

# Value Based Purchasing

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS for MEDICARE & MEDICAID SERVICES  
Center for Consumer Information and Insurance Oversight

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# National Quality Strategy promotes better health, healthcare, and lower cost

*Report to Congress*

**National Strategy for Quality Improvement in Health Care**

March 2011



# OCSQ has a wide variety of tools to achieve the three-part aim of the National Quality Strategy

## OCSQ tool kit

- National coverage determinations
- Setting clinical standard for providers
- Survey and certification
- Technical assistance for quality improvement
- Public reporting of providers' quality performance
- Value-based purchasing

**These tools allow OCSQ to define the kind of care CMS pays for and to ensure it furthers the national quality strategy**

# CMS has a variety of quality reporting and performance programs

Hospital Quality	Physician Quality Reporting	PAC and Other Setting Quality Reporting	Payment Model Reporting	“Population” Quality Reporting
<ul style="list-style-type: none"><li>• Medicare and Medicaid EHR Incentive Program</li><li>• PPS-Exempt Cancer Hospitals</li><li>• Inpatient Psychiatric Facilities</li><li>• Inpatient Quality Reporting</li><li>• HAC payment reduction program</li><li>• Readmission reduction program</li></ul>	<ul style="list-style-type: none"><li>• Medicare and Medicaid EHR Incentive Program</li><li>• PQRS</li><li>• eRx quality reporting</li></ul>	<ul style="list-style-type: none"><li>• Inpatient Rehabilitation Facility</li><li>• Nursing Home Compare Measures</li><li>• LTCH Quality Reporting</li><li>• ESRD QIP</li><li>• Hospice Quality Reporting</li><li>• Home Health Quality Reporting</li></ul>	<ul style="list-style-type: none"><li>• Medicare Shared Savings Program</li><li>• Hospital Value-based Purchasing</li><li>• Physician Feedback/Value-based Modifier*</li></ul>	<ul style="list-style-type: none"><li>• Medicaid Adult Quality Reporting*</li><li>• CHIPRA Quality Reporting*</li><li>• Health Insurance Exchange Quality Reporting*</li><li>• Medicare Part C*</li><li>• Medicare Part D*</li></ul>

\* Denotes that the program did not meet the statutory inclusion criteria for pre-rulemaking, but was included to foster alignment of program measures.

# Objectives for Medicare Part C & D plan ratings

Public reporting

Technical assistance

Policy review

Basis for  
compliance and  
enforcement  
actions

Identifying audit  
candidates

Decisions for  
application  
approval and  
denials

Payment

# Purpose statement for Value-Based Purchasing

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Value-based purchasing is a tool that allows CMS to link the National Quality Strategy with fee-for-service payments at a national scale. It is an important driver in revamping how services are paid for, moving increasingly toward rewarding providers and health systems that deliver better outcomes in health and health care at lower cost to the beneficiaries and communities they serve.

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# Background on Value-Based Purchasing

- 2003**   ▪ **Hospital Inpatient Quality Reporting**<sup>1</sup>, Medicare's first quality reporting initiative is authorized through the Medicare Prescription Drug, Improvement and Modernization Act
- 2005**   ▪ **The Hospital Inpatient Quality Reporting**<sup>1</sup> launches the market basket update
- The Deficit Reduction Act, authorized HHS to **develop a plan to implement Value-Based Purchasing (VBP)** for Medicare hospital services provided by certain hospitals paid under the Inpatient Prospective Payment System (IPPS)
- 2008**   ▪ Medicare Improvement for Patients and Providers Act authorizes CMS's first pay for performance program in Medicare, **End Stage Renal Disease Quality Improvement Program (ESRD QIP)**
- 2009**   ▪ American Recovery and Reinvestment Act authorizes **incentives to providers for the adoption of Meaningful use of electronic medical records** through HI-TECH
- 2010**   ▪ The Patient Protection and Affordable Care Act requires:
  - ⌘ **Medicare to implement it's first hospital VBP program in 2013**
  - ⌘ **Development of plans for implementing VBP programs**<sup>2</sup> for home health agencies (HHAs), skilled nursing facilities (SNFs) and ambulatory surgery centers (ASCs)
  - ⌘ **Pilots / demonstrations for VBP programs at additional provider sites** (including critical access hospitals, low volume providers, inpatient psychiatric hospitals, long term care hospitals, rehab hospitals and hospice)
  - ⌘ **Several related initiatives** (program areas) that should be considered and implemented in **collaboration with VBP**, including but not limited to: Physician Value-Based Purchasing, Public an Quality reporting, Healthcare acquired conditions

