The National Quality Agenda: Fundamental Payment Reform and Care Integration

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US Scorecard: Why Not the Best? Commonwealth Fund Commission National Scorecard

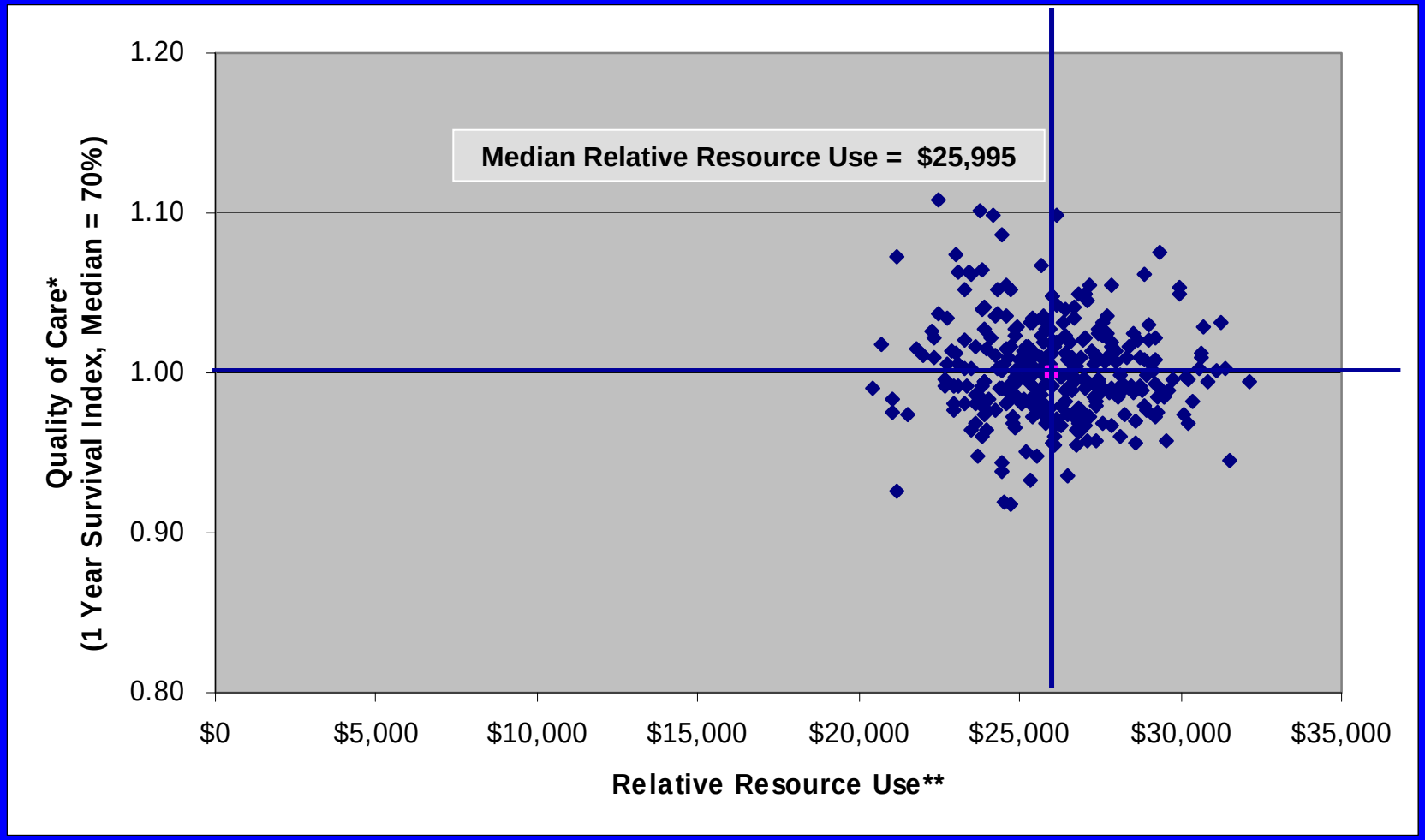
- 37+ Indicators
- U.S. compared to benchmarks

Costs of Care for Medicare Beneficiaries with Multiple Chronic Conditions, by Hospital Referral Regions, 2001

	Average annual reimbursement					Ratio of percentile groups	
	Average	10th percentile	25th percentile	75th percentile	90th percentile	90th to 10th	75th to 25th
All 3 conditions (Diabetes + CHF + COPD)	$31,792	$20,960	$23,973	$37,879	$43,973	2.10	1.58
Diabetes + CHF	$18,461	$12,747	$14,355	$20,592	$27,310	2.14	1.43
Diabetes + COPD	$13,188	$8,872	$10,304	$15,246	$18,024	2.03	1.48
CHF + COPD	$22,415	$15,355	$17,312	$25,023	$32,732	2.13	1.45

CHF = Congestive heart failure; COPD = Chronic obstructive pulmonary disease.
Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of 2001 Medicare Standard Analytical Files (SAF) 5% Inpatient Data.

Wide Variability in Quality and Costs of Care for Medicare Patients Hospitalized for Heart Attacks, Colon Cancer and Hip Fracture



* Indexed to risk-adjusted 1 year survival rate (median = 0.70).
** Risk-adjusted spending on hospital and physician services using standardized national prices.
Data: E. Fisher and D. Staiger, Dartmouth College analysis of data from a 20% national sample of Medicare beneficiaries.

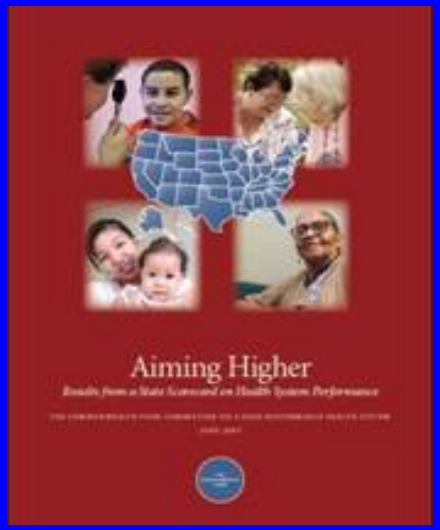
Aiming Higher: Commonwealth Fund Commission State Scorecard on Health System Performance

State Scorecard Summary of Health System Performance Across Dimensions

State Rank
- Top Quartile
- Second Quartile
- Third Quartile
- Bottom Quartile

RANK	STATE	Access	Quality	Avoidable Hospital Use & Costs	Equity	Healthy Lives
1	Hawaii					
2	Iowa					
3	New Hampshire					
3	Vermont					
5	Maine					
6	Rhode Island					
7	Connecticut					
8	Massachusetts					
9	Wisconsin					
10	South Dakota					
11	Minnesota					
12	Nebraska					
13	North Dakota					
14	Delaware					
15	Pennsylvania					
16	Michigan					
17	Montana					
17	Washington					
19	Maryland					
20	Kansas					
21	Wyoming					
22	Colorado					
22	New York					
24	Ohio					
24	Utah					
26	Alaska					
26	Arizona					
26	New Jersey					
29	Virginia					
30	Idaho					
30	North Carolina					
32	District of Columbia					
33	South Carolina					
34	Oregon					
35	New Mexico					
36	Illinois					
37	Missouri					
38	Indiana					
39	California					
40	Tennessee					
41	Alabama					
42	Georgia					
43	Florida					
44	West Virginia					
45	Kentucky					
46	Louisiana					
46	Nevada					
48	Arkansas					
49	Texas					
50	Mississippi					
50	Oklahoma					

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007



- State ranks
- 32 indicators

Five Key Strategies for High Performance

1. Extending affordable health insurance to all
2. Aligning financial incentives to enhance value and achieve savings
3. Organizing the health care system around the patient to ensure that care is accessible and coordinated
4. Meeting and raising benchmarks for high-quality, efficient care
5. Ensuring accountable national leadership and public/private collaboration

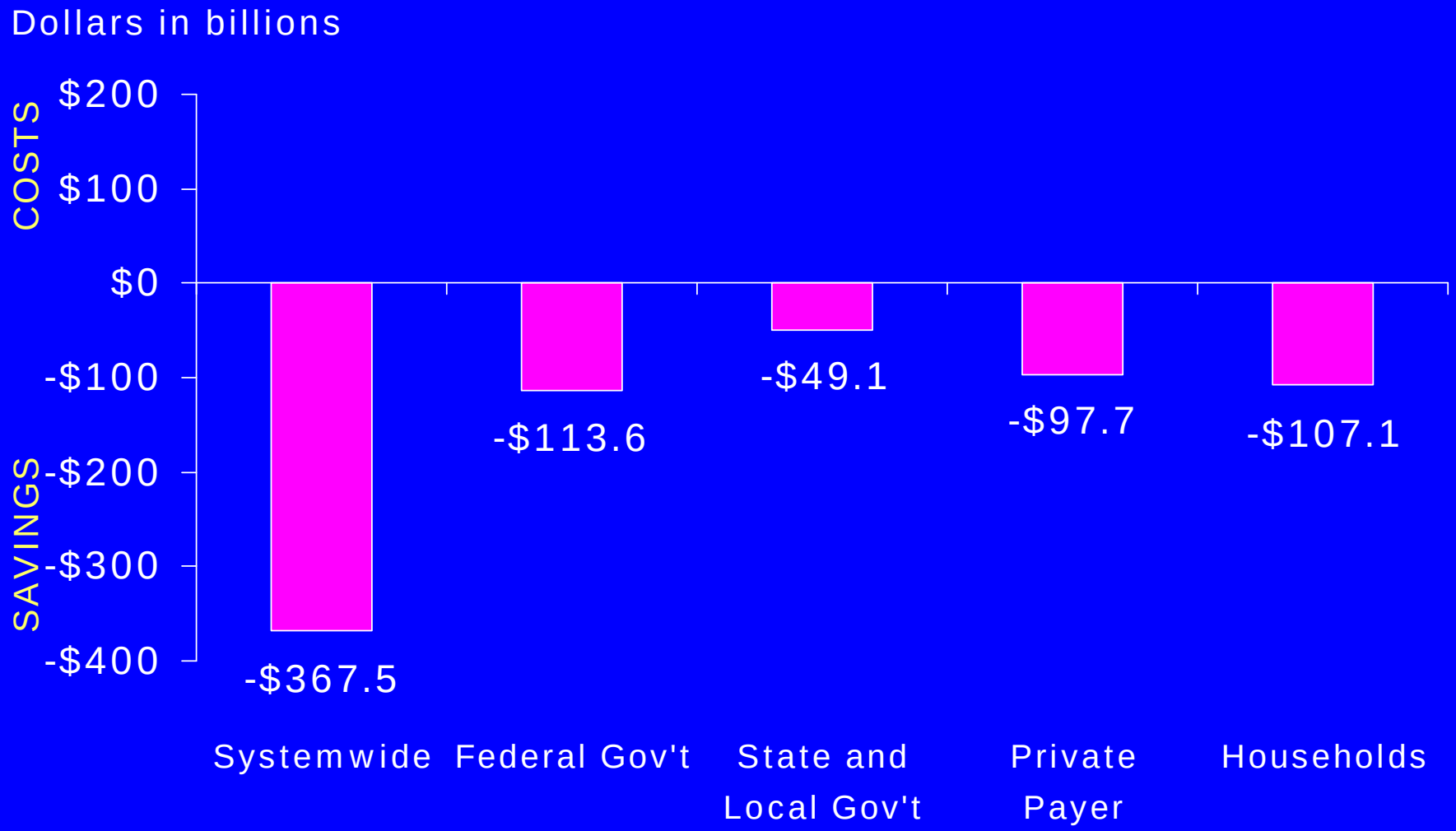
Source: Commission on a High Performance Health System, A High Performance Health System for the United States: An Ambitious Agenda for the Next President, The Commonwealth Fund, November 2007

