Strategies Today for Superior Health Care Tomorrow

Trent T. Haywood, MD, JD

Deputy Chief Medical Officer and

CMS

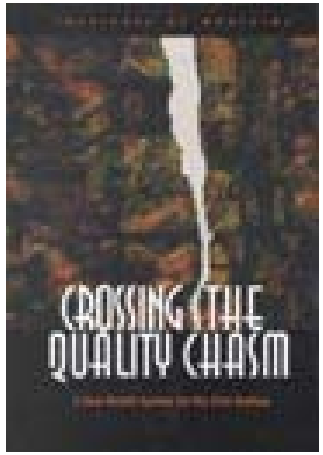
Past Environment

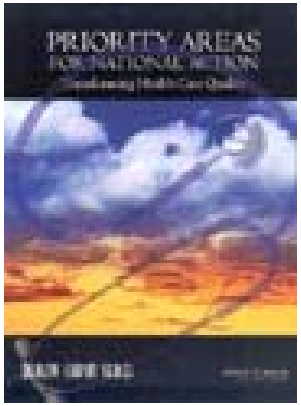
(1)"perhaps the results as a whole would not be good enough to impress the public very favorably;" (2) it is "difficult, time-consuming, and troublesome;" and (3) "neither Trustees of Hospitals nor the Public are as yet willing to pay for this kind of work."

Codman, c.1910

To Err Is Human:
BUILDING A SAFER HEALTH SYSTEM

Health care in the United States is not as safe as it should be--and can be. At least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented, according to estimates from two major studies. Even using the lower estimate, preventable medical errors in hospitals exceed attributable deaths to such feared threats as motor-vehicle wrecks, breast cancer, and AIDS.





CHAPTER TWO

How Well do Health Systems Perform?

Better health is unquestionably the primary goal of a health system. But because health care can be catastrophically costly and the need for it unpredictable, mechanisms for sharing risk and providing financial protection are important. A second goal of health systems is therefore fairness in financial contribution. A third goal – responsiveness to people's expectations in regard to non-health matters – reflects the importance of respecting people's dignity, autonomy and the confidentiality of information. WHO has engaged in a major exercise to obtain and analyse data in order to assess how far health systems in WHO Member States are achieving these goals for which they should be accountable, and how efficiently they are using their resources in doing so. By focusing on a few universal functions that health systems undertake, this report provides an evidence base to assist policy-makers improve health system performance.

Member State	ATTAINMENT OF GOALS						Health expenditure per capita in international dollars	PERFORMANCE	
	Health		Responsiveness		Fairness in financial contribution	Overall goal attainment		On level of health	Overall health system performance
	Level (DALE)	Distribution	Level	Distribution					
Syrian Arab Republic	114	107	69 – 72	79 – 81	142 – 143	112	119	91	108
Tajikistan	120	124	125	136	112 – 113	127	126	145	154
Thailand	99	74	33	50 – 52	128 – 130	57	64	102	47
The former Yugoslav Republic of Macedonia	64	85	111	95	116 – 120	89	106	69	89
Togo	159	170	155	162	152	156	180	159	152
Tonga	75	84	61	97	108 – 111	85	73	114	116
Trinidad and Tobago	57	75	141	108 – 109	69	56	65	79	67
Tunisia	90	114	94	60 – 61	108 – 111	77	79	46	52
Turkey	73	109	93	66	49 – 50	96	82	33	70
Turkmenistan	128	131	88 – 89	113	121	130	128	152	153
Tuvalu	119	116	132 – 135	153 – 155	26 – 29	120	151	128	136
Uganda	186	138	187 – 188	165	128 – 130	162	168	179	149
Ukraine	70	47	96	63 – 64	140 – 141	60	111	101	79
United Arab Emirates	50	62	30	1	20 – 22	44	35	16	27
United Kingdom	14	2	26 – 27	3 – 38	8 – 11	9	26	24	18
United Republic of Tanzania	176	172	157 – 160	150	48	158	174	180	156
United States of America	24	32	1	3 – 38	54 – 55	15	1	72	37
Uruguay	37	68	41	53 – 57	35 – 36	50	33	50	65
Uzbekistan	100	144	105 – 107	71	131 – 133	109	120	112	117
Vanuatu	135	127	127	132	62 – 63	134	132	120	127
Venezuela, Bolivarian Republic of	52	76	69 – 72	92	98	65	68	29	54
Viet Nam	116	104	51	121	187	140	147	130	160
Yemen	141	165	180	189	135	146	182	82	120
Yugoslavia	46	90	115 – 117	116	158	95	113	47	106
Zambia	188	171	132 – 135	171	155	174	148	190	182
Zimbabwe	184	98	122	166 – 167	175	147	110	191	155

Source: Annex Tables 5–10.

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

The Quality of Health Care Delivered to Adults in the United States

Elizabeth A. McGlynn, Ph.D., Steven M. Asch, M.D., M.P.H., John Adams, Ph.D., Joan Keesey, B.A., Jennifer Hicks, M.P.H., Ph.D., Alison DeCristofaro, M.P.H., and Eve A. Kerr, M.D., M.P.H.

ABSTRACT

BACKGROUND

We have little systematic information about the extent to which standard processes involved in health care — a key element of quality — are delivered in the United States.

