

The Imperative for Quality &
Efficiency:
CMS as a Public Health Agency
Pay-for-Performance

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Centers for Medicare & Medicaid Services

Alliance for Health Reform/RWJF

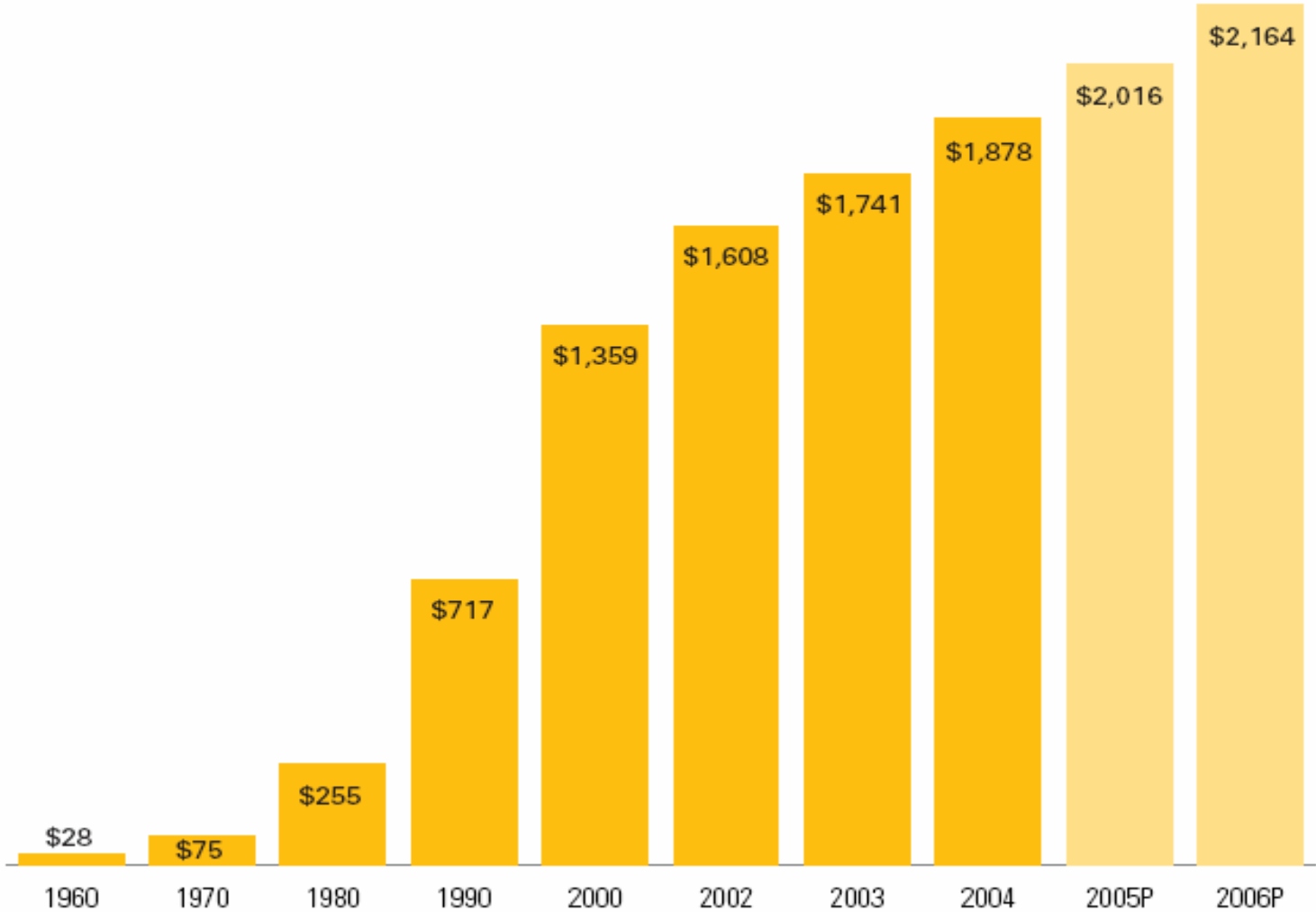
Congressional Staff Briefing

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CMS as a Public Health Agency

