

# **CMS and Value-Based Payments**

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# Overview

- **Background**
- **CMS Policy Context**
- **Building the Foundation for Health Reform**
  - **Electronic Health Record Incentives**
  - **Accountable Care Organizations**
  - **Other Affordable Care Act Provisions**
- **Achieving Health Reform**

# Background

or

*Where Are We and How Did we Get Here?*

# An Unsustainable Status Quo

~~46~~ **51** million uninsured Americans

- Health insurance premiums for family coverage at a small business increased 85% since 2000

~~16%~~ **17.6%** of our economic output tied up in the health care system

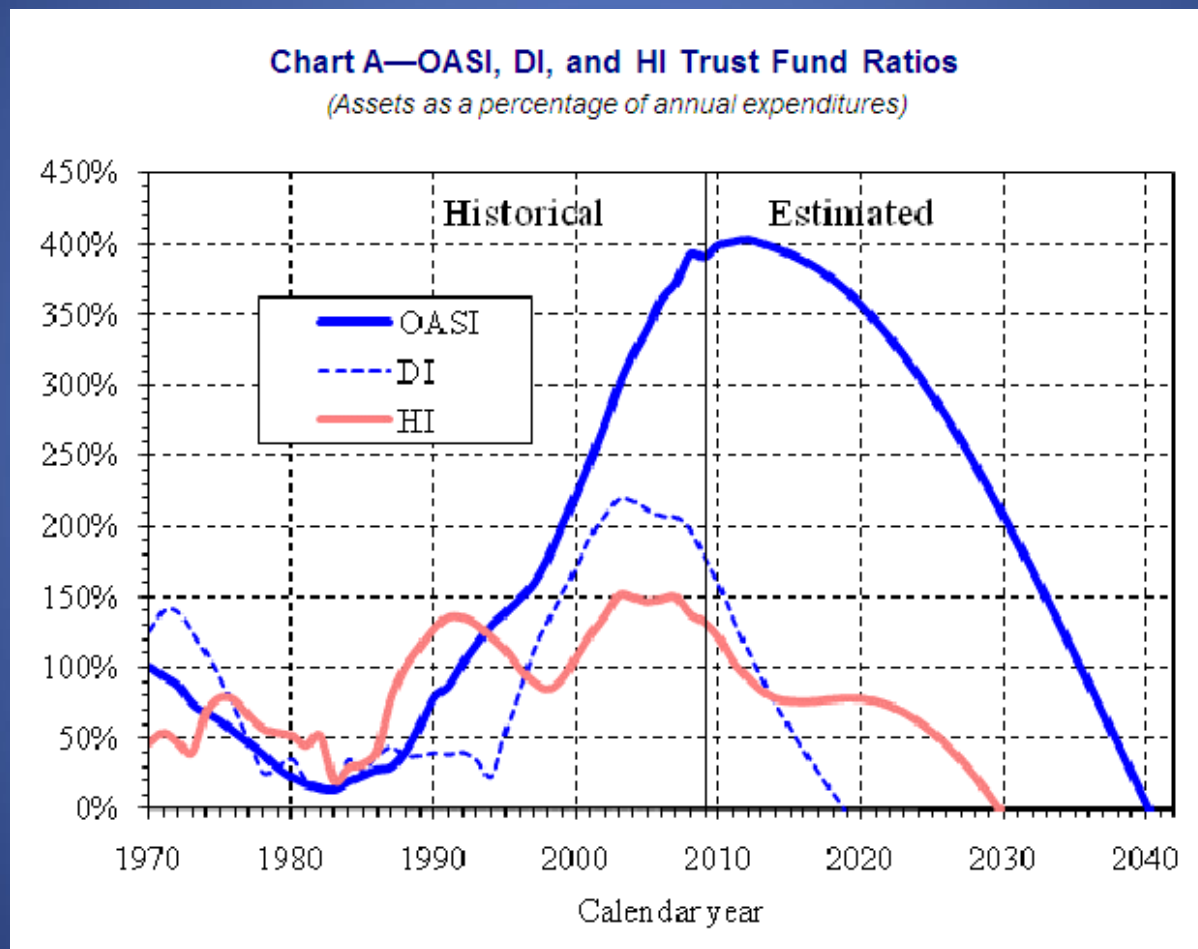
- Without reform, by 2040, 1/3 of economic output tied up in health care--15% of GDP devoted to Medicare and Medicaid
- Without reform, the number of uninsured would grow to 58 million in 2020\*

\*Source: Urban Institute: "The Cost of Failure to Enact Health Reform: 2010-2020"  
March 15, 2010

