



Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program



VISION FOR AMERICA:

- ▶ **Patient-centered, high quality care delivered efficiently.**

GOALS FOR VALUE-BASED PURCHASING:

- ▶ **Financial Viability**—where the financial viability of the traditional Medicare fee-for-service program is protected for beneficiaries and taxpayers.
- ▶ **Payment Incentives**—where Medicare payments are linked to the value (quality and efficiency) of care provided.
- ▶ **Joint Accountability**—where physicians and providers have joint clinical and financial accountability for healthcare in their communities.
- ▶ **Effectiveness**—where care is evidence-based and outcomes-driven to better manage diseases and prevent complications from them.
- ▶ **Ensuring Access**—where a restructured Medicare fee-for-service payment system provides equal access to high quality, affordable care.
- ▶ **Safety and Transparency**—where a value based payment system gives beneficiaries information on the quality, cost, and safety of their healthcare.
- ▶ **Smooth Transitions**—where payment systems support well coordinated care across different providers and settings.
- ▶ **Electronic Health Records**—where value driven healthcare supports the use of information technology to give providers the ability to deliver high quality, efficient, well coordinated care.



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Introduction

Given that CMS policies have a transformative impact on the health care system, it is important to develop the tools necessary to create rational approaches to lessen healthcare cost growth and to identify and encourage care delivery patterns that are not only high quality, but also cost-efficient.

To help address these concerns, CMS during the current Administration and with direction from Congress (e.g., through enactment of provisions in the Medicare Modernization Act, Deficit Reduction Act, and other provisions) has begun to transform itself from a passive payer of services into an active purchaser of higher quality, affordable care. Further future efforts to link payment to the quality and efficiency of care provided, would shift Medicare away from paying providers based solely on their volume of services. The catalyst for such change would be grounded in the creation of appropriate incentives encouraging all healthcare providers to deliver higher quality care at lower total costs. This is the underlying principle of value-based purchasing (VBP). The cornerstones of VBP are the development of a broad array of consensus-based clinical measures, effective resource utilization measurement, and the payment system redesign mentioned above. The overarching goal would be to foster joint clinical and financial accountability in the healthcare system.

This paper contains an inventory and status of key projects, programs and demonstrations that currently support such a transformation. It also provides CMS and other policy-makers with a roadmap, having a 3 to 5 year time frame, for restructuring the major Medicare fee-for-service (FFS) payment systems utilizing the principles of VBP. This roadmap is focused on completion of ongoing activities including implementation of requirements found in DRA and MIPPA, completion of open comment periods in the regulatory process, and completion of key demonstration programs that would be critical to implementing VBP in the current payment systems.

Vision, Goals and Objectives

Achieving transformation to achieve value for Medicare is not something that CMS can or should do by itself. It is possible that new legislation will be needed to permit certain restructuring of physician/provider relationships as well as payment system changes. CMS would need to work in partnership with physicians, providers, beneficiaries, Congress, and other stakeholders to create a healthcare financing system that promotes joint clinical and financial accountability. Physicians and providers would need to reorganize themselves in order to achieve the best clinical and financial outcomes. And CMS would need to restructure the payment systems in order to provide incentives for physicians and providers to work together to develop new ways to deliver high quality, efficient care while maintaining beneficiary access.

The road to VBP would begin by working within the currently established payment structure. Incentive payments for quality reporting and performance, efficiency, and eventually value would need to be developed and incorporated into the current payment systems, which encompass hospital, physician, skilled nursing facilities (SNFs), and other provider types and settings.

Provider-based quality incentive and shared savings programs could increase the provider communities' understanding and appreciation of the need to have joint accountability in their clinical and financial outcomes. This could support further development and expansion of accountable care organizations (ACOs), which are collaborations between physicians, hospitals, and all providers that will be clinically and financially accountable for healthcare delivery in their communities. Members of these ACOs would share a common goal to improve quality and decrease costs in their communities. Large payers, including Medicare, could help these collaborations form by providing quality and cost information for the populations they serve. ACOs could also interact with CMS in VBP payment models that could incorporate principles of competitive bidding for services, shared savings, or payment differentials based on performance.

CMS has already begun to pay for reporting of quality data for hospitals, HHAs, and physicians. As additional pay-for-performance payment strategies are established, CMS would need to provide tools to providers, based on work currently in progress, that would enable them to measure and monitor resource use and costs. Through the combination of quality metrics, resource utilization tools, and cost information, the framework for the development of measures of efficiency could be established. Implementation of payment models providing incentives to deliver efficient care, including shared savings models between CMS and providers, would follow. VBP could then be broadly applied to physician and institutional providers in a payment system that rewards the delivery of high quality, low cost care and encourages providers to compete on the basis of quality and cost.

To support these payment systems, CMS would need to consider appropriate modifications to the physician self-referral rules so that hospitals and other institutional providers may reward physicians for improving quality and efficiency in their local healthcare delivery settings. As an example, CMS could develop units of payment that go beyond the current approach of paying physicians and hospitals for their individual treatments and instead develop payments for broader bundles of service which eventually could even include entire episodes of care for all involved providers. Physicians and hospitals could then decide how best to provide these services in a more efficient manner on a patient-by-patient basis, and could allocate the payment among themselves in a way that allowed each to share in the savings. This model is already being tested in the current CMS Acute Care Episode demonstration.

The potential of health information technology to improve people's health and the functioning of the health care system is significant. Electronic health records (EHR) would be an important component of both the data strategy for VBP and for the payment incentives for VBP. EHRs are generally provider and/or physician controlled, allowing them to serve as a tool for easier collection of clinical data, thus reducing burdens on providers and improving accuracy of the data, which in turn add confidence in the VBP programs. Health information technology also enables physicians and providers to coordinate and collaborate more easily on patient care, which can improve health care outcomes and enable providers to achieve performance standards, which lead to these providers and physicians earning VBP based bonus payments.

There is also increasing interest in the consumer's role in his or her own health care and health care management. The Personal Health Record (PHR) is an adjunct tool related to the provider-based electronic health record. PHRs are generally consumer-controlled, allowing the patient, along with other parties the patient allows, such as family members and health care providers, to have access to a stored repository of his or her own personal health information and health history. In its ideal form, it would be a lifelong resource of health information used by individuals to make health care decisions, and to enable them to share information with their providers as necessary.

Another important component of VBP is transparency. Transparency of quality and cost information equips consumers to make informed decisions about their health care, while encouraging institutions and clinicians to improve the quality and efficiency of care provided to all patients. Transparency in healthcare facilitates improvement of performance, efficiency, and quality by providing facilities and physicians with the additional information necessary for benchmarking. One of the key tools HHS has developed for use of transparent information is the Chartered Value Exchange (CVE) Initiative. The CVE Initiative is supporting community collaborations to build a health care system where consumers, providers, and payers make decisions based on the value and quality of care.

In summary, VBP based payments could eventually apply not only to the individual payment systems for physician and institutional-specific services (hospitals, SNFs, End Stage Renal Disease (ESRD) facilities, etc.), but also more broadly to payments to collaborating providers, such as ACOs, which would encompass both the physician and institutional services. This would promote joint accountability between the physicians and institutional providers, and would serve to fully align incentives among these provider types. It would also provide a platform for the introduction of competitive bidding within the VBP program. EHRs would serve as a tool enabling the collection of clinical data, reducing burdens on providers and improving accuracy of the data. The healthcare consumer would have an increasing role in his or her own health care and health care management through PHR and transparency.

Purpose of This Paper

The purpose of this paper, as stated earlier, is to provide CMS and policymakers with an inventory of activities that support transformation to Value Driven Healthcare. It also intends to provide a roadmap, having a 3- to 5-year time frame, for implementing VBP-based payments for the major Medicare FFS payment systems. The roadmap focuses on the major tasks critical to implementing VBP, a refined delivery model that could achieve measurable and meaningful improvements in quality and efficiency in the traditional Medicare program.