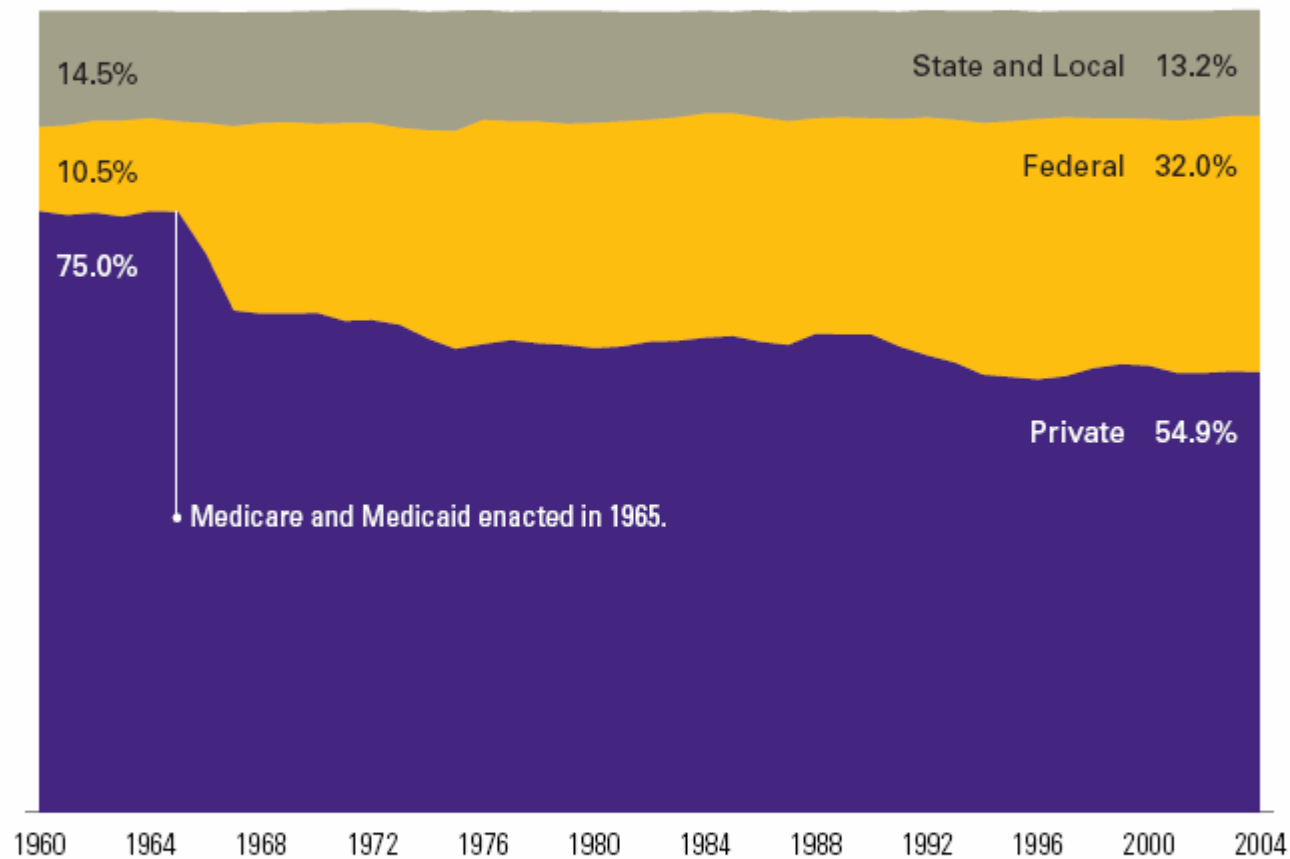
- Using CMS influence and financial leverage, in partnership with other healthcare stakeholders, to transform American healthcare system
- Focusing on not just Medicare & Medicaid, but also Commercial, uninsured, etc.
- Quality, Value, Efficiency, Cost-effectiveness
- Person-centeredness
- Assisting patients and providers in receiving evidence-based, technologically-advanced care while reducing avoidable complications & unnecessary costs

National Health Spending in Billions



Note: Selected rather than continuous years of data are shown prior to 2002. Years 2005 forward are CMS projections.
Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary.