# Medicare Solvency and Beneficiary Impact

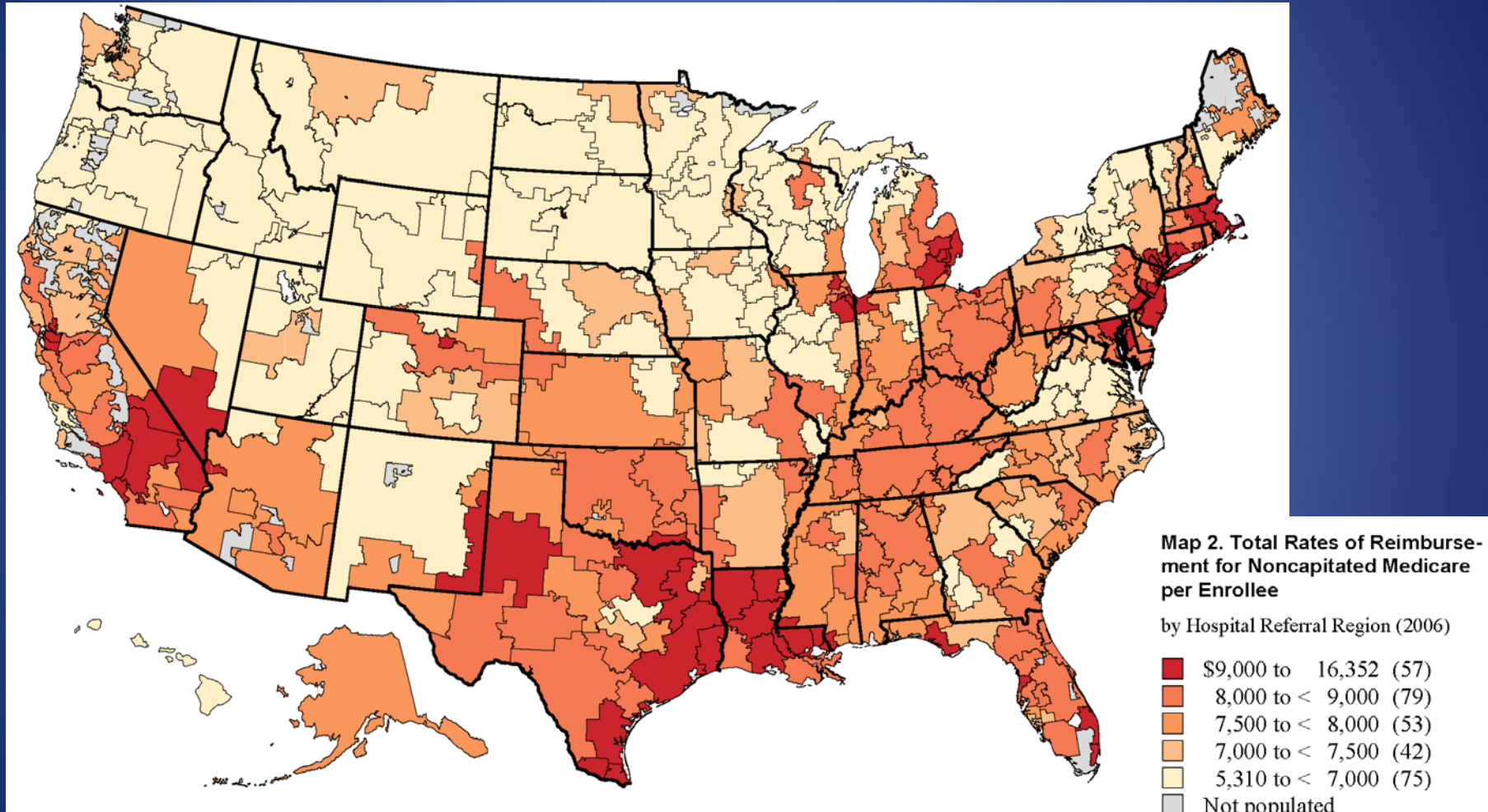
- Expenditures: \$219 billion in 2000  
\$486 billion in 2009
- Part A Trust Fund
  - Excess expenditures over income since 2007
- Part B Trust Fund
  - Expenditures increased 11% annually for last 6 years
- Medicare premiums, deductibles, and cost-sharing = 28% of average Social Security check in 2010