Bending the Curve: Fifteen Options that Achieve Savings Cumulative 10-Year Savings

Producing and Using Better Information	
• Promoting Health Information Technology	-$88 billion
• Center for Medical Effectiveness and Health Care Decision-Making	-$368 billion
• Patient Shared Decision-Making	-$9 billion
Promoting Health and Disease Prevention	
• Public Health: Reducing Tobacco Use	-$191 billion
• Public Health: Reducing Obesity	-$283 billion
• Positive Incentives for Health	-$19 billion
Aligning Incentives with Quality and Efficiency	
• Hospital Pay-for-Performance	-$34 billion
• Episode-of-Care Payment	-$229 billion
• Strengthening Primary Care and Care Coordination	-$194 billion
• Limit Federal Tax Exemptions for Premium Contributions	-$131 billion
Correcting Price Signals in the Health Care Market	
• Reset Benchmark Rates for Medicare Advantage Plans	-$50 billion
• Competitive Bidding	-$104 billion
• Negotiated Prescription Drug Prices	-$43 billion
• All-Payer Provider Payment Methods and Rates	-$122 billion
• Limit Payment Updates in High-Cost Areas	-$158 billion

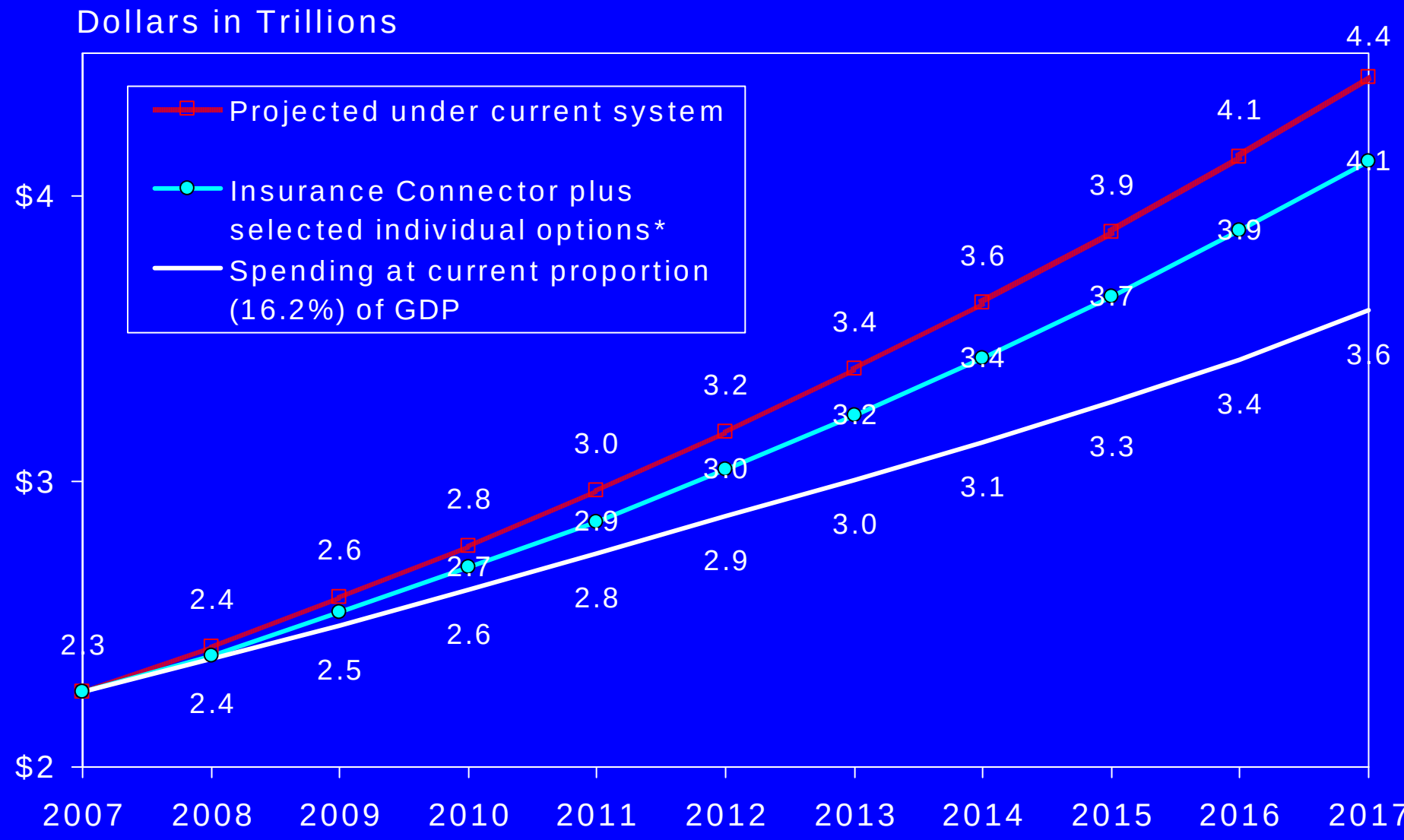
Source: C. Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, Commonwealth Fund, December 2008.

Center for Medical Effectiveness and Health Care Decision-Making: Distribution of 10-Year Impact on Spending



Source: C. Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, Commonwealth Fund, December 2008.

Total National Health Expenditures, 2008 - 2017 Projected and Various Scenarios



•Selected options include improved information, payment reform, and public health

Source: C. Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, Commonwealth Fund, December 2008.

Promising Strategies for Payment Reform and Care Coordination

1. Patient-Centered Medical Home
2. Acute Episode Global Fee
3. Pay for Performance
4. Limiting Updates for High-cost Areas and High-cost Providers
5. Targeting Waste: Hospital Readmissions, Preventable Admissions, Unsafe, or Ineffective Care

Patient-Centered Medical Homes

Patient-Centered Medical Homes

- Patient has long-term relationship with patient-centered medical home
- Care is accessible and patient-centered:
  - Practice is easy to contact by phone during regular office hours; has arrangements for “off-hours” care; can get needed care 24/7
  - Practice provides patient-centered, culturally competent care and engages patients as active partners in their care
- Care is coordinated:
  - Maintaining a complete medical record including specialist consult reports and hospital/ER use and having that record available for all patient interactions
  - Reviewing medications at each visit
  - System to ensure lab and imaging test results get communicated to patients in a timely manner
  - Specialty referrals with appropriate information records in advance and ensuring receipt of appropriate feedback
  - Ensuring that patients discharged from hospital receive appropriate follow-up care and ensuring smooth transitions in care between settings
- Practice is accountable for health of the patient:
  - Reminders for preventive care
  - Management of chronic conditions, disease registries, self-help plan for management of chronic conditions

Strategies to Spread Adoption of Patient-centered Medical Homes

1. Certification of primary care practices as patient-centered medical homes
2. Incentives for enrollee designation of medical homes
3. New payment methods for patient-centered medical homes
4. Support patient-centered medical homes within actual or virtual organized care system
    1. Assist with adoption of health information technology and health information exchange
    2. Provide technical assistance to create high-quality patient-centered medical homes
    3. Quality improvement unit for data feedback, reporting, and improvement

National Measures to Qualify Medical Homes Exist: Physician Practice Connections (PCMH)

Practice must demonstrate proficiency in at least five areas to qualify as PCMH, such as:

- Written standards for patient access and patient communication; use of data to show meeting this standard
- Use of paper or electronic-based charting tools to organize clinical information
- Use of data to identify important diagnoses and conditions in practice
- Adoption and implementation of evidence-based guidelines for three conditions
- Active support of patient self-management
- Tracking system to test and identify abnormal results
- Tracking referrals with paper-based or electronic system
- Measurement and reporting of clinical and/or service performance by physician or across the practice