1 Formerly know as (Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program; 2 Through Reports to Congress SOURCE: The Patient Protection and Affordable Care Act of 2010; Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program (2007); CMS.gov

# Value Based Purchasing Cycle



Measure development and selection

Monitoring and evaluation of process, measures, and quality improvement

Data collection

- Supportive policy and rule-making
- Integrated IT infrastructure
- Seamless communication with providers
- Public engagement and input
- Support of quality improvement
- Person-centeredness



Incentive calculation and disbursement

Data analysis and validation

# CMS quality measurement framework maps to six operational priorities

## Clinical care

- Acute care
- Chronic care
- Prevention
- Clinical efficiency and utilization

## Care coordination

- Transition of care measures
- Admission and readmission measures
- Provider communication

## Population/ community health

- Health behaviors
- Access to care
- Social and economic factors
- Physical environment
- Disparities in care (across all domains)

## Person- and Caregiver-centered experience and outcomes

- Patient experience
- Caregiver experience

## Safety

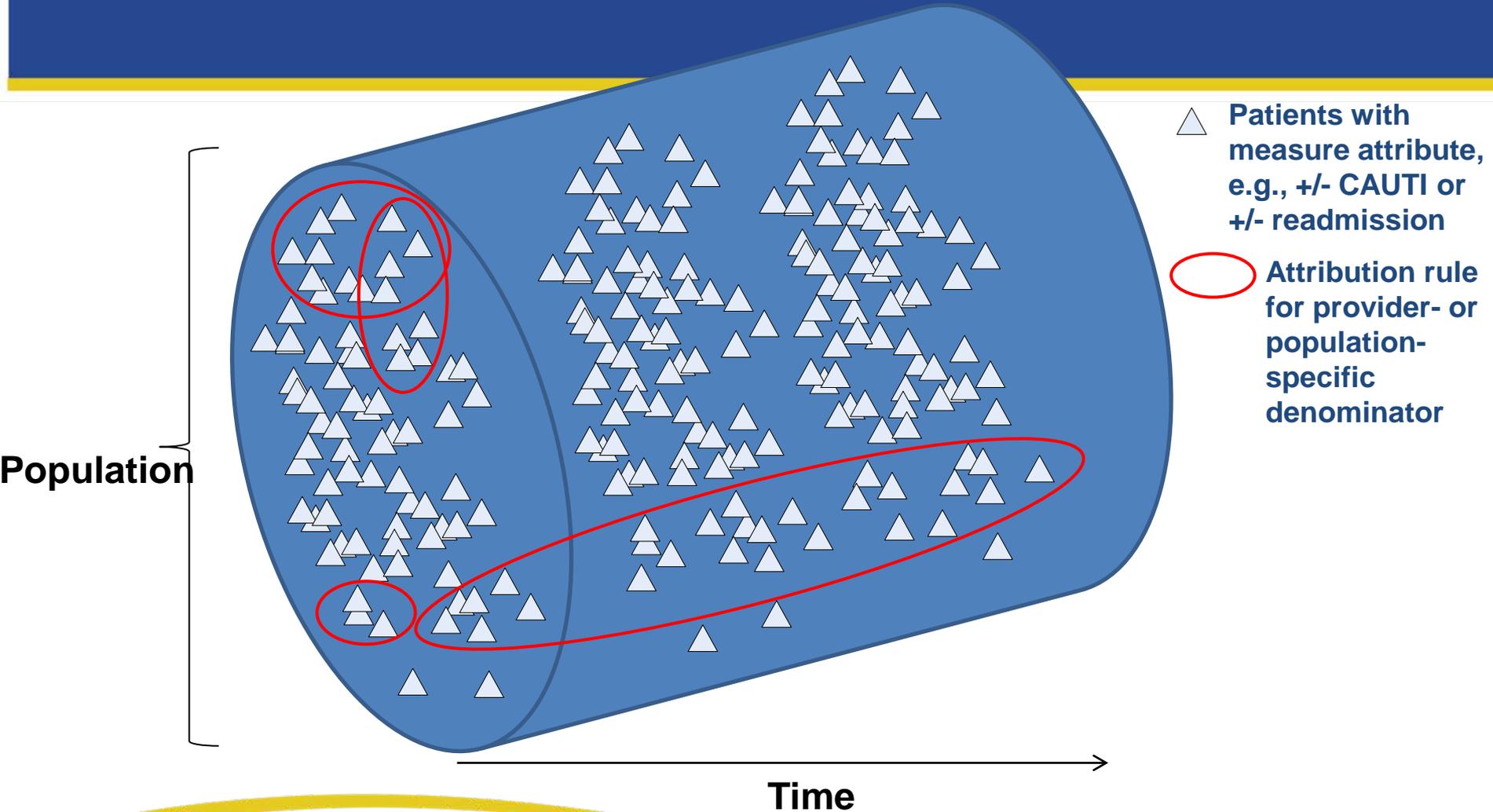
- Patient Safety
- Provider Safety

## Efficiency and cost reduction

- Annual spend measures (e.g., per capita spend)
- Episode cost measures
- Quality to cost measures

- 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**

# Denominators: Patient-centered measurement allows for quality measurement across care continuum and over time



# Hospital VBP Program

- For the first time, 3,500 hospitals across the country will be paid for inpatient acute care services based on care quality.
- In FY 2013, an estimated \$850 million will be allocated to hospitals based on their overall performance on a set of quality measures that have been shown to improve clinical processes of care and patient satisfaction.
- This funding will be taken from what Medicare otherwise would have spent, and the size of the fund will gradually increase over time, resulting in a shift from payments based on volume to payments based on performance.
