

CMS' Progress Toward Implementing Value-Based Purchasing

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Presentation Overview

- CMS' Value-Based Purchasing (VBP) Principles
- CMS' VBP Demonstrations and Pilots
- CMS' VBP Programs
 - Hospital-Acquired Conditions & Present on Admission Indicator Reporting
- Horizon Scanning and Opportunities for Participation

CMS' Quality Improvement Roadmap

- Vision: The right care for every person every time
 - Make care:
 - Safe
 - Effective
 - Efficient
 - Patient-centered
 - Timely
 - Equitable

CMS' Quality Improvement Roadmap

- Strategies
 - Work through partnerships
 - Measure quality and report comparative results
 - Value-Based Purchasing: improve quality and avoid unnecessary costs
 - Encourage adoption of effective health information technology
 - Promote innovation and the evidence base for effective use of technology

VBP Program Goals

- Improve clinical quality
- Reduce adverse events and improve patient safety
- Encourage patient-centered care
- Avoid unnecessary costs in the delivery of care
- Stimulate investments in effective structural components or systems
- Make performance results transparent and comprehensible
 - To empower consumers to make value-based decisions about their health care
 - To encourage hospitals and clinicians to improve quality of care

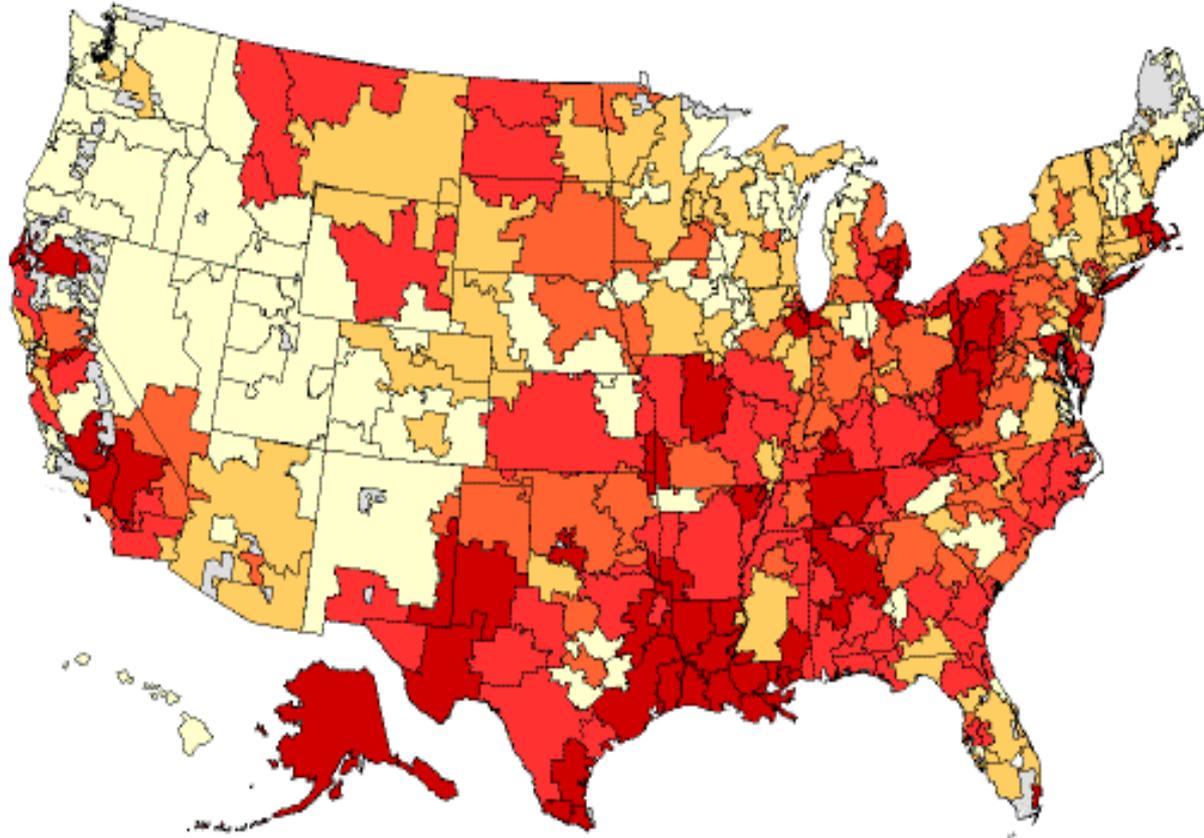
What Does VBP Mean to CMS?

