1.01 Government Programs: CMS and Pay for Performance: Current Issues

David Saÿen
CMS Regional Administrator
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Overview

- Why value-based purchasing?
- What demonstrations are underway?
  - Hospital demonstrations
  - Physician demonstrations
  - Other
- Lessons learned
- What demonstrations are planned?

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Value-Based Purchasing Drivers

- Focus on improving quality & efficiency
- Growing calls for rewarding performance, demanding value for the dollars Medicare spends
  - Lower costs without reducing quality?
  - Better outcomes at same costs?
- Challenges
  - Diverse & unique needs of 44 million beneficiaries
  - Fragmented delivery system: 700,000 physicians, 5,000 hospitals, etc.

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Value-Driven Demonstrations

- Hospital quality incentives
- Physician pay-for-performance
- ESRD disease management
- Home health pay-for-performance
- Gainsharing
- Acute care episode
- Electronic health records
- Nursing home value-based purchasing

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Hospital Quality Incentive Demonstration (HQID)

- Partnership with Premier, Inc.
  - Uses financial incentives to encourage hospitals to provide high quality inpatient care
  - Test the impact of quality incentives
- ~250 hospitals in 36 states
- Implemented October 2003
  - Phase II, 2006-2009

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HQID Goals

- Test hypothesis that quality-based incentives would raise the entire distribution of hospitals' performance on selected quality metrics
- Evaluate the impact of incentives on quality (process and outcomes) and cost

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HQID Hospital Scoring

- Hospitals scored on quality measures related to 5 conditions (36 measures and 21 test measures in year 4)
- Roll-up individual measures into overall score for each condition
- Categorized into deciles by condition to determine top performers
- Incentives paid separately for each condition

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Clinical Areas

- Heart Failure
- Community Acquired Pneumonia
- AMI
- Heart Bypass
- Hip and Knee Replacement

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Demonstration Phase II Policies

- Incentives if exceed baseline mean
  - Two years earlier
  - 40% of $$
- Pay for highest 20% attainment
  - No difference between deciles
  - 30% of $$
- Pay for 20% highest improvement
  - Must also exceed baseline mean
  - 30% of $$

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HQID Years 1 thru 4

- Quality scored improved by an average of 17% over 4-year period
- Incentive payments averaged $8.2 million to ~120 hospitals in each of years 1-3
- Incentive payments of $12 million were spread across 225 hospitals in year 4

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HQID Value Added

- Demo “proof of concept” useful in development of proposal for national value-based purchasing program
- Demo hospitals improved care, reduced morbidity and mortality for thousands of patients

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Physician Group Practice (PGP) Demonstration

- 10 physician groups (≥200 physicians)
  - ~ 5,000 physicians
  - ~ 225,000 Medicare fee-for-service beneficiaries
- April 2005 implementation (now in 5th year)

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PGP Goals & Objectives

- Encourage coordination of Medicare Part A & Part B services
- Reward physicians for improving quality and outcomes
- Promote efficiency
- Identify interventions that yielded improved outcomes and savings

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PGP Design

- Maintain FFS payments
- Give physician practices broad flexibility to redesign care processes to achieve specified outcomes
  - Performance on 32 quality measures
  - Lower spending growth than local market
- Performance payments derived from savings (shared between Medicare and practices)

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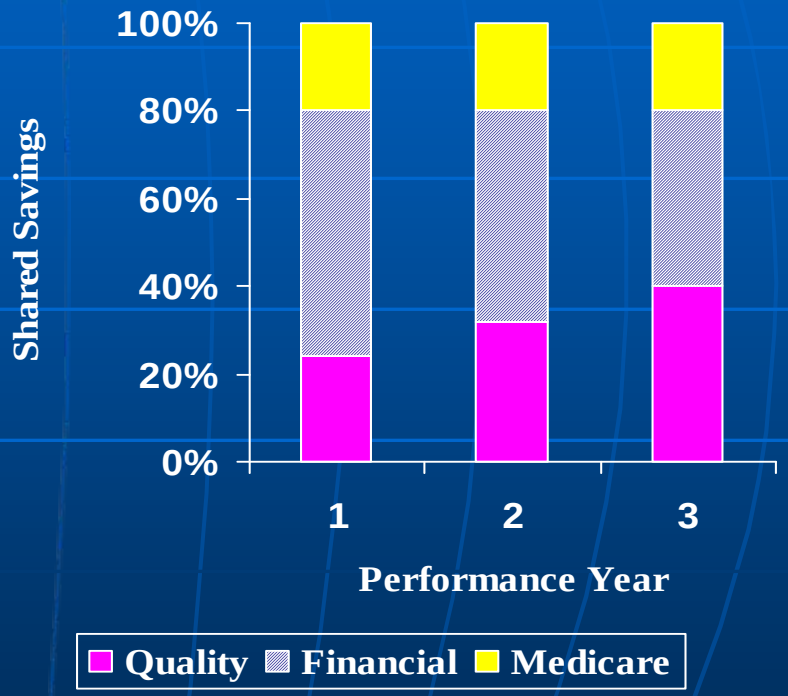
Medicare Shares Savings

