

## CMS Value-Based Purchasing ("VBP")

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

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This presentation is based on CMS's "Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program." This Paper was prepared as a service to the public and is not intended to grant rights or impose obligations. The information is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive material for a full and accurate statement of contents.

## “Restructuring the Major Medicare Fee-for-Service (FFS) Payment Systems utilizing the principles of VBP”

### “Restructuring the Major Medicare Fee-for-Service (FFS) Payment Systems utilizing the principles of VBP”

- The velocity of growth in health care costs is climbing at an unsustainable rate.
- Direction from Congress to CMS
  - Create competition in the marketplace
  - Encourage high quality, cost-efficient care delivery patterns
- CMS Response - 3 to 5 year roadmaps issued to restructure the major FFS payment systems.

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As we are all aware, the velocity of growth in health care costs is climbing at an unsustainable rate. The Centers for Medicare & Medicaid Services (CMS) recently reported that the nation is expected to double its annual spending on healthcare by the year 2017 to roughly \$4 trillion: 21 percent of gross domestic product. Because of the current economic crisis, it is now projected that the Medicare Part A Hospital Insurance Trust Fund could go bankrupt as early as the year 2016.<sup>1</sup>

Given these significant concerns, Congress has provided direction to CMS through several legislative acts to enact policies that will create competition in the market place and will encourage care delivery patterns that are not only high quality, but also cost-efficient.

In response to these concerns, CMS has formally issued three roadmaps (e.g., Quality Measurement, Resource Use Measurement, and Value-Based Purchasing)<sup>2</sup> it plans to follow over the next 3 to 5 years to restructure the major Medicare fee-for-service (FFS) payment systems.

<sup>1</sup> [CMS Outlines Foundation to Improving Healthcare Roadmaps Issued to Guide Reform of Health Care System, January 16, 2009](#)

<sup>2</sup> [Quality Initiatives Gen Info](#)

## “Restructuring the Major Medicare Fee-for-Service (FFS) Payment Systems utilizing the principles of VBP”

### The Road to VBP – What’s On the Horizon...

- **Timelines** –
  - Over the next 3 - 5 years
- **Business Issue** –
  - Prepare for CMS to fully transform from a passive payer of services to a quality and value conscious purchaser of high quality, affordable care.
- **Provider Action Plan** –
  - Prepare to compete for market-share in a new reimbursement environment based on quality and cost.

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Over the next 3 to 5 years, CMS intends to fully transform itself from a passive payer of services into a quality and value conscious purchaser of high quality, affordable care. CMS’s roadmaps offer a vision for the future and potential options for CMS to pursue to

- Improve the quality and value of health care delivered in the United States and
- Shift the Medicare FFS program away from paying providers based solely on the volume of services and instead paying them for quality and value of care.

CMS intends complete this transformation using the principles of value-based purchasing (VBP) to create appropriate incentives throughout the health care delivery system. Incentives that

- Reward the delivery of high quality, low cost care and
- Encourage all health care providers to compete on the basis of quality and cost.

## Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program – The CMS “VBP Template”

CMS has already developed a template for VBP that can be applied to all provider types and settings within the current payment systems, as well as for ACOs. The template includes:

### The Road to VBP - The CMS Template

- Transparency and public reporting
  - Broad-scale reporting to drive market-share & competition
- Payment for reporting quality measures
  - Increased priority to develop health outcome measures
- Payment for quality performance
  - Providing \$ incentives for improving quality of care
- Tools to measure physician and provider resource use
  - Means to measure efficiency gains in care delivery
- Payment for value
  - \$ Incentives to reduce the cost of care while improving quality
- Alignment of financial incentives among providers
  - Breaking down the artificial silos of care and payment

## The Road to Value-Based Purchasing –VBP Template

- **Transparency and public reporting.**

**Broad-scale reporting to drive market-share:** CMS has well-established “Compare” websites for hospitals, nursing homes, HHAs, and ESRD facilities. In addition, beginning 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 PCQRI program. These sites allow beneficiaries to identify facilities in their area and compare quality and other information to facilities in their state and nationally. One of CMS’s stated purposes for broad-scale public reporting is the empowerment of not only patients’ choices, but also the choices of stakeholders within local and regional communities, as well as nationally.

- **Payment for reporting quality measures.**

**Increased priority to develop health outcome measures:** CMS has already initiated pay-for-reporting programs for hospitals, physicians, and home health organizations. CMS envisions giving increased priority to developing health outcome measures, as well as measures that address chronic conditions and coordination of care.