- 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, gainsharing, competitive bidding, bundled payment, coverage decisions, direct provider support

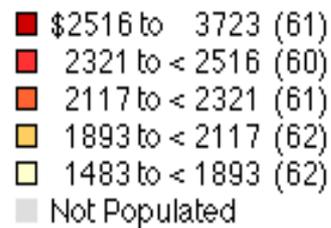
Why VBP?

- 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

Practice Variation



Map 2.5. Inpatient Hospital Services per Medicare Enrollee
by Hospital Referral Region (1995)

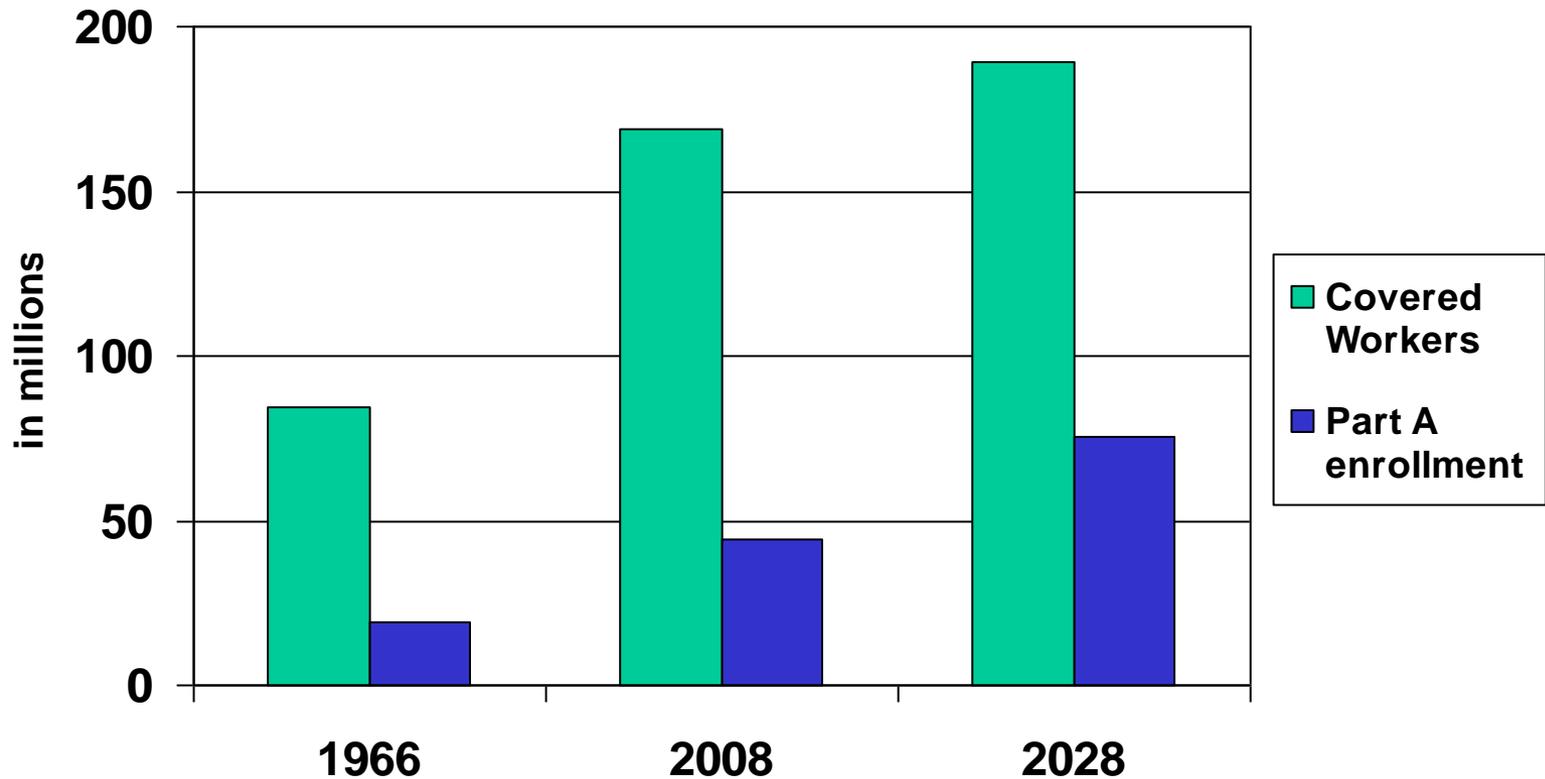


Why VBP?