- Assigned beneficiary total Medicare spending is > 2 percentage points below local market growth rate
  - Share 80% of savings
  - Allocated for cost efficiency & quality
- Maximum payment is 5% of Medicare Part A & B target



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Process & Outcome Measures

Diabetes Mellitus	Congestive Heart Failure (CHF)	Coronary Artery Disease (CAD)	Hypertension & Cancer Screening
HbA1c Management	LVEF Assessment	Antiplatelet Therapy	Blood Pressure Screening
HbA1c Control	*LVEF Testing*	Drug Therapy for Lowering LDL Cholesterol	Blood Pressure Control
Blood Pressure Management	Weight Measurement	Beta-Blocker Therapy – Prior MI	Blood Pressure 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		
Influenza Vaccination	Influenza Vaccination		
Pneumonia Vaccination	Pneumonia Vaccination		

Claims-based Measure in Italics

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PGP Quality—Year 3

- All 10 groups improved quality relative to base year on 28 of 32 measures
  - Diabetes: +10 percentage points
  - HF: +11 percentage points
  - CAD: +6 percentage points
  - Cancer screening: +10 points
  - Hypertension: +1 point
- Two groups achieved benchmark performance on all 32 measures
- No HF or CAD benchmarks missed

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PGP Savings—Years 1-3

- Two of 10 groups saved >2% and shared savings* in Year 1
- Four groups saved >2% and shared savings* in Year 2
- Five groups saved >2% and shared savings* in Year 3

* Practices share savings when 2% threshold exceeded and only amount above 2%

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PGP Value Added

- Inform agency policy on key issues related to measurement of cost and quality
- Develop operational models for collecting physician practice data on quality and efficiency that can be applied to program-wide initiatives (e.g., Physician Quality Reporting Initiative)
- Template for accountable care organizations

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Medicare Care Management Performance Demonstration

- MMA section 649
- Pay for performance for MDs who:
  - Achieve quality benchmarks for chronically ill Medicare beneficiaries
  - Adopt and implement CCHIT-certified EHRs and report quality measures electronically
- Budget neutral

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MCMP Goals

- Improve quality and coordination of care for chronically ill Medicare FFS beneficiaries
- Promote adoption and use of information technology by small-medium sized physician practices

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MCMP Demonstration

- Four states: UT, MA, CA, AR
- 700 primary care practices
  - 2,300 physicians initially enrolled
- Small and medium sized practices
  - 34% solo practitioners
  - 31% 2-3 physicians
  - 24% 4-6 physicians
  - 9% 7-10 physicians
  - 2% 11+ physicians

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Potential MCMP Payments

- Initial “pay for reporting” incentive
  - Up to $1,000/physician, $5,000 practice
- Annual “pay for performance” incentive
  - Up to $10,000/physician, $50,000 practice per year
- Annual bonus for electronic reporting
  - Up to 25% of clinical “pay for performance” payment tied to # measures reported electronically
  - Practice must be eligible for quality bonus first
  - Up to $2,500 per physician, $12,500/practice per year
- Maximum potential payment over 3 years
  - $38,500 per physician; $192,500 per practice

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MCMP Early Results

- Demonstration began July 1, 2007
- Baseline "pay for reporting" payments:
  - Total payments: $1.5 million; average payment/practice = $2,505
  - 88% of participating practices received maximum incentive for baseline
- First "pay for performance" payments:
  - 560 practices out of 610 participating practices received performance payments
  - Total: $7.5 million; average payment/practice = $14K (high $62.5K)

