



Quality Strategy

Division of Quality, Evaluation,
and Health Outcomes
CMS



Driving Forces

- Increasing share of both Federal and State budgets are directed toward the financing of Medicaid.
- Exploring options in benefit design and eligible populations alone will not ensure that payors are receiving value for the dollars spent on health care.
- Providers and employer groups continually request that CMS join national efforts to reduce duplication in effort and administrative burden.
- Consumers are expected to participate in health care through consumer-directed plans, health savings accounts, and other mechanisms and will require information on cost and quality to make informed decisions.

Price and Quality Transparency.

“ The President seeks the commitment of medical providers, insurance companies, and business leaders to help consumers obtain better information on health care prices and quality. The Administration will leverage Federal resources and work with the private sector to develop meaningful measures for health care quality and to emphasize the importance of all-inclusive price information.”

Budget of the United States, FY07



Driving Forces

- Secretary Leavitt's 500 Day Plan
 - Payers reward providers for healthy outcomes as well as quantity of care and services.
 - Inequalities in health care are eliminated
 - Expressing a clear vision of health information technology that conveys the benefits to patients, providers and payers.
 - Medicare and Medicaid are modernized to provide high-quality health care in a financially sustainable way.
 - The beneficiaries of Medicare and Medicaid are cost-conscious consumers with expanded choices of plans and treatments.
 - Medicare and Medicaid are viewed as leaders in the collaborative development and use of health information technology, quality measurement and pay for performance.