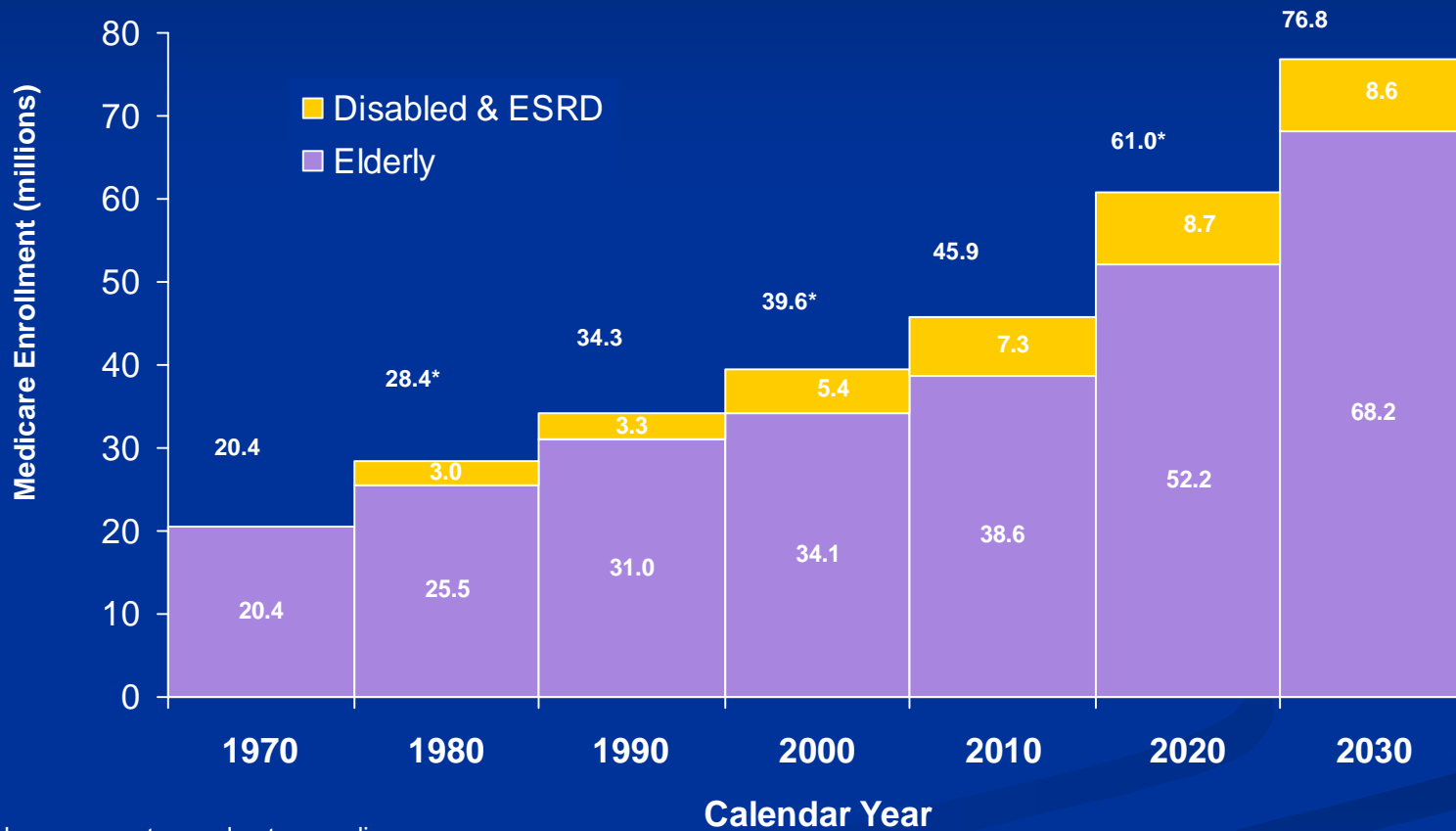
Historic Payment Sources



Notes: Chart reflects national health expenditures (NHE) by source of funds. Some years don't add to 100 percent due to rounding.
Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary.

Table 3.6 Number of Medicare Beneficiaries, 1970-2030

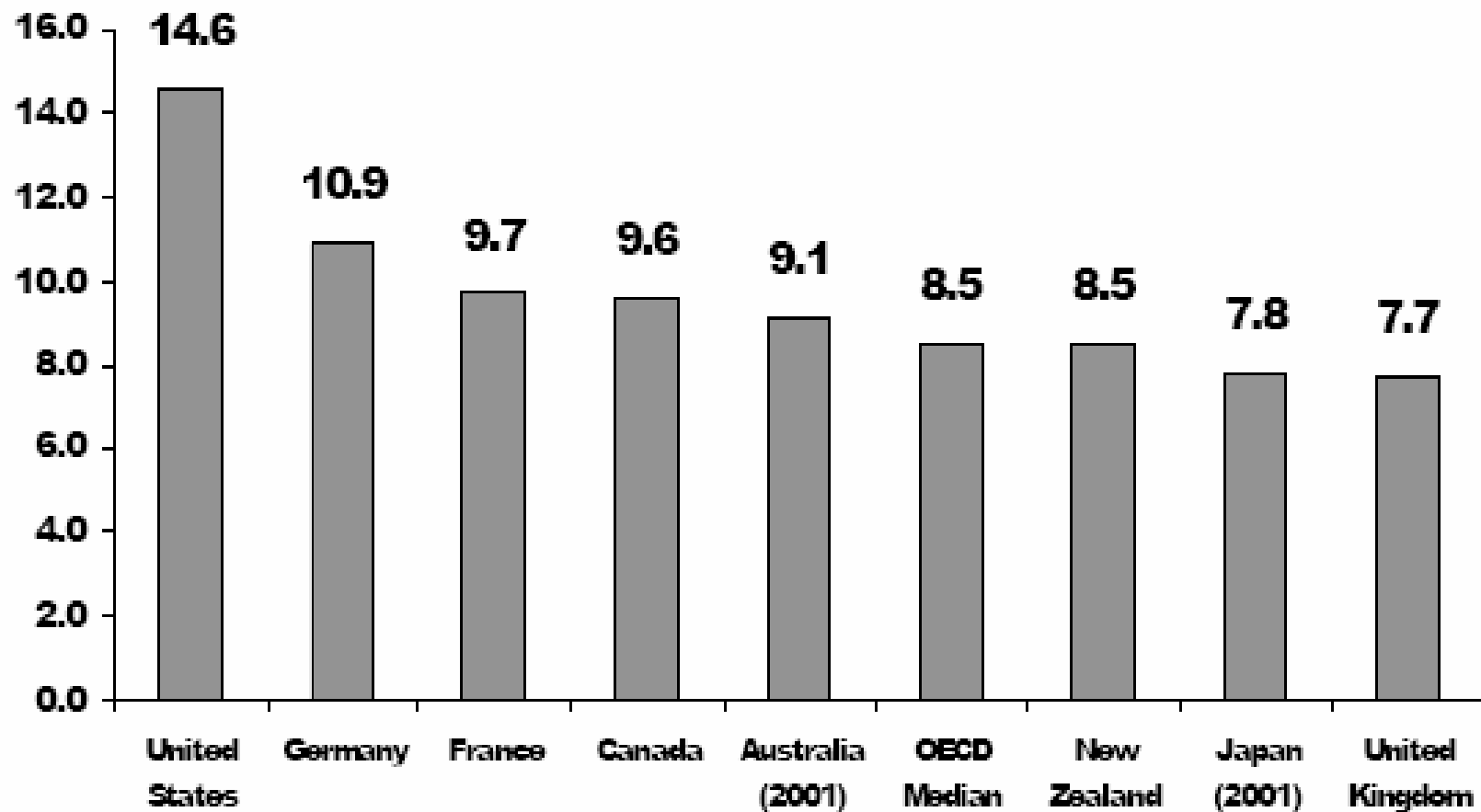
The number of people Medicare serves will nearly double by 2030.



* Numbers may not sum due to rounding.