METHODS

We telephoned a random sample of adults living in 12 metropolitan areas in the United States and asked them about selected health care experiences. We also received written consent to copy their medical records for the most recent two-year period and used this information to evaluate performance on 439 indicators of quality of care for 30 acute and chronic conditions as well as preventive care. We then constructed aggregate scores.

RESULTS

Participants received 54.9 percent (95 percent confidence interval, 54.3 to 55.5) of recommended care. We found little difference among the proportion of recommended preventive care provided (54.9 percent), the proportion of recommended acute care provided (53.5 percent), and the proportion of recommended care provided for chronic conditions (56.1 percent). Among different medical functions, adherence to the processes involved in care ranged from 52.2 percent for screening to 58.5 percent for follow-up care. Quality varied substantially according to the particular medical condition, ranging from 78.7 percent of recommended care (95 percent confidence interval, 73.3 to 84.2) for senile cataract to 10.5 percent of recommended care (95 percent confidence interval, 6.8 to 14.6) for alcohol dependence.

CONCLUSIONS

The deficits we have identified in adherence to recommended processes for basic care pose serious threats to the health of the American public. Strategies to reduce these deficits in care are warranted.

From RAND, Santa Monica, Calif. (E
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Care System, Los Angeles (S.M.A.); t
partment of Medicine, University of
nia Los Angeles, Los Angeles (S.M.A
VA Center for Practice Managemer
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print requests to Dr. McGlynn at R
1700 Main St., P.O. Box 2138, Santa
ica, CA 90407, or at beth_mcgl
rand.org.

N Engl J Med 2003;348:2635-45.

Table 3. Adherence to Quality Indicators, Overall and According to Type of Care and Function.

Variable	No. of Indicators	No. of Participants Eligible	Total No. of Times Indicator Eligibility Was Met	Percentage of Recommended Care Received (95% CI)*
Overall care	439	6712	98,649	54.9 (54.3–55.5)
Type of care				
Preventive	38	6711	55,268	54.9 (54.2–55.6)
Acute	153	2318	19,815	53.5 (52.0–55.0)
Chronic	248	3387	23,566	56.1 (55.0–57.3)
Function				
Screening	41	6711	39,486	52.2 (51.3–53.2)
Diagnosis	178	6217	29,679	55.7 (54.5–56.8)
Treatment	173	6707	23,019	57.5 (56.5–58.4)
Follow-up	47	2413	6,465	58.5 (56.6–60.4)

* CI denotes confidence interval.

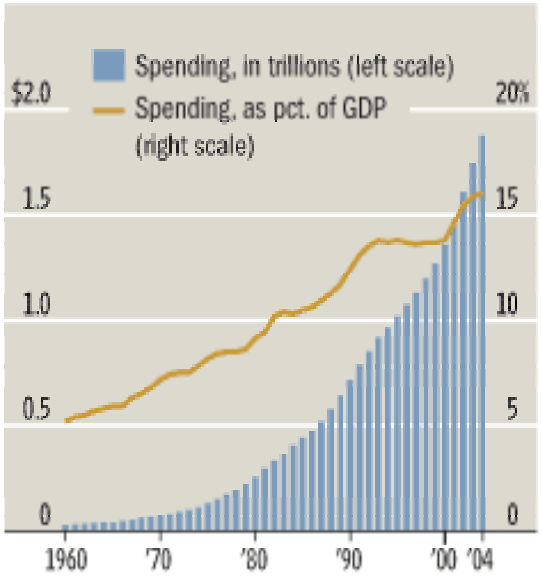
Quality Problems

- Lack of meeting expectations for American health care community
- Incomplete assessment of performance
- Incomplete infrastructure to support ideal provision of quality health care (e.g. I.T.)

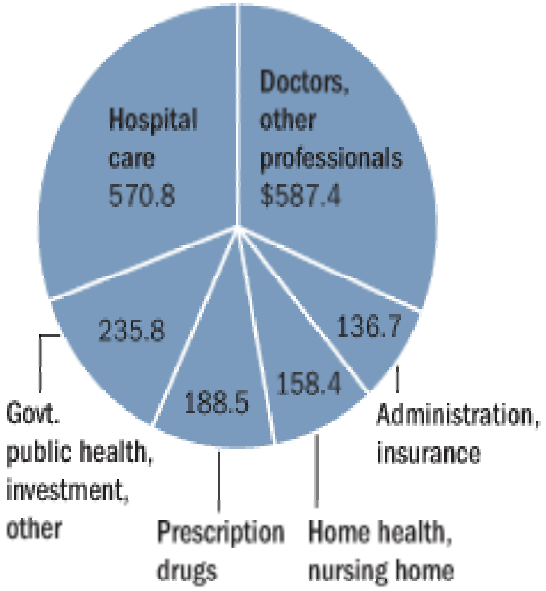
Payment Trends

Health-Care Spending, American-Style

Up, up and still up



Where the money goes, in billions



Source: Centers for Medicare & Medicaid Services

A Payment Problem

- A relatively small number of people with certain chronic illnesses -- including diabetes, hypertension, and cardiovascular and cerebrovascular conditions-- account for a disproportionate share of Medicare expenditures.