- **Payment for quality performance.**

**Providing \$ incentives for improving quality of care:** 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, a project that is measuring and providing bonus incentives for improving quality of care in five clinical areas.

- **Tools to measure physician and provider resource use.**

**Means to measure efficiency gains in care delivery:** As payments for quality performance are being implemented, CMS has committed funding for four projects to further develop tools to measure resource use. The data provided by these tools will serve as a mechanism to fully evaluate the efficiency in care delivery.

- **Payment for value**

**\$ Incentives to reduce the cost of care while improving quality:** While quality measurement, payments for quality performance, and resource utilization tools are being developed; CMS is completing a parallel step involving eight different initiatives to promote efficiency in resource use while providing high quality care.

- **Alignment of financial incentives among providers.**

**Breaking down the artificial silos of care and payment:** CMS believes that 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. CMS is conducting four different gain sharing and collaboration demonstrations to test this approach.

## Fostering Transparency and Public Reporting

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 to compare quality and other information to facilities in their state and nationally. CMS Nursing Home Star Rating System and Special Focus Facility Initiative both serve as a good example of how performance measures provided to and reported to the public by CMS can be used to improve care and reduce cost by driving market share to performing facilities.

### Compare Site Report/Star Rating Systems

In December 2008, CMS released quality ratings for each of the nation’s 15,800 nursing homes that participate in Medicare and Medicaid.

- Facilities were 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.

### Special Focus Facility (“SFF”) Initiative

The 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. Poor performance is defined as a nursing home that moves 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.

- As part of another key 2008 transparency initiative, CMS posted the names of 52 poor performing nursing homes on [medicare.gov](http://medicare.gov).
- In addition, for the first time in April 2008, information about nursing homes on the Compare website lists whether a home is or has been on the SFF list.
- According to CMS 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.

## Pay-for-Reporting - Promoting the Use of Quality Measures

CMS has already begun pay-for-reporting programs for hospital inpatient prospective payment system (IPPS), physician fee schedule, and home health services.

- **Purpose of the initiative:**
  - Equip consumers with meaningful information to make informed decisions.
  - Motivate health care providers to improve the quality of inpatient care provided to all patients.
- **Roadmap for motivating Providers:**
  - Develop quality measures to gauge how well an entity provides care to its patients
  - Populate public-use websites with reported data
  - Apply monetary rewards based on correct submission of data
- **Plan for the future:**
  - Increased priority to develop more health outcome measures

## Pay-for-Reporting – (continued)

### Hospital IPPS - Pay-for-Reporting

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

- CMS will collect a total of 44 quality measures for FY 2010<sup>3</sup>.
- Data from this initiative is used to populate the Hospital compare website.
- Hospitals that do not submit data correctly will currently receive a reduction in their payment update of 2.0 percentage points for FY 2007 and beyond.

### Home Health - Pay-for-Reporting

Section 5201(c) of the Deficit Reduction Act (DRA) of 2005 required an adjustment of the home health market basket percentage update for CY 2007 and subsequent years based on the submission of quality data. HHAs are now required to collect and report Outcome and Assessment Information Set (OASIS) data to receive payments based on the full home health market basket update.

- There were a total of 12 measures reported by HHAs in CY 2008.
- CMS posts the nationally accepted and approved quality measures on the Medicare Home Health Compare website.
- Non-compliance results in a market basket percentage increase reduction of 2.0 percentage points.

### Physicians - Pay-for-Reporting<sup>4</sup>

The Physician Quality Reporting Initiative (PQRI) Program was established by CMS to facilitate reporting data on quality measures for covered professional services furnished to Medicare beneficiaries.

- A total of 74 clinical quality measures were available for reporting for 2007. There are 153 measures from which eligible professionals can select for 2009<sup>5</sup>. The PQRI program for 2010 will be detailed in the course of the regulatory process for establishing the 2010 Medicare physician fee schedule.
- 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<sup>6</sup>, and whether they report individual measures or measures groups.
- CMS enhanced the existing Physician and Other Healthcare Professionals Directory by making public a limited amount of information related to the 2007 PQRI program. CMS expects to continue to enhance this information with more comprehensive physician performance information as that information becomes available.
- Physicians that correctly report data on quality measures will receive an incentive payment of 2.0 percent of their allowed charges for covered professional services in 2009 and 2010.

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<sup>3</sup> 9 CMS-calculated AHRQ Patient Safety Indicators and Inpatient Quality Indicators and Composite Measures; Participation in a Systematic Database for Cardiac Surgery; Nursing Sensitive Measure on Failure to Rescue; and 30-day Readmission Measures for Acute Myocardial Infarction and Pneumonia.