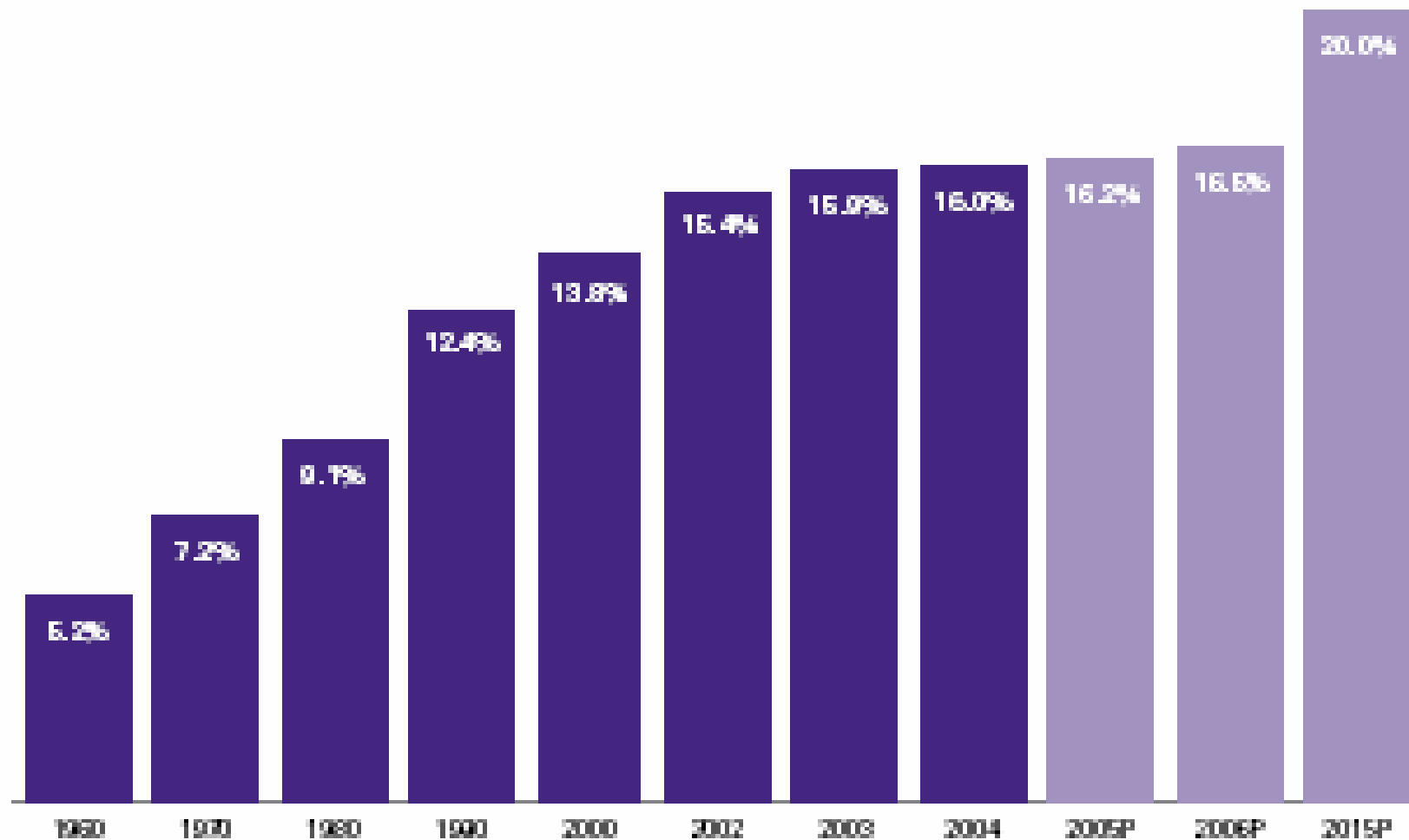
Source: CMS, Office of the Actuary.

Percent of gross domestic product (GDP) spent on health care, 2002



Source: G. F. Anderson and P. S. Hussey, *Multinational Comparisons of Health Systems Data 2004*, The Commonwealth Fund, October 2004. OECD data.

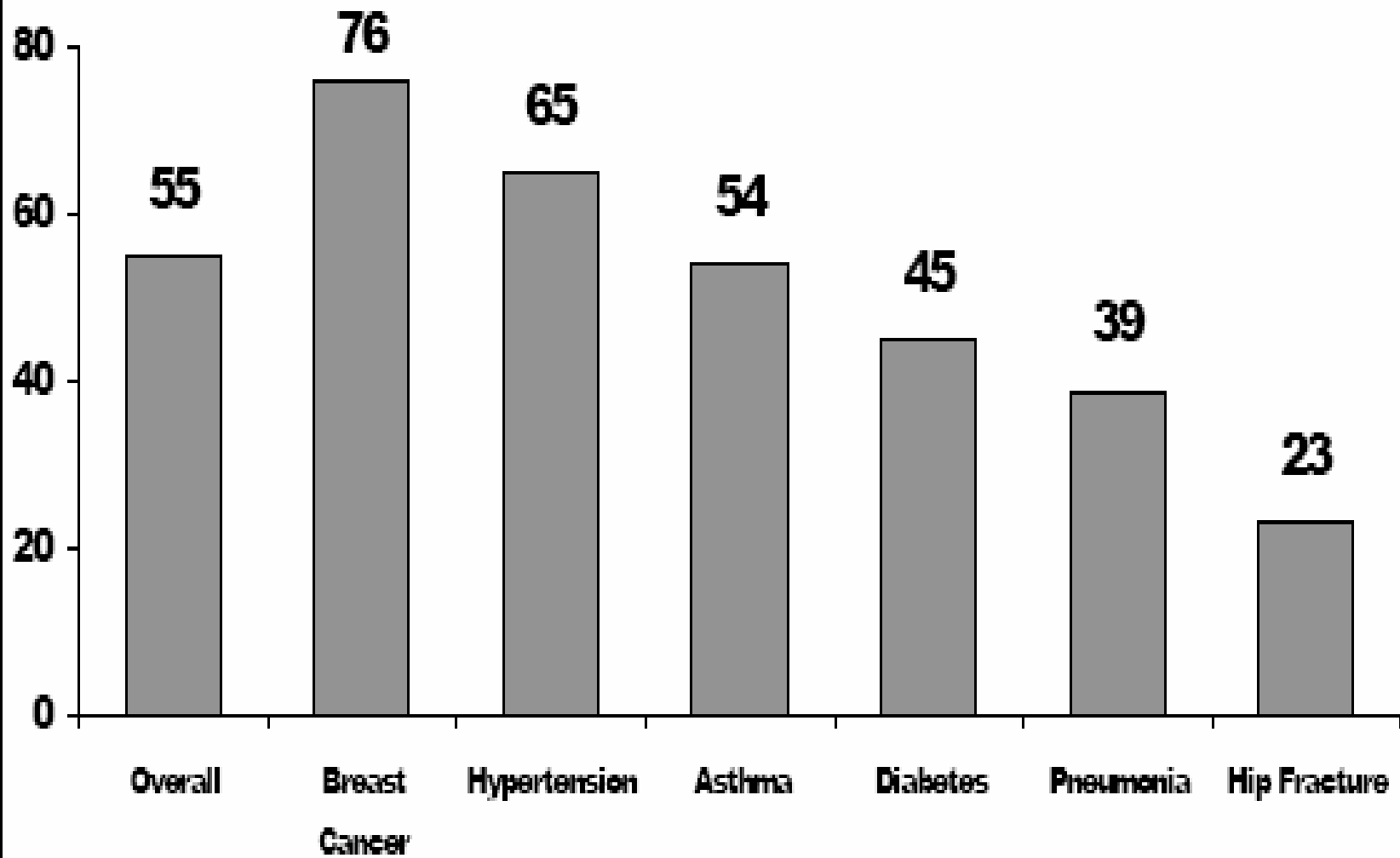
National Health Spending as a Share of Gross Domestic Product



