MEDICARE "PAY FOR PERFORMANCE (P4P)" INITIATIVES

Medicare has various initiatives to encourage improved quality of care in all health care settings where Medicare beneficiaries receive their health care services, including physicians’ offices and ambulatory care facilities, hospitals, nursing homes, home health care agencies and dialysis facilities.

The foundation of effective pay-for-performance initiatives is collaboration with providers and other stakeholders, to ensure that valid quality measures are used, that providers aren’t being pulled in conflicting directions, and that providers have support for achieving actual improvement. Consequently, to develop and implement these initiatives, CMS is collaborating with a wide range of other public agencies and private organizations who have a common goal of improving quality and avoiding unnecessary health care costs, including the National Quality Forum (NQF), the Joint Commission of the Accreditation of Health Care Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), the Agency for Health Care Research and Quality (AHRQ), the American Medical Association (AMA), and many other organizations. CMS is also providing technical assistance to a wide range of health care providers through its Quality Improvement Organizations (QIOs).

Through these collaborative efforts, CMS is developing and implementing a set of pay-for-performance initiatives to support quality improvement in the care of Medicare beneficiaries. In addition to the initiatives for hospitals, physicians, and physician groups described below, CMS is also exploring opportunities in nursing home care – building on the progress of the Nursing Home Quality Initiative – and is considering approaches for home health and dialysis providers as well. Finally, recognizing that many of the best opportunities for quality improvement are patient-focused and cut across settings of care, CMS is pursuing pay-for-performance initiatives to support better care coordination for patients with chronic illnesses.
HOSPITALS

Hospital Quality Initiative  (MMA section 501(b))

This is part of HHS’ broader National Quality Initiative that focuses on an initial set of 10 quality measures by linking reporting of those measures to the payments the hospitals receive for each discharge. Hospitals that submit the required data receive the full payment update to their Medicare DRG payments. Nearly all (98.3%) of the hospitals eligible to participate in this program are complying with the requirements of the provision.

Premier Hospital Quality Incentive Demonstration

The purpose of the demonstration is to improve the quality of inpatient care for Medicare beneficiaries by giving financial incentives to almost 300 hospitals for high quality. Under this demonstration, CMS is collecting data on 34 quality measures relating to five clinical conditions. Hospital specific performance will be publicly reported on CMS’s web site. Hospitals scoring in the top 10% for a given set of quality measures will receive a 2% bonus payment on top of the standard DRG payment for the relevant discharges. Those scoring in the next highest 10% will receive a 1% bonus. In the third year of the demonstration, those hospitals that do not meet a predetermined threshold score on quality measures will be subject to reductions in payment.

PHYSICIANS OR INTEGRATED HEALTH SYSTEMS

Physician Group Practice Demonstration (BIPA 2000)

Mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), this demonstration is the first pay-for-performance initiative for physicians under the Medicare program. The demonstration rewards physicians for improving the quality and efficiency of health care services delivered to Medicare fee-for-service beneficiaries. The demonstration seeks to encourage coordination of Part A and Part B services, promote efficiency through investment in administrative structure and process, and reward physicians for improving health outcomes.

Ten large (200+ physicians) group practices across the country will be participating in this demonstration, which will be operational April, 2005. The physician group practices will be able to earn performance-
based payments after achieving savings in comparison to a control group. The performance payment is largely based on various quality results.

**Medicare Care Management Performance Demonstration (MMA section 649)**

Modeled on the “Bridges to Excellence” program, this is a three-year pay-for-performance demonstration with physicians to promote the adoption and use of health information technology to improve the quality of patient care for chronically ill Medicare patients. Doctors who meet or exceed performance standards established by CMS in clinical delivery systems and patient outcomes will receive bonus payments for managing the care of eligible Medicare beneficiaries. In contrast to the Physician Group Practice Demonstration, this demonstration, which is currently under development, is focused on small and medium-sized physician practices. It will be implemented in four states: Arkansas, California, Massachusetts, and Utah, with the support of the Quality Improvement Organizations in those states.

