

# Medicare Demonstrations Overview

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# Overview

- Premier Hospital Quality Incentive Demonstration
- Physician Group Practice Demonstration
- Medicare Care Management Performance Demonstration
- Medical Home Demonstration
- Electronic Health Records Demonstration

# Premier 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

# 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

# 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

# Clinical Areas

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

# HQID Years 1 and 2 Results

- Average quality scored improved 15.7% over 3-year period
- \$8.9 million awarded to 123 top performers in year 1
- \$8.7 million to 115 top performers in year 2

# HQID 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 \$\$

# Lessons Learned

- Value-based purchasing can work: provides focus and incentives
- Modest dollars can have big impacts
- Continued improvement in each year
- Important spillover to overall quality, not just “teach to the test”

# 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

# Physician Pay for Performance

- Physician Group Practice Demonstration
  - April 2005 implementation
- Medicare Care Management Performance Demonstration
  - July 2007 implementation

# 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

# 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)

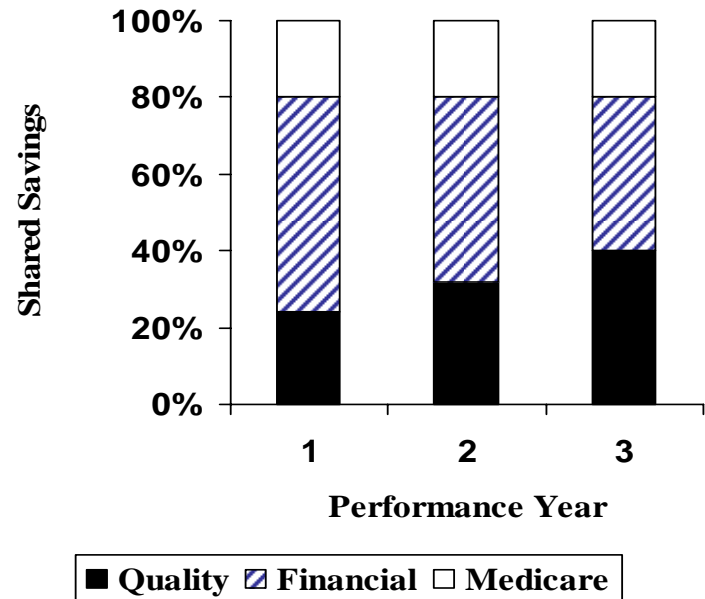
# Physician Group Practices

**10 Physician Groups Represent 5,000 Physicians  
& 224,000 Assigned Medicare Fee-For-Service Patients**

- **Billings Clinic**  
Billings, Montana
- **Dartmouth-Hitchcock Clinic**  
Bedford, New Hampshire
- **The Everett Clinic**  
Everett, Washington
- **Forsyth Medical Group**  
Winston-Salem, North Carolina
- **Geisinger Health System**  
Danville, Pennsylvania
- **Marshfield Clinic**  
Marshfield, Wisconsin
- **Middlesex Health System**  
Middletown, Connecticut
- **Park Nicollet Health Services**  
St. Louis Park, Minnesota
- **St. John's Health System**  
Springfield, Missouri
- **University of Michigan Faculty Group Practice**  
Ann Arbor, Michigan

# Medicare Shares Savings

- Assigned beneficiary total Medicare spending is Greater Than 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