# Effect of Affordable Care Act on Medicare Trust Funds



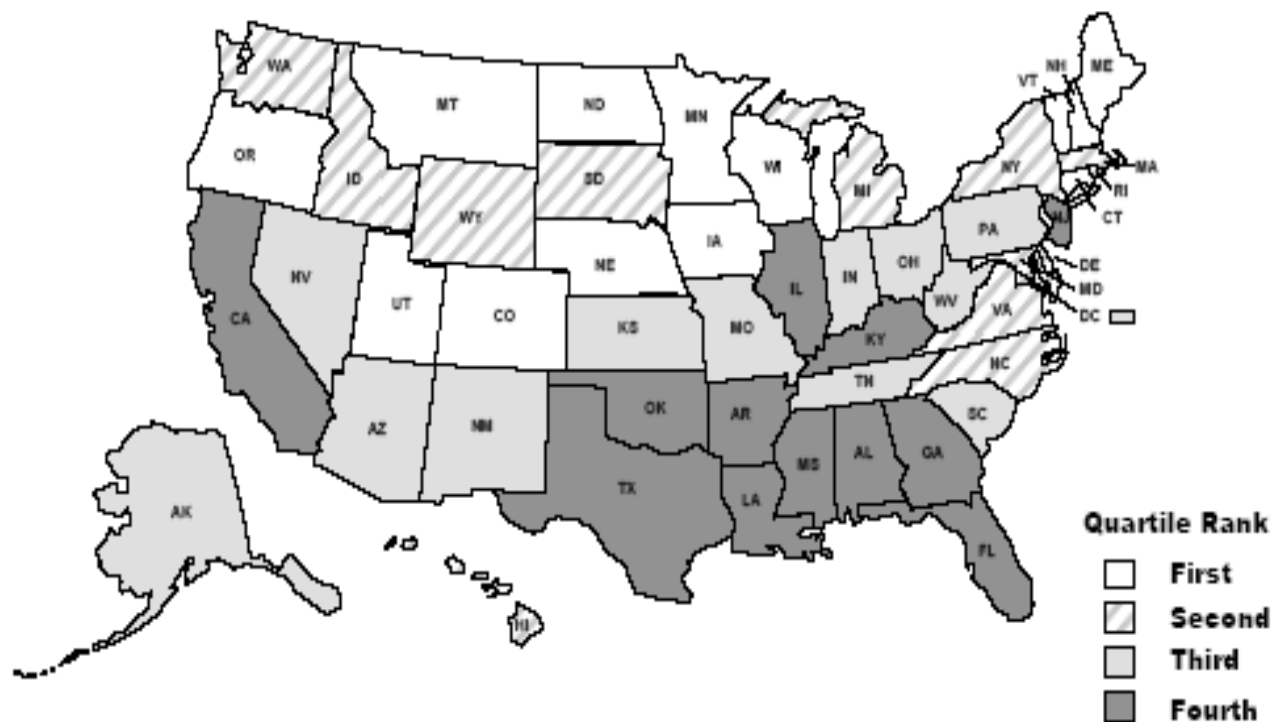
August 2010: Annual report on the financial status of the Social Security program, Social Security Administration

# Practice Variation



# Practice Variation

## Performance on Medicare Quality Indicators, 2000-2001



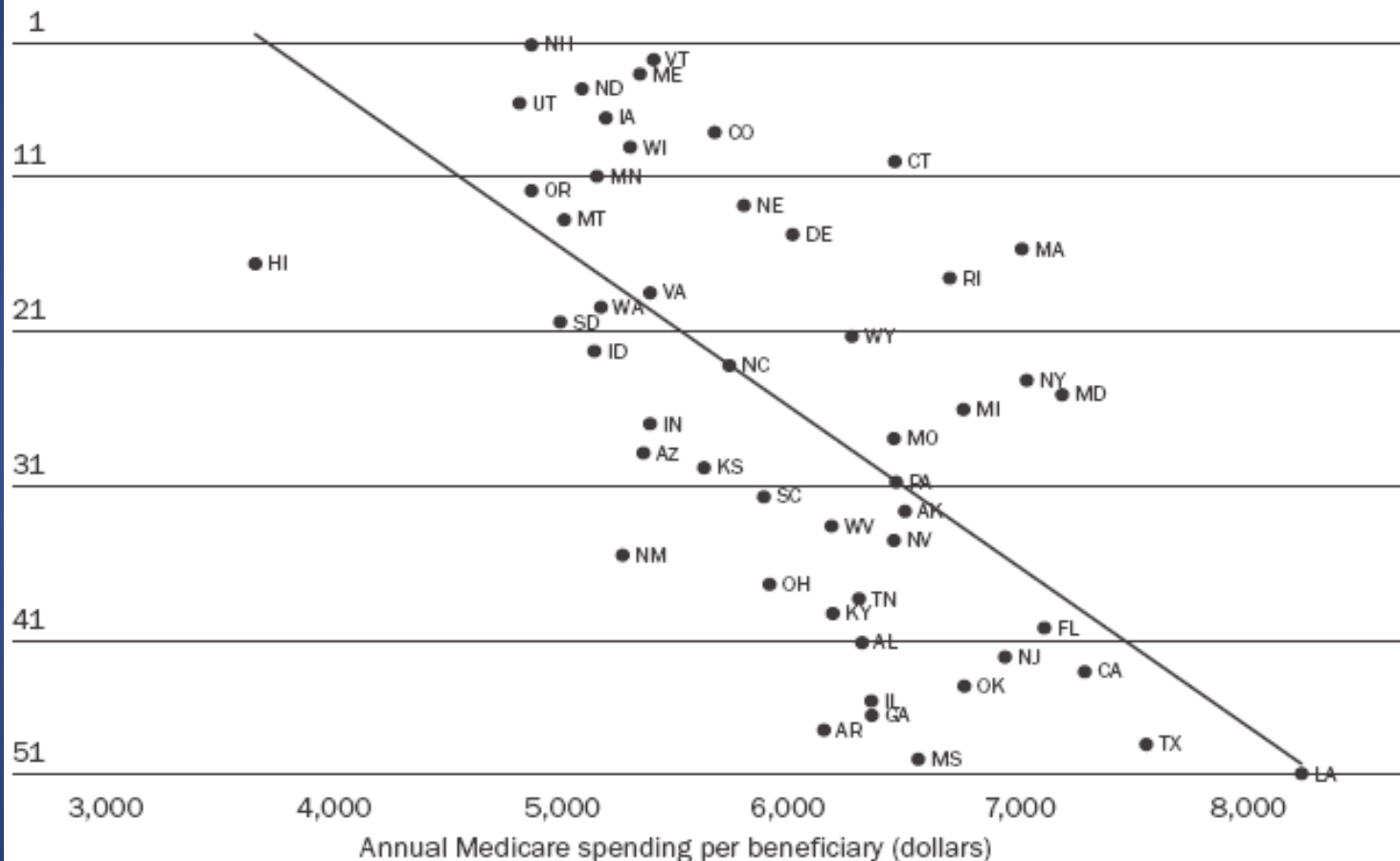
Source: S. F. Jencks, E. D. Huff, and T. Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001," *Journal of the American Medical Association* 289 (Jan. 15, 2003): 305-312.