- 5% of enrollees consume 47% of the dollars and 50% only consume 2% of the dollars (CBO, 2002)

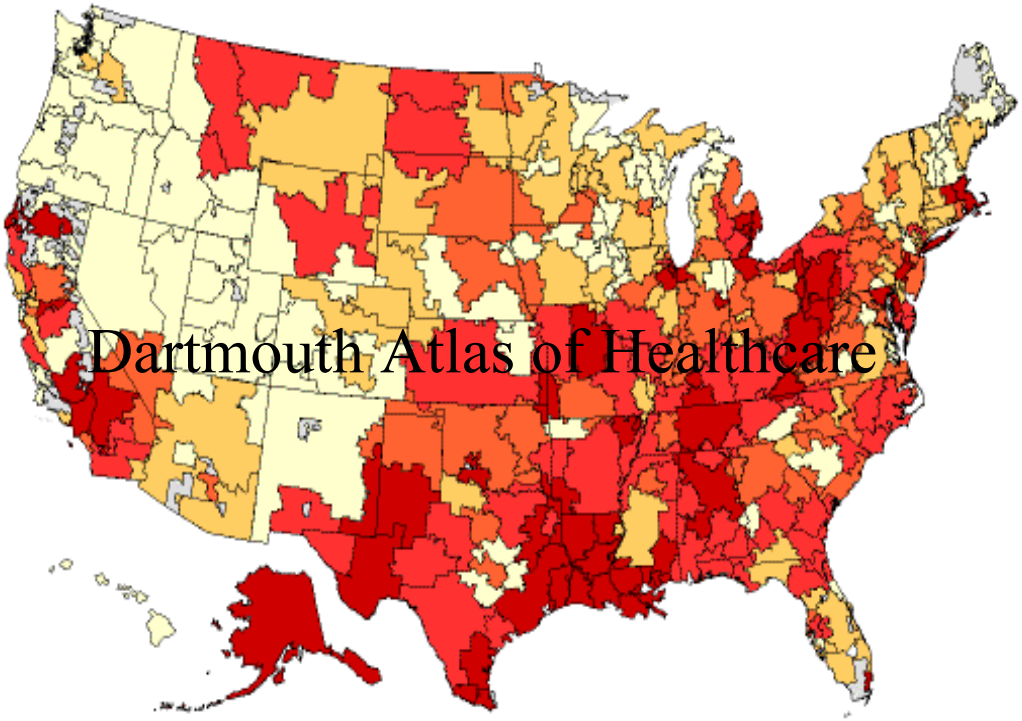
Another Payment Problem

TOTAL MEDICARE PAYMENTS FOR PQI HOSPITALIZATIONS, 1995 AND 2001

	Year 2001 Payments	5% Saving	10% Saving	20% Saving
CONGESTIVE HEART FAILURE	3,829,131,296	191,456,565	382,913,130	765,826,259
BACTERIAL PNEUMONIA	3,083,086,363	154,154,318	308,308,636	616,617,273
COPD	1,767,023,938	88,351,197	176,702,394	353,404,788
DIABETES LONG TERM COMPLICATION	947,957,162	47,397,858	94,795,716	189,591,432
URINARY INFECTION	869,616,059	43,480,803	86,961,606	173,923,212
DEHYDRATION	755,833,815	37,791,691	75,583,382	151,166,763
LOWER EXTREMITY AMPUTATION	643,469,317	32,173,466	64,346,932	128,693,863
ADULT ASTHMA	308,802,016	15,440,101	30,880,202	61,760,403
PERFORATED APPENDIX	129,726,461	6,486,323	12,972,646	25,945,292
ANGINA	120,711,633	6,035,582	12,071,163	24,142,327
HYPERTENSION	120,096,630	6,004,832	12,009,663	24,019,326
DIABETES SHORT TERM COMPLICATION	109,323,970	5,466,199	10,932,397	21,864,794
DIABETES UNCONTROLLED	77,422,587	3,871,129	7,742,259	15,484,517
Total	**12,762,201,247**	**638,110,062**	**1,276,220,125**	**2,552,440,249**

Notes: Includes hospitalizations among FFS Medicare beneficiaries for AHRQ PQI measures. Dollars are nominal dollars.

A Variation Problem



Map 2.5. Inpatient Hospital Services per Medicare Enrollee
by Hospital Referral Region (1995)

- $2516 to 3723 (61)
- 2321 to < 2516 (60)
- 2117 to < 2321 (61)
- 1893 to < 2117 (62)
- 1483 to < 1893 (62)
- Not Populated

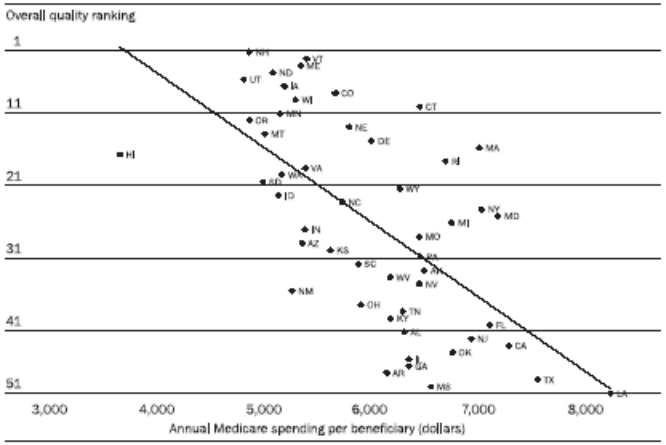
Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Care

Areas with a high concentration of specialists also show higher spending and less use of high-quality, effective care.

by Katherine Baicker and Amitabh Chandra

ABSTRACT: The quality of care received by Medicare beneficiaries varies across areas. We find that states with higher Medicare spending have lower-quality care. This negative relationship may be driven by the use of intensive, costly care that crowds out the use of more effective care. One mechanism for this trade-off may be the mix of the provider workforce: States with more general practitioners use more effective care and have lower spending, while those with more specialists have higher costs and lower quality. Improving the quality of beneficiaries' care could be accomplished with more effective use of existing dollars.