Requirements for Implementing VBP in the Medicare FFS Program

If CMS were to implement VBP into the traditional Medicare FFS program, CMS would need, for each FFS payment system:

- Quality/efficiency measures and other implementation tools,
- Payment system redesign through:
 - Demonstration projects and/or
 - Statutory and regulatory authority,
- Resources to develop and implement VBP-based payments, and
- Data infrastructure (such as EHR, PHR, and interoperable systems between payment and quality data).

A template for VBP that can be applied to all provider types and settings within the current payment systems, as well as for ACOs, has been developed. This includes:

- Identification and promotion of the use of quality measures through pay for reporting,
- Payment for quality performance,
- Measures of physician and provider resource use,
- Payment for value-- promote efficiency in resource use while providing high quality care,
- Alignment of financial incentives among providers, and
- Transparency and public reporting.

This does not mean each component of the template would be required for each provider payment system. For example, the Medicare Improvements for Patients and Providers Act (MIPPA) requires performance-based payments beginning in 2012 for ESRD facilities, so there would be no need to establish a separate step to pay for reporting of quality data for ESRD.

CMS has already identified hospitals, physicians, home health, SNFS, and ESRD facilities as priorities, and has begun developing VBP plans for each of these areas.

See attachment for a more detailed list of the currently identified factors to be considered for implementing VBP in the Medicare FFS program. It is especially important to recognize the significant amount of resources that would be required to develop and implement VBP-based payments. These would include resources for revising the current payment systems, development of new systems, development of measures, and outreach and education, all of which are essential.

Roadmap and Current Work in Implementing VBP in the Medicare FFS Program

To move toward meeting these requirements, and in order to implement VBP-based payments for Medicare, CMS is already doing the following:

Identifying and Promoting the Use of Quality Measures through Pay-for-Reporting

Development of quality measures is essential for all VBP programs because VBP aligns payment more directly to the quality and efficiency of care provided, by rewarding providers for their measured performance across the dimensions of quality. CMS has concurrently developed a separate, more detailed roadmap for quality measure development which envisions giving increased priority to developing health outcome measures, and measures that address chronic conditions and coordination of care as well.

In pursuit of its VBP program, CMS has already begun paying for reporting of quality data for hospital inpatient prospective payment system (IPPS), physician fee schedule, and home health services:

Hospital IPPS: Pay-for-Reporting

The hospital pay-for-reporting initiative is intended to equip consumers with quality of care information to make more informed decisions about their health care, while encouraging hospitals and clinicians to improve the quality of inpatient care provided to all patients.

In December 2002, the Department announced a partnership with several collaborators intended to promote hospital quality improvement and public reporting of hospital quality information. In July 2003, CMS began the National Voluntary Hospital Reporting Initiative. This initiative is now known as the Hospital Quality Alliance: Improving Care through Information, which is a public-private collaboration to improve the quality of care provided by the nation's hospitals by measuring and publicly reporting on that care. An important element of the collaboration, Hospital Compare, a website tool developed to publicly report credible and user-friendly information about the quality of care delivered in the nation's hospitals, debuted on April 1, 2005.

CMS established a set of quality measures, used to gauge how well an entity provides care to its patients. Measures are based on scientific evidence and can reflect guidelines, standards of care,

or practice parameters. In this instance, a quality measure converts medical information from patient records into a rate or percentage that allows facilities to assess their performance. Hospitals submit quality data through the secure portion of the QualityNet Web site (www.QualityNet.org). Data from this initiative are used to populate the Hospital Compare website.

Hospitals that did not submit data received a reduction in their payment update of 2.0 percentage points for FY 2007 and beyond. For FY 2007, CMS required that hospitals submit data regarding 21 quality measures. The quality data collected included a number of infection-related measures and encompassed the following conditions: acute myocardial infarction, heart failure, pneumonia, and surgical care improvement.

CMS will collect a total of 44 quality measures for FY 2010, including: (1) 9 CMS-calculated AHRQ Patient Safety Indicators and Inpatient Quality Indicators and Composite Measures; (2) Participation in a Systematic Database for Cardiac Surgery; (3) Nursing Sensitive Measure on Failure to Rescue; and (5) 30-day Readmission Measures for Acute Myocardial Infarction and Pneumonia.

Physicians: Pay-for-Reporting

CMS has been actively moving forward to develop VBP for physician services. The Tax Relief and Health Care Act of 2006 (TRHCA) (P.L. 109-432) required the establishment of a quality reporting system for eligible professionals, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period). CMS named this program the Physician Quality Reporting Initiative (PQRI). A total of 74 clinical quality measures were available for reporting for 2007. Reporting for 2007 occurred only via claims. Payments to physicians and other eligible professionals who satisfactorily reported under the PQRI were made in late summer, 2008.

TRHCA also required that CMS establish a PQRI measure set for 2008, including structural measures. In the 2008 PQRI, there are a total of 119 measures that eligible professional can select from: 117 clinical quality measures and 2 structural measures (use of EHRs and electronic prescribing). CMS and physicians have been gaining valuable experience through implementing the PQRI program for 2007 and 2008.

Congress extended PQRI under MIPPA, which continues the program indefinitely and increased the incentive that eligible professionals can receive for satisfactorily reporting data on quality measures from 1.5 percent to 2.0 percent of their allowed charges for covered professional services in 2009 and 2010.

CMS added 52 new quality measures (bringing to 153 the total number of measures from which eligible professionals can select for 2009 PQRI). These new measures address such areas as osteoarthritis, rheumatoid arthritis, back pain, coronary artery bypass graft (CABG), chronic kidney disease (CKD), melanoma, oncology, coronary artery disease, hepatitis, and HIV/AIDS. The provision includes 18 measures that are reported exclusively through registries. Four new measures groups will simplify reporting for encounters pertaining to CABG, rheumatoid arthritis, perioperative

care, and back pain. This brings to seven the total number of measures groups. Professionals can continue to report using measures groups for diabetes, CKD, and preventive services. Composite measures, or groups of measures, aggregate several measures that address similar clinical conditions: an eligible professional can report all the measures in a measures group for a specified number of patients in order to qualify for the incentive payment.

PQRI participants can choose whether to report quality data for 2009 under one of two periods (depending on the type of measures reported): Jan. 1, 2009 – Dec. 31, 2009; or July 1, 2009 – Dec. 31, 2009, for measures groups and registry-based reporting. Eligible professionals who satisfactorily report data on quality measures during the annual reporting period would receive an incentive payment based on an estimate of allowed charges for covered professional services furnished during the full-year, and eligible professionals who satisfactorily report data on quality measures during the six-month reporting period would receive incentives based on an estimate of allowed charges for covered professional services furnished during the six-month reporting period. PQRI participants will be able to choose whether they wish to report PQRI data as part of their Medicare claims or through a clinical registry, and whether they wish to report individual measures or measures groups.

The PQRI program for 2010 will be detailed in the course of the regulatory process for establishing the 2010 Medicare physician fee schedule.

Home Health: Pay-for-Reporting

Medicare pays HHAs through a prospective payment system (PPS) that provides for higher payment rates to care for those beneficiaries with greater needs. Payment rates are based on relevant clinical data from patient assessments required to be performed by all Medicare-participating HHAs.

Home health payment rates have been historically updated annually by either the full home health market basket, or by the home health market basket as adjusted by Congress. The home health market basket index measures inflation in the prices of an appropriate mix of items and services furnished by HHAs. Section 5201(c) of the Deficit Reduction Act (DRA) of 2005 requires an adjustment of the home health market basket percentage update for CY 2007 and subsequent years based on the submission of quality data.