- 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

Workers per Medicare Beneficiary

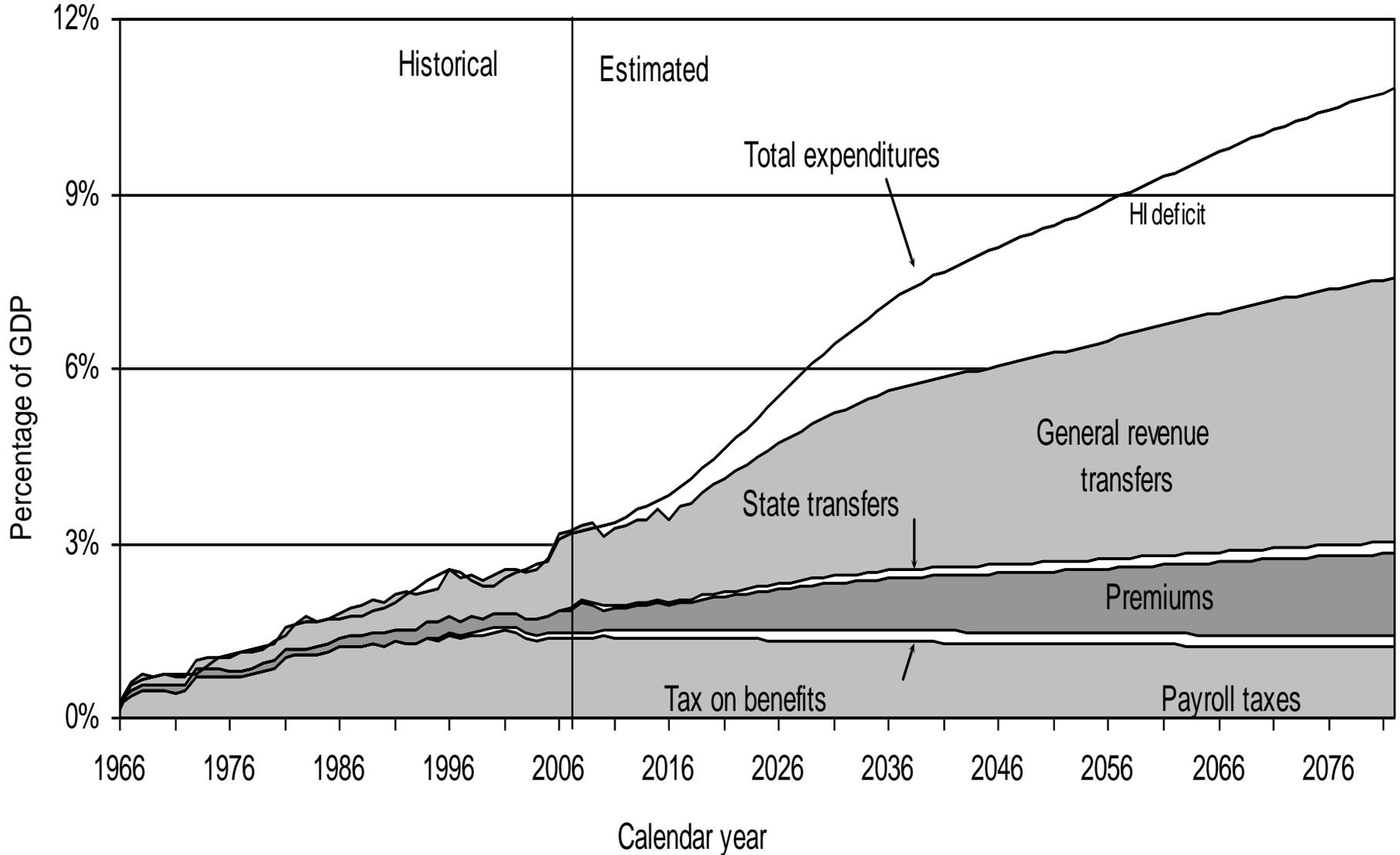
Selected Years



Worker to Beneficiary Ratio	1966	2008	2028
	4.46	3.39	2.49

Source: OACT CMS and SSA

Under Current Law, Medicare Will Place An Unprecedented Strain on the Federal Budget



Source: 2008 Trustees Report

Support for VBP

- 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

VBP Demonstrations and Pilots

- Premier Hospital Quality Incentive Demonstration
- Physician Group Practice Demonstration