EXHIBIT 1
Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001



SOURCES: Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.
NOTE: For quality ranking, smaller values equal higher quality.

Geography And The Debate Over Medicare Reform

A reform proposal that addresses some underlying causes of Medicare funding woes: geographic variation and lack of incentive for efficient medical practices.

by John E. Wennberg, Elliott S. Fisher, and Jonathan S. Skinner

ABSTRACT: Medicare spending varies more than twofold among regions, and the variations persist even after differences in health are corrected for. Higher levels of Medicare spending are due largely to increased use of "supply-sensitive" services—physician visits, specialist consultations, and hospitalizations, particularly for those with chronic illnesses or in their last six months of life. Also, higher spending does not result in more effective care, elevated rates of elective surgery, or better health outcomes. To improve the quality and efficiency of care, we propose a new approach to Medicare reform based on the principles of shared decision making and the promotion of centers of medical excellence. We suggest that our proposal be tested in a major demonstration project.

MEDICARE REFORM

IN SOME REGIONS OF THE UNITED STATES Medicare pays more than twice as much per person for health care as it pays in other regions. For example, age-, sex-, and race-adjusted spending for traditional, fee-for-service (FFS) Medicare in the Miami hospital referral region in 1996 was $8,414—nearly two and a half times the $3,341 spent that year in the Minneapolis region.[1]

Even after differences in price levels across regions are adjusted for, there are no obvious patterns that suggest why some areas spend more than others. Spending in urban areas in the Northeast tends to be higher than average, but spending in rural regions in the South and urban areas in Southern California is as high or even

John Wennberg directs the Center for Evaluative Clinical Sciences and is the Peggy Y. Thomson Professor for Evaluative Clinical Sciences, Dartmouth Medical School, in Hanover, New Hampshire. Elliott Fisher is codirector of the Outcomes Group, Department of Veterans Affairs Medical Center, and professor of medicine and community and family medicine, Dartmouth Medical School and the Center for the Evaluative Clinical Sciences. Jonathan Skinner is the John French Professor of Economics, Dartmouth College; senior research associate, Center for the Evaluative Clinical Sciences, Dartmouth Medical School; and a research associate at the National Bureau of Economic Research.

Who You Are And Where You Live: How Race And Geography Affect The Treatment Of Medicare Beneficiaries

There is no simple story that explains the regional patterns of racial disparities in health care.

by Katherine Baicker, Amitabh Chandra, Jonathan S. Skinner, and John E. Wennberg

ABSTRACT: The existence of overall racial and ethnic disparities in health care is well documented, but this average effect masks variation across regions and types of care. Medicare claims data are used to document the extent of these variations. Regions with high racial disparities in one procedure are not more likely to be high in other procedures. Unusually large racial disparities in surgery are often the result of high white rates rather than low black rates. Differences in end-of-life care are driven more by residence than by race. Policies should focus on getting the rates right, rather than solely on racial differences.

THERE IS AN EXTENSIVE LITERATURE documenting racial and ethnic disparities in the use of health care in the United States. A recent Institute of Medicine (IOM) report concluded that there are large, significant disparities in the quality and quantity of health care received by minority groups.[1] Most studies have used national samples to study racial disparities in health care, so their results represent an average across U.S. regions. Other studies extrapolate from the experiences of a single area or a single hospital.[2] One might reasonably infer from these studies' findings that racial and ethnic disparities in health care use are pervasive in every region and for all types of care. However, recent studies have shown that overall national differences mask sizable variation across regions and across procedures in racial and ethnic disparities in utilization rates.[3]

Katherine Baicker (kbaicker@dartmouth.edu) and Amitabh Chandra are assistant professors of economics at Dartmouth College (Hanover, New Hampshire); senior research associates, Center for the Evaluative Clinical Sciences, Dartmouth Medical School; and faculty research fellows at the National Bureau of Economic Research (NBER). Jonathan Skinner is the John French Professor of Economics at Dartmouth; a senior research associate at the center; a professor in the Department of Family and Community Medicine, Dartmouth Medical School; and a research associate at NBER. John Wennberg directs the center; he is the Peggy Y. Thomson Professor for Evaluative Clinical Sciences, Dartmouth Medical School.