HHAs collect and report Outcome and Assessment Information Set (OASIS) data. Payment rates are adjusted for the non-reporting of OASIS assessment quality data. HHAs that submit the quality data as required receive payments based on the full home health market basket update. If a HHA does not submit quality data, the home health market basket percentage increase is reduced by 2.0 percentage points. CMS posts the nationally accepted and approved quality measures on the Medicare Home Health Compare website (note: there are a total of 12 measures reported by HHAs in CY 2008).

Paying for Quality Performance

In the next step for implementing VBP, CMS recognizes the need to pay for quality performance. Consistent with the desires of the provider community, performance-based demonstrations have begun. These include the Premier Demonstration, which is described below, highlighting its positive impact on quality. CMS submitted a report to Congress on November 21, 2007 supporting introduction of a broad VBP payment policy for hospitals, which will include payments for quality performance. CMS is also working on a physician VBP report to Congress due in May 2010. These will be discussed in a later section.

Hospital Pay-for-Performance: Premier Demonstration

CMS currently has several demonstration projects undergoing implementation or operations that are designed to test methods to improve the value of healthcare. One of the most important of these is the Premier Hospital Quality Incentive Demonstration, which includes approximately 250 hospitals in 38 states in collaboration with Premier, Inc., which operates a large quality measurement and improvement operation. That demonstration started in October 2003, and has documented substantial improvements in the quality of inpatient care. The demonstration is measuring and providing bonus incentives for improving quality of care in five clinical areas: acute myocardial infarction (AMI), pneumonia, heart failure, CABG, and hip and knee replacement. In the initial 3 years of operations, the average composite quality scores (CQS), an aggregate of all quality measures within each clinical area, improved significantly between the inception of the program and the end of Year 3 in all five clinical focus areas:

- From 87.5 percent to 96.1 percent for patients with AMI
- From 84.8 percent to 97.4 percent for patients with CABG
- From 64.5 percent to 88.7 percent for patients with heart failure
- From 69.3 percent to 90.5 percent for patients with pneumonia
- From 84.6 percent to 96.9 percent for patients with hip and knee replacement

The average improvement of the CQS between the project's second and third year was 4.4 percentage points, for total gains of 15.8 percentage points over the project's first 3 years. In addition, the range of variance among participating hospitals also is smaller, as those hospitals in the lower quality range continue to improve their quality scores and close the gap between themselves and the demonstration's top performers.

The demonstration has been extended for a second 3-year period. CMS added new quality measures for testing, including all of the Surgical Care Improvement Project measures. It is too early to determine the extent to which these new measures will show improvement.

Developing and Using Measures of Physician and Provider Resource Use

As payments for quality performance are being implemented, providers must also be given the tools to measure resource use in order to have a mechanism to fully evaluate their efficiency in care delivery. CMS has committed funding to further develop resource use measurement as described below.

Internal Workgroup to Develop Resource Use Measures

To implement VBP programs, CMS needs to be able to define and measure resource use, and develop tools that physicians and providers can use to promote greater efficiency in their practice. CMS has developed a separate roadmap for resource use measurement. To promote the development of efficiency measures and tools, CMS formed an internal workgroup referred to as the Physician and Hospital Resource Use (PHRU) workgroup. The PHRU workgroup has pursued projects that explore: (1) measurement of high cost imaging services through non-episode-based resource use reports, (2) the potential for Medicare to use existing commercial grouper products, (3) issues associated with applying relative resource use measures to physicians, such as attribution, sample size, risk-adjustment and benchmarking., (4) strategies for best defining episodes for purposes of comparing relative resources use, and (5) alternatives to using episodes as a unit of measurement.

CMS's Office of Clinical Standards and Quality is also considering additional efficiency measures, including imaging efficiency measures and hospital efficiency measures which focus on hospital readmission rates for certain conditions.

CMS also has a demonstration entitled the Physician Group Practice (PGP) demonstration (discussed later in this paper) that uses a calculation of per capita resource use to assess whether practices that improve care management have saved a set amount of dollars for the Medicare program. Using an actual versus expected calculation, the group practices are able to share in a portion of those savings if they meet certain quality and cost thresholds.

MIPPA Implementation

MIPPA required Medicare to implement a program to provide confidential reporting to physicians on their resource use. CMS is currently using episode groupers in Phase I of the Physician Resource Use Reporting Program. MIPPA provided significant flexibility in determining how to provide resource use reports, therefore short-term and longer-term strategy for the program can vary. In Phase I of the program, feedback will be provided to individual physicians in a subset of regions on selected conditions. This program is building on lessons learned from previous and ongoing episode grouper research to ensure that the resource use reports we provide physicians are as useful as possible.

Paying for Value: Promoting Efficiency in Resource Use While Providing High Quality Care

During development of quality measurement, payments for quality performance, and resource utilization tools, a parallel step in achieving a fully mature VBP program is the development of efficiency models that inform providers about the value of their care delivery models. Incentives to promote the adoption of these models are being tested in current policy and/or demonstrations.

As an initial step in this process, CMS has implemented a policy required by the Medicare statute to stop paying for certain reasonably preventable Hospital Acquired Conditions (HACs). In addition, CMS has already sent a plan to Congress laying out the steps to move hospitals from pay-for-reporting to pay-for-performance. CMS is currently developing a VBP plan for physician services, which is required to be submitted to Congress by May 2010. MIPPA establishes requirements for CMS to transition to a bundled ESRD payment system starting in 2011, and requires CMS to implement, beginning in 2012, quality incentives into the ESRD bundled payment system.

CMS has also established demonstration projects that are directed towards provider-specific types and settings and are designed to evaluate the concept of whether meaningful payment reform can occur through incentives for efficient care delivery. The demonstrations cut across provider types and settings and include physicians, home health, and SNFs. Incentives for the delivery of highly efficient and high quality care might be provided through shared savings payment programs.

The following is a summary of these efforts to promote efficiency in resource use while providing high quality care.

HACs and Present on Admission (POA) Indicator Reporting

The HAC provision, together with POA indicator reporting, are two other hospital-related VBP initiatives that CMS is using to promote increased quality and efficiency of care. The HAC provision is one approach that CMS is using to combat healthcare-associated complications, including infections, in the hospital setting. The Medicare statute requires CMS to select conditions that will no longer trigger higher payment when they are acquired during hospitalization. The selected conditions must be: (1) high cost, high volume, or both; (2) assigned to a higher paying MS-DRG when present as a secondary diagnosis; and (3) could reasonably have been prevented through the application of evidence-based guidelines.

Beginning October 1, 2008, Medicare can no longer assign an inpatient hospital discharge to a higher paying Medicare-severity diagnosis-related group (MS-DRG) if a selected condition is listed on the claim and was not POA. That is, the case will be paid as though the condition were not present. Medicare will continue to assign a discharge to a higher paying MS-DRG if the selected condition is POA. However, if any non-selected complicating condition appears on the claim, the claim will be paid at the higher MS-DRG rate; to cause a lower payment, all complicating conditions on the claim must be selected conditions for the HAC payment provision.

CMS has also begun collecting a POA indicator to determine whether diagnoses were POA or acquired during hospitalization. On October 1, 2007, CMS began requiring hospitals to submit this information on Medicare claims. The POA indicator is necessary to identify which conditions are HACs for payment purposes, and this information is also valuable for broader public health uses of Medicare data.

On December 18, 2008, CMS hosted a Listening Session on HAC payments in the inpatient and outpatient hospital settings. This session was held along with other DHHS partner agencies.