<sup>4</sup> 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). Congress has extended PQRI indefinitely under MIPPA.

<sup>5</sup> These new measures for 2009 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.

<sup>6</sup> The provision includes 18 measures that are reported exclusively through registries. Seven measures groups are available to simplify reporting for encounters pertaining to diabetes, CKD, preventive services, CABG, rheumatoid arthritis, perioperative care, and back pain.

## Paying for Quality Performance

CMS has several hospital demonstration projects currently operating or in the process of implementation that are designed to test methods to improve the value of healthcare based on bonus payments for quality performance. One of the most important demonstration projects is the Premier Hospital Quality Incentive Demonstration.

- The Premier demonstration is measuring and providing bonus incentives to approximately 250 hospitals in 38 states for improving quality of care in five clinical areas:
  - (1) Acute myocardial infarction (AMI),
  - (2) Pneumonia,
  - (3) Heart failure,
  - (4) CABG, and
  - (5) Hip and knee replacement.
- Based on the positive impact on quality documented in these performance-based demonstrations, 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.

## Developing and Using Measures of Physician and Provider Resource Use

CMS recognizes that providers must have access to tools that proficiently measure resource use to fully evaluate their efficiency in care delivery. CMS has committed funding to further develop resource use measurement as described below.

### Physician Group Practice (PGP) demonstration

- Resource benchmarks are established and compared to actual Program cost to assess whether practices that improve care management also save the Medicare Program a set amount of dollars.
- PGP shares in a portion of savings when they meet quality and cost thresholds.<sup>7</sup>

### The Medicare Improvements for Patients and Providers Act (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.

### Physician and Hospital Resource Use (PHRU) workgroup

The Workgroup has pursued projects that explore issues like

- Feasibility of applying relative resource use measures to physicians, such as attribution, sample size, risk-adjustment and benchmarking.
- Strategies for best defining episodes for purposes of comparing relative resources use, and
- Alternatives to using episodes as a unit of measurement.

### CMS's Office of Clinical Standards and Quality

The Office is considering additional efficiency measures, including Imaging and Hospital efficiency measures which focus on hospital readmission rates for certain conditions.

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<sup>7</sup> Using an actual versus expected calculation

## 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, CMS is completing a parallel step to promote efficiency in resource use while providing high quality care. The following is a summary of these efforts:

- **HACs and Present on Admission (POA) Indicator Reporting**  
**Certain complications acquired during the hospital stay no longer reimbursed.** The HAC provision is one approach that CMS is using to combat healthcare-associated complications, including infections, in the hospital setting. CMS will no longer reimburse hospitals for certain complications acquired during the hospital stay.
- **Hospital VBP Plan**  
**Earn back a portion of Medicare payments.** CMS has sent a plan to Congress laying out the steps to move hospitals from pay-for-reporting to pay-for-performance. Essentially, hospitals will have to earn back a portion of their Medicare payments by performing at a high level or improving their performance.
- **Physician VBP Plan Development**  
**Physician plan is in the works.** The Secretary shall submit a Report to Congress containing the plan with recommendations for legislation and administrative action no later than May 1, 2010.
- **Payment for ESRD Patients**  
**Bundled payments and quality measures on their way.** MIPPA requires CMS to transition to a bundled payment system starting in 2011 and implement quality incentives into the ESRD bundled payment system in 2012.
- **Physician: PGP Demonstration**  
**Gain-sharing to improve quality and cost efficiency.** The PGP Demonstration rewards physicians for improving the quality and cost efficiency of health care services delivered to a Medicare fee-for-service population.
- **Home Health Pay-for-Performance Demonstration**  
**Incentive pool shared between the top performers (20%).** 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.
- **Nursing Home VBP Demonstration**  
**Incentive pool shared between the top performers (20%).** 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.
- **Medical Home Demonstration**  
**Gain-sharing under specific conditions.** CMS is developing a demonstration program to determine if a medical home could provide better health care at lower cost to people with Medicare.

## Paying for Value - (Continued)

### HACs and Present on Admission (POA) Indicator Reporting

The HAC provision is one approach that CMS is using to combat healthcare-associated complications, including infections, in the hospital setting. In the past, these conditions triggered higher payment when the MS-DRG was listed on the claim.

- The Medicare statute now requires CMS to select conditions based on pre-defined criteria that will no longer be reimbursed when they are acquired during hospitalization.
- On October 1, 2007, CMS began requiring hospitals to submit POA indicators on Medicare claims to determine whether diagnoses were POA or acquired during hospitalization.
- 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.