You can always count on Americans to do the right thing - after they've tried everything else.
Winston Churchill

Current Environment

NCQA, ABIM TO ALIGN REQUIREMENTS, SHARE DATA; AGREEMENT WILL ALLOW JOINT APPLICATION FOR MAINTAINING BOARD CERTIFICATION, RECOGNITION

Agreement with American Board of Internal Medicine reduces redundancy for physicians seeking recognition from NCQA and its partners

Current Environment

California's Pay for Performance Program for Doctors Announces First Year Results: Estimated $50 Million Bonus Payout

buyers health care action group
BHCAG
For Better Health Care

MHQP
MASSACHUSETTS HEALTH QUALITY PARTNERS
providing information to improve healthcare

FOR IMMEDIATE RELEASE

For more information, contact:
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New Report Rates Quality of Health Care in Massachusetts Significantly Above National Average

Comparative Quality Data for Nine Major Physician Networks Now Available Online for Doctors and Consumers

Paying For Performance: Medicare Should Lead

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J.P. Morgan Partners LLC, Washington, DC

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Project HOPE, Bethesda, MD

We the undersigned are united in our belief that a unique opportunity now exists to address the crisis of quality facing the nation's health system. The human and financial costs of medical error and substandard care have been exhaustively documented. A robust inventory of measures and standards for quality improvement has been developed and continues to grow. The strategic concept of paying for performance—a bedrock principle in most industries—has begun to emerge in health care in a variety of experiments in both the private and public sectors. But further progress is by no means assured.

Despite a few initial successes, the inertia of the health system could easily overwhelm nascent efforts to raise average performance levels out of mediocrity. At issue is not the dedication of health professionals but the lack of systems—including information systems—that reduce error and reinforce best practices, as such systems do in other industries such as aviation and nuclear power. We have concluded that such systematic changes will not come forth quickly enough unless strong financial incentives are offered to get the attention of managers and governing boards. As the biggest purchaser in the system, the Medicare program should take the lead in this regard. Decisive change will occur only when Medicare, with the full support of the administration and Congress, creates financial incentives that promote pursuit of improved quality.

Quality is not an issue for partisanship. Nor, in urging that Medicare take a leading role, are we suggesting that such an initiative be dominated by government. Indeed, both private payers and public agencies have made important strides in recent years in tackling the quality challenge. The National Committee for Quality Assurance has promulgated widely used performance indicators for health plans. The National Quality Forum has brought public and private payers together with consumers, researchers, and clinicians to broaden consensus on performance measures and best practices for a growing portfolio of health care settings, conditions, and treatments. The Agency for Healthcare Research and Quality (AHRQ) has established itself as an honest broker of evidence-based treatment standards. The self-insured employers in the Leapfrog Group have moved boldly to tie provider payment to selected performance indicators; and many insurers, health plans, and provider systems are testing new disease management models and other approaches that tie payment to performance.

The Centers for Medicare and Medicaid Services (CMS) has taken significant steps toward a quality strategy based on quality measurement and incentives. The agency's publication of performance data on nursing homes and home health agencies has heightened public awareness of the value of information on quality

DOI 10.1377/hlthaff.22.6.8

THE COMMONWEALTH FUND

NEWS RELEASE

12:01 a.m.,
Friday, May 13, 2005

For further information, contact:
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HEALTH CARE LEADERS: PAY-FOR-PERFORMANCE MOST EFFECTIVE WAY TO REDUCE HEALTH CARE COSTS

Disease Management for High-Cost Conditions, Primary Care Case Management Best Ways to Reduce Unnecessary Care

Shifting More Costs to Patients Seen as Least Effective Way to Cut Unneeded Services

HOW EFFECTIVE DO YOU THINK EACH OF THESE POSSIBLE ACTIONS WOULD BE TO REDUCE HEALTH CARE COSTS?

(Percent saying extremely or very effective)

Reward more efficient and high-quality medical-care providers	57%
Improve disease management and primary care case management	56%
Use evidence-based guidelines to determine when a test or procedure should be done	52%
Expand the use of information technology	46%
Have all payers, including private insurers, Medicare, and Medicaid, adopt common payment methods and rates	44%
Have patients pay a substantially higher share of their health care costs	31%

CHAPTER 2

Quality of care for Medicare beneficiaries

CHAPTER 4

Strategies to improve care: Pay for performance and information technology

Strategies to improve care: Pay for performance and information technology

In this chapter

- Pay for performance in Medicare
- Hospitals
- Home health agencies
- Physicians
- Implementation issues
- Accelerate adoption of health information technology
- Provide financial incentives
- Help providers navigate the IT market and implement systems
- Promote sharing of information across providers and patients

Medicare payment systems are neutral and sometimes negative toward quality. The Congress should adopt pay-for-performance programs for hospitals, home health agencies, and physicians. We earlier recommended pay-for-performance programs for Medicare Advantage plans and dialysis providers. The amount of payment should be small at first, but increase over time. Quality measurement can begin for hospitals—with process, structural, and outcomes measures; for home health agencies—with outcomes measures; and for physicians—with structural and, after a transition, process measures. We recommend several approaches to broaden measure sets for these programs, including reporting lab values. The measure sets should evolve over time. To accelerate adoption of information technology (IT), pay-for-performance programs should include measures of quality-enhancing activities supported by IT. A standard vocabulary to report lab values would increase electronic sharing of clinical data.

WSJ.com THE WALL STREET JOURNAL. ONLINE

May 4, 2005
HEALTH

Push for Performance-Based Pay in Health Care Receives a Boost

"Medicare is dipping its toe in the water. But even when a gorilla sticks its toe in the water, it will still have a ripple effect,"

- David Cutler,
Economics Professor
Dean of Social Sciences
Harvard University.