## EXHIBIT 1

### Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000-2001

Overall quality ranking



**SOURCES:** Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305-312.

**NOTE:** For quality ranking, smaller values equal higher quality.

# CMS Policy Context

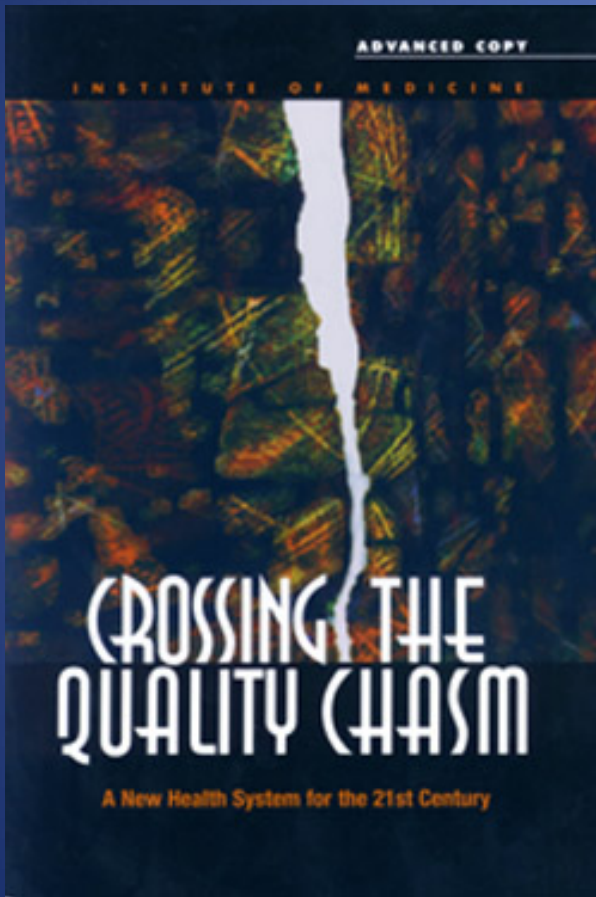
or

*Where Are We Going?*

# *Better Care*

## *Closing the Quality Chasm*

### **CMS Specific Aims for Health System Improvement**



- Safety
- Effectiveness
- Patient-centeredness
- Timeliness
- Efficiency
- Equity

# **CMS' Value-Based Purchasing (VBP) Principles**

- **Transform Medicare from passive payer of services to active purchaser of higher quality, more efficient health care**
- **VBP Program goals:**
  - **Improve clinical quality of care rendered**
  - **Improve the health of beneficiaries**
  - **Reduce adverse events and improve patient safety**
  - **Encourage coordination of patient care**
  - **Avoid unnecessary costs in the delivery of care**
  - **Stimulate investments in effective structural systems**
  - **Make performance results transparent and comprehensible**

# CMS' Value-Based Purchasing Activities Involving Physicians\*

- CMS VBP programs and initiatives:
  - Electronic Health Record (EHR) Incentive
  - Physician Quality Reporting Initiative (PQRI)
  - Electronic Prescribing (eRx)
  - Physician Resource Use Measurement and Reporting (RUR)
  - Generating Medicare Physician Quality Performance Measurement Results (GEM)
- CMS VBP demonstrations:
  - Physician Group Practice (PGP)
  - Medicare Care Management Performance (MCMP)
  - Medical Home
  - Electronic Health Records (EHR)
  - Acute Care Episode (ACE)
  - Gainsharing

\* Partial list

# Physician VBP Issues Paper

U.S. Department of Health & Human Services

Development of a Plan to Transition to a Medicare Value-Based Purchasing Program for  
Physician and Other Professional Services

**Issues Paper**

Public Listening Session

December 9, 2008



- **Posted November 2008**

Available at: <http://www.cms.hhs.gov/PhysicianFeeSched/downloads/PhysicianVBP-Plan-Issues-Paper.pdf>