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MCMP Early Results

- Operational and implementation issues
  - Smaller practices have limited resources
    - Staff, time
  - Smaller practices may have limited IT experience
  - Significant support needed

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MCMP Value Added

- Establishes foundation for accelerated implementation of EHR demonstration

- Use lessons from MCMP to shape value-based initiatives for physician services under Medicare (e.g., PQRI, EHR)

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ESRD Disease Management Demonstration Goals

- Test disease management models for beneficiaries with ESRD
- Evaluate results in a managed care setting
- Pilot test quality incentive payments for ESRD measures

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Quality Incentive Payment

- Five percent of capitation payment reserved for quality incentive payment
- Two kinds of quality outcome objectives
  - Improvement over prior year performance
  - Improvement over a national target

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Clinical Indicators

- Adequacy of hemodialysis
- Anemia management
- Albumin-corrected serum calcium
- Serum phosphorus
- Vascular access
  - Percent of patients with catheter in use
  - Percent of patients with AV fistula in use

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What Have We Learned?

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Lessons Learned

- Value-based purchasing can work: it provides a framework for an organizational focus on quality
- Potential spillover to overall quality, not just “teach to the test”
- Jury still out re: public reporting alone, savings, unintended consequences

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Lessons Learned: Financial Incentives

- Modest financial incentives can be adequate to change behavior, yield sustained improvement over time
- Measurement of savings is highly sensitive to target setting methodology, risk adjustment of beneficiary population, size of demo population
- Generating savings or reducing expenditure growth is difficult

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Lessons Learned: Quality Measures

- Determining quality measures is difficult and requires much development
  - Clearly defined goals, measure specifications and reporting methodology
  - Consistent with clinical practice and high quality care—physician/provider buy-in
  - Easier to measure underuse (gaps in care) than overuse (unnecessary, duplicative, futile)

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Lessons Learned: Quality Measures

- Changing measures frequently creates provider angst
- Processes more readily moved than outcomes
  - Ceiling effect may render some measures obsolete
  - Effect potential continued improvement by shift to person-level measurement (appropriate-care model)

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Lessons Learned: Quality Reporting

- Increases awareness and documentation of care processes
- Outreach and education are important for provider understanding and accurate and consistent reporting
- Measuring/reporting quality creates opportunity for providers to standardize care processes and redesign workflows to improve delivery at point of care

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Lessons Learned: Organizational Participation

- Leadership, organizational champions and dedicated resources are critical
- Providers volunteer to gain experience with initiatives consistent with their strategic visions and market objectives
- Wide distribution of incentives (improvement and attainment) may help maintain interest and support
- Administrative, clinical, data (EHR) and financial integration appears necessary (but not sufficient) to produce savings

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Whither Next?

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Home Health Pay-for-Performance Demonstration

- Objective: Test whether performance-based incentives can improve quality and reduce program costs of Medicare home health beneficiaries. Two year demonstration, ended on Dec. 31, 2009.

- ~ 600 home health agencies in 4 regions randomized into intervention and control groups
  - Northeast: Connecticut, Massachusetts
  - Midwest: Illinois
  - South: Alabama, Georgia, Tennessee
  - West: California

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Home Health Pay-for-Performance Demonstration

- 7 quality measures (Acute care hospitalization, Emergent care, Bathing, Ambulation/Locomotion, Transferring, Management of oral medications, Status of surgical wounds)

- Performance scored and incentives paid to HHAs for each measure separately
  - HHAs w/ top 20% of performance scores
  - HHAs w/ top 20% of improvement gains

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Gainsharing Overview

- Means to align incentives between hospitals and physicians
- Hospitals pay physicians a share of savings that result from collaborative efforts between the hospital and the physician to improve quality and efficiency
- Requires waiver of civil money penalties

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Two Gainsharing Demonstrations

- DRA Sec. 5007: Medicare Hospital Gainsharing Demonstration
  - 2 hospitals
  - October 2008 implementation (ends Dec. 2009)
- MMA Sec. 646: Physician Hospital Collaboration Demonstration
  - Consortium of 12 New Jersey hospitals
  - July 2009 implementation