Hospital VBP Plan Development

CMS sent a plan to Congress laying out the steps to move hospitals from pay-for-reporting to pay-for-performance. The Congress, under Section 5001(b) of the Deficit Reduction Act of 2005, required the Secretary to develop a plan to implement a value based purchasing program for Medicare payment for subsection (d) hospitals, beginning with FY 2009. The plan discusses options for implementing a Medicare Hospital VBP program, which builds on Medicare's current Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program, which since FY 2005 has provided differential payments to hospitals that meet certain requirements, including publicly reporting their performance on a defined set of inpatient care performance measures. Building on the foundation of RHQDAPU, CMS recommends replacing the current quality reporting program with a new program that could include both public reporting and financial incentives for better performance as tools to drive improvements in clinical quality, patient-centeredness, and efficiency. A Medicare Hospital VBP Program should be implemented in a manner that does not increase Medicare spending.

The performance assessment model is the methodology that could be used for scoring hospital performance on specific measures. Those aggregate scores could then be used to determine an incentive payment. The model evaluates a hospital's performance on each measure based on the higher of either an attainment score or an improvement score. The improvement score could be determined by comparing the hospital's current score with its baseline performance.

A hospital's performance on individual measures would be summed within each measurement domain—such as process of care, outcomes, or patient experience—and then the domains would be weighted and summed to yield the hospital's total performance score. Using an exchange function, the hospital's total performance score would be translated into an incentive payment. The source of the incentive payment could be a percentage of the hospital's base operating DRG payments. Essentially, hospitals would have to earn back a portion of their Medicare payments by performing at a high level or improving their performance.

To qualify for the incentive payment under the Plan, a hospital would need to report on all measures relevant to its service mix. Measures of various aspects of health care quality, such as patient safety, process of care, outcomes, patient experience, efficiency, and care coordination, could be added over time. A subset of the current hospital pay-for-reporting measures could be used for initial implementation, including the current infectious-condition measures related to pneumonia and surgical infection prevention. As measures related to infectious conditions

emerge from development and testing, they could be adopted for the VBP financial incentives and public reporting.

The Hospital VBP Plan addresses a number of other issues related to the design and implementation of hospital performance-based payment. The current infrastructure for reporting hospital data could be improved through streamlining and improving the data submission process, including compressing the data submission period, allowing resubmissions, improving feedback reports, and enhancing user support, and through strengthening data validation. The Hospital Compare website could continue to serve as the platform for public display of performance results. Given the relative newness of performance-based payment, mechanisms for real-time monitoring and in-depth evaluation would be necessary for timely corrective action of unintended consequences and future enhancements.

Medicare would require additional statutory authority and resources to pay hospitals under a fully implemented VBP program.

Physician VBP Plan Development

Section 131(d) of MIPPA requires the Secretary to develop a plan to transition to a VBP program for Medicare payment for professional services. No later than May 1, 2010, the Secretary shall submit a Report to Congress containing the plan with recommendations for legislation and administrative action.

To meet this statutory requirement, CMS has formed an internal workgroup and held a public listening session on December 9, 2008. Feedback from this meeting will be useful for developing the VBP plan for physician services.

Payment for ESRD Patients

ESRD services under Part B are furnished on an outpatient basis in freestanding and hospital-based dialysis facilities. Currently, Medicare pays for certain dialysis services under a partial bundled rate, referred to as the composite rate. Payments for these composite rate services represent about 60 percent of total Medicare payments to ESRD facilities. The remaining 40 percent of Medicare spending for dialysis services is for separately billed items such as drugs, but may also include laboratory services, supplies, and blood products.

Earlier this year, CMS submitted a report to Congress on a new, fully bundled Medicare payment system for ESRD patients that would encourage more efficient, higher quality care. The report, required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), describes the recommendations for the elements, features, and methodology for a fully bundled prospective payment system (PPS) for dialysis services. Both MedPAC and the Government Accountability Office have supported fully bundled payment approaches for the payment of these services.

The report discusses establishing a base treatment payment rate for the services related to a dialysis session, including the services in the current composite rate as well as items that are

billed separately. The base rate would be adjusted for case-mix factors, such as the patient's age, gender, height and weight, and how long they have been on dialysis.

Subsequently, Congress passed MIPPA, which establishes requirements for CMS to transition to a bundled payment system starting in 2011. In addition, MIPPA requires CMS to implement, beginning in 2012, quality incentives into the ESRD bundled payment system.

Physician: PGP Demonstration

The PGP Demonstration rewards physicians for improving the quality and cost efficiency of health care services delivered to a Medicare fee-for-service population. Mandated by Section 412 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the goals of the demonstration are to: (1) encourage coordination of Part A and Part B services, (2) promote cost efficiency through investment in care management programs, process redesign, and tools for physicians and their clinical care teams, and (3) reward physicians for improving health outcomes.

During the 5-year project, CMS rewards physician groups that improve patient quality and financial outcomes by proactively coordinating their patients' Part A and Part B health care services, especially for beneficiaries with a chronic illness or multiple co-morbidities, and those near the end of life. Because they will share in any financial savings that result from improving the quality and cost efficiency of care, the groups have incentives to use new care management strategies and electronic tools that, based on clinical evidence and patient data, improve patient outcomes and lower total medical costs.

Performance payments are divided between cost efficiency for generating savings and performance on 32 quality measures phased in during the demonstration. Physician groups may earn performance payments of up to 80 percent of the savings they generate. As quality measures are added in performance years 2 and 3, the quality portion is increased so that by the third performance year 50 percent of any performance payment is for cost efficiency and 50 percent is for achieving national benchmarks or improvement targets on quality.

All physician groups participating in the PGP Demonstration improved the quality of care delivered to patients with congestive heart failure, coronary artery disease, and diabetes mellitus during performance year 2 of the demonstration. As a result, the 10 groups earned \$16.7 million in incentive payments under the demonstration, which rewards health care providers for improving health outcomes and coordinating the overall health care needs of Medicare patients assigned to the groups. All 10 of the participating physician groups achieved benchmark or target performance on at least 25 out of 27 quality markers for patients with diabetes, coronary artery disease, and congestive heart failure.

The groups also improved the quality of care delivered to Medicare beneficiaries on the chronic conditions measured. Physician groups increased their quality scores an average of 9 percentage points across the diabetes mellitus measures, 11 percentage points across the heart failure measures, and 5 percentage points across the coronary artery disease measures. These groups achieved outstanding levels of performance by having clinical champions

(physicians or nurses who are in charge of quality reporting for the practice) at the practice, redesigning clinical care processes, and investing in health information technology. The enhancements to their EHRs and patient registries allow practices to more easily identify gaps in care, alert physicians to these gaps during patient visits, and provide interim feedback on performance.

In addition to achieving benchmark performance for quality, several physician groups also experienced favorable financial performance under the demonstration's performance payment methodology. For patients with diabetes or coronary artery disease, Medicare expenditures grew more slowly for beneficiaries assigned to the physician groups than for beneficiaries in the comparison group with the same conditions.

This lower expenditure growth for chronic conditions, as well as complex patients treated in the ambulatory and hospital settings, contributed to four physician groups sharing in savings for improving the overall efficiency of care they furnish their patients.

The four physician groups – Dartmouth-Hitchcock Clinic, The Everett Clinic, Marshfield Clinic, and the University of Michigan Faculty Group Practice – earned \$13.8 million in performance payments for improving the quality and cost efficiency of care as their share of a total of \$17.4 million in Medicare savings. This compares to two physician groups that earned \$7.3 million in performance payments under the first year of the demonstration.

Home Health Pay-for-Performance Demonstration

CMS, with the assistance of Abt Associates, has designed a Home Health Pay-for-Performance demonstration to determine the impact of incentive payments to HHAs for improving the quality of care of Medicare beneficiaries who receive home health services. Under this voluntary demonstration HHAs will be eligible to receive incentive payments if their quality improvement efforts result in the highest performance levels or significant quality improvements as determined by Outcome-Based Quality Improvement measures. The availability of the incentive payments will depend on whether the demonstration results in savings to the Medicare program overall. These savings could be generated by reduced use of hospital, emergency room, nursing facility, and other Medicare-covered services as a consequence of improved home health outcomes for patients served by a comparison group of HHAs.

