 1-page application and submit certain data to CMS.
- Data will include detailed staffing information and a census of residents for the most recent quarter-year
- CMS will stratify the applicant nursing homes and randomly assign them to demonstration and comparison groups.
- States that are selected are expected to have at least 100 applicants so that we can assign 50 nursing homes each to the demo and comparison groups.

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PAC Payment Reform Demonstration

Develop a uniform assessment instrument to measure and compare Medicare beneficiaries' health and functional status across provider settings, over time.

- SNFs: Skilled Nursing Facility Minimum Data Set (MDS)
- HHAs: Home Health Agency-Outcome & Assessment Information Set (OASIS)
- IRFs: Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI).



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CARE Opportunities

Development of "CARE"

(Continuity Assessment Record & Evaluation)

- Serves as a continuity of care record to support clinical excellence.
- Optimizes efficiencies available through information technology advances.
- Moves us forward toward an electronic health record.
- Collects data predictive of outcomes and resource utilization to guide quality and payment policy development.
- 3 year Demonstration

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Importance to Beneficiaries & Stakeholders

- Safe Transition of patients between care providers
- Electronic record for Continuity of Care
- Rapid, accurate communication of critical info
- Electronic efficiencies to reduce data entry burden
- Core set of assessment items
 - Functional
 - Social/Environmental
 - Cognitive
 - Continuity of Care

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Transparency-Nursing Home Compare

Chronic Care-14 Measures

- High and Low risk PU
- Physical Restraints
- Pain Management
- Depression

Acute Care- 5 Measures

- Pressure Ulcers
- Pain Management
- www.medicare.gov www.medic.org

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Transparency The 5 Star Rating System

1 to 5 Stars

Data taken from three data sources

Rating will include:

- Health survey inspections
- Quality measures
- Nurse staffing

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Transparency-Hospital Compare

- Process of Care
- Outcomes of Care
- Patients Hospital Experiences (HCAHPS)
- Payment and Volume
- Categorical information-Better than, no different than, worse than

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Physician P4P

- Physician Group Practice Demonstration – April 2005 implementation
- Medicare Care Management Performance Demonstration – July 2007 implementation

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Gainsharing

- Means to align incentives between hospitals and physicians
- Hospitals pay physicians a share of savings that result from collaborative efforts between the hospital and the physician to improve quality and efficiency
 - In the absence of statutory authority, gainsharing is restricted law
- MMA : Physician Hospital Collaboration Demonstration
- Deficit Reduction Act : Physician Hospital Gainsharing

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Medical Home

- "... to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high need populations"
- 3 years
- No more than 8-States
- Include physicians in practices with fewer than three full time equivalent physicians
- Include physicians in larger practices (particularly in rural and underserved areas)

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Personal Physician

- Board certified
 - First point of contact
 - Continuous care
 - May be specialist or sub-specialist
- Ongoing support, oversight, guidance to implement plan of care
- Staff & resources to manage comprehensive & coordinated care

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Timeline

- Finalize design: Fall 2008
- Announce geographic areas: Early 2009
- Recruitment & application process: Spring 2009
- Practices submit documentation: Spring/Summer 2009
- Demonstration begins: January 2010

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www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp

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Physician Quality Reporting Initiative (PQRI)

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Quality and PQRI

- PQRI has focused attention on measuring quality of care
 - Foundation is evidence-based measures developed by professionals
 - Reporting data for quality measurement is rewarded with financial incentive
 - Measurement enables improvements in care
 - Reporting is the first step toward pay for performance

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Overview

- Two Reporting Periods
 - 12 months (January 1—December 31, 2008)
 - 6 months (July 1—December 31, 2008)
- Total of 9 PQRI Reporting Methods
 - 3 claims-based
 - 6 registry-based

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Overview

- 119 Measures
- 4 Measure Groups
 - Diabetes
 - 5 measures
 - End Stage Renal Disease (ESRD)
 - 4 measures
 - Chronic Kidney Disease (CKD)
 - 4 measures
 - Preventive Care
 - 9 measures

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Registries

- 32 registries have been selected for “production” (eligible to earn a payment incentive for their providers)
- The final list of “qualified” registries is posted on the PQRI website at: http://www.cms.hhs.gov/PQRI/20_Reportin_g.asp#TopOfPage and go to the first download (“2008 List of Qualified Registries”)

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2007 PQRI Incentive Payment

- **Only Medicare Part B claims which contained an individual National Provider Identifier (NPI) were included in the 2007 incentive payment calculation.**
- Incentive amounts were calculated at the individual eligible provider (NPI) level
- Incentive payments were paid at the practice (TIN) level
- For 2007 & 2008 Incentive payment 1.5% total allowable Part B Medicare chargess

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2007 PQRI Reporting Participation Statistics

- 109,349 NPI/TINs – Attempted to Submit
- 101,138 NPI/TINs – Submitted a Quality Data Code Successfully
 - A feedback report is available
- 70,207 NPI/TINs – Satisfactorily Reported 1 or more measures
 - A feedback report is available
- 56,722 NPI/TINs – Earned Incentive
 - A feedback report & incentive payment are available

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MIPPA Legislation - PQRI

- The Medicare Improvements for Patients and Providers Act (MIPPA), passed in July 2008, contained several new authorities and requirements for quality reporting and PQRI for 2009 and beyond.
- Section 131 directly impacts PQRI
- Section 132 contains the new electronic prescribing incentive provisions.