# Physician VBP Issues Paper: Planning Objectives

1. Promote evidence-based medicine through measurement, payment incentives, and transparency
2. Reduce fragmentation and duplication through accountability across settings, alignment of measures and incentives across settings, better care coordination for smoother transitions, and attention to episodes of care
3. Encourage effective management of chronic disease by improving early detection and prevention, focusing on preventable hospital readmissions, and emphasizing the importance of advanced care planning and appropriate end-of-life care
4. Accelerate the adoption of effective interoperable HIT, including clinical registries, e-prescribing, and electronic health records

# Building the Foundation for Health Reform

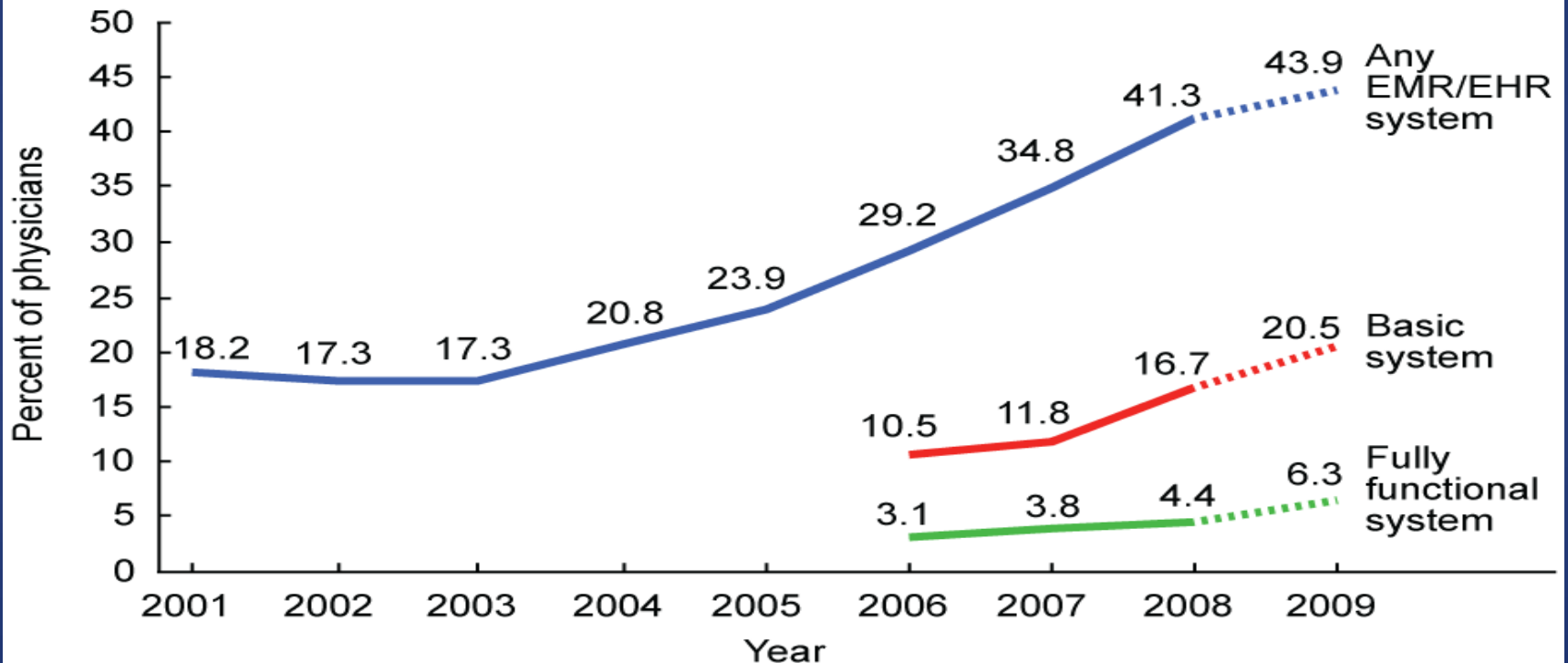
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*How Are We Going to Get There?*