This demonstration will determine the impact of offering incentive payments to HHAs for improving the quality of care rendered to Medicare beneficiaries when such quality of care results in reduced need for additional services and reduces cost.

Recruitment for participation in the demonstration began in October 2007, with implementation of the demonstration in January 2008, and will continue through December 2009. The demonstration will be implemented in the following states: Connecticut and Massachusetts in the Northeast; Illinois in the Midwest; Alabama, Georgia, and Tennessee in the South; and California in the West. Participating agencies represent more than 30 percent of all Medicare-certified HHAs.

HHAs were randomly assigned to the demonstration study or the comparison group. Only those participating in the demonstration group will be eligible for performance incentives. Agencies

will not be at any financial risk or be required to collect any additional data as a result of participating in this demonstration.

An incentive pool will be generated out of savings accrued from the reduction in the use of more costly Medicare services. The pool will be shared with HHAs that produced the highest level of patient care or produced the greatest improvement in patient care as measured by seven OASIS measures. It is anticipated that 75 percent of the incentive pool will be shared with the top 20 percent of those with high levels of performance and twenty-five percent of the pool will be shared with the top 20 percent making the biggest improvements in patient care. These measures are from the existing OASIS data set and include measures of the incidence of acute care hospitalization and emergency care, improvement in select activities of daily living, and improvement in the status of wounds and management of oral medications. If there are no savings, there will be no incentive payments.

Nursing Home VBP Demonstration

The Nursing Home VBP Demonstration is another part of the CMS initiative to improve the quality and efficiency of care furnished to Medicare beneficiaries. This demonstration is currently in open solicitation stage. Under this demonstration, CMS will offer financial incentives to nursing homes that perform the best or improve the most in the level of care that they provide. The demonstration will be open to free-standing and hospital-based facilities and will include beneficiaries who are on a Part A stay as well as those with Part B coverage only. CMS intends to conduct the demonstration in up to five states.

The demonstration will be budget neutral to Medicare. We anticipate that potentially avoidable hospitalizations may be reduced as a result of improvements in quality of care. The reduction in hospitalizations and subsequent SNF stays is expected to result in savings to Medicare. These savings would be used to fund a savings pool from which payment awards would be made.

Each year of the demonstration, CMS will assess each participating nursing home's quality performance based on four domains: staffing (staffing levels and turnover rates), hospitalizations (rate of potentially avoidable hospitalizations), MDS-outcomes (select outcomes from already available resident MDS assessments), and survey deficiencies (from state survey inspections). CMS will award points to each nursing home based on how it performs on the measures within each of the domains. These points will be summed to produce an overall quality score. For each state, nursing homes with scores in the top 20 percent and homes that are in the top 20 percent in terms of improvement in their scores will be eligible for a share of that state's savings pool.

A separate savings pool will be estimated for each state in the demonstration. Nursing homes that volunteer to participate in the demonstration will be stratified and randomly assigned to experimental and control groups. After each year, CMS will compare total risk-adjusted Medicare expenditures between the experimental and control groups in each state. The actual savings pool for each state will be determined based on the difference in the growth of risk-adjusted Medicare expenditures between the two groups.

CMS is currently conducting a two-stage solicitation process. During the winter of 2009 we expect to select up to five states to host the demonstration. In the spring of 2009 we expect to solicit nursing homes within those states. We anticipate that the demonstration will begin in the summer of 2009.

Medical Home Demonstration

CMS is developing a demonstration program to determine if a medical home could provide better health care at lower cost to people with Medicare. This demonstration is a 3-year project required by the Tax Relief and Health Care Act of 2006, for rural, urban, and underserved areas in up to eight states. Under this demonstration project, a board-certified physician will provide comprehensive and coordinated care as the “personal physician” to Medicare beneficiaries with multiple chronic illnesses. The doctors selected will receive a care management fee, in addition to the payments for whatever Medicare-covered services they may provide. CMS anticipates that savings, which will be partially shared with participants under specific conditions, will be generated from reduced resource utilization and readmissions and will offset the administrative costs as well as the management fees for the program. We are expecting the project to be implemented in 2010.

Promoting Better Alignment of Financial Incentives Among Providers

As indicated earlier, CMS needs to work in partnership with physicians, providers, beneficiaries and other stakeholders to create a health financing system where there is joint clinical and financial accountability. In order to drive towards higher quality care and more efficient healthcare delivery, the artificial silos of care and payment based on the structure of the Medicare Part A and B Trust Funds need to be broken down. Physicians and providers should be jointly accountable for the care they provide, but also should be able to share in any resulting savings. This could include actions by CMS to revise the physician self-referral regulations. This approach is being tested through gainsharing demonstrations, the ACE demonstration, and other provider based programs for which OIG has recently issued favorable advisory opinions.

In addition, CMS has implemented a Post Acute Care payment reform demonstration for the purpose of understanding costs and outcomes across different post-acute care sites. It is expected that the data collected during this demonstration will generate recommendations for potential payment alternatives to help assure that post acute care patients are treated in the clinically most appropriate setting.

Proposed Exception to the Physician Self-Referral Rules

In support of this initiative, CMS proposed a specific exception to the physician self-referral rules in the CY 2009 physician fee schedule (PFS) proposed rule, and reopened the comment period in the CY 2009 PFS final rule to solicit comments on specific issues with the intent of moving forward with the establishment of an exception (or exceptions) to the physician self-referral law for properly structured, non-abusive incentive payment and shared savings programs. As mentioned above, several provider-based programs have recently been the subject of favorable advisory opinions from OIG, allowing quality incentive payments, as well as shared savings payments, to flow from hospitals to physicians in recognition of their impact on quality and programmatic cost savings. For example, OIG recently issued a favorable advisory opinion regarding a 3-year arrangement in which cardiologists will receive a percentage of the savings accrued if the physicians reduce the hospital's costs through the use of specific supplies for certain cardiac catheterization services.

Medicare Hospital Gain-sharing Demonstration

Section 5007 of the DRA requires the Secretary of Health and Human Services to establish a gainsharing demonstration program to test and evaluate arrangements between hospitals and physicians designed to improve the quality and efficiency of care provided to beneficiaries. The demonstration allows hospitals to provide gainsharing payments to physicians that represent a share of the savings incurred as a result of collaborative efforts to improve overall quality and efficiency. In the absence of this DRA authority, gainsharing is restricted by the civil monetary penalty law, which prohibits hospitals from rewarding physicians for reducing services to patients, even if such reductions are limited to duplicative services or otherwise represent improvements in quality.

The demonstration will determine if gainsharing aligns incentives between hospitals and physicians in order to improve the quality and efficiency of inpatient care, and to improve hospital operational and financial performance. This demonstration began on October 1, 2008, and is scheduled to end on December 31, 2009. Hospitals receiving payment under the hospital inpatient PPS are eligible to participate in this project. Continuous monitoring of quality and efficiency is required to ensure care provided to beneficiaries is not compromised throughout the demonstration. The evaluation will consider short-term improvements in quality and efficiency that occur during the inpatient stay and immediately following discharge. Participating hospitals must guarantee budget neutrality or savings to Medicare over the entire episode of care for the period of the demonstration.

Physician Hospital Collaboration Demonstration

CMS will operate the Physician Hospital Collaboration under authority provided under MMA Section 646 to examine health delivery factors that encourage delivery of improved quality of care. This demonstration will examine the effects of gainsharing aimed at improving the quality of care in a health delivery system. This demonstration will examine approaches that involve long-term follow-up to assure both documented improvements in quality and reductions in the overall costs of care beyond the acute inpatient stay. CMS will operate demonstration designs

that track patients well beyond a hospital episode, to determine the impact of hospital-physician collaborations on preventing short and longer-term complications, duplication of services, coordination of care across settings, and other quality improvements that hold great promise for eliminating preventable complications and unnecessary costs.