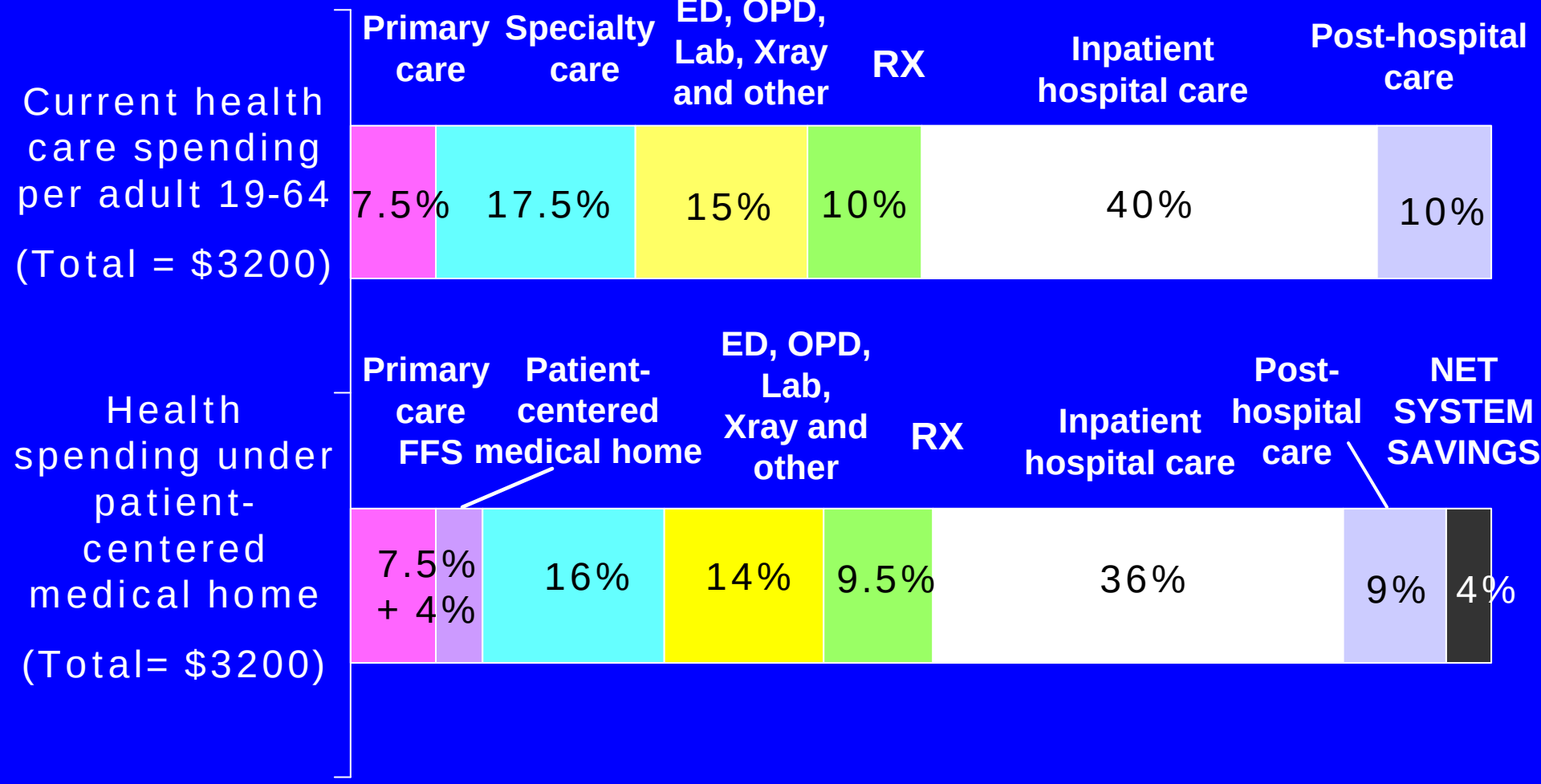
National Committee for Quality Assurance, Measures for Patient-Centered Medical Home, 2007.

Bridges to Excellence Medical Home Payment Initiative

- A multi-state, multiple employer initiative which gives primary care physicians $125/patient covered by participating employer for providing “medical homes”
- Participants include large employers (Ford, GE, Humana, P&G, UPS, and Verizon), health plans, NCQA, MEDSTAT and WebMD, among others
- Medical home metrics include: follow-up on referrals to other MDs, systematically tracking tests, flagging abnormal results in a standardized way, and adhering to medical guidelines to monitor and treat chronic conditions like diabetes and hypertension.
- Improvements in quality is estimated to save $250-$300 per patient in the first year

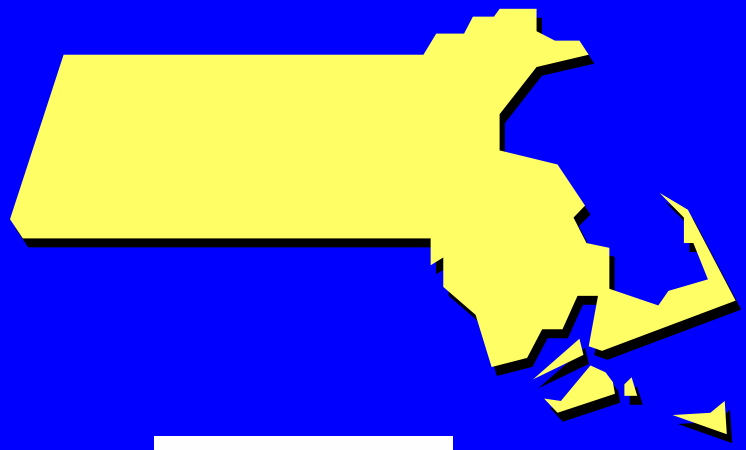
Source: V. Fuhrmans, “Group offers doctors bonuses for better care,” Wall Street Journal, January 31, 2008

Illustrative Example of Structure and Expectations for Patient-Centered Medical Home Payment Reform



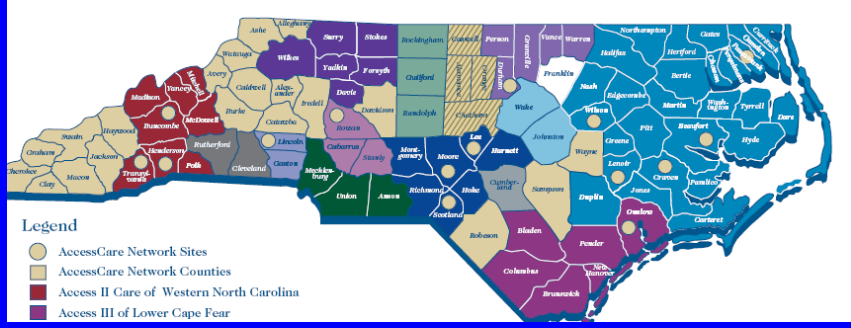
BCBS Massachusetts: New Model of Reimbursement

- Flat fee to doctors and hospitals each year
- Adjusted for age and sickness of patients
- Up to 10% bonus to improve care on over 20 quality standards, such as chronic disease control and providing easy access at all hours
- Payment covers all services from primary care doctors, specialists, counselors, and hospitals – encourages coordination



Source: A. Dember, “New therapy for old woes, Blue Cross measure aims to slow runaway costs, improve quality of health care,” Boston Globe, January, 22, 2008

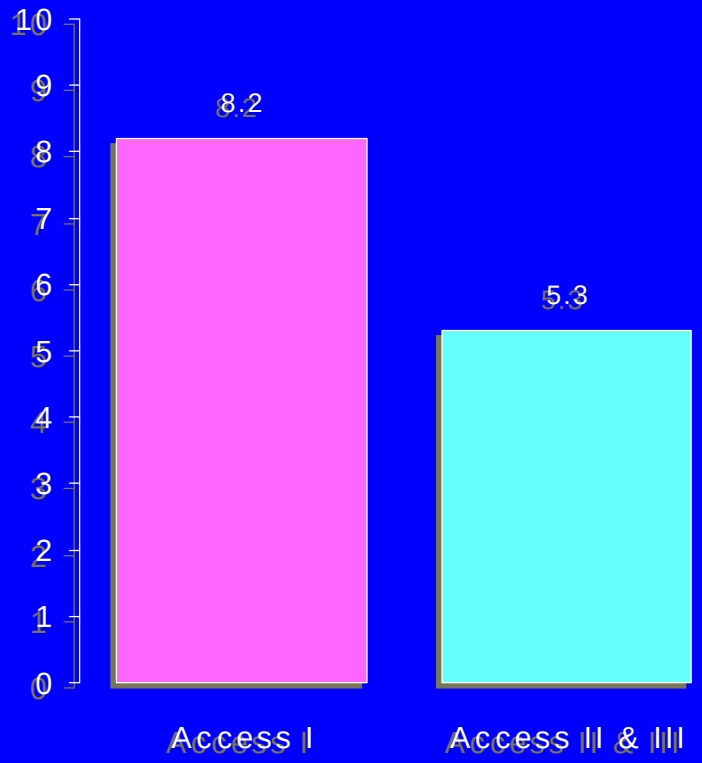
Community Care of North Carolina: Medicaid



Asthma Initiative: Pediatric Asthma Hospitalization rates

(April 2000 – December 2002)

In patient admission rate per 1000 member months



- 15 networks, 3500 MDs, >750,000 patients
- Receive $3.00 PM/PM from the State
- Hire care managers/medical management staff
- PCP also get $2.50 PMPM to serve as medical home and to participate in disease management
- Care improvement: asthma, diabetes, screening/referral of young children for developmental problems, and more!
- Case management: identify and facilitate management of costly patients
- Cost (FY2003) - $8.1 Million; Savings (per Mercer analysis) $60M compared to FY2002

Source: L. Allen Dobson, MD, presentation to ERISA Industry Committee, Washington, DC, March 12, 2007

Commonwealth Fund National Initiative: Transforming Safety Net Clinics Into Patient-Centered Medical Homes

Objective:

- To develop and demonstrate a replicable and sustainable implementation model to transform safety net primary care practices into patient-centered medical homes (PCMH)
- To achieve benchmark performance in quality, patient experience and efficiency in safety net primary care practices

Timeline:

- Currently in planning and development in collaboration with Qualis, QIO for state of Washington)
- Through RFP, select 4 regions from across the country
  - 50 total safety net providers in initiative
  - Active stakeholder group that includes payers to recommend policy improvements to sustain and spread PCMH