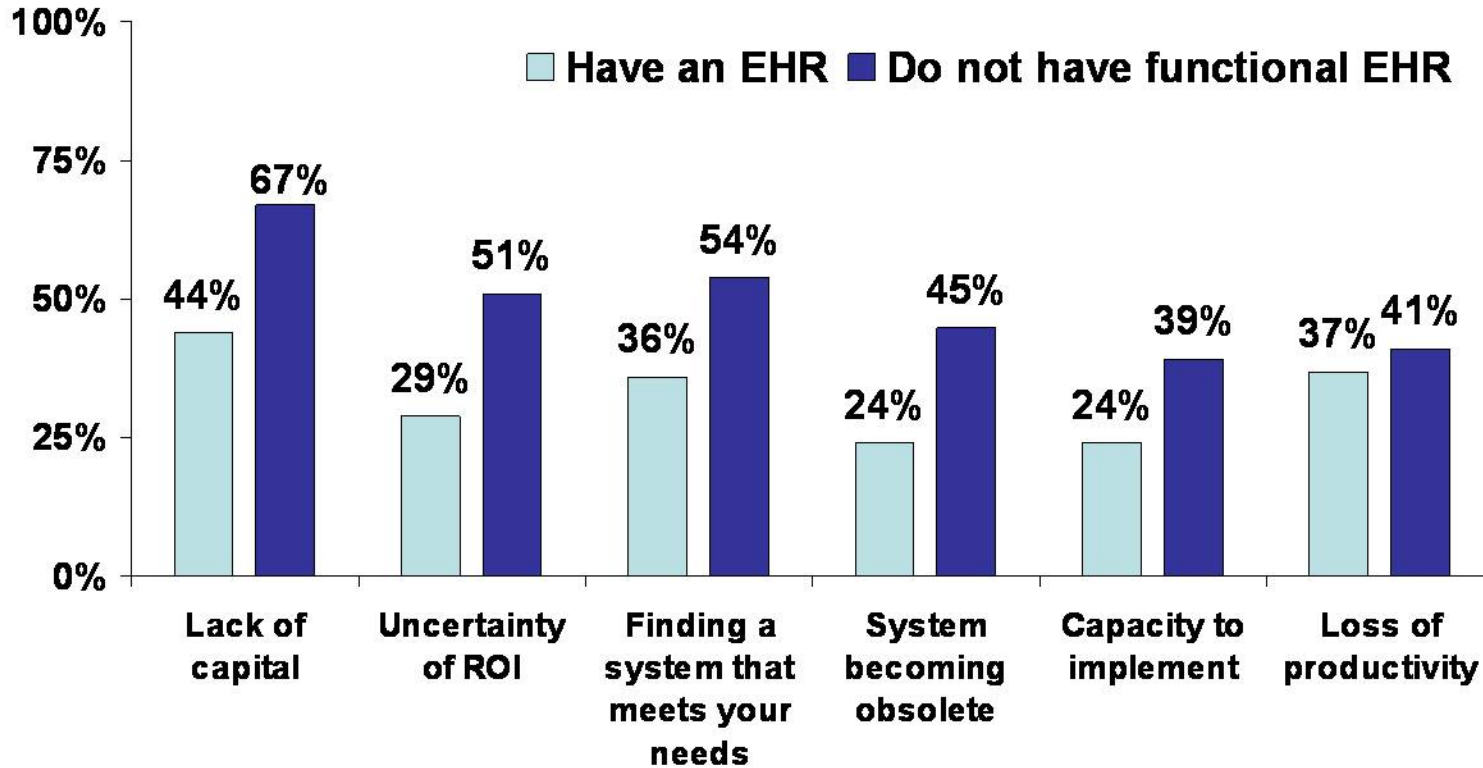
# Physician EHR Adoption

**Figure. Percentage of office-based physicians using electronic medical records/electronic health records (EMRs/EHRs): United States, 2001–2008 and preliminary 2009**



NOTES: Any EMR/EHR is a medical or health record system that is either all or partially electronic (excluding systems solely for billing). The 2009 data are preliminary estimates (as shown on dashed lines), based only on the mail survey. Estimates of basic and fully functional systems prior to 2006 could not be computed because some items were not collected in the survey. Starting in 2007, the skip pattern after the all or partial EMR/EHR systems question was removed. Includes nonfederal, office-based physicians. Excludes radiologists, anesthesiologists, and pathologists. SOURCE: CDC/NCHS, National Ambulatory Medical Care Survey.