This 3-year project is expected to begin in 2009. Eligible organizations include physician groups, integrated delivery systems (IDSs) or regional coalitions of physician groups or IDSs.

Participating hospitals must guarantee budget neutrality or savings to Medicare over the entire episode of care for the period of the demonstration. The evaluation will examine quality of care, cost savings within the hospital, budget neutrality to CMS, and the operational feasibility and transferability of the project.

Acute Care Episode (ACE) Demonstration

ACE is a new hospital-based demonstration that will test the use of a bundled payment for both hospital and physician services for a select set of inpatient episodes of care to improve the quality of care delivered through Medicare fee-for-service. In this demonstration, CMS announced in January, 2009 that five hospitals in the South Central states will participate in a project in which they are paid global fees for cardiac and/or orthopedic procedures, meaning that they will be paid a single fee for the hospital facility fee and for all of the physician fees, including the surgeon, any consulting physicians, radiologists, anesthesiologists, and other physicians/practitioners included in the care of the patient. Also, the participating hospitals and physicians will be permitted to use gainsharing to improve incentives for collaboration. This demonstration is intended to improve internal hospital cost efficiency and quality of care, reduce costs for the Medicare program, and improve transparency of information for beneficiaries. Quality will be measured through a series of reported process and outcome measures, including several that focus on surgical infections such as selection and administration of antibiotics and deep sternal wound infection rate.

Post Acute Care (PAC) Payment Reform Demonstration

Section 5008 of the DRA directed the Secretary of Health and Human Services to develop a PAC payment reform demonstration. The purpose of the demonstration is to understand costs and outcomes across different post-acute care sites. It is expected that the data collected during this demonstration will generate recommendations for potential payment alternatives to help assure that post acute care patients are treated in the clinically most appropriate setting. This demonstration will provide standardized information on patient health and functional status, independent of PAC site of care, and examine resources and outcomes associated with treatment in each type of setting. Consistent case-mix data is needed to determine whether similar patients are treated in different settings. Similarly, good information on resource use within each setting is needed to understand differences in patient treatment and outcomes.

To assist the Secretary in carrying out this mandate, CMS has contracted with RTI, International to: (1) develop a Standardized Patient Assessment Tool for use at acute hospital discharge and at PAC admission and discharge, and (2) conduct PAC Payment Reform related analyses to

examine differences in costs and outcomes for PAC patients of similar case mix who use different types of PAC providers.

Fostering Transparency and Public Reporting

Transparency is a broad-scale effort intended to equip consumers with quality of care information to make informed decisions about their health care, while encouraging institutions and clinicians to improve the quality of care provided to all patients. Transparency in health care facilitates improvement of performance, efficiency, and quality by providing facilities and physicians with the additional information necessary for benchmarking.

Public reporting enhances accountability in health care by increasing the transparency of quality data. Public reporting is designed to create both indirect financial and non-financial incentives to improve quality of care. Indirect financial incentives result when public reporting drives patients' choices and, therefore, market share. Non-financial incentives include publicizing performance, reputation, competition, motivation, accountability, and public recognition. Providing reliable quality and cost information empowers not only patients' choices, but also the choices of stakeholders within local and regional communities, as well as nationally. Professionals are more likely to seek to join the staff of high performing hospitals. Choice leads to incentives at all levels and motivates the entire system; improvements take place as providers compete.

Compare Site Reporting Upgrades/Star Rating Systems

CMS has well-established "Compare" websites for hospitals, nursing homes, HHAs, and ESRD facilities. These sites allow beneficiaries to identify facilities in their area and compare quality and other information to facilities in their state and nationally. (Note: the data on these websites are available to download.) For instance, for nursing homes, beneficiaries can compare 19 quality measures, information on the number of nursing staff hours for a resident, and survey deficiency information as well as information regarding ownership and chain status.

Beginning in March 2008, CMS began posting cost in addition to quality information on Hospital Compare about selected inpatient hospital stays provided to Medicare patients. The new information shows how often Medicare patients were admitted to the hospital for these conditions and what Medicare pays for those services. This new information will give consumers even more insight into the quality of the health care that is available at their local hospitals and what Medicare pays for those services. Specifically, CMS recently announced the posting of new patient survey information to our Hospital Compare website, which now contains 26 quality measures plus 10 new measures of patient experience of care. We also are adding information about the number of Medicare patients treated for certain conditions and provided certain hospital procedures, and the average Medicare payment. For the first time, consumers have access to the three critical elements they need to make effective decisions about the quality and value of health care available to them through local hospitals: quality information, patient satisfaction survey information, and pricing information for specific procedures.

Regarding nursing homes, in December 2008, CMS released quality ratings for each of the nation's 15,800 nursing homes that participate in Medicare and Medicaid. Facilities are assigned star ratings from a low of one star to a high of five stars based on health inspection surveys, staffing information, and quality of care measures. The ratings are publicly available on the Nursing Home Compare web site.

In another key transparency initiative, in 2008, CMS posted the names of 52 poor performing nursing homes on medicare.gov as part of our "Special Focus Facility" initiative. These are nursing homes that move in and out of compliance with standards by fixing only the minimum number of safety and quality of care problems that allow them to temporarily comply with requirements, only to lapse back into unacceptable quality shortly afterwards. This list included facilities owned by large and small chains, as well as individual owners. There were two reasons to post this list. One, to inform the residents, their families, and the community that these particular homes were chronic under-performers. Two, to encourage these facilities to transform themselves into environments of quality care, or turn themselves over to a management team that would do so.

Posting the poor performing nursing homes on the website was not an isolated activity, but just one milestone in a year-long, special effort to move nursing homes forward on quality. It includes a pay-for-performance initiative for nursing homes, a pilot demonstrating a comprehensive system of criminal and other background checks for prospective new-hires in nursing homes, and strengthened surveillance of infection control and nutrition in nursing homes.

In April 2008, for the first time, information about nursing homes on the Compare website lists whether a home is or has been on the SFF list. The agency's SFF initiative gives heightened scrutiny to nursing homes that have a history of poor performance or repeated violations of state and federal health and safety rules.

In addition, in December 2008 CMS enhanced the existing Physician and Other Healthcare Professionals Directory by making public a limited amount of information related to the 2007 PQRI program. The public information was limited to listing eligible professionals who participated in the 2007 PQRI program, without regard to whether they qualified for the incentive payment. Thus, any eligible professional who submitted a quality data code would be considered to have participated. CMS expects to continue to enhance this information with more comprehensive physician performance information as that information becomes available.

Charted Value Exchanges (CVE): Communities Designated by HHS as Working to Improve Quality and Value of Health Care

HHS, through the CVE initiative, is supporting community collaborations to build a health care system where consumers, providers, payers, and health plans make decisions based on the value and quality of care. The CVE program is being administered by AHRQ, with participation by other HHS components, including CMS. Currently, there are 24 communities recognized by HHS as being CVEs, which are local collaborations of health care providers, purchasers, insurers, and consumers working jointly to improve care and make quality and price information widely available. Local public-private collaboration is essential to achieving a health system based on quality and value. The CVE program supports a view that the most effective strategy for achieving long-term improvement in health care is national level development of measures and standards, and the implementation of local solutions to utilize them.

As CVEs, these communities have access to information from Medicare that gauges the quality of care that physicians provide to patients, consistent with the Department's efforts to make Medicare data publicly available. Currently, CMS provides CVEs with data for 12 consensus developed measures. These performance measurement results may be combined with similar private-sector data to produce a more comprehensive guide to the quality of care in these communities.