Note: Selected nonfederal and federal year of data are shown prior to 2003. From 2003 forward are CMS projections.

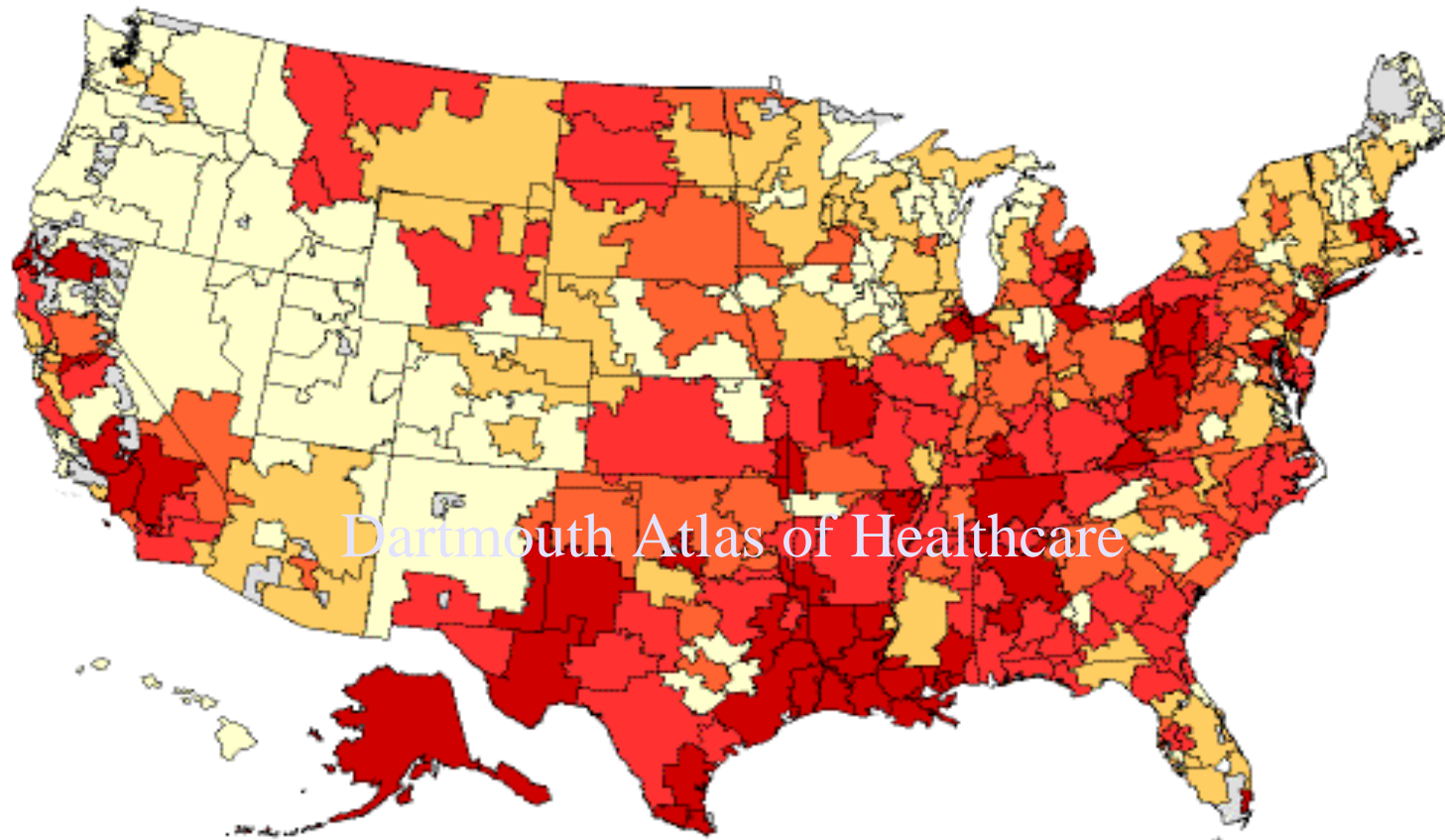
Source: Center for Medicare and Medicaid Services (CMS), Office of the Actuary

Percent of recommended care received



Source: E. McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *The New England Journal of Medicine* (June 26, 2003): 2635-2645.