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PQRI and e-prescribing MIPPA Provisions

- Section 131: PQRI for 2009 and Beyond
 - Incentive increased to 2%
 - Audiologists added as qualified professionals
- Section 132: e-prescribing incentives
 - Incentive 2% for 2009-10, then 1% for 2011-12, then 0.5% for 2013
 - Penalty of 1% begins in 2012, then 1.5% for 2013, then 2% for 2014
 - Hardship exception
 - E-Prescribing measure will be removed from PQRI for 2009 and added to the E-Prescribing incentive program.

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2008 PQRI – E-Prescribing Measure

- Electronic Prescribing Structural Measure (measure #125) qualifies as one of three required measures in PQRI to earn an incentive payment.
- Requirement for 2008 PQRI is to report the measure on 80% or more of eligible patients
- No separate incentive for successful E-Prescribing in 2008 PQRI

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Electronic Prescribing Measure in 2008 PQRI

- Currently eligible professionals (EPs) can report that they electronically prescribe (eRx) medications using a qualified program as defined in PQRI measure #125 Adoption/Use of e-Prescribing by reporting one of the G-codes in the measure
- You must have *and regularly use* an electronic prescribing program to report the measure
- The electronic prescribing program must meet ALL of the requirements listed in PQRI measure #125
- If you have not adopted an electronic prescribing system that meets the specifications of the measure you cannot report on this measure

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Qualified Electronic Prescribing Systems – Measure #125

- The measure assesses eligible professional's use of electronic prescribing *using a qualified* system.
- As a *qualified system*, the program must be able to perform the following tasks:
 - Generate a medication list
 - Selecting medications, transmitting prescriptions electronically and conducting safety checks*
 - Providing information on lower cost alternatives
 - Providing information on formulary or tiered formulary medications, patient eligibility and authorization requirements received electronically from the patient's drug plan
- *Safety checks include: automated prompts that offer information on the drug being prescribed, potential inappropriate dose or route of administration of the drug, drug-drug interactions, allergy concerns, and warnings/cautions.

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Measure #125 for 2009 eRx

- The secretary may change the measure specifications until 12/31/08.

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Successful Reporting of the eRx Measure for 2009

- The measure is intended to be reported on for EVERY patient visit in the denominator.
- Successful reporting is defined as reporting the measure on at least 50% of eligible patients.
 - Limitation: CPT codes that make up the denominator MUST account for at least 10% of the provider's total allowed charges for Medicare Part B covered services.

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Incentives for Successful electronic prescribing under MIPPA

- A 2% payment incentive for successful use of e-prescribing is available for 2009 & 2010.
- In 2011 & 2012 the payment incentive drops to 1% of covered Medicare Part B charges.
- In 2013 the incentive drops to 0.5% of the covered Medicare Part B charges

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Future Penalties for Not Electronically Prescribing

- Eligible professionals who are not successfully using electronic prescribing by 2012 **will be penalized 1% of their covered Medicare Part B charges.**
 - This means that these providers will be paid at 99% for their covered Medicare Part B fee schedule services.
- Limitation applies as for incentives
- Fee reduction is prospective, providers will have to electronically prescribe by a date to be determined to be sure their fees are not reduced in 2012.
- This date will not be before 2010.
- Hardship exemption

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Future Penalties for Not Electronically Prescribing

- In 2013 - 1.5% deducted from their covered Medicare Part B services.
 - Professionals will be paid at 98.5% of the physician fee schedule for covered services.
- In 2014 and beyond penalty will increase to 2%.
 - Professionals will receive 98% of the physician fee schedule for the covered services they provide.

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Part D Information

- The Secretary has the authority to change the requirements for successful E-Prescribing in the future.
- The MIPPA legislation allows for future use of Part D data in lieu of claims-based reporting by eligible professionals.

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Implementation Schedule for 2009 PQRI and e-Prescriber Incentive

- 2009 PQRI including applicable MIPPA provisions
 - Include in 2009 PFS Rule – comment period ended 8/29/08
- 2009 Electronic Prescribing Incentive
 - Those relevant to 2009 will be included in PFS Final Rule or otherwise implemented

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Additional Information

- Secretary Leavitt will be hosting an electronic prescribing summit in Boston on October 6 & 7.
 - This will include presentations, panel discussions, and vendor demonstrations, etc.
 - Registration for the summit can be accessed at:
<http://www.epsilonregistration.com/er/EventHomePage/CustomPage.jsp?ActivityID=378&ItemID=1117>

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Questions?

www.cms.hhs.gov/pqri

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