- Medicare Care Management Performance Demonstration
- Nursing Home Value-Based Purchasing Demonstration
- Home Health Pay for Performance Demonstration

VBP Demonstrations and Pilots

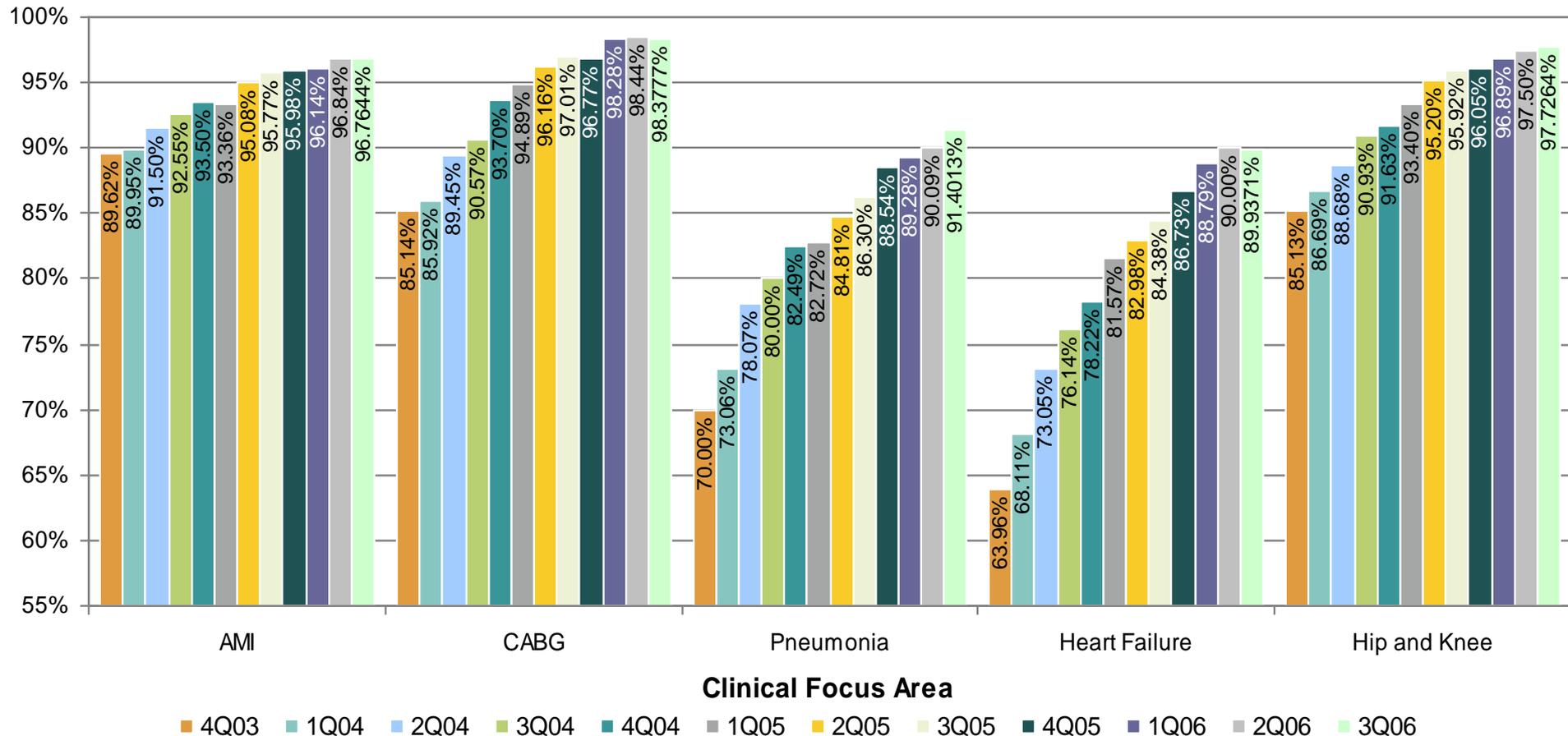
- Medicare Health Support Pilots
- Care Management for High-Cost Beneficiaries Demonstration
- Medicare Healthcare Quality Demonstration
- Gainsharing Demonstrations
- Accountable Care Episode (ACE) Demonstration
- Better Quality Information (BQI) Pilots
- Electronic Health Records (EHR) Demonstration
- Medical Home Demonstration