In addition, these communities participate in a nationwide Learning Network sponsored by AHRQ. The Learning Network is the vehicle through which the CVEs receive technical assistance from experts and from each other through several mechanisms: 1) A webinar series, approximately two per month, with topics selected by CVEs; 2) a private Web site for CVEs; 3) in-person meetings, approximately two per year, for up to 6 stakeholders from each CVE; and 4) topic-specific workgroups, such as one on CVE sustainability. Topics include but are not limited to: 1) Collaborative Leadership and CVE Sustainability; 2) Public at-large Engagement; 3) Data Aggregation and Quality and Efficiency Measurement; 4) Public Reporting on Quality and Efficiency; 5) Provider Incentives for Quality; 6) Consumer Incentives for Quality; 7) Cross-organizational Capacity for Improving Quality; and 8) Health Information Technology.

Implementing and Adopting EHRs and Health Information Technology

The potential of health information technology to improve people's health and the functioning of the health care system is significant. EHRs are an important component of both the data strategy for VBP and for the payment incentives for VBP. EHRs are generally provider and/or physician controlled, allowing them to serve as a tool for easier collection of clinical data, thus reducing burdens on providers and improving accuracy of the data, which in turn add confidence in the VBP programs. Health information technology enables physicians and providers to coordinate and collaborate more easily on patient care, which can improve health care outcomes and enable providers to achieve performance standards, which lead to these providers and physicians earning VBP based bonus payments.

There is also increasing interest in the consumer's role in his or her own health care and health care management. The PHR is an adjunct tool related to the provider based electronic health record. PHRs are generally consumer-controlled, allowing the patient, along with other parties the patient allows, such as family members and health care providers, to have access to a stored repository of his or her own personal health information and health history. In its ideal form, it would be a lifelong resource of health information used by individuals to make health care decisions, and to enable them to share information with their providers as necessary. While a uniform, standard definition does not yet exist of a PHR, consistent applications for PHRs are beginning to emerge. The ideal is for a PHR to provide a complete summary of an individual's health and medical history with information gathered from many sources, including self entries. PHRs will have stringent controls to protect the privacy and security of the information, and individuals will have control over who has access to the information. Today, PHRs are offered by health plans, providers, and independent vendors. Standards are being developed and the tools will continue to evolve along with all of the health information technologies under way.

E-Prescribing Incentive Program

Physicians and other eligible professionals who meet the requirements of being a successful e-prescriber by reporting on an e-prescribing quality measure may earn an additional incentive payment of 2.0 percent of their total Medicare allowed charges for covered professional services furnished during 2009. Widespread adoption of e-prescribing can eliminate medication errors that result from the misreading of handwritten prescriptions. Medicare beneficiaries may also have reduced out-of-pocket costs as e-prescribing facilitates communication between prescribers and pharmacies on lower-cost generic alternatives.

The E-Prescribing initiative for 2010 will be detailed in the course of the regulatory process for establishing the 2010 Medicare physician fee schedule.

EHR Demonstration

CMS has implemented a 5-year demonstration project that will encourage small- to medium-sized primary care physician practices to use EHRs to improve the quality of patient care. The goal is to revolutionize the way health care information is managed, producing better health outcomes and greater patient satisfaction. This project is a major step toward the goal of most Americans having access to a secure, interoperable EHR by 2014.

The demonstration is designed to show that widespread adoption and use of interoperable EHRs may reduce medical errors and improve the quality of care for an estimated 3.6 million consumers. Over a 5-year period, the project will provide financial incentives to as many as 1,200 physician practices that use certified EHRs to improve quality as measured by their performance on specific clinical quality measures. Additional bonus payments will be available, based on a standardized survey measuring the number of EHR functionalities a physician practice has incorporated. The basis for financial incentives that will be provided to physician practices will vary over the 5-year period, including payments for both reporting and performance on quality measures. To further amplify the effect of this demonstration project,

CMS is encouraging private and public payers to offer similar financial incentives consistent with applicable law.

The demonstration will be implemented in two phases. The four communities selected for Phase I implementation are Louisiana, Maryland/Washington, D.C., Pittsburgh (and surrounding counties), and South Dakota (and surrounding counties in Iowa, Minnesota, and North Dakota).

Eight communities have been selected for Phase II implementation, including Alabama, Delaware, Jacksonville, FL (and surrounding counties), Georgia, Maine, Oklahoma, Virginia, and Madison, WI (and surrounding counties). During the first year, participants may earn a maximum of \$5,000 per physician or \$25,000 per practice.

PHR Choice Pilot

The pilot program will offer Fee-for-Service (FFS) Medicare beneficiaries in the states of Arizona and Utah the opportunity to maintain their health records electronically, using a product called a Personal Health Record (PHR) and to request that their Medicare claims data be transferred electronically to their PHR. In order to take advantage of the automatic claims data transfer, the beneficiaries must choose a PHR offered by any one of four PHR vendors selected by CMS's contractor. CMS announced the pilot on November 12, 2008, and the pilot is expected to officially launch in early 2009. The Medicare Administrative Contractor (MAC) Noridian Administrative Services (NAS) is managing the pilot and will supply the data. NAS solicited for PHR vendors to participate in the pilot and selected several PHRs to serve beneficiaries in the two states. NAS will also develop and implement authentication, authorization, and data exchange processes to transfer the Medicare claims data to the vendors. PHR vendors will use HITSP standards as applicable.

Next Steps for Implementing VBP in the Medicare FFS Program

To restructure payment systems, CMS and the Congress would need to develop incentives for physicians and providers to work together to develop new ways to provide beneficiary access to high quality, efficient care. Additional statutory authority is required in order to allow for performance-based payments in all Medicare FFS payment systems, except for payment for ESRD patients. The ESRD payment system is the first that Congress has specifically provided statutory authority for Medicare to base payments on performance.

A primary responsibility for CMS to help push this agenda forward is to clarify goals and objectives, and to establish an implementation process and operational infrastructure. As part of its responsibilities to continue to implement VBP into the Medicare FFS payment systems, CMS would focus its efforts on the activities listed below over the next 3 to 5 years. These activities are either required by statute, active in open comment periods of the regulatory process, or represent ongoing key demonstrations. The completion of these demonstrations and the results

of the already completed demonstrations noted in this paper could be used to formulate future health policy and payment reform in the traditional Medicare FFS payment system.

Payment for ESRD Services

As indicated earlier, ESRD services under Part B are furnished on an outpatient basis in freestanding and hospital-based dialysis facilities. Currently, Medicare pays for certain dialysis services under a partial bundled rate, referred to as the composite rate. Congress passed MIPPA, which establishes requirements for CMS to transition to a bundled payment system over 4 years, starting in 2011. CMS will need to establish case-mix adjustors using the most recent data available, go through the required notice and comment rulemaking process, update its systems infrastructure, and conduct provider and beneficiary education about the new payment system.

In addition, MIPPA requires CMS to implement, beginning in 2012, quality incentives into the ESRD bundled payment system. The payment incentives go beyond mere reporting of data and include a requirement that in order to receive full payment, an ESRD facility must achieve a total performance score that meets or exceeds a level as determined by the Secretary. Specifically, CMS will be required to develop and implement a new system that will assess each ESRD facility regarding a wide range of performance standards, including anemia management and other possible factors such as patient satisfaction.

Hospital VBP Plan Follow-up

As indicated earlier, CMS sent a plan to Congress laying out the steps to move hospitals from pay-for-reporting to pay-for-performance.