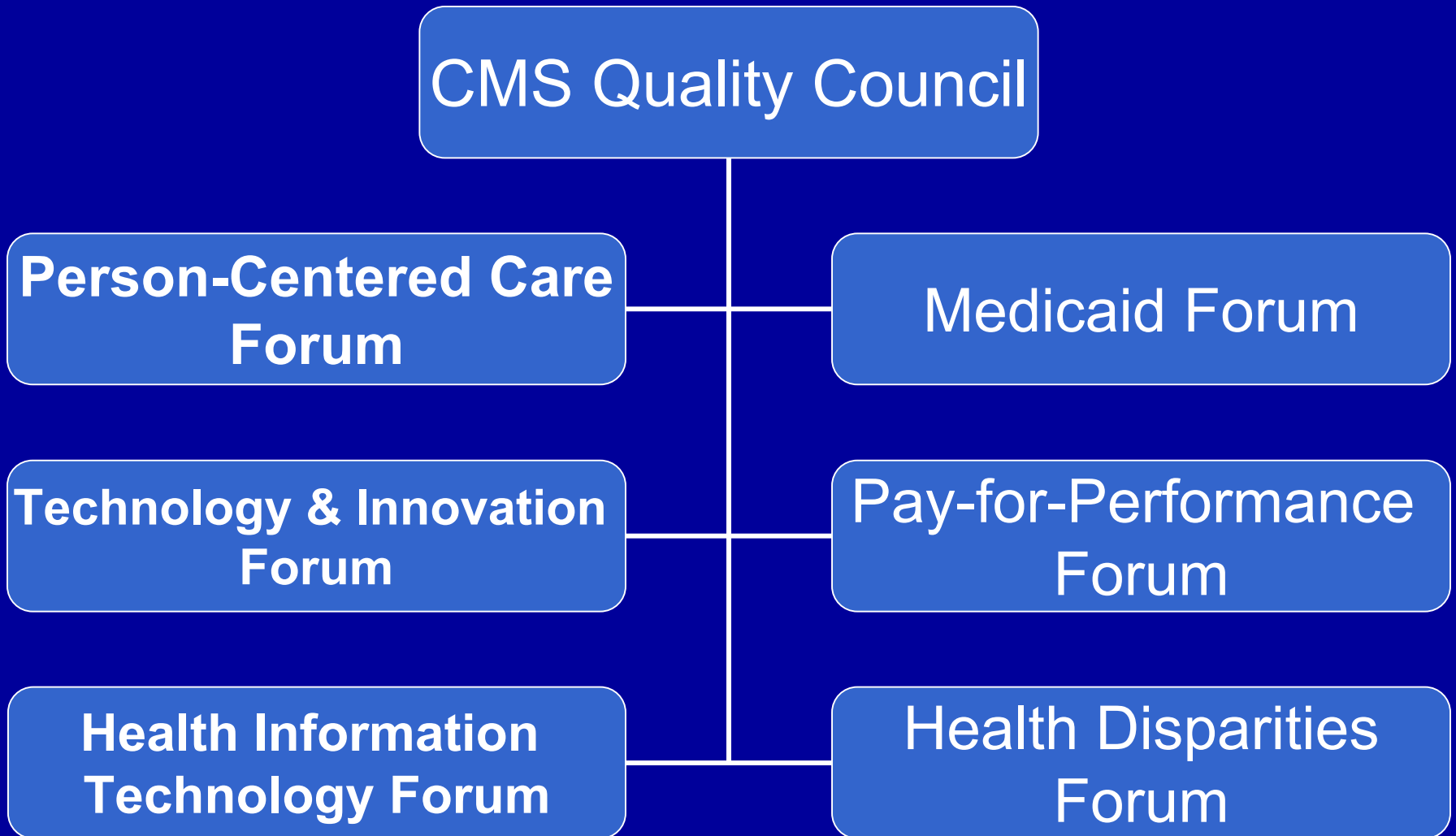
Driving Forces



CMS Administrator FY06 Goals

- Strengthen and expand the health care safety net by identifying and supporting five Medicaid Best Practices
- Incorporate the reduction of health care disparities as a priority area in the newly created Medicaid/SCHIP Quality Strategy; disseminate strategy to States, and provide information on promising practices to State Medicaid and SCHIP agencies
- Develop a fully detailed P4P strategy covering five settings and establish key quality alliances to support appropriate quality measures
- Improve health care quality across Medicaid and SCHIP in accordance with GPRA Plan [FS]. (CMSO)

CMS Quality Council Forums



CMS Quality Improvement Roadmap

Released in August 2005

- **Vision: The right care for every person every time**



Aims:
Make care
safe,
effective,
efficient,
patient-
centered,
timely;
and
equitable 7

Medicaid/SCHIP Quality Strategy

- Builds upon the CMS Quality Roadmap and structured to recognize the unique relationship between the Federal Government and States.
- The pillars of the Medicaid/SCHIP framework are:
 - Evidenced-Based Care and Quality Measurement
 - Supporting Performance based Payment
 - Health Information Technology
 - Partnerships
 - Information Dissemination and Technical Assistance

Evidenced Based Care and Quality Measurement

Encourage development and utilization of validated and tested measures for assessing the performance of health care providers and plans

CMSO Aims:

- Determine through discussion with States, what measures would be most useful to States and work to disseminate available information or encourage the development of the required measures
- Learn from current State efforts and disseminate best practices.
- Enhance the consistency of data collection in performance measurement across payors.
- Work with States as they develop waiver applications, carry out terms and conditions, develop state quality strategies, contract for EQRO reporting, and design program evaluations.

Neonatal Outcomes Improvement Project

We envision a future in which low birth weight infants survive with high quality of life. We wish to reduce the disease burden as well as death rate associated with a low birth weight and prematurity. The United States has one of the highest infant mortality rates among industrialized countries. Medicaid pays a significant part of the cost associated with neonatal care.

- Antenatal Practices:
- Immediate Postnatal Practices:
- Postnatal Practices:



Supporting Efforts in Performance Based Payment

A quality improvement and reimbursement methodology which is aimed at moving towards payments that creates much stronger financial support for patient focused, high value care.

