

Value-Based Payment and Health System Transformation



National Health Policy Forum

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Discussion

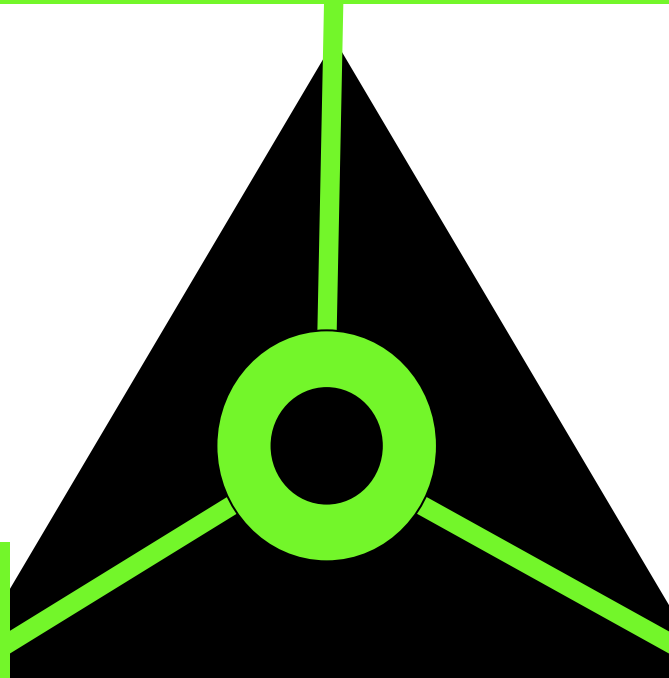
- **CMS Quality Strategy**
- **Value Based Purchasing**
- **Center for Medicare and Medicaid Innovation**
- **Future and Opportunities for collaboration**

Our Aims

**Better Health for
the Population**

**Better Care
for Individuals**

**Lower Cost
Through
Improvement**



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

CMS has a variety of quality reporting and performance programs

Hospital Quality

- Medicare and Medicaid EHR Incentive Program
- PPS-Exempt Cancer Hospitals
- Inpatient Psychiatric Facilities
- Inpatient Quality Reporting
- Outpatient Quality Reporting

Physician Quality Reporting

- Medicare and Medicaid EHR Incentive Program
- PQRS
- eRx quality reporting

PAC and Other Setting Quality Reporting

- Inpatient Rehabilitation Facility
- Nursing Home Compare Measures
- LTCH Quality Reporting
- Hospice Quality Reporting
- Home Health Quality Reporting
- Ambulatory Surgical Center Quality Reporting