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)



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
- Medicaid

VBP Initiatives

Hospital-Acquired Conditions and Present on Admission Indicator Reporting

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>.

The HAC Problem

- In 2000, CDC estimated that hospital-acquired infections add nearly \$5 billion to U.S. health care costs annually

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

- A 2007 study found that, in 2002, 1.7 million hospital-acquired infections were associated with 99,000 deaths

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

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

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

Statutory Selection Criteria

- CMS must select conditions that are:
 1. High cost, high volume, or both
 2. Assigned to a higher paying DRG when present as a secondary diagnosis
 3. Reasonably preventable through the application of evidence-based guidelines

Statutory Selection Criteria

- Focus
 - Incidence, cost, morbidity, and mortality
- Coding
 - Clearly identified using ICD-9 codes
 - Triggers higher paying MS-DRG
- Availability of Evidence-Based Guidelines
- Preventability
 - “Reasonably preventable” does not mean “always preventable”

Statutory Selection Criteria

- Condition must trigger higher payment
 - Complications, including infections, can be designated complicating conditions (CCs) or major complicating conditions (MCCs)
 - MS-DRGs may split into three different levels of severity, based on complications (no CC or MCC, CC, or MCC)
 - The presence of a CCs or MCCs as a secondary diagnosis on a claim generates higher payment