# Barriers to EHR Adoption



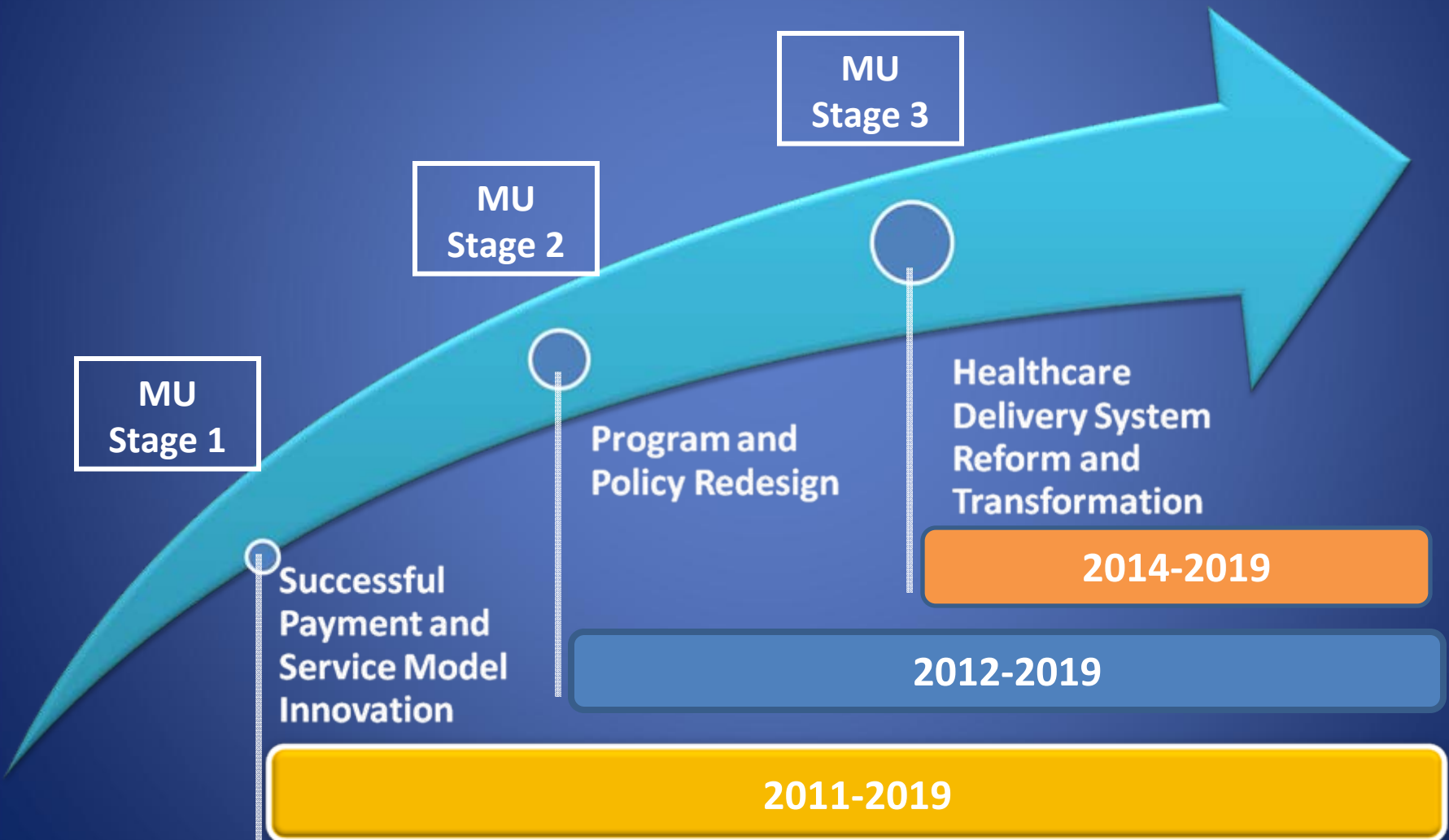
Source: DesRoches CM et al. Electronic health records in ambulatory care—a national survey of physicians. *N Engl J Med.* 359(1):50-60, 2008 Jul 3.

# Federal Government Responds: HITECH Act

- Part of American Recovery and Reinvestment Act of 2009 (ARRA)
- Goal: Every American to have an EHR by 2014
- Systematically addresses major barriers to adoption and Meaningful Use:
  - Money/market reform
  - Technical assistance, support, and better information
  - Health information exchange
  - Privacy and security



# Timeline for Delivery System Reform and Transformation, 2011-2019



# The Affordable Care Act

- **Patient Protection and Affordable Care Act (PPACA)**
  - Signed into law H.R. 3590 on March 23, 2010
  - Makes numerous statutory changes to Medicare program
- **The Health Care and Education Reconciliation Act of 2010 (HCERA)**
  - Signed into law H.R. 4872 on March 30, 2010
  - Modifies PPACA and adds several new provisions
- **Together called the Affordable Care Act**

# Center for Medicare & Medicaid Innovation

- Test innovative payment and service delivery models
  - Reduce program expenditures
  - Preserve or enhance the quality of care
- 20 possible models could be tested
  - Successful models can be expanded nationally
- Provide report to Congress on these activities
- Effective no later than January 1, 2011

ACA  
Section  
3021

# Accountable Care Organizations (ACOs)

- **Pediatric Accountable Care Organization Demonstration Project (Section 2706)**
- **Medicare Shared Savings Program (Section 3022)**
- **Health Homes**
- **Models will rely on lessons learned from the CMS Physician Group Practice Demonstration**





# ACA: Improving Medicare

- **VBP modifier under PFS (Section 3007)**
  - Quality compared to costs
  - Budget neutrality specified
  - Rulemaking during 2013, implementation 2015
- **Payment adjustment for conditions acquired in hospitals (Section 3008)**
  - 1% payment reduction for HACs starting 2015
  - Risk adjustment required
  - Public reporting required
  - Study by 1/1/2012 on extending to other providers

# Physician Quality Reporting Initiative (PQRI)

- Improvements to PQRI
  - Extends payments through 2014
  - Provides incentives to physicians who report quality data
  - Creates appeals and feedback processes
  - Establishes participation pathway for physicians who complete Maintenance of Certification program
- Effective on date of enactment

ACA  
Section  
3002 &  
10327

# Containing Costs, Now and in the Future

ACA  
Section  
3021-26

- CMS Center for Innovation
- Bundling payments
- Reducing avoidable hospital readmissions
- Independent Payment Advisory Board
- Excise tax on high cost health plans
- Incentives for better quality
- Administrative simplification for Federal, State, and private plans
- Driving down waste, fraud and abuse in Medicare and Medicaid