  Implementation and technical assistance, 2009-2012

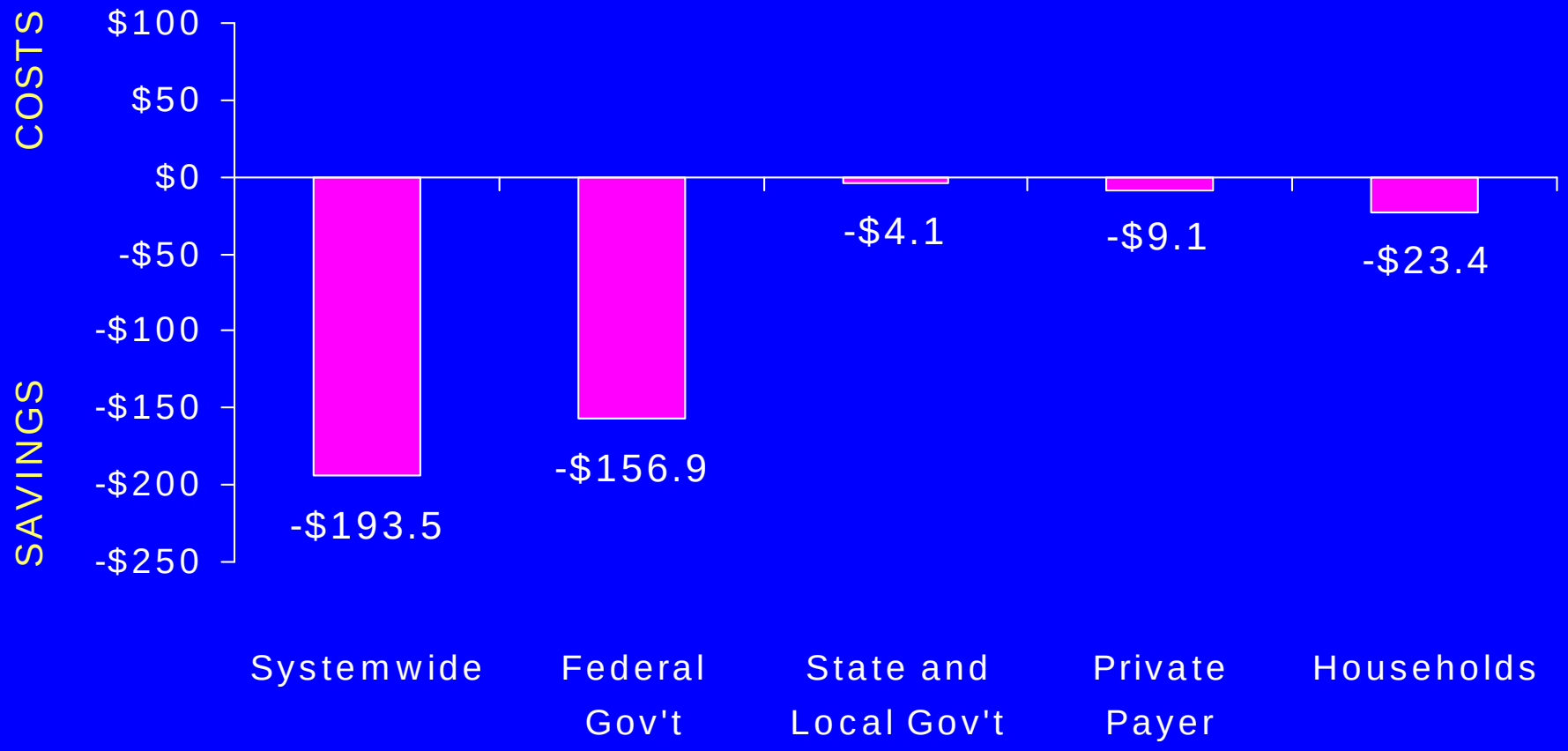
  Evaluation

Funding: Commitment of $ 7 million over five years

CONTACT: Melinda Abrams, Senior Program Officer, Commonwealth Fund mka@cmwf.org

Strengthening Primary Care and Care Coordination in Medicare: Distribution of 10-Year Impact on Spending

Dollars in billions



Source: C. Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, Commonwealth Fund, December 2008.

Payment for Acute Episodes of Care

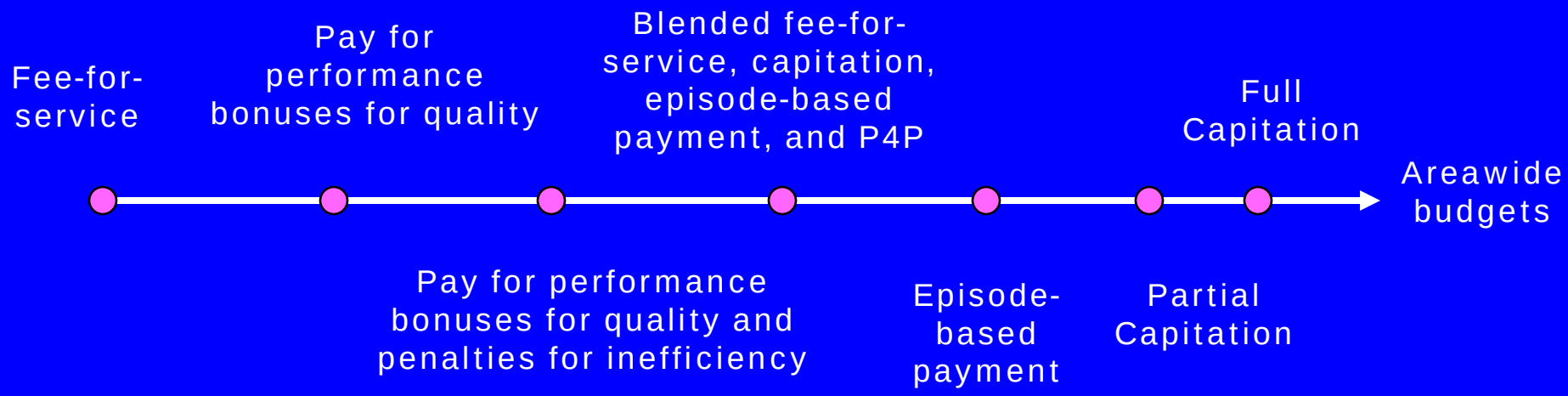
Acute Episode-based Payment

- Establish episode-based payment rate for all care for a given acute episode over a period of time (e.g. 90 day)
  - Use commercial episode grouper methods to calculate average claims cost for different acute and chronic conditions, or
  - Use expert opinion to build “episode case rates” from the ground up based on evidence-informed appropriate services – Prometheus, or
  - Seek provider bids for bundled payment rate with warranty – Geisinger ProvenCare
- Link payment or network participation to acute episode
  - Exclude providers with higher costs from networks
  - Pay providers global fee, allocated among hospital and physicians proportionately, or
  - Pay global fee to actual or virtual organized care systems

Improving Quality & Efficiency: Informing the Dialogue on Value-Based Payment Reform

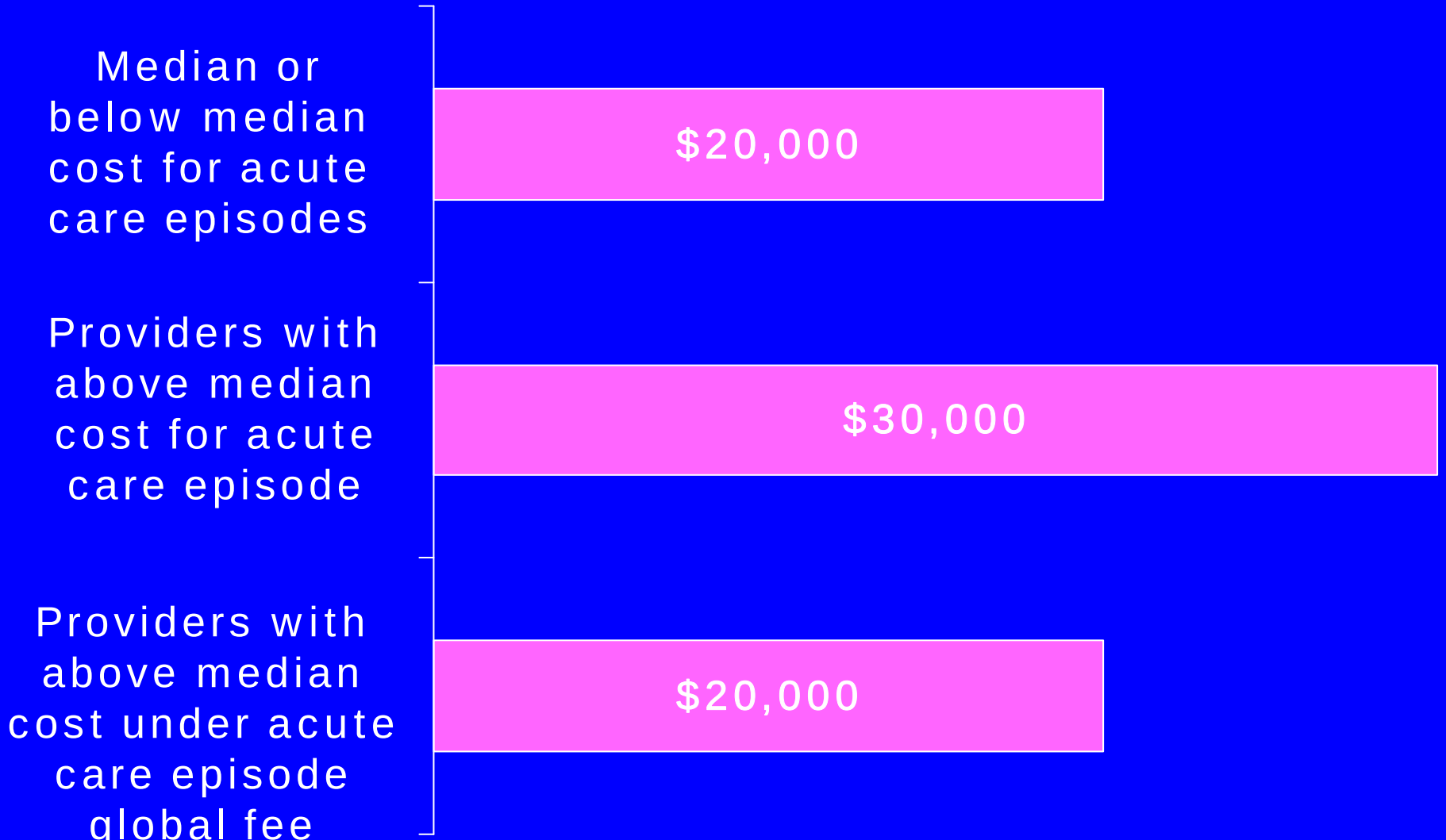
- The Commonwealth Fund is actively engaged in seeking solutions:
  - Reports on pay for performance
    - LeapFrog compendium (>100 current programs)
    - 2007 Medicaid P4P Fund Report (85% of states will have P4P programs in place within 5 years)
  - NRHI (Network for Regional Health Improvement) Summit: "Creating Payment Systems to Accelerate Value-Driven Health Care" (Pittsburgh, March 2007)
  - Fund Publication, "Evidence-Informed Case Rates: A New Payment Model" (April 2007) from the Fund-supported Prometheus Payment Model
  - Support for National Quality Forum framework for efficiency