MS-DRG Assignment (Examples for a single secondary diagnosis)	POA Status of Secondary Diagnosis	Average Payment
Principal Diagnosis: MS-DRG 066 <ul style="list-style-type: none"> ▪ Stroke without CC/MCC 	--	\$5,347.98
Principal Diagnosis: MS-DRG 065 <ul style="list-style-type: none"> ▪ Stroke with CC Example Secondary Diagnosis: <ul style="list-style-type: none"> ▪ Injury due to a fall (code 836.4 (CC)) 	Y	\$6,177.43
Principal Diagnosis: MS-DRG 066 <ul style="list-style-type: none"> ▪ Stroke with CC Example Secondary Diagnosis: <ul style="list-style-type: none"> ▪ Injury due to a fall (code 836.4 (CC)) 	N	\$5,347.98
Principal Diagnosis: MS-DRG 064 <ul style="list-style-type: none"> ▪ Stroke with MCC Example Secondary Diagnosis: <ul style="list-style-type: none"> ▪ Stage III pressure ulcer (code 707.23 (MCC)) 	Y	\$8,030.28
Principal Diagnosis: MS-DRG 066 <ul style="list-style-type: none"> ▪ Stroke with MCC Example Secondary Diagnosis: <ul style="list-style-type: none"> ▪ Stage III pressure ulcer (code 707.23 (MCC)) 	N	\$5,347.98

HAC Selection Process

- The CMS and Centers for Disease Control and Prevention (CDC) internal Workgroup selected the HACs
- Informal comments from stakeholders
 - CMS/CDC sponsored Listening Session
 - December 17, 2007
 - Ad hoc meetings with stakeholders
- Inpatient Prospective Payment System (IPPS) rulemaking
 - Proposed and Final rules for Fiscal Years (FY) 2007, 2008, 2009

Selected HACs 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

Selected HACs for Implementation

6. Manifestations of poor glycemic control
 - Hypoglycemic coma
 - Diabetic ketoacidosis
 - Nonkeototic 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

Selected HACs 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

Infectious Agents

- Directly addressed by selecting infections as HACs
 - Example: MRSA
- Coding
 - To be selected as an HAC, the conditions must be a CC or MCC
- Considerations
 - Community-acquired v. hospital-acquired
 - Colonization v. infection

Relationship Between CMS' HACs and NQF's "Never Events"

- In 2002, NQF created a list of 27 Serious Reportable Events, which was expanded to 28 events in 2006
- The list of NQF "never events" was used to inform selection of HACs

Relationship Between CMS' HACs and NQF's "Never Events"

- NQF's selection criteria for Serious Reportable Adverse Events
 - Unambiguous: clearly identifiable and measurable
 - Usually preventable: recognizing that some events are not always avoidable
 - Serious: resulting in death or loss of a body part, disability, or more transient loss of a body function
 - Indicative of a problem in a health care facility's safety systems
 - Important for public credibility or public accountability

Relationship Between CMS' HACs and NQF's "Never Events"

1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility
4. Pressure ulcers
5. Falls
6. Burns
7. Electric Shock
8. Hypoglycemic Coma

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

- CMS applies its authorities in various ways, beyond the HAC payment provision, to combat "never events:"
 - Conditions of participation for survey and certification
 - Quality Improvement Organization (QIO) retrospective review
 - Medicaid partnerships
 - Coverage policy

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

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>

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

Present on Admission Indicator (POA)

CMS' Implementation of POA Indicator Reporting

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)

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.
1	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.

POA Indicator Reporting Options

- POA indicator
 - CMS pays the CC/MCC for HACs that are coded as “Y” & “W”
 - CMS does NOT pay the CC/MCC for HACs that are coded “N” & “U”

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

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

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

Horizon Scanning and Opportunities for Participation

- IOM Payment Incentives Report
 - Three-part series: *Pathways to Quality Health Care*
- MedPAC
 - Ongoing studies and recommendations regarding VBP
- Congress
 - VBP legislation this session?
- CMS Proposed Regulations
 - Seeking public comment on the VBP building blocks
- CMS Demonstrations and Pilots
 - Periodic evaluations and opportunities to participate

Horizon Scanning and Opportunities for Participation

- CMS Implementation of MMA, DRA, TRHCA, MMSEA, and MIPPA VBP provisions
 - Demonstrations, P4R programs, VBP planning
- Measure Development
 - Foundation of VBP
- Value-Driven Health Care Initiative
 - Expanding nationwide
- Quality Alliances and Quality Alliance Steering Committee
 - AQA Alliance and HQA adoption of measure sets and oversight of transparency initiative

Thank You

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