Physician VBP Plan Development

As discussed earlier, MIPPA requires the Secretary to develop a plan to transition to a VBP program for Medicare payment for professional services. Thus far, CMS has:

1. Summarized the state-of-the-art of physician VBP, including programs from both the private sector and relevant Medicare demonstrations.
2. Developed and made available on the CMS webpage a physician VBP issues paper that builds on the synthesis of the current state of physician VBP to frame the key issues that must be addressed in developing the Medicare Physician VBP Plan.
3. Conducted a Listening Session in December 2008, to engage physicians, other health professionals, consumers/purchasers, quality experts, and other key stakeholders in plan development.

In addition, through the development of this VBP plan for physician services, CMS would need to prepare the Physician VBP Plan Report to Congress.

Post Acute Care (PAC) Payment Reform Demonstration

Section 5008 of the DRA directed the Secretary of Health and Human Services to develop a PAC Payment Reform Demonstration. CMS has contracted with RTI International to assist the Secretary in carrying out this mandate. Further information is available from CMS's Office of Research, Development, and Information.

Promote Better Alignment of Financial Incentives Among Providers

As indicated earlier, CMS would need to work in partnership with physicians, providers, beneficiaries, and other stakeholders to create a health financing system where there is joint clinical and financial accountability. To carry out such a system, physicians and providers would need to be not only jointly accountable for the care they provide, but also would need to be able to share in any resulting savings. Key actions to promote better alignment of financial incentives among providers will include:

1. Actions by CMS to revise the physician self-referral regulations to allow providers to develop ACOs. In support of this initiative, CMS proposed a specific exception to the physician self-referral rules in the CY 2009 Physician Fee Schedule (PFS) proposed rule and, in the CY 2009 PFS final rule, reopened the comment period to solicit comments on specific issues, with the intent of moving forward with the establishment of an exception (or exceptions) to the physician self-referral law for properly structured, non-abusive incentive payment and shared savings programs.
2. Completion and evaluation of the gainsharing and ACE demonstrations.

Conclusion

To move Medicare away from being a passive purchaser of services to an active purchaser of high quality efficient care, the current traditional Medicare FFS payment systems would need to be redesigned. This restructuring would envision including the use of VBP in order to provide incentives that could create the needed changes and foster joint clinical and financial accountability in the healthcare system. The purpose of this paper was twofold: 1) to provide an inventory of the work CMS has undertaken to achieve these goals and 2) to provide CMS and policy-makers with a roadmap, having a 3- to 5-year time frame, for continuing the work already begun under this administration to move towards VBP-based payments in the major Medicare FFS payment systems. The paper focuses on the major tasks that are underway and would be critical to implementing VBP, a payment system redesign that could achieve measurable and meaningful improvements in quality and efficiency in the traditional Medicare program.

To fully implement VBP into the traditional Medicare FFS program, consistent with the vision, goals and objectives as discussed in this paper, CMS would need, for each FFS payment system:

- Quality/efficiency measures and other implementation tools,
- Payment system redesign through:
 - Demonstration projects and/or
 - Statutory and regulatory authority,
- Resources to develop and implement VBP based payments, and
- Data infrastructure (such as EHR, PHR, and interoperable systems between payment and quality data).

A template for VBP that can be applied to all provider types and settings within the current payment systems, as well as in potential new joint provider arrangements such as ACOs, has been identified and is being applied or tested in demonstrations and pilot programs. This includes:

- Pay for reporting--identify and promote the use of quality measures through reporting,
- Pay for quality performance,
- Develop measures of physician and provider resource use,
- Pay for value--promote efficiency in resource use while providing high quality care,
- Promote better alignment of financial incentives among providers, and
- Transparency and public reporting.

CMS has identified hospitals, physicians, home health, SNFs, and ESRD facilities as priorities, and has begun developing VBP plans for each of these areas. Medicare has made significant progress to date. CMS has already gained valuable experience through its numerous VBP-related demonstration programs such as the Premier Quality Incentive Demonstration and the PGP Demonstration. CMS's November 2007 report to Congress on Hospital VBP draws heavily on lessons learned from Premier. This report to Congress is important as it lays out the steps to move hospitals from pay-for-reporting to pay-for-performance. The next phase of implementation of hospital VBP awaits authority from Congress.

A few other examples of the many other accomplishments outlined in this paper are:

- Physicians and other professionals, through the PQRI, now can receive additional payments for reporting on a standard set of quality measures they themselves helped to develop.
- CMS implemented a Deficit Reduction Act provision disallowing Medicare payment for preventable conditions—high cost, high volume or both—acquired in the hospital. If a patient is discharged with one of eight complications in addition to the admitting diagnosis, Medicare will pay for the admitting diagnosis only.

It is clear that CMS has made significant progress in introducing VBP in the major traditional Medicare payment systems, either by implementing legislation or through demonstration and pilot programs. Many challenges lie ahead, but done properly and with continued stakeholder involvement, the appropriate alignment of incentives should occur so that payers, providers, and patients develop joint accountability in the healthcare system.

Attachment: Currently Identified Factors to be Considered for Implementing VBP in the Medicare FFS Program

Policy infrastructure

Research to guide program development

- Demonstrations to serve as models for program development
- Statutory authority
 - To establish the program and allow for performance based payments
 - Funding for incentive payments
- Regulatory authority
 - To implement program per statute
 - Self-referral exceptions to allow shared savings/risk between physicians and providers
- Implementing program policies

Operational infrastructure

Meaningful measures (i.e., measures that would make a meaningful difference if physicians/providers changed behavior to be compliant with the measures)

- Measures:
 - Quality: structural, process, outcome
 - Efficiency
 - Patient satisfaction
 - Risk adjustment of measures as appropriate
- Alignment of measures across settings
- Resources to develop and implement VBP-based payments (MAC contracts, research/administrative resources, systems development, and staff with expertise)
- Tools to measure resource use (e.g., episode groupers)
- Data sources: surveys, assessment instruments, registries, claims, other administrative data such as ESRD network data
- VBP data usable by stakeholders
- Unique identifiers for providers and for individual physicians and groups
- Coding systems: ICD-9 CM (future: ICD-10), HCPCS, revenue codes, National Uniform Billing Committee approval
- Interoperable systems that:
 - Collect measure data
 - Assess performance
 - Provide feedback to providers
 - Provide public transparency
 - Offer education and support systems (e.g., MLN articles, help desks)
 - Make payment to providers.

Acronyms

ACE	Acute Care Episode	NAS	Noridian Administrative Services
ACO	Accountable Care Organization	NOF	National Quality Forum
AHRQ	Agency for Healthcare Research and Quality	OASIS	Outcome and Assessment Information Set
AMI	Acute Myocardial Infarction	OIG	Office of Inspector General
CABG	Coronary Artery Bypass Graft	PAC	Post-Acute Care
CKD	Chronic Kidney Disease	PFS	Physician Fee Schedule
CQS	Composite Quality Scores	PGP	Physician Group Practice
CVE	Chartered Value Exchange	PHR	Personal Health Record
DRA	Deficit Reduction Act	PHRU	Physician and Hospital Resource Use
DRG	Diagnosis-Related Group	POA	Present on Admission
EHR	Electronic Health Record	PPS	Prospective Payment System
ESRD	End Stage Renal Disease	PQRI	Physician Quality Reporting Initiative
FFS	Fee for Service	RHQDAPU	Reporting Hospital Quality Data for Annual Payment Update
GDP	Gross Domestic Product	SFF	Special Focus Facility
HAC	Hospital-Acquired Condition	SNF	Skilled Nursing Facility
HHA	Home Health Agency	TRHCA	Tax Relief and Health Care Act
IDS	Integrated Delivery System	VBP	Value-Based Purchasing
IPPS	Inpatient Prospective Payment System		
MAC	Medicare Administrative Contractor		
MIPPA	Medicare Improvements for Patients and Providers Act		
MS-DRG	Medicare-Severity Diagnosis-Related Group		