Physicians and Providers

- Issues:
  - Trust or Credibility in measurement
  - Trust in appropriate use of measurement
  - Unintended consequences or perverse incentives if not appropriate methods where needed (e.g. risk adjustment for outcomes)

Physicians and Providers

- Benefits
  - Rewards superior performance and encourages overall improvement
  - Aligns financial model to actual professional goals of improving the quality of health care services
  - Focus on volume is diminished as focus on quality is heightened

Issues to Consider in Paying for Performance

- Vehicles for Encouraging Quality
  - Information collection
  - Information dissemination
  - Financial rewards
    (provide incentives, remove hindrances)

Issues to Consider in Paying for Performance

- What to Reward
  - Relative quality
  - Absolute threshold
  - Improvement
- How to Finance Incentives
  - Across-the-board reduction to create pool
  - Offsetting penalties
  - Offsetting savings

CMS Current Activities

- Hospital Quality Incentive Demonstration
- Hospital 501(b) Reporting
- Physician Group Practice Demonstration
- Section 649 MCMP Demonstration
- Chronic Care Improvement Program
- Section 646 Medicare Health Care Quality Demo.
- Hospital Quality Alliance – Public Reporting

CMS Current Activities

- ESRD Disease Management Demonstration
- Disease Management for Severely Chronically Ill Medicare Beneficiaries
- Care Management for High Cost Beneficiaries

Premier Hospital Quality Incentive Demonstration

- CMS partnership with Premier, Inc.
  - Nationwide organization of not-for-profit hospitals
  - Members share information on quality and efficiency
  - Uses financial incentives to encourage hospitals to provide high quality inpatient care
  - Public reporting on CMS website

Premier Hospital Quality Incentive Demonstration

- Eligibility: Hospitals in Premier Perspective system as of March 31, 2003
- Voluntary: about 280 hospitals participating
- Demonstration project: pilot test of concept

The Premier Hospital Quality Incentive Demonstration

5 clinical conditions (34 measures)

- Acute MI
- Heart Failure
- Pneumonia
- Coronary Artery Bypass Graft
- Hip and Knee Replacement

Source of Quality Indicators

AMI - Inpatient mortality rate[1,2]

CABG - Inpatient mortality rate[3]

CABG - Post operative hemorrhage or hematoma[4]

CABG - Post operative physiologic/metabolic derangement[4]

Hip/Knee -Post operative hemorrhage or hematoma[4,5]

Hip/Knee - Post operative physiologic/metabolic derangement[4,5]

Hip/Knee - Readmission 30 days post discharge[5]