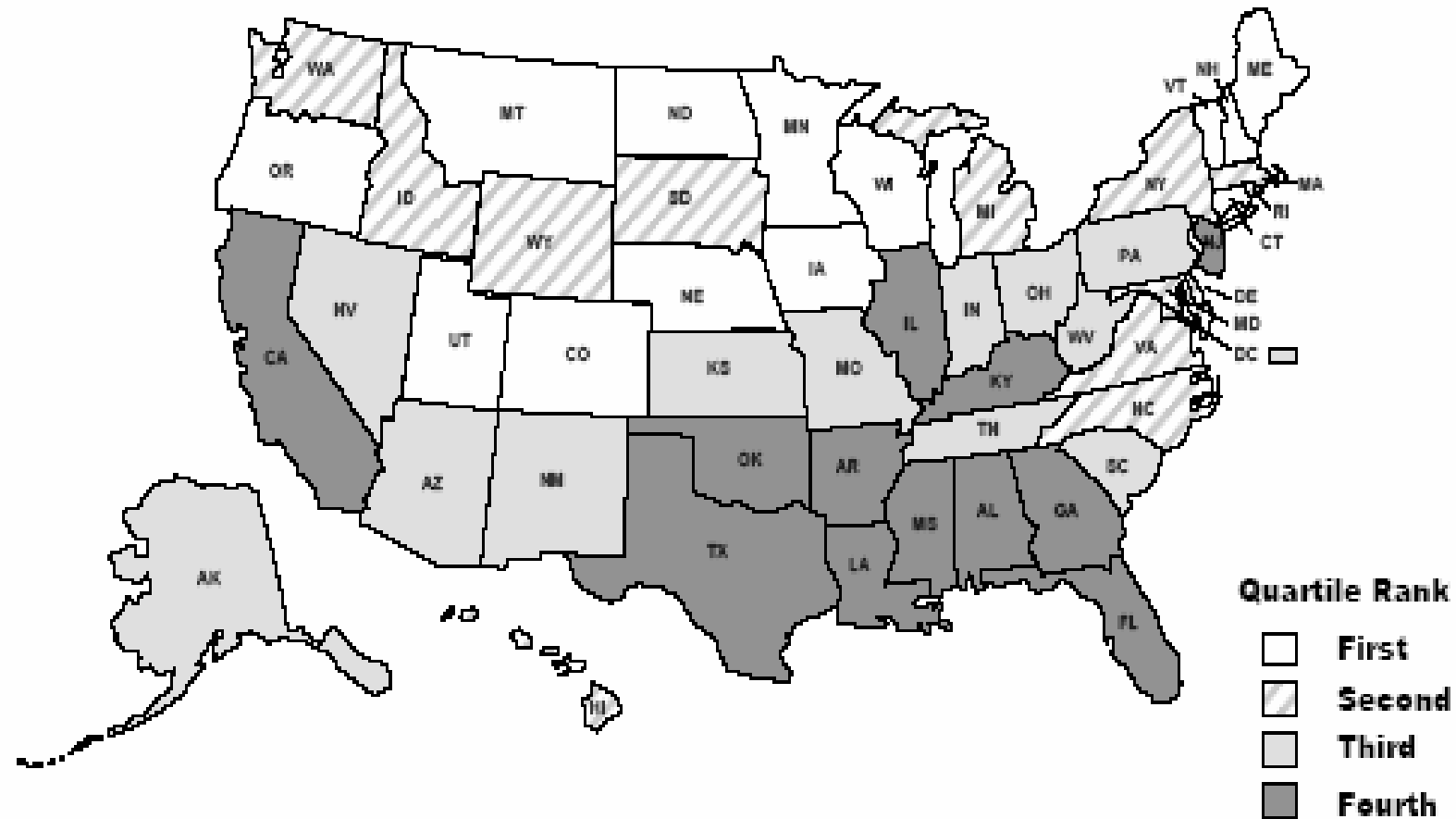
A Variation Problem



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

Performance on Medicare Quality Indicators, 2000-2001



Source: S. F. Jencks, E. D. Huff, and T. Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001," *Journal of the American Medical Association* 289 (Jan. 15, 2003): 305-312.

The Healthcare Quality Challenge

- We spend more per capita on healthcare than any other country in the world
- In spite of those expenditures, US Healthcare quality is often inferior to other nations and often doesn't meet expected evidence-based guidelines
- There are significant variations in quality and costs across the nation
- CMS is responsible for the healthcare of a growing number of persons
- CMS, in partnership and collaboration with other healthcare leaders, must demonstrate leadership in addressing these issues

CMS Quality Roadmap

- **VISION:** *The right care for every person every time*
 - *Make care:*
 - *Safe*
 - *Effective*
 - *Efficient*
 - *Patient-centered*
 - *Timely*
 - *Equitable*

CMS Quality Roadmap: Strategies

1. Work through partnerships to achieve specific quality goals
2. Publish quality measurements and information as a basis for supporting more effective quality improvement efforts
3. Pay in a way that expresses our commitment to quality, and that helps providers and patients to take steps to improve health and avoid unnecessary costs

CMS Quality Roadmap: Strategies for QI

4. Assist practitioners in making care more effective and less costly, especially by promoting the adoption of HIT
5. Bring effective new treatments to patients more rapidly and help develop better evidence so that doctors and patients can use medical technologies and treatments more effectively, improve quality and avoid unnecessary complications and costs

CMS Quality Initiatives

- Hospitals
 - Nursing Homes
- Home Health Agencies
 - Dialysis Facilities
 - Physician Offices
- More to come.....