Payment Reform Strategies



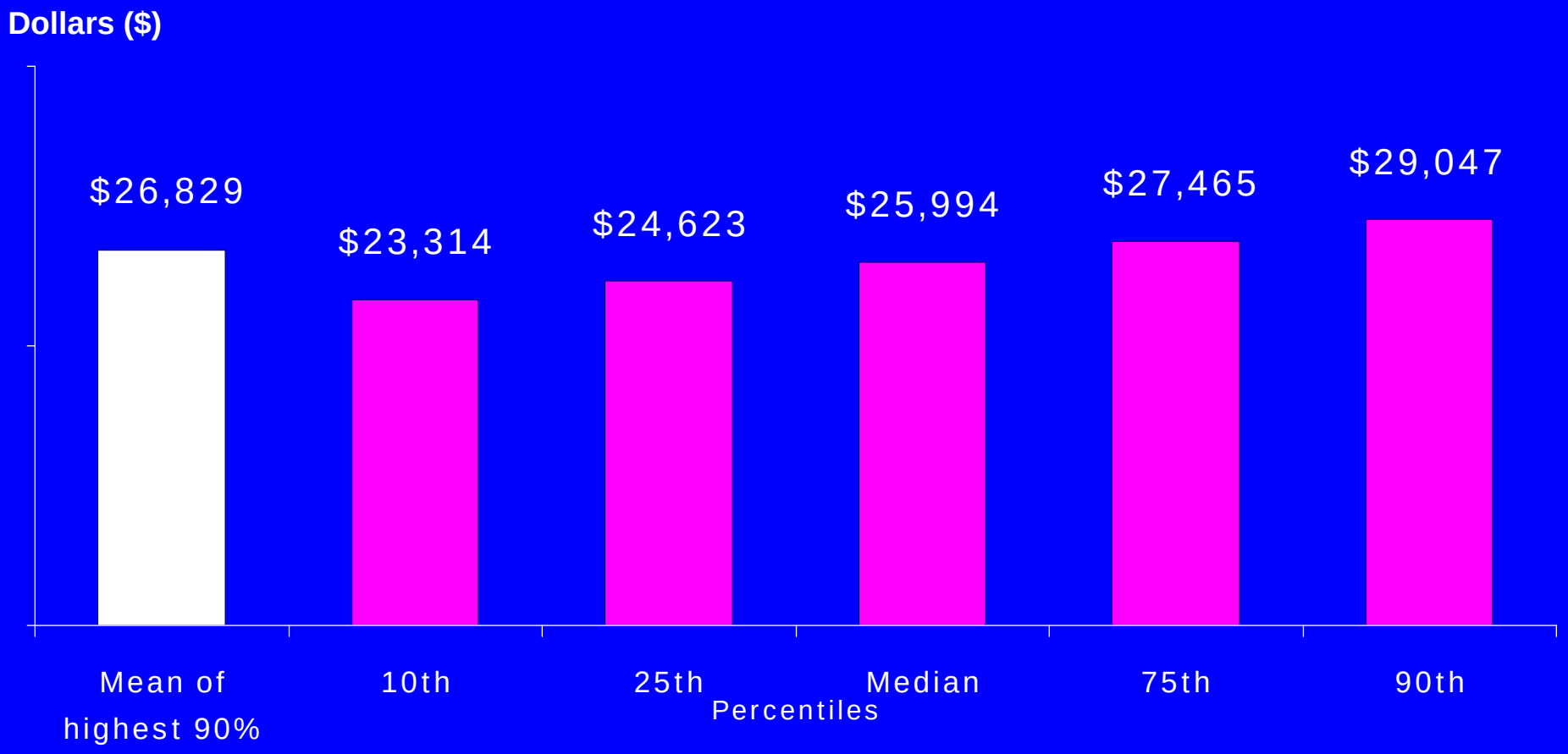
Source: Adapted from Harold Miller, CREATING PAYMENT SYSTEMS TO ACCELERATE VALUE-DRIVEN HEALTH CARE: Issues and Options for Policy Reform, Pittsburgh Regional Health Initiative, Commonwealth Fund, 2007.

Illustrative Example of Acute Care Payment Reform



Costs of Care for Medicare Patients Hospitalized for Heart Attacks, Colon Cancer, and Hip Fracture, by Hospital Referral Regions, 2000–2002

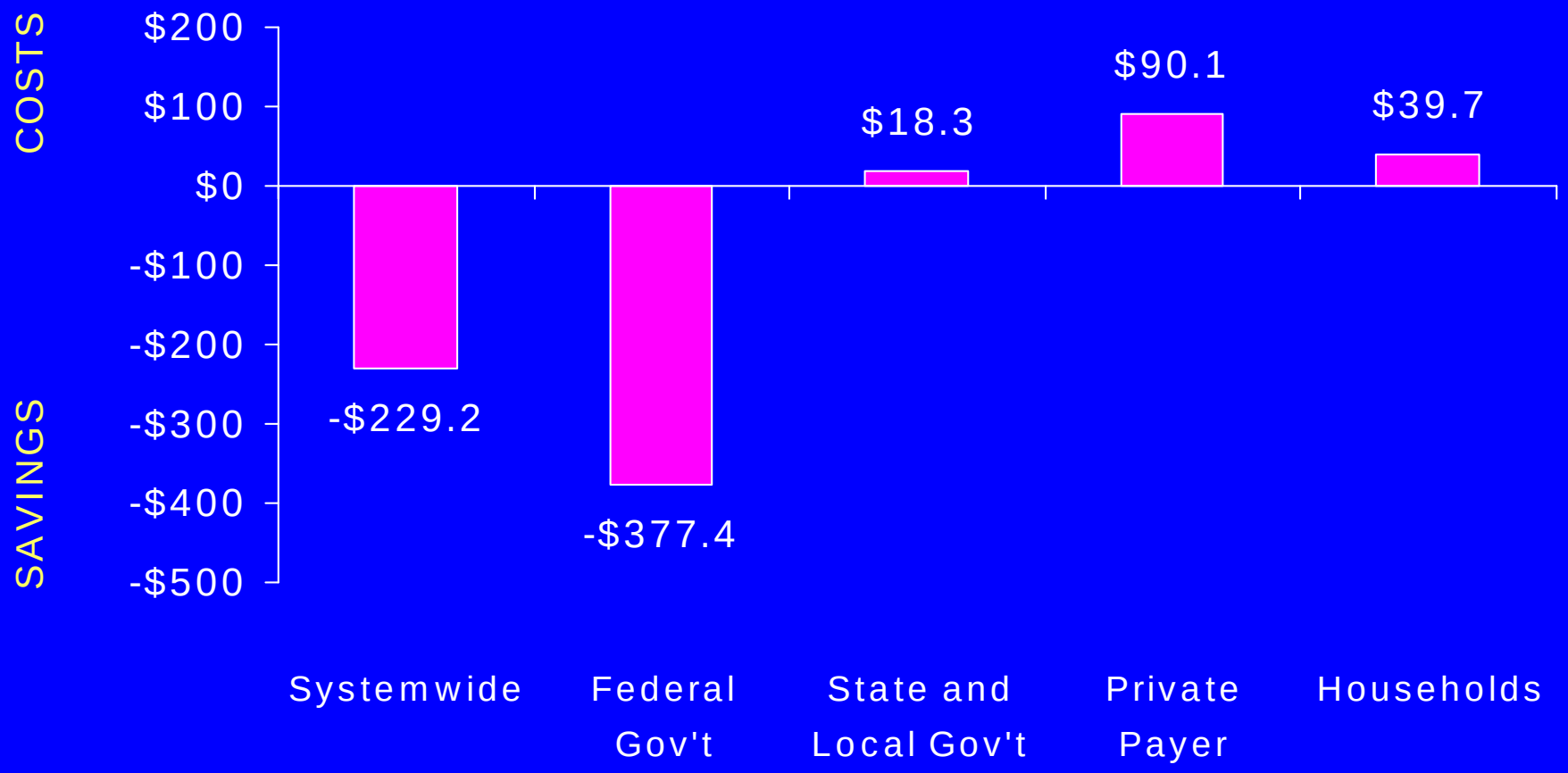
Annual relative resource use*



* Risk-adjusted spending on hospital and physician services using standardized national prices.
Data: E. Fisher and D. Staiger, Dartmouth College analysis of data from a 20% national sample of Medicare beneficiaries.

Medicare Episode-of-Care Payment: Distribution of 10-Year Impact on Spending

Dollars in billions



Source: C. Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, Commonwealth Fund, December 2008.