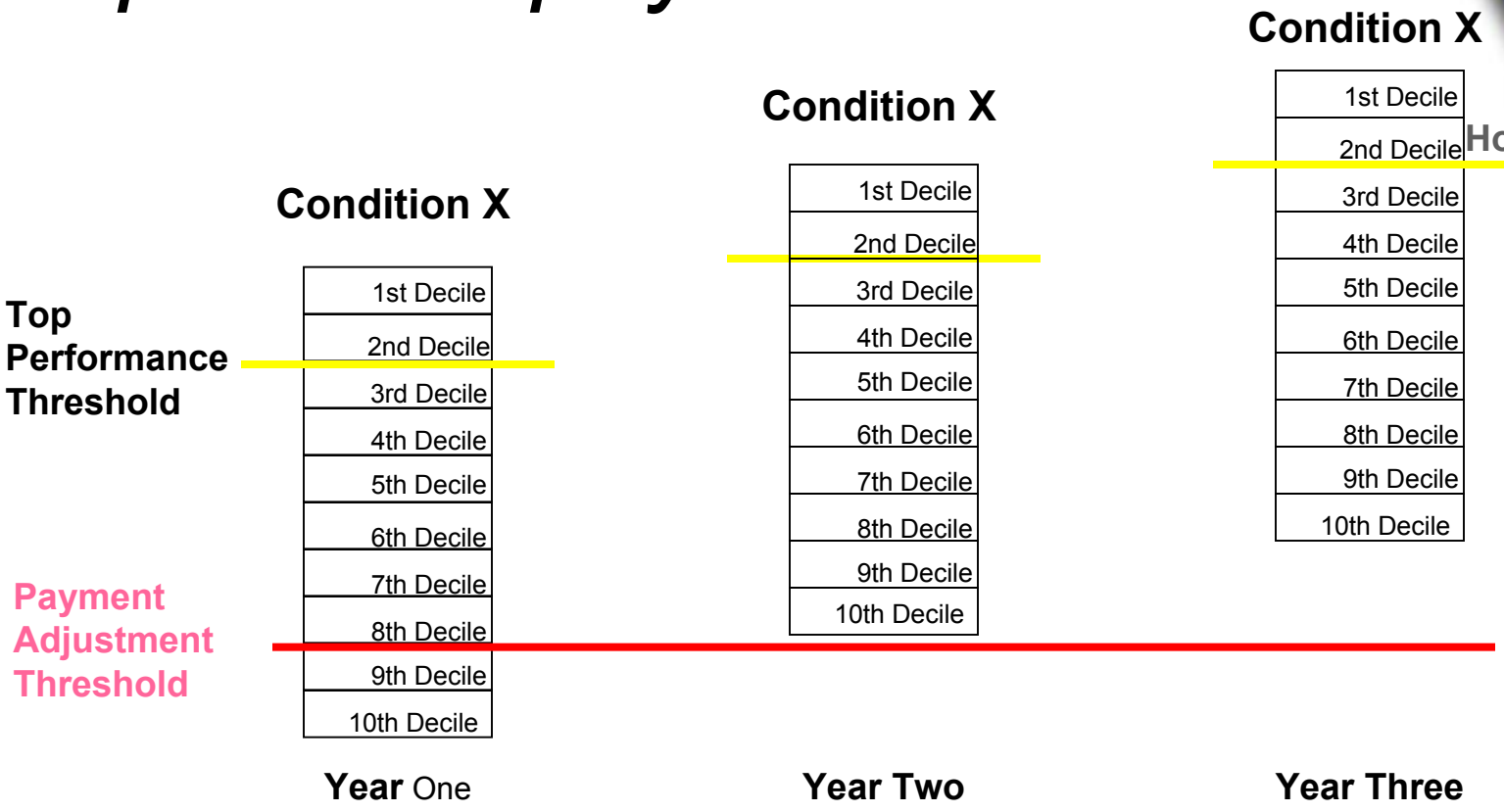
Recognition & Financial Rewards

- Top 50% of hospitals in each clinical area publicly acknowledged on CMS website
- Top 20% of hospitals in each clinical area receive bonuses
  - Hospitals in top decile get 2% bonus on their Medicare DRG payments for discharges in those categories
  - Hospitals in second decile get 1% bonus

Recognition & Financial Rewards

- Baseline performance thresholds set in year 1
  - Separate threshold for each clinical area
  - Thresholds set at 80th and 90th percentiles
- Year 1 thresholds applied in year 3
  - Hospitals below thresholds receive reduced payment
  - 1% reduction for score below 80th percentile threshold; 2% reduction for score below 90th percentile threshold
- Provides extra incentive for all hospitals to improve performance

One possible payment scenario



Early Data Results

- The preliminary analysis of first-year performance found median quality scores for hospitals improved:
-
- From 90 percent to 93 percent for patients with acute myocardial infarction (heart attack).
- From 86 percent to 90 percent for patients with coronary artery bypass graft.
- From 64 percent to76 percent for patients with heart failure.
- From 85 percent to 91 percent for patients with hip and knee replacement.
- From 70 percent to 80 percent for patients with pneumonia.

Physician Group Practice Demonstration

- Mandated by BIPA
- Large (200+ physicians), multi-specialty groups
- Affiliations with other providers
- Well-developed clinical and management information systems

Physician Group Practice Demonstration

- Encourage coordination of Part A and Part B services
- Promote efficiency through investment in administrative structure and process
- Reward physicians for improving health outcomes

Physician Group Practice Demonstration

- Annual performance targets established for each group
- Bonus earned if actual Medicare spending for assigned beneficiaries is less than the annual performance target (minus a 2% savings threshold)

Physician Group Practice Demonstration

- 2% savings threshold
- Medicare retains 20% of savings beyond threshold
- Bonus to groups allocated based on
  - Savings (70%)
  - Quality (30%)
- 15% limit on bonus

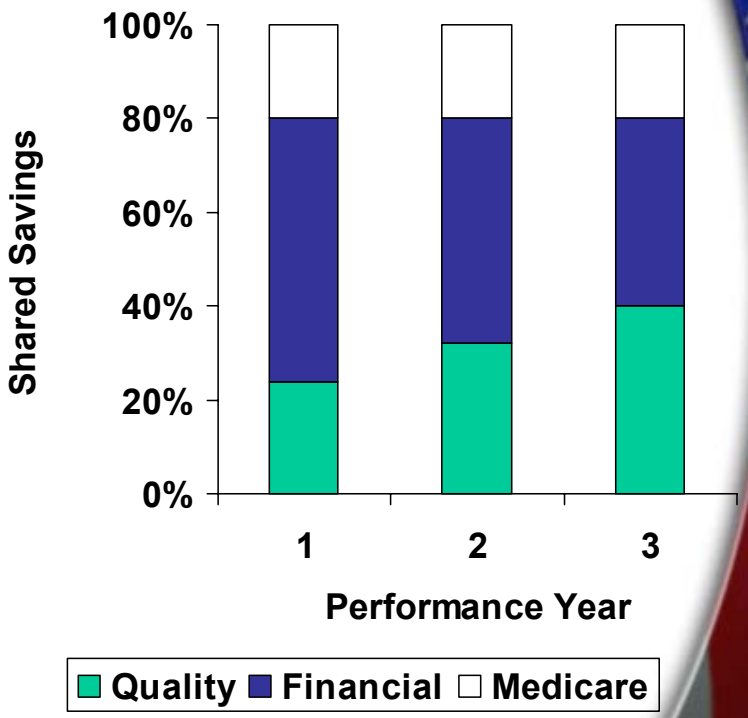
Physician Group Practice Demonstration

Evaluation Criteria for practices:

- Organizational structure
- Leadership & management
- Financial stability
- Quality assurance
- Process and outcome measurement
- Demonstration implementation plan
- Location