# Process & Outcome Measures

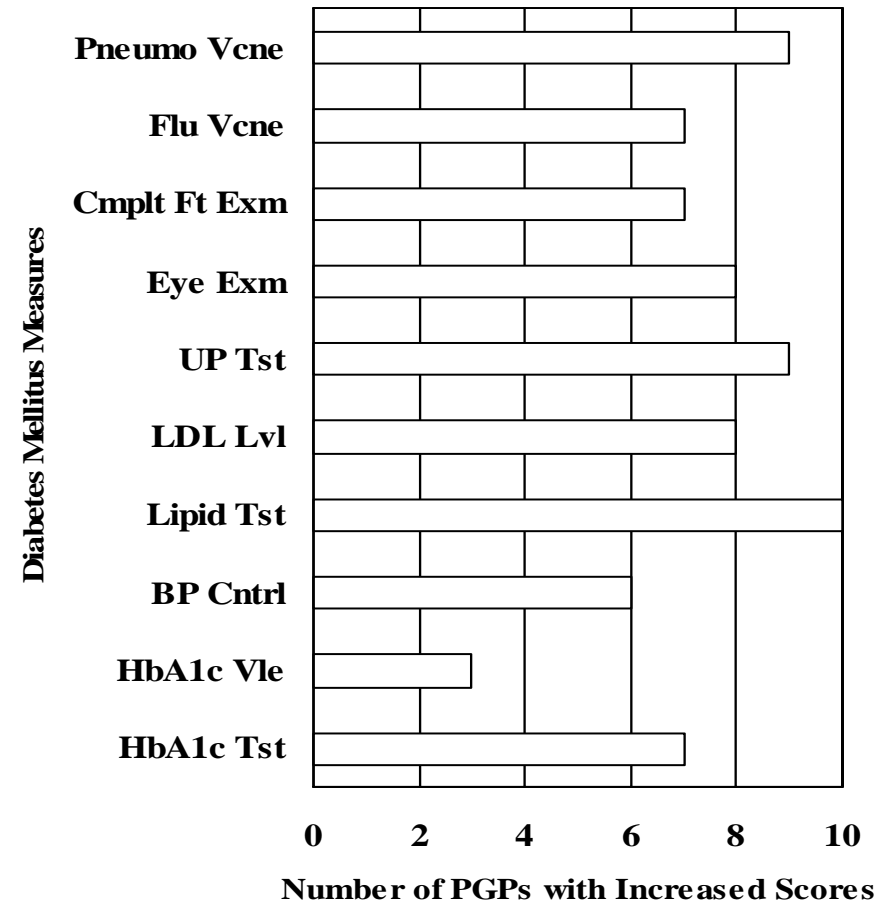
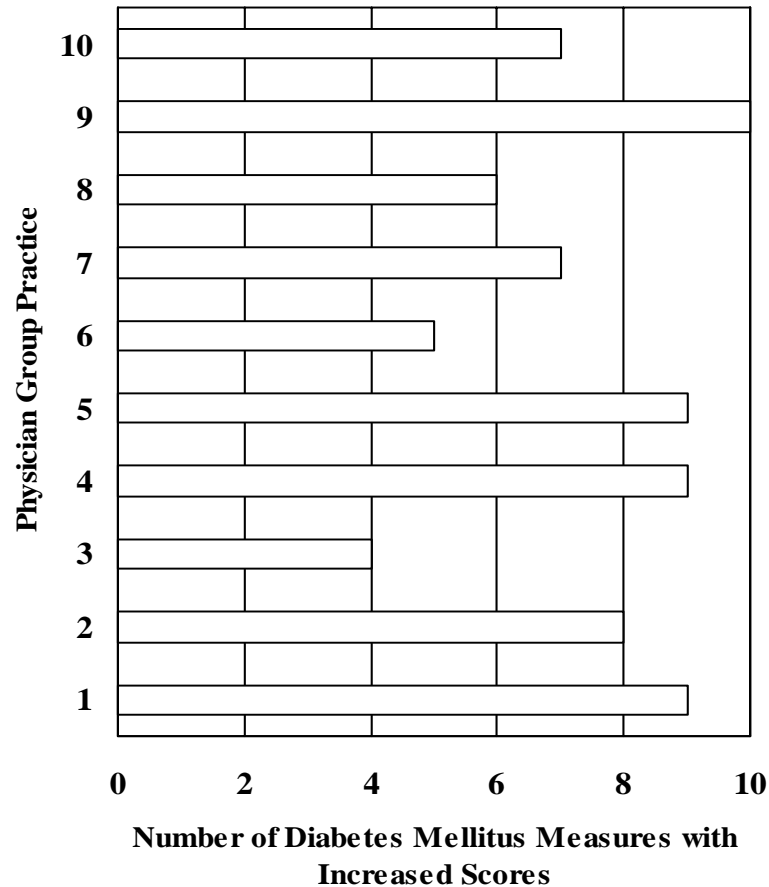
Diabetes Mellitus	Congestive Heart Failure	Coronary Artery Disease	Hypertension & Cancer Screening
<i>HbA1c Management</i>	LVEF Assessment	Antiplatelet Therapy	Blood Pressure Screening
HbA1c Control	<i>LVEF Testing</i>	Drug Therapy for Lowering LDL Cholesterol	Blood Pressure Control
Blood Pressure Management	Weight Measurement	Beta-Blocker Therapy – Prior MI	Blood Pressure Plan of Care
<i>Lipid Measurement</i>	Blood Pressure Screening	Blood Pressure	<i>Breast Cancer Screening</i>
LDL Cholesterol Level	Patient Education	<i>Lipid Profile</i>	Colorectal Cancer Screening
<i>Urine Protein Testing</i>	Beta-Blocker Therapy	LDL Cholesterol Level	
<i>Eye Exam</i>	Ace Inhibitor Therapy	Ace Inhibitor Therapy	
Foot Exam	Warfarin Therapy		
Influenza Vaccination	Influenza Vaccination		
Pneumonia Vaccination	Pneumonia Vaccination		