ProvenCare℠:

Coronary Artery Bypass

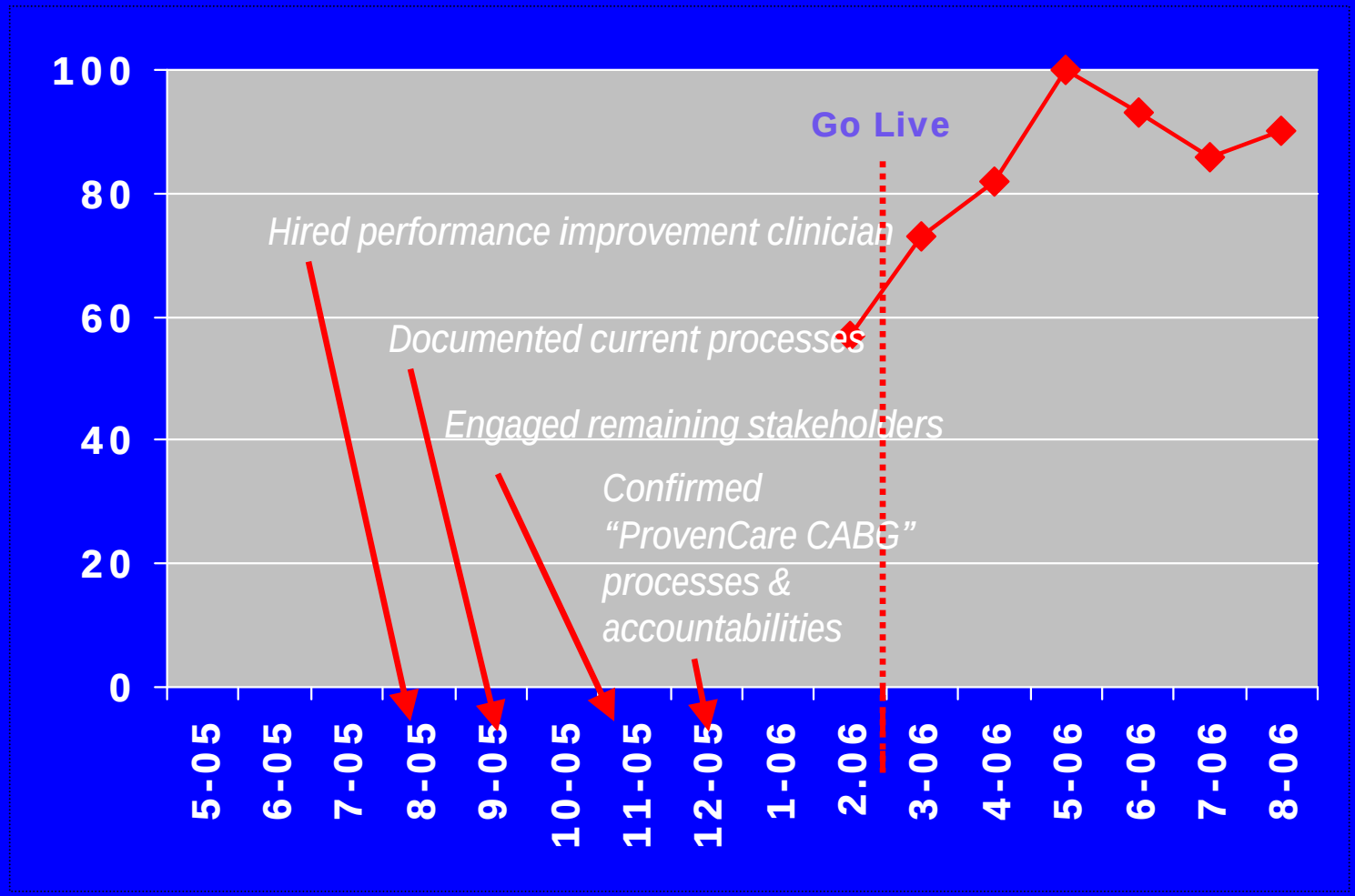
A Provider-Driven, Acute Episodic Care
"Pay-for-Performance" Initiative:

The New York Times

Reed Abelson, In Bid for Better Care, Surgery With a Warranty
New York Times - May 17, 2007

ProvenCare™:Coronary Artery Bypass

% of patients who receive <u>all</u> components of care

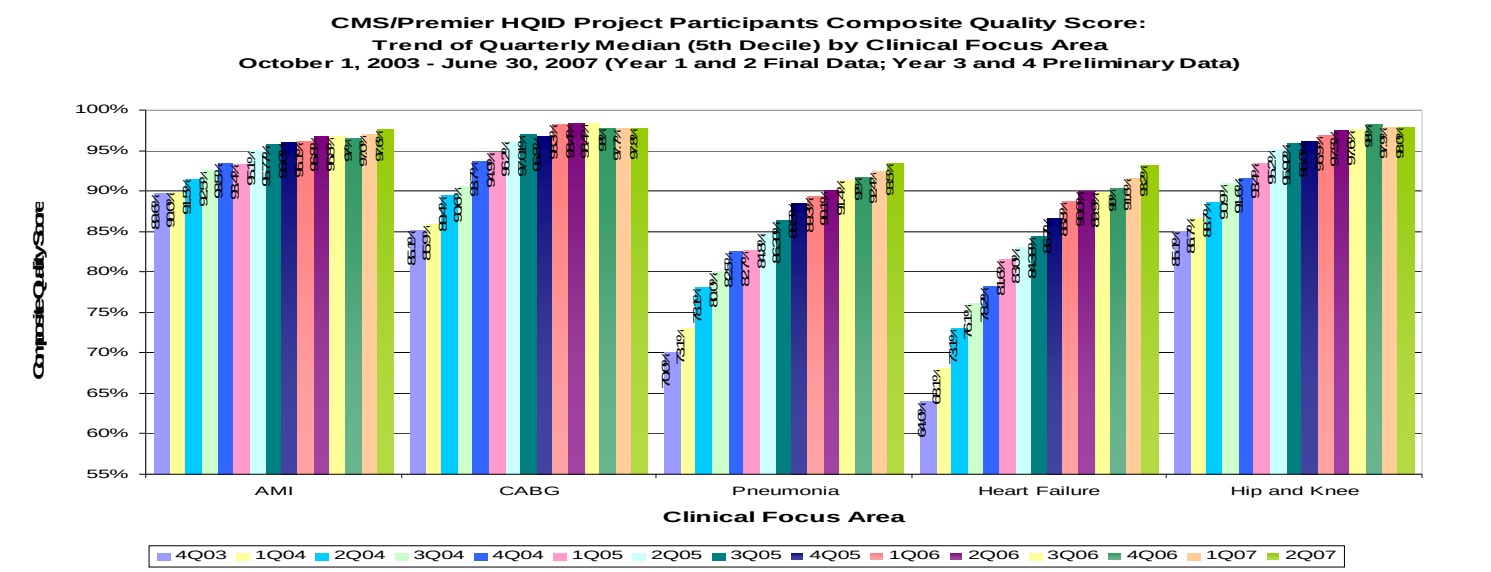


Payment for Hospital Pay-for-Performance

HQID Hospital Performance Update
Composite Quality Scores for 15 Quarters

For hospitals participating in the Premier healthcare alliance, Centers for Medicare and Medicaid Services (CMS) Hospital Quality Incentive Demonstration (HQID) pay-for-performance project, the median composite quality scores (CQS), a combination of clinical quality measures and outcome measures, improved significantly between the inception of the program in October 1, 2003 through June 30, 2007 (15 quarters) in all five clinical focus areas:

Clinical Area	# of Patients	Start (Oct 03)	End (June 07)	Absolute Increase	Percent Increase	Percent of Total Improvement Opportunity'
AMI (heart attack)	277,090	89.6%	97.6%	8.0%	8.9%	77%
CABG (Bypass)	118,851	85.1%	97.8%	12.7%	14.9%	85%
Pneumonia	462,161	70.0%	93.5%	23.5%	33.6%	78%
Heart Failure	409,401	64.0%	93.2%	29.3%	45.8%	81%
Hip and Knee	173,623	85.1%	98.0%	12.8%	15.1%	86%
Overall	1,441,126	78.8%	96.0%	17.3%	21.9%	81%



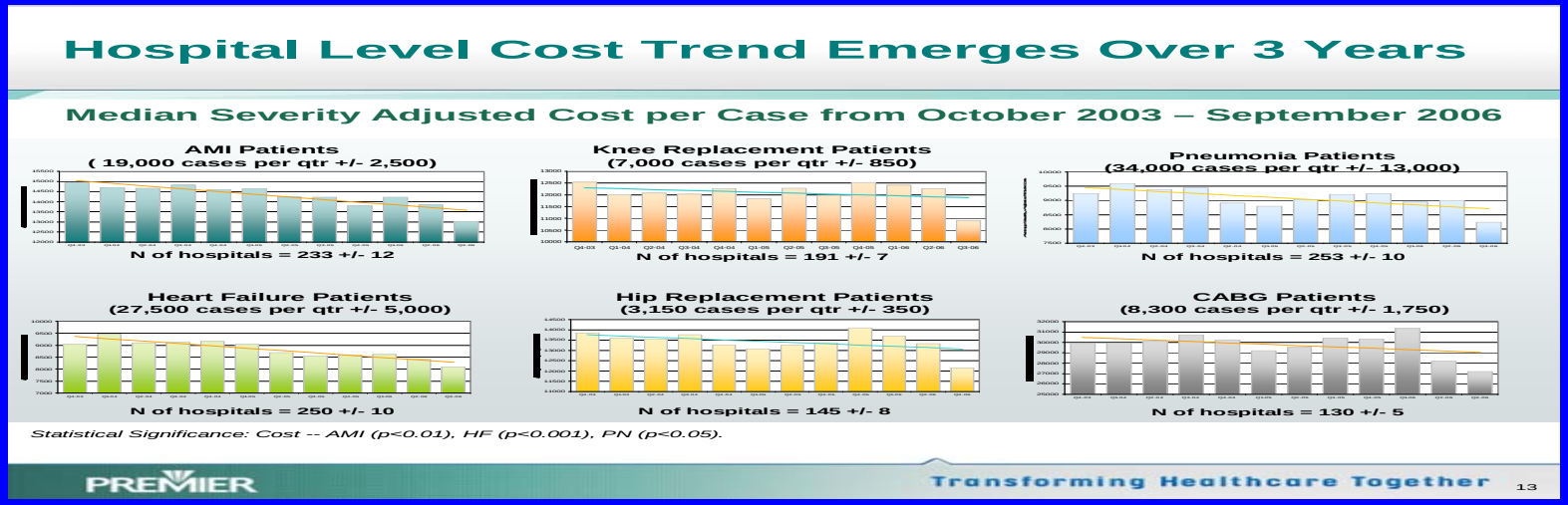
Association Between Quality and Cost

Based on Premier analysis of 1.1 million patients

Hospital costs and mortality rates are declining among participants in the Centers for Medicare and Medicaid Services (CMS), Premier Hospital Quality Incentive Demonstration (HQID) pay-for-performance (P4P) project, according to a recent analysis by the Premier Inc. healthcare alliance of over 1.1 million patient records from Premier's Perspective™ database.