CMS Quality Initiatives

- Broad Quality Alliances
 - Hospital Quality Alliance
 - Ambulatory Care Quality Alliance
 - Pharmacy, ESRD, Cancer Quality Alliances with more emerging
- Quality data
 - Collection
 - Aggregation
 - Reporting
- Linking payment to quality and efficiency

CMS Incentive Payment Initiatives

- Hospital Quality Initiative
- Premier Hospital Quality Incentive Demo
- Physician Voluntary Reporting Program (PVRP)
- Medicare Health Support Program
- Medicare Care Management Performance Demo
- High Cost Beneficiary Program
- Section 646 and Section 649 demos
- Gainsharing demonstration
- Post-acute care payment reform demo

CMS Incentive Payment Initiatives

- Development and implementation of standard performance measures in every setting
- Efficiency measures analysis and development
- P4P Initiatives being developed in all settings
- AQA Pilots on shared data aggregation and reporting
- Expansion of AQA pilots to include:
 - Focus on Efficiency
 - Hospital pilots
 - Transparency
 - Consumer choice, responsibility, empowerment

Common Quality Themes

- Physician-Patient partnership
- Benefits of group practice and systems integration
- Efficiency & value through coordinated care, systems improvement, health information technology, etc.
- Management of chronic illness
- Benefits of prevention
- Use of evidence-based medicine
- Focus on care across the continuum
- Transparency in the health care system

Congressional & Payment Reform

- Many opportunities for improving the quality of healthcare services, outcomes and efficiency
- Increasing reimbursement for healthcare services leads to:
 - No uniform or widespread improvement in quality
 - Increased utilization of some services
 - Net increase in overall healthcare expenditures
- Congress looking to CMS and healthcare providers to demonstrate ability to improve quality, avoid unnecessary complications and costs
 - Overall Medicare payment reform contingent linked

CMS P4P: Paths on the Roadmap

- Hospital Quality Initiative & the Hospital Quality Alliance
- Premier Hospital Demonstration
- Physician Voluntary Reporting Program
- Multiple Demonstrations

Components of Hospital Quality Initiative

- National Voluntary Hospital Reporting Initiative (NVHRI) public-private initiative
 - Federation of American Hospitals
 - AHA
 - AAMC
 - CMS , JCAHO, others
- Hospital Quality Alliance
- Medicare Modernization Act of 2003: Section 501b
 - Financial incentive

Hospital Quality Measures

Acute Myocardial Infarction

- ASA at arrival
- ASA at discharge
- Beta Blocker at arrival
- Beta Blocker at DC
- ACE inhibitor for LV systolic dysfunction

Heart Failure

- LV function assess
- ACE inhibitor for LV systolic dysfunction

Pneumonia

- Initial antibiotic timing
- Pneumococcal vaccination
- Oxygenation assessment

Premier Hospital Quality Demonstration

- 260 participating hospitals
- 34 Quality Metrics
 - Acute myocardial infarction (9)
 - Coronary artery bypass graft (8)
 - Heart failure (4)
 - Community acquired pneumonia (7)
 - Hip and knee replacement (6)

Premier Demonstration

- Hospital scores
 - “Rolling up” individual measures into one score for each disease category
 - Each disease category will be categorized by hospital scores by decile
- Public reporting of all data available
- Financial awards
 - Hospitals in top 20% will be given bonuses: 2% for top decile, 1% for second decile
 - Cost of bonuses will be \$7 million per year, \$21 million over three years

