

CENTERS FOR MEDICARE & MEDICAID SERVICES



# CMS ROADMAPS OVERVIEW

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# **CMS Roadmaps for the Traditional Fee-for-Service (FFS) Program: Overview**

The Centers for Medicare & Medicaid Services (CMS) is the single largest payer for health care in the United States. Nearly 90 million Americans rely on health care benefits through Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). These three major programs are administered by CMS, an agency of the U.S. Department of Health and Human Services (HHS).

As the steward for health care services for these individuals, many of whom are the nation's most vulnerable residents, CMS must ensure that these individuals have access to high quality care. This role becomes even more critical as the projected rate of growth in health care costs climbs at an unsustainable rate.

Health care today represents one-seventh of the economy with spending totaling more than \$2 trillion annually. By 2017, the nation is expected to spend roughly \$4 trillion on health care: 21 percent of gross domestic product.

Medicare costs are continuing to skyrocket as well. Last spring, the Medicare Part A Hospital Insurance Trust Fund had been projected to go bankrupt in 2019, 11 years from now. The Medicare chief actuary recently observed that because of the current economic crisis, this date could be moved three years earlier to 2016.

In the early years of the Medicare program, health care providers were paid for their reasonable costs or charges. Today most FFS Medicare services are paid on a fee schedule or prospective payment basis designed for a particular Medicare benefit. As a consequence, Medicare pays health care providers to perform services without regard to their quality and offers few financial incentives for the coordination of a patient's care or provision of preventive services.

The question is how could the Medicare of the future be paying health care providers? Are there ways to reward them for care delivered in a safe, effective, or efficient manner? Are there ways to recognize and reward care that is coordinated, that encourages good communication between health care providers and their patients, and that eliminates redundancy or care that is proven to be ineffective?

CMS is releasing the following Quality Measure, Resource Use Measurement, and Value Based Purchasing Roadmaps for the traditional Medicare FFS program. These documents are meant to synthesize CMS' efforts to improve the quality and value of health care delivered in the United States and to 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.

These documents do not represent official guidance, new regulation, or a legislative proposal, but it is the leadership's hope that this vision and the issues addressed will be useful in advancing the transformation of our health care system to be a system based on value. To implement this transformation, it is important to work in collaboration with health care providers to develop a broad array of up-to-date consensus based clinical measures, develop effective resource utilization measurement, and consider how to pay for Medicare services that are coordinated, collaborative, high quality, and efficient.

The papers linked to *this site* outline the activities that CMS has undertaken to implement value driven health care, including summaries of the various projects to test the policy and concepts designed to provide high quality, affordable health care. The papers provide steps to implement quality and resource use measurement to improve the delivery of care and offer a roadmap to assist in implementing value-based purchasing for Medicare's FFS payment systems. These papers are intended to provide information to policy makers about the demonstrations and pilot programs that are already underway and to articulate the overarching principles guiding further efforts.