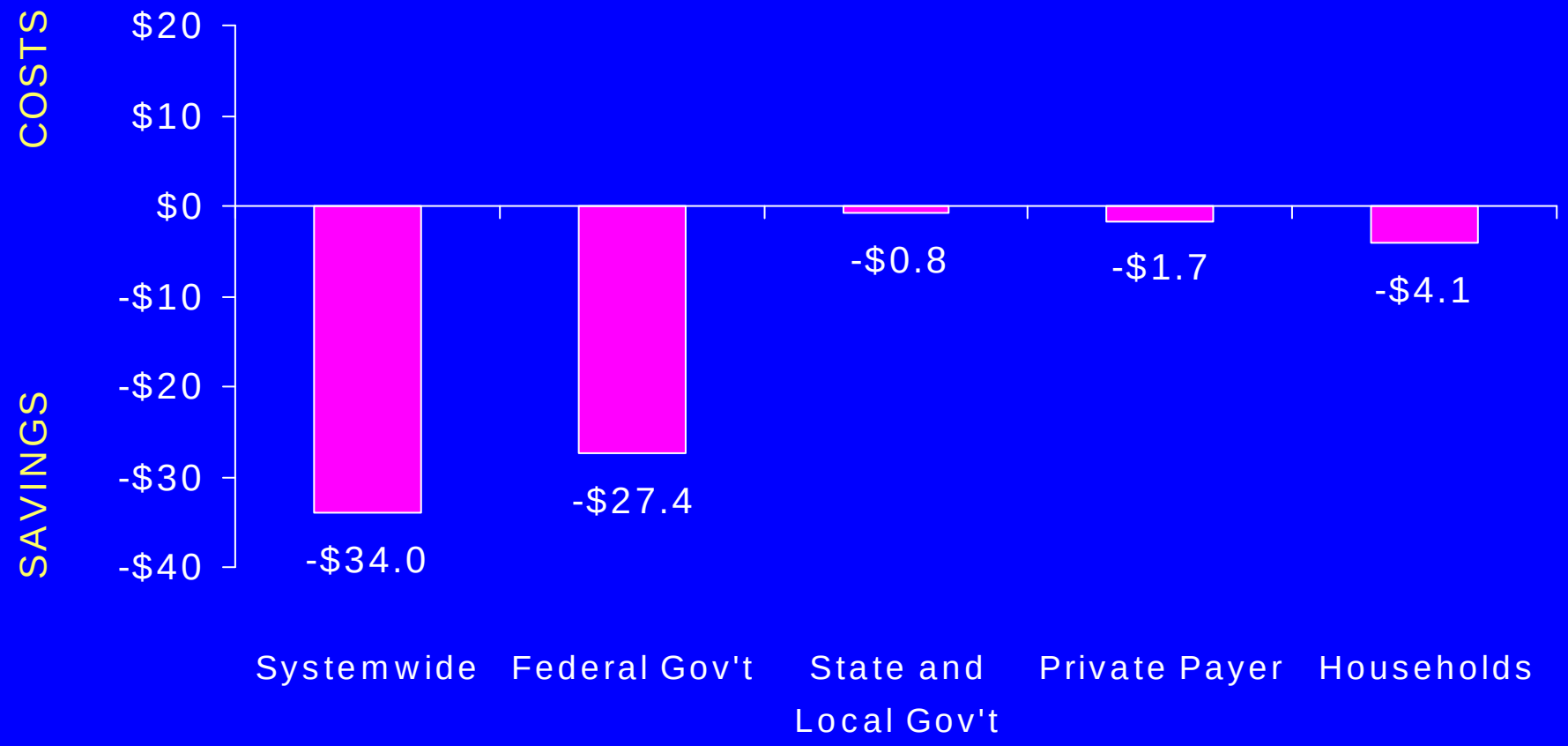
Hospital Cost Trends

The average hospital cost decreased significantly from October 1, 2003 through September 30, 2006 (12 quarters) for project participants in three of six clinical areas:



Medicare Hospital Pay-for-Performance: Distribution of 10-Year Impact on Spending

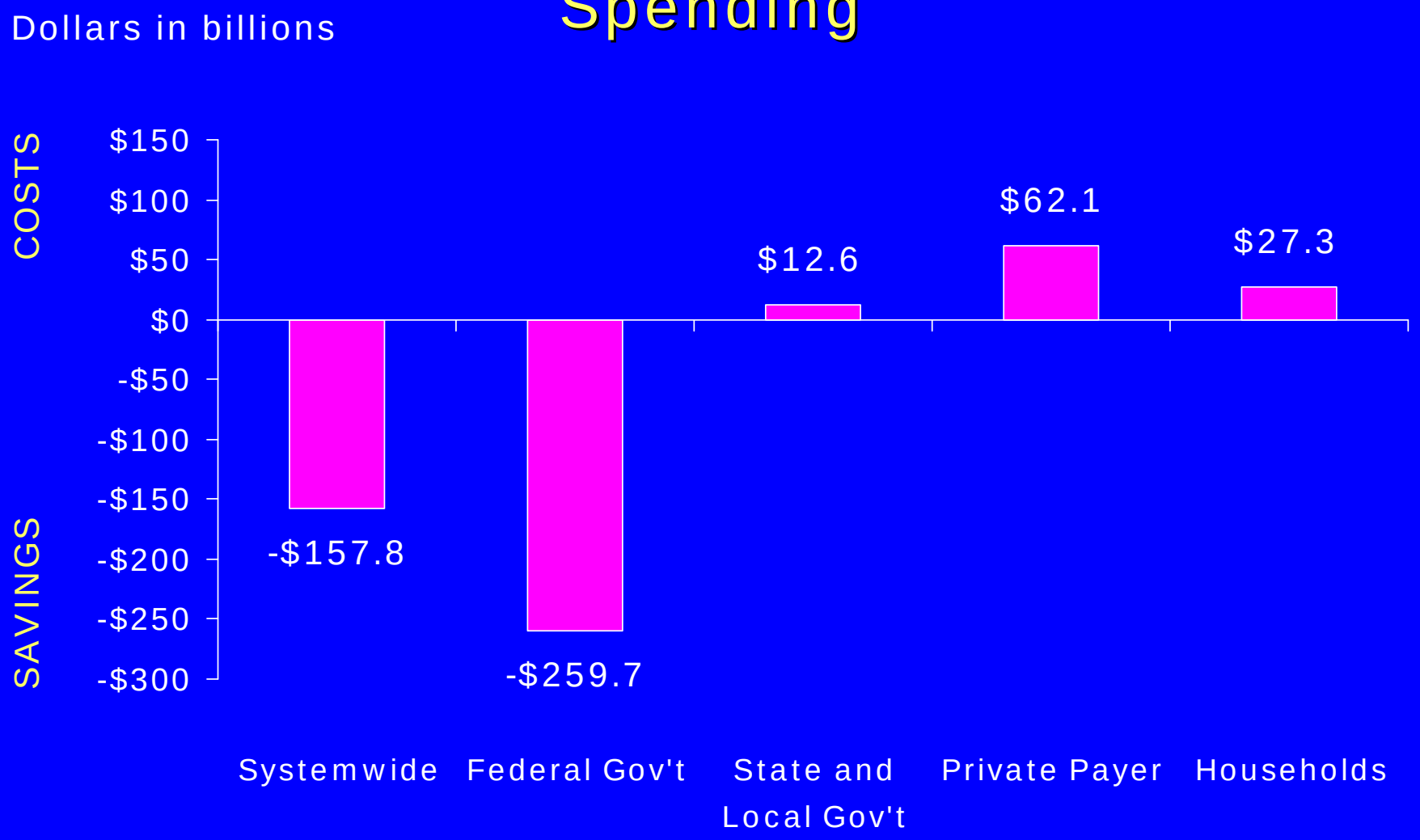
Dollars in billions



Source: C. Schoen, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, Commonwealth Fund, December 2008.

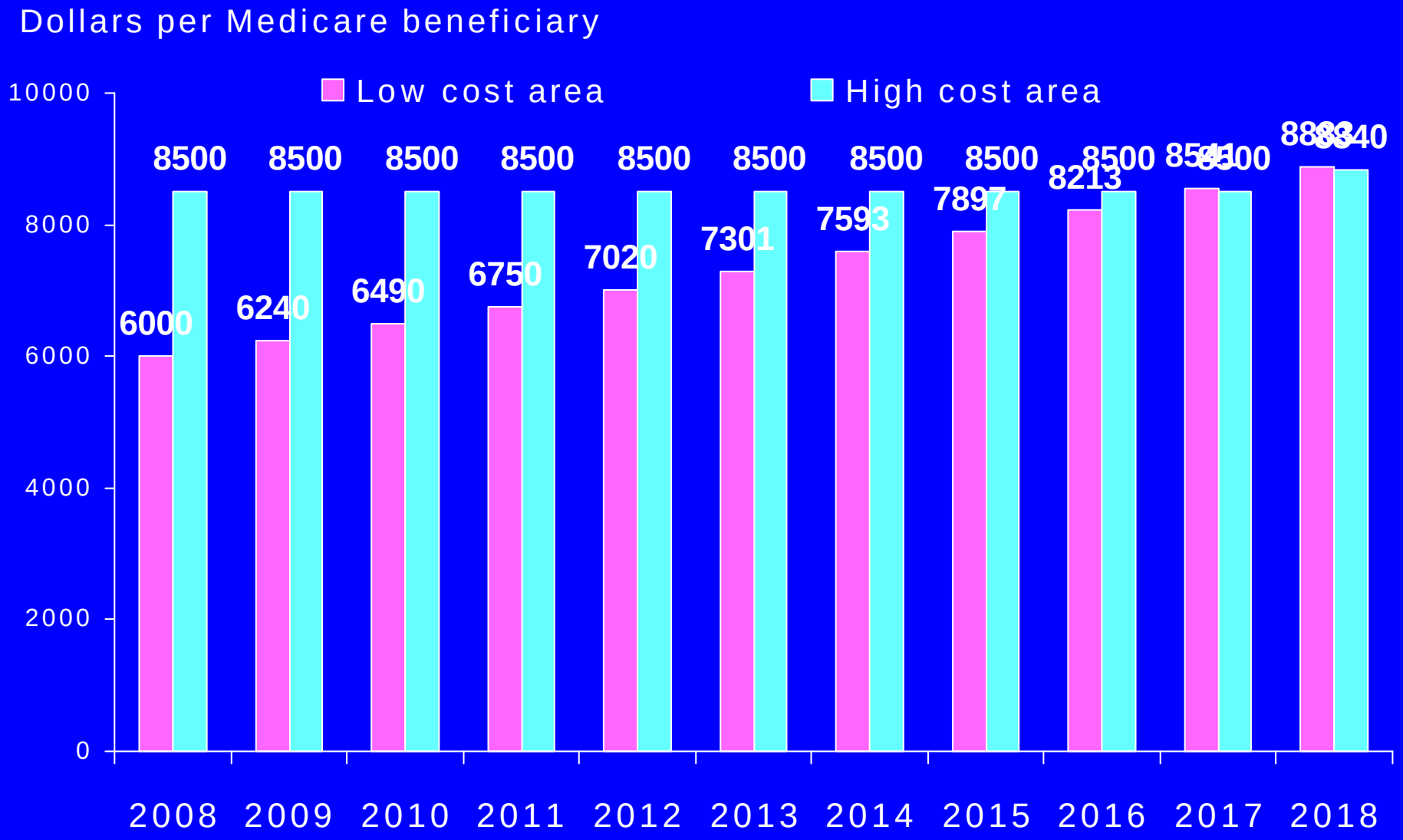
Payment Updates in High-Cost Areas for High-Cost Providers