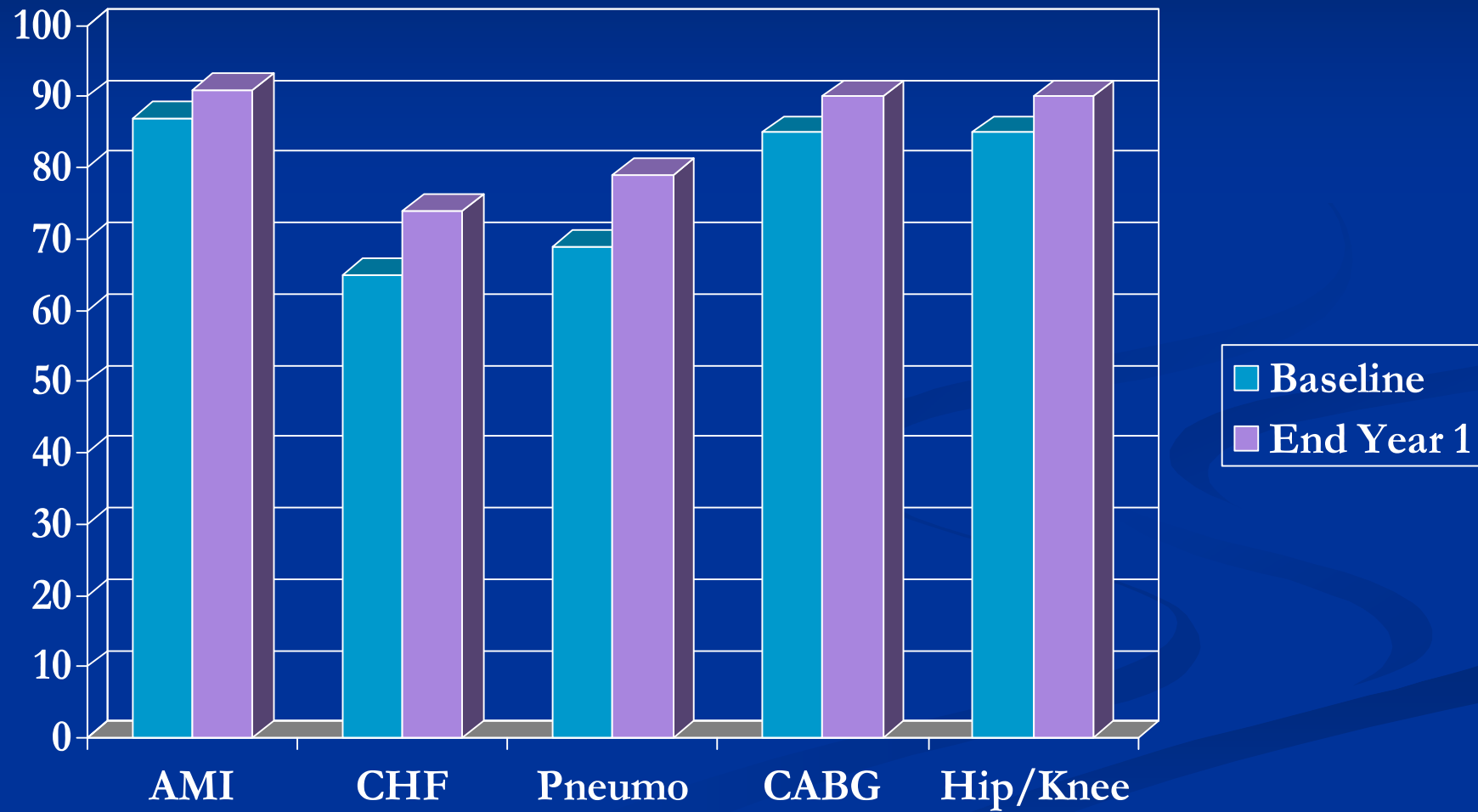
Premier Demonstration

- Improvement over baseline
 - Hospitals that do not improve over demonstration baseline will have adjusted payments
 - Demonstration baseline cut-off will be at level of the 9th and 10th deciles of base year
 - Hospitals below baseline 9th decile will have 1% reduction in DRG reimbursement
 - Hospitals below baseline 10th decile will have 2% reduction in DRG reimbursement

Premier Hospital Demo: Results

- \$8.85 million paid in first year
 - AMI – \$1.756 million to 49 hospitals
 - CHF – \$1.818 million to 57 hospitals
 - Pneumonia – \$1.139 million to 52 hospitals
 - CABG – \$2.078 million to 27 hospitals
 - Hip & Knee Replacement - \$2.061 million to 43 hospitals
- 49 out of 260 participating hospitals received bonuses
- 39 out of 260 have < 100 beds, several with awards
- All five clinical quality areas demonstrably improved

Premier Hospital Results



Premier Hospital Results

- Two hospitals in top two deciles for all 5 conditions
 - Hackensack University Hospital, NJ
 - McLeod Regional Medical Center, SC
 - Fairview Lakes Medical Center, MN in 3/5
- Individual category top performers
 - AMI – Fairview Lakes Medical Center, MN
 - CHF – Lourdes Hospital, KY
 - Pneumonia – St. Francis Hospital, Broken Arrow, OK
 - CABG – Greenville Hospital, SC
 - Hip & Knee – Bone & Joint Hospital, Oklahoma City

Appropriate Use of Resources

- Wide variation in resource use raises question of whether Medicare is getting good value in all areas
- CMS supports and is implementing MedPAC's March recommendation to Congress that:

“The Secretary should use Medicare claims data to measure fee-for-service physicians’ resource use and share results with physicians confidentially to educate them about how they compare with aggregated peer performance.”

PVRP: The Message

- *Voluntary*
- An interim step to more sophisticated systems using EHRs, outcomes and efficiency measures
- Allows physicians and CMS to test various collecting and reporting methods together, getting things correct for eventual P4P
- Allows physician offices to gain experience in data reporting prior to initiation of P4P
- Demonstrates to Congress physician and CMS commitment to measure and improve quality

Physician Voluntary Reporting Program (PVRP)

- Program implementation began January 2006
- G-code submission for relevant measures
- Distilled down to a starter set of 16 measures
- Need for progressive additional measures development
- Burden being scrutinized and addressed
- CMS will calculate results
- Feedback to clinicians as early as Summer 2006
- No public reporting, anonymous QI focus only
- Fact sheet: <http://www.cms.hhs.gov/pvrp>

PVRRP Measures

- ASA arrival AMI
- Beta blocker
 - Arrival AMI
 - Prior MI
- Antibiotic timing for pneumonia
- Control in DM
 - HbA1c
 - LDL
 - Blood pressure
- LVSD
 - ACEI or ARB
 - Beta blocker
- CAD
 - Anti-platelet therapy
 - LDL control
- Osteoporosis screening in elderly women

PVRP Measures

- Screening
 - Falls in elderly
- ESRD
 - Dialysis adequacy
 - Anemia control
 - AV fistula use
- Antidepressant medication in acute phase depression
- Surgical patient
 - Antibiotic prophylaxis
 - Thromboembolism prophylaxis
- CABG
 - Internal mammary artery
 - Pre-op beta blocker

Physician P4P: A Potential Timeline

- 2006: Voluntary reporting and performance feedback
- 2007: Pay-for-reporting and test-run P4P
- 2008: P4P for quality
- 2009: P4P for efficiency
- Timetable not fixed
 - Congressional actions would modify

Deficit Reduction Act of 2005

- Medicare Part A
 - Hospital Value-based purchasing plan
 - Demonstration projects in gainsharing
 - Post-acute care payment reform demonstration project
 - Hospital quality reporting
- Medicare Part A and Part B
 - Home Health Agency quality reporting
- Prelude to wider P4P nationally?

Contact Information

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