- Funded by a 1% withhold from participating hospitals' Diagnosis-Related Group (DRG) payments raising to 2% by 2017.

# Background on the Payment Year 2012 ESRD QIP

## Background on the Payment Year 2012 ESRD QIP



- **Section 153(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) mandates the establishment of a QIP, which requires CMS to:**
  - Assess the quality of dialysis care by selecting quality measures, establishing performance standards and a performance period, and evaluating performance with respect to the standards.
  - Starting January 1, 2012, apply payment reductions of up to 2% for providers that do not meet standards (*based on scoring methodology published in the ESRD QIP Final Rule on January 5, 2011*).
  - Publicly report provider performance through a website and provide a Performance Score Certificate for each facility to post in their patient area.
- **The ESRD QIP is intended to complement the Prospective Payment System (PPS) by establishing a financial incentive for providing high-quality dialysis care.**

## Value-based modifier links quality with physician payment

- Physician Feedback/Value-Based Modifier Program provides comparative performance information to physicians
- Two primary components of the program:
  - Physician Quality and Resource Use Reports (QRURs, also referred to here as "the Reports")
  - Value-based Payment Modifier (VBPM)
- **Reports**–provided to participating physicians since 2009; beginning in 2015 and beyond, for physicians who will be impacted by the VBPM, the QRURs will contain composite measures of quality and cost that display the bases for the VBPM
- **Value-based Payment Modifier**–Starting in 2015, some physicians' payments by Medicare will be affected by application of the VBPM; by 2017, most physicians paid under the MPFS will see the VBPM applied to claims they submit to Medicare
- Objective is to align quality measurement and incentives across programs and care settings to establish common goals for quality improvement and shared accountability for performance

## Numerous CMS-led state-based programs focus on quality measurement and improvement

- **Health home Medicaid State Plan Option**
- **Voluntary state-based Medicaid quality reporting**
- **Duals Financial Alignment Initiative**

# When all is said and done...