# ACA: Conclusions

- **Adds specific mandates and statutory authority that provides opportunity for all stakeholders to:**
  - **Set priorities**
  - **Define a strategic framework to achieve specific goals and objectives**
  - **Collaborate and leverage resources, efforts, knowledge, influence**
- **Patient Safety clearly a priority**

# Achieving Health Reform

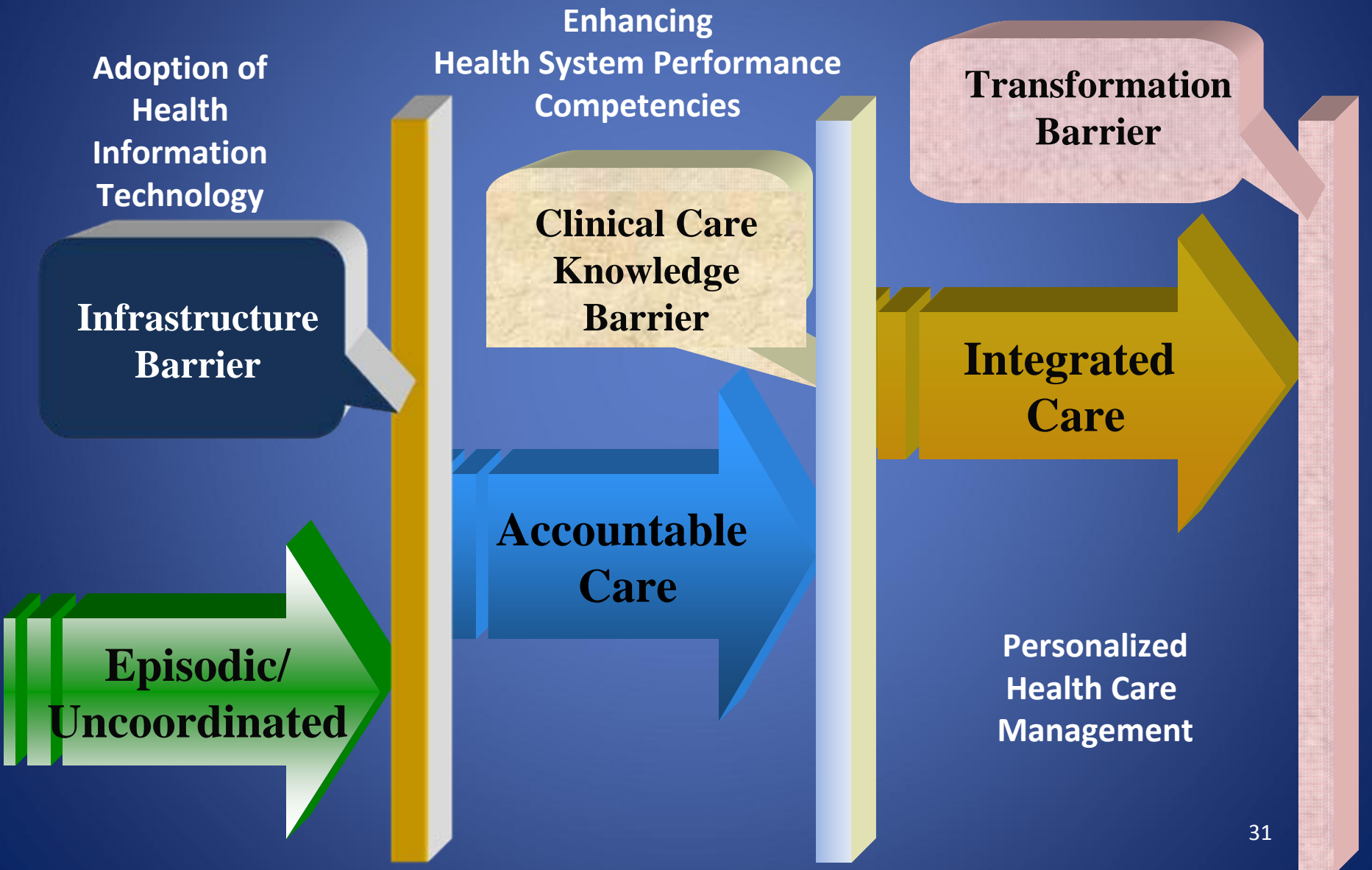
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*How Will We Know We've Arrived?*

# The Three Part Aim 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

# Health Care Delivery System Transformation



# Summary

- **Status quo is unsustainable**
- **Health reform is built on quality and value**
  - **Requires meaningful use of EMRs**
  - **Affordable Care Act**
  - **All of us working together**
- **Many opportunities and challenges ahead**



# Resources

<http://www.cms.gov/EHRIncentivePrograms/>

EHR incentive program

<http://www.healthcare.gov/>

Affordable Care Act

**Thank you!**

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