Limiting Medicare Payment Updates in High-Cost Areas: Distribution of 10-Year Impact on Spending



Source: C. Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, Commonwealth Fund, December 2008.

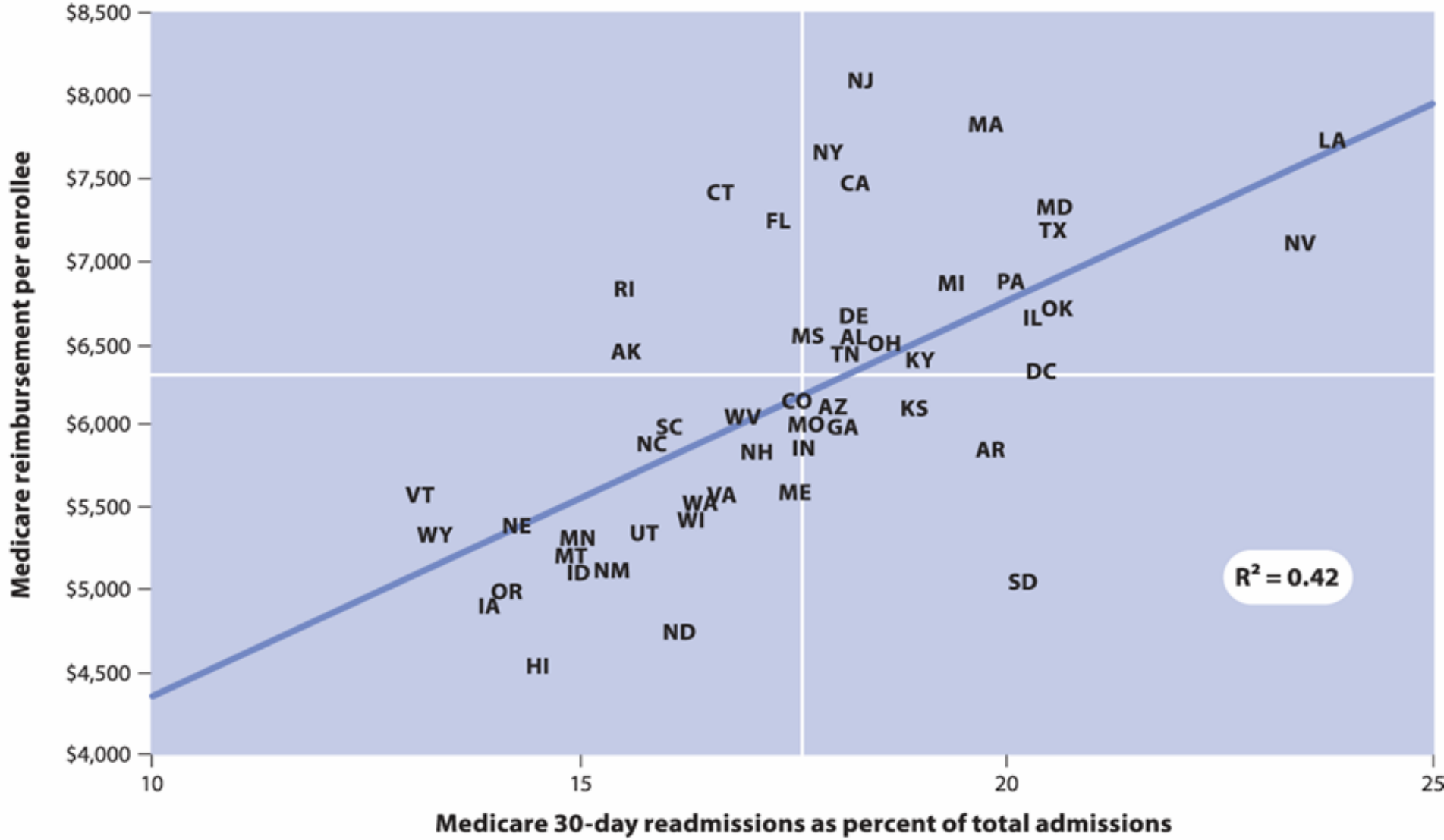
Illustrative Example of Limits on Medicare Payment Updates in High Cost Areas



Targeting Specific Areas of Waste:

Hospital Readmissions, Preventable Admissions, Unsafe or Ineffective Care

Medicare Reimbursement and 30-Day Readmissions by State, 2003

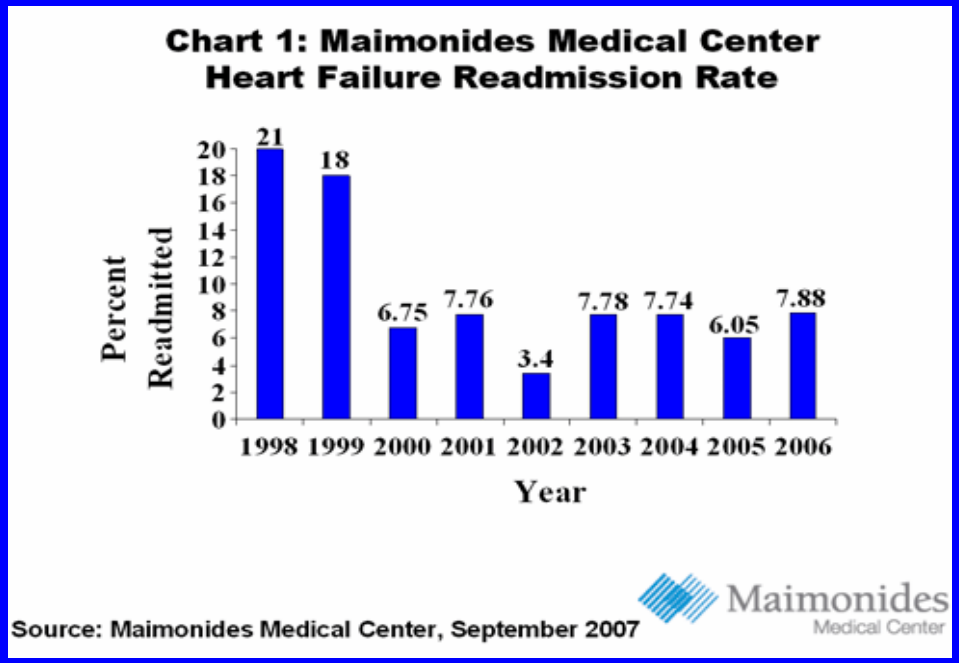


DATA: Medicare reimbursement – 2003 Dartmouth Atlas of Health Care; Medicare readmissions – 2003 Medicare SAF 5% Inpatient Data
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

Hospital Readmissions: Many (or most) are Potentially Preventable

2007 MedPAC report notes that 75% (13.3%/17.6%) of Medicare 30-day readmissions are potentially preventable

Maimonides Medical Center (NY) reduced readmissions by over 50% through coordinated team-based inpatient care and support with transition post-discharge.



Source: MedPAC Report to the Congress: Promoting Greater Efficiency in Medicare, June 2007; Quality Matters: Mortality Data and Quality Improvement, September/October 2007, The Commonwealth Fund, Vol. 26

Commonwealth Fund National Initiative: Reducing Avoidable Hospital Admissions

Objective: To develop and demonstrate a large-scale model for reducing avoidable hospitalizations, focusing initially on readmissions.

5-year Timeline:

- Currently in planning stages with the Institute of HealthCare Improvement (IHI); 1st year will be devoted to model development and state recruitment
- In years 2-4, implement and evaluate initiatives in 3-5 states or large regions
- In year 5, plan and launch national initiative

Key activities: Provider and community intervention; coalition building; realigning payment incentives

Funding: Fund commitment of $4.5 million over five years; additional local foundation support expected

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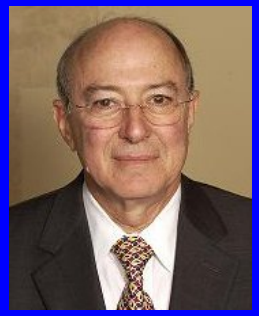
Future Direction for Fundamental Payment Reform

- Adoption of patient-centered medical home per enrollee fee by private insurers, Medicare, and Medicaid/SCHIP
- Framework for efficiency by National Quality Forum and advance efficiency measurement and data reporting on resource use
- Greater exclusion of high episode cost providers from networks in private insurer plans and spread of acute episode global fees
- Expansion of Medicare/Premier HQID Demonstration
- Establishment of Center on Medical Effectiveness and Health Care Decision-Making
- Medicare budget savings targeted on high cost areas, high cost providers, waste, and unsafe or ineffective care:
  - Freeze on payment updates to hospitals and physicians in high-cost regions (possible exceptions for organized care system providers with median or below costs)
  - Incentives for reduced hospital readmissions
  - No payment for hospital-acquired infections and “never events”

Thank You!



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