### Hospital VBP Plan

CMS has sent a plan to Congress laying out the steps to move hospitals from pay-for-reporting to pay-for-performance.<sup>8</sup> The Plan 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.

- 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.<sup>9</sup>
- The performance assessment model is the methodology that could be used for scoring hospital performance on specific measures.<sup>10</sup>
  - The model evaluates a hospital's performance on each measure based on the highest of an attainment score or an improvement score.
  - The improvement score could be determined by comparing the hospital's current score with its baseline performance.
  - 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.

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<sup>8</sup>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.

<sup>9</sup> 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.

<sup>10</sup> 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.

### **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. The Secretary shall submit a Report to Congress containing the plan with recommendations for legislation and administrative action no later than May 1, 2010.

### **Payment for ESRD Patients**

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.

- CMS recently 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 discussed 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**

In the PGP Demonstration, physician groups share in any financial savings that are achieved by improving the quality and cost efficiency of health care services delivered to a Medicare fee-for-service population.

- 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 the first measurement year.
- 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.
- With these financial rewards established, the PGP Demonstration Groups have responded to 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.

### **Home Health Pay-for-Performance Demonstration**

Under this voluntary demonstration<sup>11</sup> 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.

- An incentive pool will be generated out of savings accrued from the reduction in the use of more costly Medicare services.<sup>12</sup> 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.<sup>13</sup>
- 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.<sup>14</sup> 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.

- CMS will assess each participating nursing home's quality performance based on four domains:
  - (1) Staffing (staffing levels and turnover rates),
  - (2) Hospitalizations (rate of potentially avoidable hospitalizations),
  - (3) MDS-outcomes (select outcomes from already available resident MDS assessments), and
  - (4) Survey deficiencies (from state survey inspections).
- 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.

### **Medical Home Demonstration<sup>15</sup>**

CMS is developing a demonstration program to determine if a medical home could provide better health care at lower cost to people with Medicare.

- 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.
- CMS expects the project to be implemented in 2010.

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<sup>11</sup> 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.

<sup>12</sup> 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.

<sup>13</sup> 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.

<sup>14</sup> The demonstration will be open to freestanding and hospital-based facilities and will include beneficiaries who are on a Part A stay as well as those with Part B coverage only.

<sup>15</sup> 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

## Promoting Better Alignment of Financial Incentives Among Providers

CMS believes the structure of the Medicare Part A and B Trust Funds has created artificial silos of care and payment that will need to be broken down to effectively drive towards higher quality care and more efficient healthcare delivery.<sup>16</sup> CMS has established several gain-sharing demonstrations to test this premise.

- **Medicare Hospital Gain-sharing Demonstration**  
This evaluation will consider short-term improvements in quality and efficiency that occur during the inpatient stay and immediately following discharge.
- **Physician Hospital Collaboration Demonstration**  
This 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**  
The purpose of this demonstration is to understand costs and outcomes across different post-acute care sites.
- **Post Acute Care (PAC) Payment Reform Demonstration**  
The purpose of the demonstration is to understand costs and outcomes across different post-acute care sites.

### **Medicare Hospital Gain-Sharing Demonstration**<sup>17</sup>

This evaluation will consider short-term improvements in quality and efficiency that occur during the inpatient stay and immediately following discharge.<sup>18</sup>

- Hospitals will be allowed to provide gain-sharing payments to physicians that represent a share of the savings incurred as a result of collaborative efforts to improve overall quality and efficiency.
- Quality and efficiency of inpatient care, and hospital operational and financial performance will then be measured to determine if gain sharing aligns incentives between hospitals and physicians to improve quality and efficiency of inpatient care.

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<sup>16</sup> 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. 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.

<sup>17</sup> Section 5007 of the DRA requires the Secretary of Health and Human Services to establish a gain-sharing demonstration program to test and evaluate arrangements between hospitals and physicians designed to improve the quality and efficiency of care provided to beneficiaries. 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. Participating hospitals must guarantee budget neutrality or savings to Medicare over the entire episode of care for the period of the demonstration.

<sup>18</sup> Continuous monitoring of quality and efficiency is required to ensure care provided to beneficiaries is not compromised throughout the demonstration.

## Promoting Better Alignment of Financial Incentives (Continued)

### Physician Hospital Collaboration Demonstration<sup>19</sup>

This evaluation will examine quality of care, cost savings within the hospital, budget neutrality to CMS, and the operational feasibility and transferability of the project. <sup>20</sup>

- 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 improvements that will likely eliminate preventable complications and unnecessary costs.

### Acute Care Episode (ACE) Demonstration<sup>21</sup>

The ACE demonstration will test the use of a bundled payment for both hospital and physician services for a select set of inpatient episodes. In this demonstration,

- Participants will be paid a single fee for cardiac and/or orthopedic procedures. The payment is intended to reimburse hospital facility fee and all physician fees, including the surgeon, any consulting physicians, radiologists, anesthesiologists, and other physicians/practitioners included in the care of the patient.
- Participating hospitals and physicians will be permitted to use gain-sharing incentives.
- 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<sup>22</sup>

The PAC demonstration will be implemented to better 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.<sup>23</sup> Similarly, good information on resource use within each setting is needed to understand differences in patient treatment and outcomes.

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<sup>19</sup>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.

<sup>20</sup> 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.

<sup>21</sup> ACE is a new hospital-based demonstration that is intended to improve internal hospital cost efficiency and quality of care, reduce costs for the Medicare program, and improves transparency of information for beneficiaries. 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

<sup>22</sup> Section 5008 of the DRA directed the Secretary of Health and Human Services to develop a PAC payment reform demonstration.

<sup>23</sup> 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.

## Preparing to Compete in a Value Driven Healthcare Delivery Environment.

Over the next 3 to 5 years, CMS intends to build a payment model that will use clinical and financial data to reward high-performers who achieve success in improving quality care, reduce resource consumption, and improve operating margins through cost savings.

As quality leaders work to position themselves as community high-performers, they can more easily drive positive behaviors within patient populations when they have access to the tools and methods to pro-actively monitor and manage meaningful clinical and operational performance metrics.

### The Road to VBP - The Cornerstones

- **Tools and Methods.**
  - Readily accessible to report meaningful clinical and financial data.
- **Clinical and operational performance metrics.**
  - Actively monitored and managed to drive positive behaviors within patient populations.
- **Financial rewards.**
  - Quality of care, reductions in resource consumption, and improvements in operating margins through cost savings.
- **Collaborations between physicians & hospitals.**
  - Joint accountability of clinical and financial results
- **Shared-saving payment models implemented.**
  - **Efficiency gains by sharing savings between providers and between CMS.**

**First Steps and Last Steps – Maintain access to meaningful clinical and financial data... Baseline Data Points:** Listed below is a summary of basic data records that should be captured, combined and reported in dashboards and management reports to help leaders more effectively compete in the CMS VBP reimbursement model.

– **Demographics**

- Age, Sex, Chief Complaint, Zip Code, Referring Physician, Admitting Physician, Primary and Secondary Payer.

– **Scheduling/Admission/Discharge**

- Date scheduled, Date Admitted, and Date Discharged
- Average waiting time for patients to be scheduled for elective surgery
- Average waiting time for new patients to be enrolled in outpatient programs
- Average waiting time in the emergency department
- Inpatient Admissions by zip code
- Inpatient Admissions by product line
- Inpatient Admissions by payer
- Inpatient Admissions by referral source
- Average daily census by service
- OP referrals by physician
- OP visits by program and site
- OP surgical procedures by specialty and physician
- OP ancillary tests and procedures ordered by physician and performed by department

– **Medical Record**

- Quality Data – Pay for Reporting
- Quality Data – Pay for Performance

– **Billing Record**

- Provider number and tax ID
- Physician name and UPIN number Diagnosis codes
- Procedure codes
- Admission source and discharge disposition codes (UB-92 only)
- Occurrence codes (UB-92 only)
- Charges, itemized or summarized by revenue code
- Associated CPT-4/HCPCS codes
- Hospital Acquired Conditions
- National Correct Coding Initiative Edits
- Medically Unlikely Edits
- Bill Drop Date and Clearinghouse Confirmation Date

– **Procedure Costs for cost containment and gain-sharing initiatives –**

- Pharmaceutical, Material and Labor costs by physician for selected diagnosis
- Length of Stay (MS-DRG, Physician, and Payer)
- Severity adjusted mortality and morbidity data for selected diagnosis
- Number of patients treated for complex or resource-intensive procedures
- Percentage of patients discharged on a timely basis to appropriate levels of follow-up care

– **Payment Record**

- Deposit Date and Cash Posting Date
- Contract Management (rate, terms and conditions)
- Final Adjudicated – Zero Payment (Denials, Billing Errors, Charity, etc.)
- Final Adjudicated – Short Payment
- No-Pay/Short-Pay – Aging against expected payment timelines