- National Medicare pay-for-performance efforts underway
- Medicaid in early stages of development
- Several States already have implemented performance based payment programs
- Important that evolving programs include an evaluation component to answer the question of effectiveness
- Considerations related to the approach a State uses to implement program (e.g. State Plan, Waiver, etc.)

Overarching Principles: Medicaid P4P programs should be:

- Data driven
- Beneficiary-centered
- Transparent
- Developed through partnerships
- Administratively flexible

Quality Components: P4P programs should be built on:

- Evidence-based guidelines
- Consistent measures of access, quality, costs, and satisfaction
- Coordinated care programs
- Health information technology

Incentive Structure: P4P incentives consideration:

- Equitable and fair to program participants including the beneficiary
- Timely
- Sufficient to motivate improvement
- Flexible enough to provide payment for innovative care processes
- Structured to avoid unintended consequences

Medicaid/SCHIP State Health Official Letter

- Provides a brief description of pay-for-performance as a strategy to stimulate improvements in the quality of care and more appropriately align resources.
- Indicates the authority under which States may implement pay-for-performance strategies.
- Answers questions regarding financial considerations, including the Federal Financial Participation, budget neutrality and cost effectiveness issues when implementing pay-for-performance strategies.
- Provides a chart describing strategies several States have implemented to provide performance incentives to providers and managed care organizations including the measures and incentive methodologies used.
- Informs States of potential opportunities to partner with CMS in a nursing home pay-for-performance demonstration.
- Informs of the availability of technical assistance to States interested in pursuing pay-for-performance purchasing mechanisms.

Incentives to Improve Quality

- Public reporting of quality information
- Performance based rate adjustments
- Performance based bonuses
- Competitive payment schedule
- Tiered payment levels
- Performance based fee schedules
- Performance based payment withholds
- Quality Grants
- Autoassignments

Public Reporting of Quality

- Arizona
- Arkansas
- Colorado
- Maine
- Maryland
- Michigan
- New York
- North Carolina
- Ohio
- Wisconsin

Performance Based Bonuses

– Michigan

- Based on a plan's clinical and access scores:
 - HEDIS Submission
 - CAHPS scores
 - Accreditation status
 - Proportion of Medicaid managed care populations

– Rhode Island

- Based on HEDIS, CAHPS, and other measures
 - Additional incentives for plan with the highest scores for given areas such as member services and grievances

Withholds and Penalties

– New Mexico

- Withholds of one half of one percent of the health plan's payments for performance on HEDIS and non-HEDIS measures

– Maryland

- Health plan penalties for measures where the minimum target is not met
 - Penalty of 1/9 of 1/2% of total capitation is collected

Other Incentive Plans

- **Competitive Payment Schedules**
 - California
 - Points awarded relative to other plans; based on the statistical significance of scores between plans
- **Tiered Payment Levels**
 - North Carolina
 - Based on achieving best practice stretch goal or top 15th percentile of baseline
 - Quality Improvement- improve from own baseline by 20%
 - Nevada
 - Health plan performance based on HEDIS scores
 - Full payment at or above the National HEDIS 90th Percentile
 - No payment below the national median
 - Prorated payments between the national median and the 90th percentile



Partnerships

...collaborative efforts to improve quality of health care in areas of mutual interest

Examples of external partners with whom CMSO has met to discuss areas of potential collaboration:

- Agency for Health Research and Quality
- HHS Office of Disabilities
- National Association of Children's Hospitals
- Center for Health Care Strategies
- Commonwealth Fund
- Centers for Disease Control
- Medicaid Medical Directors (AHRQ Learning Network)
- National Association of State Medicaid Directors
- National Committee for Quality Assurance
- Child and Adolescent Health Measurement Initiative
- CMSO works through APHSA to convene Quality Technical Advisory Group (Q-TAG) to obtain state input on jointly defined issues

For More Information

www.cms.hhs.gov/MedicaidSCHIPQualPrac/

*The Right Care for Every
Person Every Time*