**Medicare Health Care Quality Demonstration (MMA section 646)**

This demonstration, which was mandated by section 646 of the MMA, will be a five-year demonstration program under which projects enhance quality by improving patient safety; reducing variations in utilization by appropriate use of evidence-based care and best practice guidelines, encouraging shared decision making, and using culturally and ethnically appropriate care. Eligible entities include physician groups, integrated health systems, or regional coalitions of the same.

**DISEASE MANAGEMENT/CHRONIC CARE IMPROVEMENT**

**Chronic Care Improvement Program (MMA section 721)**

This pilot program will test a population based model of disease management, whereby the participating organizations are paid a monthly per beneficiary fee for managing a population of chronically ill beneficiaries with advanced congestive heart failure and/or complex diabetes. These organizations, which include disease management vendors and larger organizations such as insurance companies, must guarantee CMS a savings of at least 5% plus the cost of the monthly fees compared to a similar population of beneficiaries. Payment of fees is also contingent upon performance on quality measures and
satisfaction of both beneficiaries and providers. Nine sites have been selected for the pilot phase: Humana in South and Central Florida, XLHealth in Tennessee, Aetna in Illinois, LifeMasters in Oklahoma, McKesson in Mississippi, CIGNA in Georgia, Health Dialog in Pennsylvania, American Healthways in Washington, DC and Maryland, and Visiting Nurse Service of NY and United Healthcare in Queens and Brooklyn, New York. After two years, pending successful interim results, this pilot may be expanded more broadly, possibly nationally.

**ESRD Disease Management Demonstration (MMA section 623)**

This 3-year demonstration will test a fully case-mix adjusted payment system for an expanded bundle of end stage renal disease (ESRD) services. A portion of the payment will be linked to ESRD-related quality measures. An advisory board for the demonstration is required by the legislation and will be holding its first public meeting in February. The demonstration is projected to be operational in 2006.

**Disease Management Demonstration for Severely Chronically Ill Medicare Beneficiaries (BIPA 2000)**

This demonstration, which began enrollment in February 2004, is designed to test whether applying disease management and prescription drug coverage in a fee-for-service environment for beneficiaries with illnesses such as congestive heart failure, diabetes, or coronary artery disease can improve health outcomes and reduce costs. Three disease management organizations: XLHealth in Texas, CorSolutions in Louisiana, and HeartPartners in California and Arizona, are participating. They receive a monthly payment for every beneficiary they enroll to provide disease management services and a comprehensive drug benefit, and must guarantee that there will be a net reduction in Medicare expenditures as a result of their services. Submission of data on a number of relevant clinical measures is required to permit evaluation of the demonstration’s impact on quality.

**Disease Management Demonstration for Chronically Ill Dual Eligible Beneficiaries**

Under this demonstration, disease management services are being provided to dually (Medicare & Medicaid) eligible beneficiaries in Florida who suffer from advanced-stage congestive heart failure, diabetes, or coronary heart disease. The demonstration provides the opportunity to combine the resources of the state’s Medicaid pharmacy benefit with a disease management activity funded by Medicare to
coordinate the services of both programs and achieve improved quality with lower total program costs. LifeMasters, the demonstration organization, is being paid a fixed monthly amount per beneficiary and is at risk for 100% of its fees if performance targets are not met. Savings above the targeted amount will be shared equally between CMS and LifeMasters. Submission of data on a variety of relevant clinical measures is required to permit evaluation of the demonstration’s impact on quality.

**Care Management For High Cost Beneficiaries**

This demonstration will test models of care management in a Medicare fee-for-service population. The demonstration will target beneficiaries who are both high-cost and high-risk. The announcement for this demonstration was published in the *Federal Register* on October 6, 2004 and applications were due in January 2005. The payment methodology will be similar to that implemented in the Chronic Care Improvement Program, with participating providers required to meet relevant clinical quality standards as well as guarantee savings to the Medicare program.