*Claims-based Measure in Italics*

# PGP First-Year Results

- All 10 groups improved quality relative to base year on 10 diabetes measures
- Two of 10 groups saved >2 percent and shared savings
- Six of 10 groups expenditures grew between 0 and 2 percent lower than comparison group
  - Share savings when 2% threshold exceeded

# Improved Diabetes Care



# PGP Value Added

- Identify interventions that yield improved outcomes and savings
- 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)

# 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

# MCMP Goals

- Improve quality (same measures as PGP) and coordination of care for chronically ill Medicare FFS beneficiaries
- Promote adoption and use of information technology by small and medium-sized physician practices ( $\leq 10$  physicians)

# 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

# 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

# MCMP Early Results

- Demonstration began July 1, 2007
- Practices currently collecting and submitting baseline clinical data
- Operational and implementation issues
  - Smaller practices have limited resources (staff, time)
  - Smaller practices may have limited IT experience
  - Significant support needed

# MCMP Value Added

- Establishes foundation and platforms for implementation of other physician demonstrations
- Use lessons from MCMP to shape value-based initiatives for physician services under Medicare (e.g., PQRI, EHR)

# Medical Home Demonstration

- Tax Relief and Health Care Act of 2006
  - Sec. 204 ...redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations

# Key Parameters

- 3 years
- 8 sites—urban, rural, underserved areas
- “Personal physician”
- Monthly care management fee plus shared savings
- High-need patients, especially those with multiple chronic illnesses

# Medical Home Definition

- Physician practice responsible for:
  - Targeting beneficiaries for participation
  - Providing safe, secure technology to promote patient access to personal health info
  - Developing a health assessment tool
  - Providing training programs for personnel involved in care coordination

# Personal Physician

- Must be board certified
- Provides first contact and continuous care for individuals under his/her care.
- Has the staff and resources to manage the comprehensive and coordinated health care of each such individual.
- Performs medical home services
- May be a specialist

# Medical Home Services

- Ongoing support, oversight, guidance to implement integrated cross-discipline plan of care developed in partnership with patients, all other physicians furnishing care to them, and other appropriate medical personnel or agencies (such as home health agencies)
- Evidence-based medicine and clinical decision support tools to guide decision-making at the point-of-care based on patient-specific factors
- Health IT to monitor and track health status of patients and to provide patients with enhanced and convenient access to services
- Encouragement of patient engagement in the management of their own health through education and support systems

# Electronic Health Records Demo

- Secretary's initiative
- Goal is to support President's Executive Order and encourage adoption of EHRs by small physician practices
- Opportunity for private payers to align with model, including Chartered Value Exchange & BQI locations

# Electronic Health Records

- 5-year demonstration
- Up to 2,400 practices in up to 12 sites (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

# Discussion Questions

- Medical Home
  - Can small practices meet the medical home requirements?
  - Should CMS recognize different tiers of medical homes based on the extent to which they can deliver medical home services?
  - Will physician practices restructure the organization and delivery of care for only part of their patient population? Or should CMS attempt to conduct this demonstration in areas where the private sector is also paying for the medical home model?
  - How should the performance of a medical home be measured?

# Discussion Questions

- Electronic Health Records
  - What core functions of an EHR ought to be required to ensure that Medicare does not pay incentives for the use of an EHR merely as an electronic file cabinet?
  - If a practice does not have an EHR at the outset of the demo, it must have one and be able to report quality measures by the end of the second year. Is that sufficient time for practices that have not yet adopted an EHR?
  - What are likely to be effective ways of recruiting physician practices into this demonstration?

# For More Information

- Visit the Medicare demonstrations Web page
  - [www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp](http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp)
- Contact information

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