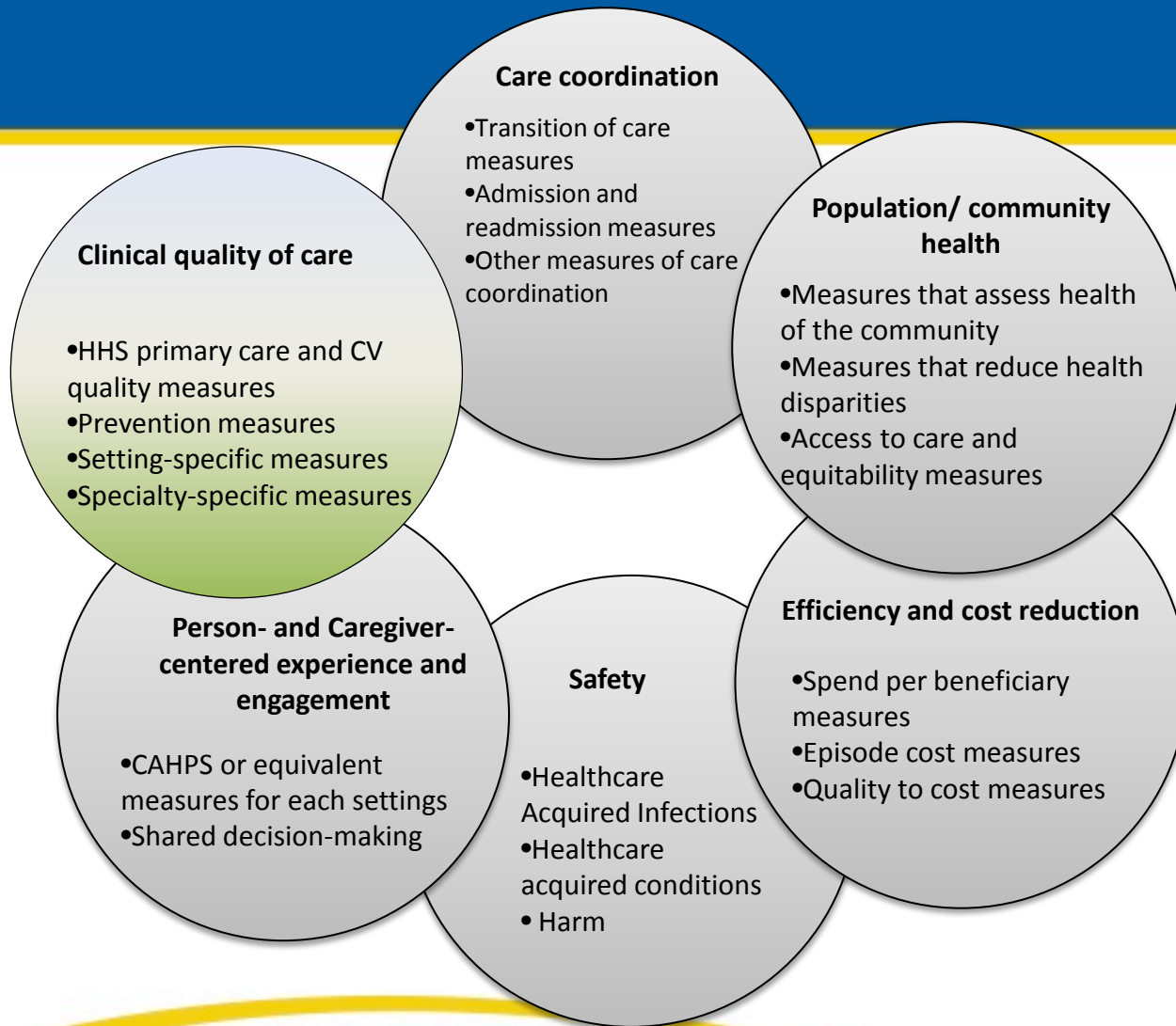
Value Based Purchasing

- Medicare Shared Savings Program
- Hospital Value-Based Purchasing
- Physician Feedback/Value-Based Modifier
- HAC payment reduction program
- Readmission reduction program
- ESRD QIP

"Population" Quality Reporting

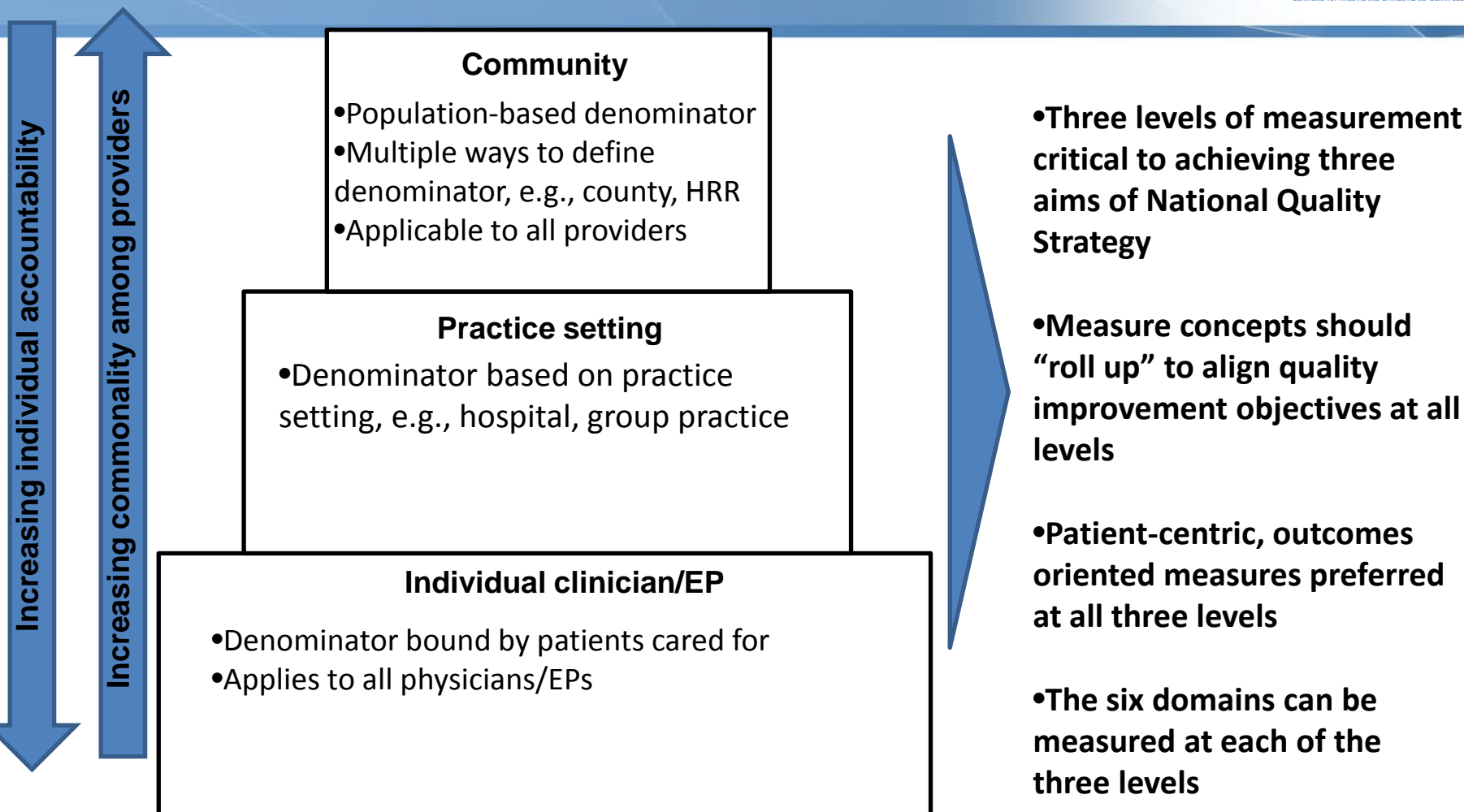
- Medicaid Adult Quality Reporting
- CHIPRA Quality Reporting
- Health Insurance Exchange Quality Reporting
- Medicare Part C
- Medicare Part D

