

Medicare Care Management Performance Demonstration

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Demonstration 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

Overview

- Practice Eligibility
- Beneficiary Assignment
- Clinical Quality Measures
- Payment
 - Pay for Reporting
 - Pay for Performance
 - Incentive for Electronic Reporting
- Independent Evaluation
- Timeline
- