

The Centers for Medicare and Medicaid Services' Approach to Value-Based Purchasing

Bettina Berman, RN

Although evidence suggests that both the quality and the affordability of health care can be improved¹, it is likely that such improvements will come at great cost. Healthcare expenditures in the United States (U.S.) are expected to rise precipitously - from \$1.5 trillion in 2005 to over \$4 trillion in 2016.² Medicare, the nation's single largest health care purchaser, spent an estimated \$425 billion on health services in 2007. With the projected growth in Medicare beneficiaries, the amount may surpass \$800 billion by 2017, placing the government under significant pressure to control health care costs.³

This article is intended as a brief summary of the Centers for Medicare and Medicaid Services' (CMS) experience and its prospective strategies for health care quality improvement, including relevant legislation and potential future trends for value-based programs under CMS.

Initially, the Medicare payment system was based on provider claims for "customary, reasonable, and necessary costs." In the 1980's, Medicare introduced a prospective payment system for hospitals based on Diagnosis-Related Groups (DRG), but maintained a fee-for-service payment for ambulatory services. This payment system rewards providers for volume of services rather than the quality of those services, and encourages high resource consumption rather than efficient health care delivery. An increasing body of evidence² has revealed wide variations in quality and costs for the health care services provided to Medicare beneficiaries.

Armed with this knowledge, CMS developed a "Roadmap for Quality," aimed at "transforming Medicare from a passive payer to an active purchaser of high quality efficient care."⁴ In an effort to take a leadership role in transforming the health care system by supporting the Institute of Medicine's (IOM) 6 aims for health care (ie, Safe, Effective, Patient-centered, Timely, Efficient, and Equitable), CMS adopted the following strategies for achieving high quality, patient centered care:

1. Work through partnerships
2. Publish quality measurement and information
3. Pay in a way that expresses a commitment to quality and rewards rather than inadvertently punishing providers and practitioners for doing the right thing
4. Promote health information technology
5. Become an active partner in creating and using information about the effectiveness of healthcare technologies

The Deficit Reduction Act of 2005 (DRA) required a quality adjustment in Medicare Diagnosis Related Group (DRG) payment for certain hospital-acquired conditions (HAC), including serious preventable events, pressure ulcers, falls, and vascular catheter-associated infections. The legislation also authorized the development of a plan for a hospital value-based program to commence in FY 2009. CMS has received support for the

value-based plan from multiple stakeholders, including private insurers, the National Quality Forum (NQF), and the Medicare Payment Advisory Commission (MedPAC).

In its report, “Rewarding Provider Performance”⁵, the IOM recommended that “the Secretary of the Department of Health and Human Services (DHHS) should implement pay for performance in Medicare using a phased approach as a stimulus to foster comprehensive and system wide improvements in the quality of health care.” The report recommended transparency and incentive measures, stating that such measures will likely improve health care quality, but not necessarily reduce costs.

The final plan for a hospital payment system based on value was presented to the Congress in November of 2007.⁶ The plan proposes a value-based program which will eventually phase out Medicare’s current Reporting of Hospital Quality Data for Annual Payment Update Program (RHQDAPU). Under the new program, up to 5 percent of hospital payments would be made on the basis of a total performance score derived from measures that evaluate both clinical care and patient satisfaction.

In December of 2006, President Bush signed the Tax Relief and Health Care Act (TRHCA), paving the way for the Physician Quality Reporting Initiative (PQRI), a voluntary pay-for-reporting system aimed at individual physician and non-physician providers of Medicare services. The 2007 PQRI program, consisting of 74 measures, went into effect on July 1, 2007. For 2008, the PQRI incorporates 119 measures of clinical care, resource utilization, and structural measures (eg, electronic health records). Quality codes (CPT-II codes) are linked to the diagnostic codes (CPT-I and/or ICD-9) and submitted through the claims system. In order to qualify for a bonus of up to 1.5% of the total allowed charges for Medicare services, providers must reach a reporting compliance of 80%. Bonus payments and feedback reports from CMS, including reporting and performance rates, are expected by mid-2008.

According to CMS, the future of Medicare reimbursement for all payment systems is value-based purchasing.⁷ Future development of value-based purchasing programs for hospitals includes an emphasis on development of efficiency measures. For physicians, CMS is currently exploring the feasibility of providing resource utilization reports for individual providers. Another area being investigated by CMS is an “episode of care” payment system that offers an incentive to physicians who provide both well-coordinated and cost-effective care⁸ for individual Medicare beneficiaries.

Bettina Berman, RN is the Project Director for Quality Improvement in the Department of Health Policy at Jefferson Medical College. She can be reached at: Bettina.Berman@jefferson.edu.

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