CMS framework for measurement maps to the six national priorities



- 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



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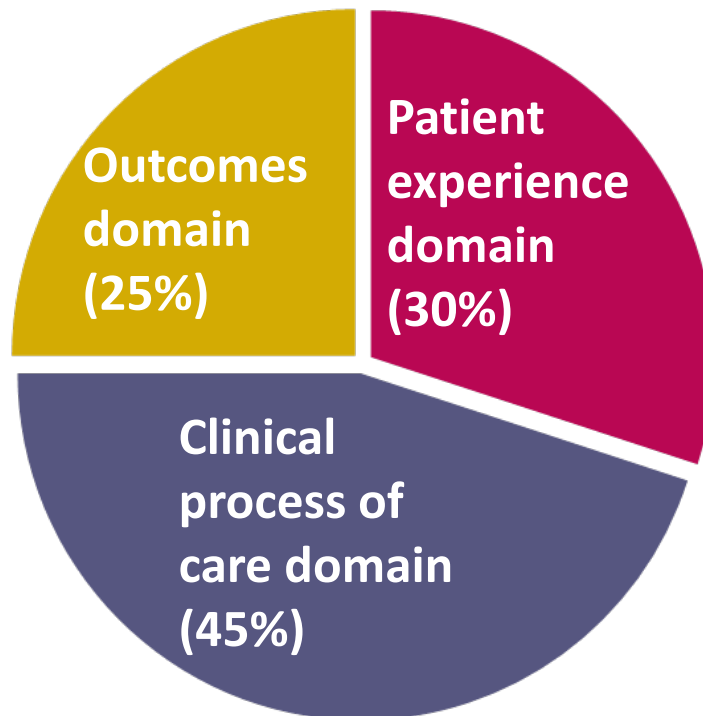
Value-Based Purchasing

- **Adjusts FFS payments based on quality and cost performance**
- **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**

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

FY 2014 Hospital VBP 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 – more outcomes weighting and safety measures, align with NQS domains
- Over \$1 billion in payments redistributed