Medicare Shares Savings

- Medicare Retains 20% of Savings
- Groups May Earn up to 80% of Savings
  - Performance Payments Earned for Efficiency & Quality
  - Increasing Percentage of Performance Payments Linked to Quality
- Maximum Annual Performance Payment Capped at 5% of Medicare Part A & Part B Target



Financial Measurement Issues

- Assigned Beneficiaries
  - Retrospective Assignment
  - Group Must Provide Plurality of Outpatient E&M Services
  - No Lock-In, No Enrollment
- Savings Measured on Actual Claims Experience of Group & Local Market
  - Reconciliation & Claims Lag Implications
- Three Year Performance Period
  - No Annual Rebasing

Quality Measures & Phase In Plan

---------- Year 1 ----------			
----------Year 2 ----------			
----------Year 3 ----------			
Diabetes Mellitus	**Congestive Heart Failure**	**Coronary Artery Disease**	**Preventive Care**
HbA1c Management	Left Ventricular Function Assessment	Antiplatelet Therapy	Blood Pressure Screening
HbA1c Control	Left Ventricular Ejection Fraction Testing	Drug Therapy for Lowering LDL Cholesterol	Blood Pressure Control
Blood Pressure Management	Weight Measurement	Beta-Blocker Therapy – Prior MI	Blood Pressure Control Plan of Care
Lipid Measurement	Blood Pressure Screening	Blood Pressure	Breast Cancer Screening
LDL Cholesterol Level	Patient Education	Lipid Profile	Colorectal Cancer Screening
Urine Protein Testing	Beta-Blocker Therapy	LDL Cholesterol Level	
Eye Exam	Ace Inhibitor Therapy	Ace Inhibitor Therapy	
Foot Exam	Warfarin Therapy for Patients HF		
Influenza Vaccination	Influenza Vaccination		
Pneumonia Vaccination	Pneumonia Vaccination		

Ten Physician Groups Represent 5,000 Physicians

& Over 200,000 Medicare Fee-For-Service Beneficiaries

Dartmouth-Hitchcock Clinic	Southwest New Hampshire / Eastern Vermont
Deaconess Billings Clinic	Souteast Montana / Northern Wyoming
Geisinger Clinic	Central-Northeast Pennsylvania
Middlesex Health System	South-Central Connecticut
Marshfield Clinic	North-Central Wisconsin
Novant Medical Group	Northwest North Carolina
Park Nicollett Health Services	South-Central Minnesota
St. John's Health System	Southwest Missouri / Northwest Arkansas
The Everett Clinic	West-Central Washignton
University of Michigan Faculty Group Practice	Michigan

ESRD Disease Management Demonstration

- Capitated payment for bundle of services used by ESRD patients
- Portion of payment set-aside for achievement of ESRD-related quality measures
- In the final stages of waiver approval process

Care Management Performance Demonstration (Sec. 649)

- Small to medium-sized physician practices
- To promote adoption and use of IT in physician offices
- Create infrastructure for Medicare receipt of data from electronic office-based systems for use in technical assistance and public reporting
- To improve the ability to manage patient care

Care Management Performance Demonstration (Sec. 649)

- Incorporation of health information technology
- Broad waiver authority
- Eligible organizations
  - Physician groups
  - Integrated delivery systems (IDSs)
  - Regional coalitions of physician groups or IDS's

Medicare Health Care Quality Demonstrations (Sec. 646)

- Payment models
  - Shared Savings
  - Capitation or Partial Capitation
  - Per Member Per Month Fee
  - Restructured Fee-for-Service Payments
  - Regional Global Budget
  - Other?

Medicare Health Support Program

- Phase I, series of demos:
  - Develop, test and evaluate care improvement programs using randomized controlled trials.
  - Offered on a voluntary basis to certain eligible beneficiaries in geographic areas that in aggregate consist of 10% of total beneficiaries (approx. 300,000 beneficiaries)
- Phase II, successful projects expanded nationwide

Medicare Health Support Program

- **Oklahoma**: LifeMasters Supported SelfCare, Inc. (1-888-713-2837) - started 8/1/05
- **W. Pennsylvania**: Health Dialog Services Corp. (1-800-574-8475) - started 8/15/05
- **Washington D.C. & MD**: American Healthways, Inc. (1-866-807-4486) - started 8/1/05
- **Mississippi**: McKesson Health Solutions, (1-800-919-9110) – started 8/22/05
- **Chicago, Illinois**: Aetna Life Insurance Company, (1-888-713-2836) – started 9/1/05
- **Northwest Georgia**: CIGNA Health Support, LLC, (1-866-563-4551) – started 9/12/05
- **Central Florida**: Green Ribbon Health. (1-800-372-8931) – started November 1, 2005
- **Tennessee**: XLHealth Corporation (1-877-717-2247) – to start January, 2006

Medicare Health Support Program

- Achieving a **net savings of 5%**,
- Achieving **improvement in indicators of clinical quality**
- Achieving a negotiated level of **satisfaction with the MHS program experience**

Physician Voluntary Reporting Program

- Announced – October 28, 2005
- Implementation – January 2006
- 16 measures of clinical quality
- G code indicators submitted through claims system*
- Voluntary, phased-in approach

*Working with AMA to allow use of CPT Category II codes

Thanks!

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