

Medicare Health Care Quality Demonstration Programs – Indiana Health Information Exchange Project FACT SHEET

Summary: Medicare Health Care Quality (MHCQ) Demonstration Programs are designed to examine the extent to which major, multi-faceted changes to traditional Medicare's health delivery and financing systems lead to improvements in the quality of care provided to Medicare beneficiaries, without increasing total program expenditures. As the first project to be implemented under the MHCQ demonstration, the Indiana Health Information Exchange (IHIE) will implement a regional, multi-payer, pay-for-performance and quality reporting program, based (by-and-large) on a common set of quality measures. IHIE's interventions are expected to provide important empirical evidence on the effectiveness of pay-for-performance, health IT, and multi-payer initiatives in improving the quality and efficiency of care provided to Medicare beneficiaries. Demonstration waiver authority will be used in this project to share a portion of Medicare savings; in the event IHIE has proven it has reduced anticipated Medicare spending for treated patients.

Demonstration Background: Section 1866C of the Social Security Act, as added by section 646 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P. L. 108-173. Section 1866C(b) requires the Secretary to establish a 5-year demonstration program under which the Secretary may approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care. This section also authorizes the Secretary to waive compliance with such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as may be necessary for the purposes of carrying out the demonstration project. In the event the demonstration site reduces Medicare costs and qualifies for a portion of Medicare savings, waiver authority related to title XVIII will be exercised.

- Three types of "health care groups" were applicable to participate in the MHCQ demonstration: a) 1) groups of physicians, 2) integrated health care delivery systems (IDS), and 3) organizations representing regional coalitions of groups or systems described previously.
- The Centers for Medicare and Medicaid Services published a solicitation for demonstration proposals in 2005. All proposals were reviewed by a panel of experts. Those proposals that appeared to be both promising and feasible were recommended to the CMS Administrator, who made the final selection of participants.
- The IHIE project started July 1, 2009 and is scheduled to end June 30, 2014.

IHIE Background: IHIE is a not-for-profit 501c3 corporation founded in 2004 by a collaboration of 13 institutions representing hospitals, providers, researchers, public health organization, and economic development groups in the Indianapolis area. Besides its approximately 800 participating physicians, IHIE has also established relationships with local employers and public and private payers. IHIE has routinely been recognized in both the health care and health IT communities as one of the nation's most respected health information exchange organizations, supported by their designation as a Chartered Value Exchange (CVE), approval to become a Physician Quality Reporting Initiative (PQRI) Registry and

participation in the Better Quality Information (BQI) to Improve Care for Medicare Beneficiaries (BQI) Project. IHIE's program(s) are supported by the Indiana Network for Patient Care (INPC) database, which is run by the Regenstrief Institute. In addition to CMS data that will be sent under the demonstration, the INPC is comprised of clinical medical data (i.e. admissions, discharge, pathology, physician notes, etc.), commercial insurer medical and pharmacy claims, and patient lab and demographic data from physician offices and employer on-site settings.

IHIE will aggregate CMS claims and administrative data in the demonstration with other data processed in conjunction with its regional health information exchange (HIE). Data from the various sources will be used to generate patient-level and provider level quality reports, alerts and reminders for participating providers. By incorporating CMS data into IHIE's HIE and producing these quality reports, IHIE will provide participating physicians with a more complete picture of the care that is or isn't being provided to treated Medicare patients and give physicians the information they need to positively impact the quality and cost of care being provided.

IHIE Participating Physicians: Any physician group and/or individual physician, practicing in one of the nine Indiana counties selected for the demonstration, with a signed Quality health 1st agreement prior to the start of the demonstration performance year will be deemed an IHIE participating physician. As of July 2009, IHIE reported approximately 800 participating physicians meeting these requirements. The majority of physicians currently participating are focused (specialize) in general medicine and/or primary care. IHIE will attribute patients to participating physicians, after reviewing clinical and administrative data. Physicians can provide feedback to IHIE about patients that have been assigned to their care.

Intervention Population: CMS will be reviewing cost and quality data for Medicare fee-for-service beneficiaries that receive at least one office or other outpatient evaluation and management (E&M) visit with an IHIE participating physician. It is expected that an estimated 100,000 Medicare beneficiaries, residing in the Indianapolis metropolitan area, will meet this criteria in each year of the demonstration.

Quality Measurement: Quality of care will be measured at the population-level using a set of Medicare-specific quality measures (i.e., performance measurement will focus on whether or not the site has achieved improvements in quality when looking at the entire group of treated patient). Improvements in the quality of care provided to Medicare beneficiaries will be based on the extent to which IHIE participating physicians are able to reduce the gap between the maximum attainable level for a quality measure and the baseline performance for the quality measure. Approximately 14 ambulatory care quality measures will be used in the first year, growing to approximately 30 in year five.

Quality-contingent Shared Savings: CMS will calculate savings in the intervention population by comparing actual costs to expected costs for treated beneficiaries. Expected costs for the intervention group will be projected using adjusted utilization trends from the comparison group. In general, Medicare savings will be calculated as the difference between the expected costs and actual costs for beneficiaries in the intervention group. At least 50 percent of shared savings that are available to be paid to the site will be contingent on quality of care results for the year. Only after quality of care

performance results for a year are determined can the final amount of shared savings to be paid to the site be determined.

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