PAY FOR PERFORMANCE (P4P) via IT INVESTMENTS in CALIFORNIA MEDICAL GROUPS

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CMS
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What is Quality?

- **IOM: "…the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"**
- **AHRQ: "Quality health care means doing the right thing at the right time in the right way for the right person and having the best results possible"**
- **CMS – Likes both definitions**

(IOM-Institute of Medicine)
(AHRQ-Agency for Healthcare Research and Quality)

CMS Approach to Quality

- **Announced November 2001 by Administrator Scully and Secretary Thompson:**
  - **Empower consumers to make more informed decisions regarding their healthcare**
  - **Stimulate / support providers & clinicians to improve the quality of health care**

Physician-Focused Quality Initiatives

- DOQ – test and develop quality measures in physician office setting
- DOQ-IT – assist physician offices adapt IT
- DOQ-IT Pilot Project – rewarding public reporting of superior quality care through the adoption of IT
- Several payment demonstrations

DOQ-IT

- **Premise: optimal improvement in physician office quality cannot be achieved without adoption of health information technology and process redesign**

DOQ-IT

- Make high quality, affordable systems more available
- Provide assistance to physician offices
  - IT adoption decision
  - Implementation and workflow efficiencies
  - Care management/patient self-management
- Financial incentives: CMP demonstration (MMA Sec. 649)

DOQ-IT Pilot Project: Care Management Performance Demonstration, Sec. 649

Requirements for higher payment

- **Physician offices adopt specified IT systems to improve safety/quality and manage patients with chronic disease**
  - **Full EHR *or***
  - **E-Rx, e-lab results management, e-registry**
- **Demonstrate use of such systems through electronic data transmitted to data warehouse**
- **Meet performance targets – public reporting**
- **Quality Improvement Organizations provide support**

Chronic Care Improvement Program (CCIP)

- Created by the Medicare Modernization Act of 2003
- First large-scale chronic care improvement initiative under the Medicare fee-for-service program
  - improve/strengthen traditional fee-for-service Medicare program
  - improve the quality of care for people living with multiple chronic illnesses
    - help them manage their conditions
    - encourage better coordinated care

Chronic Care Improvement Program (cont.)

- ~14% of Medicare beneficiaries have congestive heart failure, accounting for 43% of Medicare spending
- ~18% of Medicare beneficiaries have diabetes, accounting for 32% of Medicare spending

Chronic Care Improvement Program (cont.)

- CMS will select organizations that offer self-care guidance and support to chronically ill beneficiaries
  - organizations will help beneficiaries who choose to participate to:
    - manage their health,
    - adhere to their physicians' plans of care, and
    - assure that they seek/obtain needed medical care to reduce their health risks
- Solicitations reviewed
- Expect first site to be operational in early 2005

Chronic Care Improvement Program (cont.)

- **Phase I, Pilot Phase**
  - **~10 regional Chronic Care Improvement programs, serving approximately 150,000-300,000 Medicare fee-for-service beneficiaries with multiple chronic conditions, e.g., congestive heart failure, complex diabetes, chronic obstructive pulmonary disease**
  - **in regions where at least 10% of Medicare beneficiaries reside**
  - **operate for 3 years**
  - **evaluated through randomized controlled trials**
    - **focus on setting measurable performance goals and tracking improvements in clinical quality, provider and beneficiary satisfaction, and cost-effectiveness in a regional, population-based framework**

Chronic Care Improvement Program (cont.)

- Phase II
  - Secretary will expand Phase I programs/program components that prove to be successful to additional regions, possibly nationally
  - Secretary shall begin the Phase II expansion within 2-3½ years after Phase I
- Not testing whether Chronic Care Improvement is a good idea
  - rather, how to incorporate such services into traditional fee-for-service Medicare
- http://www.cms.hhs.gov/medicarereform/ccip/

Medicare Disease Management Demonstration (2004)

- Mandated by the Benefits Improvement and Protection Act of 2000
- Pilot project to improve care for chronically ill Medicare fee-for-service patients with heart problems and diabetes
- CMS to assess whether disease management programs, along with outpatient drug coverage, can:
  - improve medical treatment plans,
  - reduce unnecessary hospital admissions, and
  - promote other desirable outcomes

Medicare Disease Management Demonstration (cont.)

- CMS payment for all disease management services and prescription drug costs, whether or not they relate to beneficiary's chronic health condition
- Each participating organization required to guarantee projected savings to the Medicare program
  - HeartPartners ^{SM}, a Santa Ana, California-based collaboration among PacifiCare, QMed, Alere Medical, and Prescription Solutions approved to serve 15,000 beneficiaries with heart failure in California and Arizona

Medicare Disease Management Demonstration (cont.)

- At risk for achieving savings from treatment group Medicare claims, relative to control group claims greater than cost of disease program and drug benefit
- First enrollees February 1, 2004
- Demonstration runs through January 2007

Care Management for High-Cost Beneficiaries Demonstration

- CMS to study various care management models for high-cost beneficiaries in traditional Medicare fee-for-service program
  - e.g., intensive case management, increased provider availability, structured chronic care programs, restructured physician practices, expanded flexibility in care settings
  - How do models reduce Medicare costs while improving the quality of care and quality of life for beneficiaries?

Care Management for High-Cost Beneficiaries Demonstration (cont.)

- ~4-6 organizations will be selected to participate in 3-year demonstration
- Applications received on/before January 4, 2005
- Physician groups, hospitals, and integrated delivery systems may submit proposals
  - other organizations may apply but must be part of consortium that includes at least one of the above-mentioned entities

Care Management for High-Cost Beneficiaries Demonstration (cont.)

- Applicants may propose a monthly fee to cover administrative and/or care management costs
  - may propose plan to share portion of savings from demonstration (for net savings in excess of 5%)
  - organizations failing to produce 5% savings net of fees will be required to refund savings shortfall up to the full amount of their fees

Care Management for High-Cost Beneficiaries Demonstration (cont.)

- Eligible beneficiaries identified by CMS as meeting high-cost guidelines and any additional targeting criteria for the individual programs
  - applicants to specify types of conditions and demographic/other beneficiary characteristics
- Independent evaluation of clinical quality improvement, provider/beneficiary satisfaction, outcomes, savings to Medicare program

  http://www.cms.hhs.gov/researchers/ demos/cmhcb.asp
- Direct your questions to cmhcbdemo@cms.hhs.gov

More Information

- www.cms.hhs.gov/medicarereform/
- www.cms.hhs.gov/researchers/demos

Thank you!

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