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Demonstration Goals

- Improve quality and efficiency of care
- Encourage physician-hospital collaboration by permitting hospitals to share internal savings
- CMS open to wide variety of models; projects must be budget neutral

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Gainsharing Payments

- *No change in Medicare payments* to gainsharing hospitals
- Must represent share of internal *hospital* savings and be tied to quality improvement
- No payments for referrals
- Limited to 25% of physician fees for care of patients affected by quality improvement activity

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Gainsharing Payments

- Gainsharing must be a transparent arrangement that clearly identifies the actions that are expected to result in cost savings
- Incentives must be reviewable, auditable, and implemented uniformly across physicians
- Payments must be linked to quality and efficiency

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Possible Approaches

- Reduced time to diagnosis
- Improved scheduling of OR, ICU
- Reduced duplicate or marginal tests
- Reduced drug interactions, adverse events
- Improved discharge planning and care coordination
- Reduced surgical infections and complications
- Reduced cost of devices and supplies

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Acute Care Episode (ACE) Demonstration

- Tests a discounted global payment for acute care hospital stay and corresponding physician services
- Includes 28 cardiovascular and 9 orthopedic MS-DRGs
- Covers Medicare fee-for-service admissions at selected sites
- Will use 22 quality measures to monitor the program

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Demonstration Goals

- Improve quality of care through consumer and provider understanding of both price and quality information
- Increase provider collaboration
- Reduce Medicare payments for acute care services using market mechanisms
- Build platform for potential expansions—geography, additional MS-DRGs, post-acute care

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Demonstration Benefits

- Medicare – 1-6 percent discount depending upon the site
- Providers – gainsharing and potential for increased patient volume
- Beneficiaries – shared savings payments based upon 50 percent of Medicare savings
- Potential model
  - Expanded use of bundling
  - Quality-driven patient decision-making

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Demonstration Sites

- 3-year demonstration began May 2009
- Initiated in one MAC service area: TX, NM, OK, and CO
- Hospitals known as Value-Based Care Centers
  - Hillcrest Medical Center – Tulsa
  - Baptist Health System – San Antonio
  - Lovelace Health System – Albuquerque
  - Oklahoma Heart Hospital – Oklahoma City
  - Exempla Saint Joseph Hospital – Denver

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Electronic Health Records

- Former Secretary's initiative
- Goal is to support former President Bush's Executive Order and encourage adoption of EHRs by small physician practices
- Opportunity to inform "meaningful use" definition for ARRA funds
- Opportunity for private payers to align with model

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Electronic Health Records

- 5-year demonstration began June 1, 2009
- ~800 practices in 4 states (randomized into intervention and control groups)
- Modeled on MCMP Demonstration and platforms
  - Base payment for performance on 26 quality measures
  - Bonus for use of CCHIT-certified EHRs with higher payment for greater functionality

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Nursing Home Value-Based Purchasing Demonstration

- Objective: Improve quality of care for all Medicare beneficiaries in nursing homes (short-stay or long-stay)
- Performance payments based on nursing home quality of care in 4 domains:
  - Nurse staffing levels
  - Hospitalization rates
  - MDS outcomes
  - Survey deficiencies

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Nursing Home Value-Based Purchasing Demonstration

- 3 states—AZ, NY, WI—selected based on state interest in “hosting” demo
- ~300 nursing homes (100 per state) randomized into intervention and control groups
- Budget neutral: Incentive payments to be made from each state’s “savings pool,” which will be generated from reductions in inappropriate hospitalizations
- The demonstration began July 1, 2009.

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Into the Future

- Medical home pilot – mixed models
- Accountable care organizations
- Paying for episodes of care
  - Expand ACE demo – more sites, more DRGs
  - Incorporate post-acute care
- Preventing readmissions
- Guarantees for medical care (Geisinger "Proven Care" model)

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For More Information

- Visit the Medicare demonstrations Web page:

  http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp

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Thank you!

David Saÿen
CMS Regional Administrator,
San Francisco, Region IX

Centers for Medicare & Medicaid Services
90 Seventh Street
Suite 5-300
San Francisco, CA 94103

david.sayen@cms.hhs.gov
(415) 744-3501

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