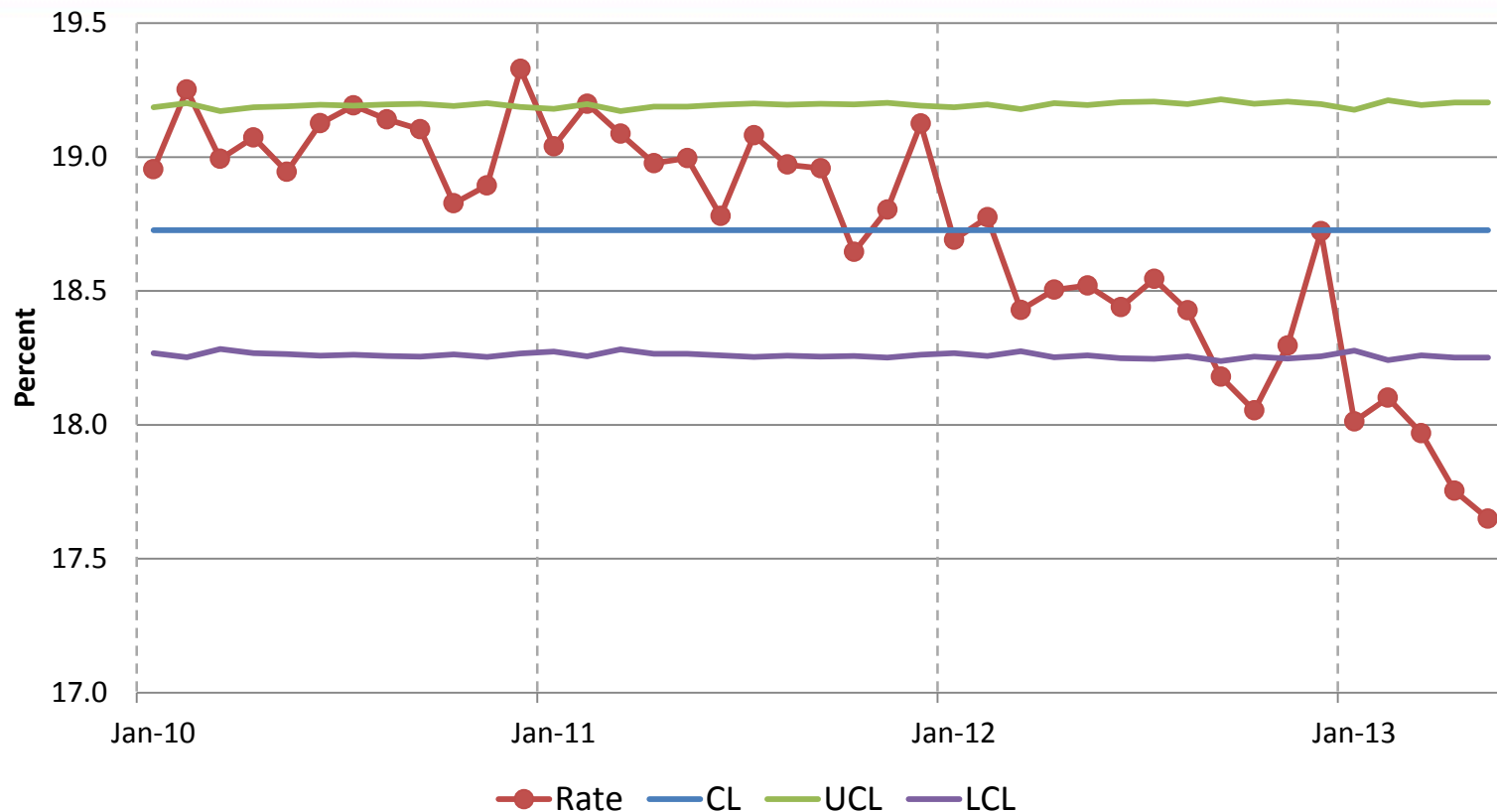
End Stage Renal Disease Quality Incentive Program (ESRD-QIP)

- **Required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) to link Medicare payments to quality**
- **Allows payment reductions of up to 2% from the ESRD Prospective Payment System**
- **Proposed 16 measures in current rule covering infections, clinical care, anemia management, patient experience and other dimensions of quality**

Other Value-Based Payment Adjustment Programs

- Starting in Oct 2012, hospitals with excess risk adjusted Medicare readmissions had payments reduced (5 conditions finalized for FY15)
- Payment reductions for hospitals in bottom quartile of healthcare acquired conditions starting Oct 2014
 - Finalized 2 domains: healthcare acquired infections (65% weight) and healthcare acquired conditions (35% weight)
 - Need to move beyond claims-based HAC measures over time

Medicare All Cause, 30 Day Hospital Readmission Rate



Source: Office of Information Products and Data Analytics, CMS

Physician Quality Reporting Programs

- Proposed for 2014 to be able to 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
- Qualified Clinical Data Registries
- Group reporting growth, including for ACOs, is fastest
- Challenge of covering diversity of clinical care but also focusing on outcomes and not simple process measures
- 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 Value-Based Modifier

- Physician value modifier started in 2013 with groups of 100 or more and option for “quality tiering”
- Proposed to include groups of 10 or more for 2014 with only upside (if report successfully) but require up and downside risk for groups of 100 or more
- Proposed to increase payment percentage at risk to 2.0%
- Payment is based on 3x3 table of low/avg/high quality and cost with high quality/low cost receiving largest increase in payment
- By 2017 statute requires adjusting all Medicare payments to physicians based on quality and cost

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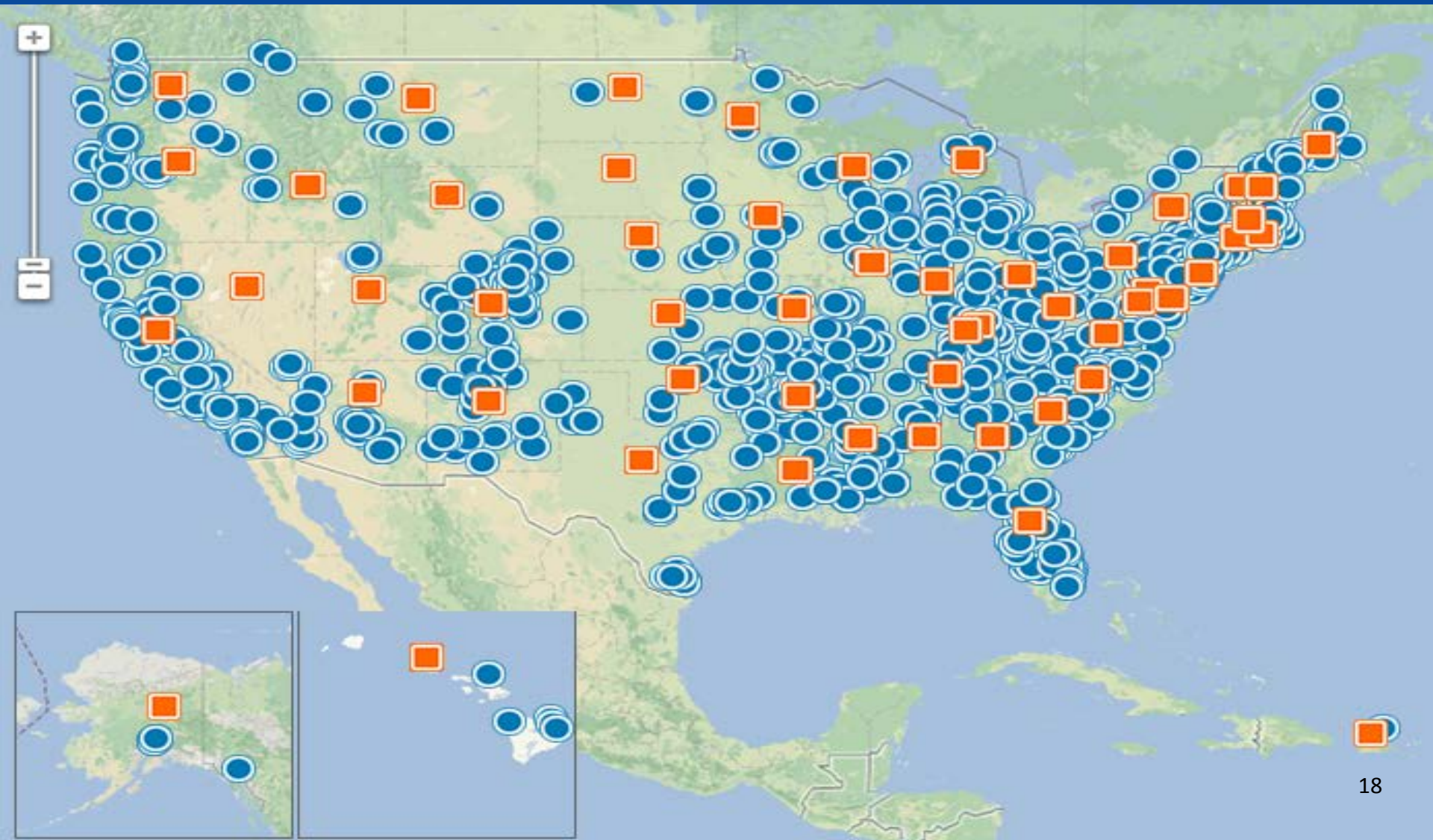
The CMS Innovation Center

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*

Innovation is happening broadly across the country



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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Opportunities and Challenges of a Lifelong Health System

- **Goal of system to optimize health outcomes and lower costs over much longer time horizons**
- **Payers, including Medicare and Medicaid, increasingly responsible for care for longer periods of time**
- **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**

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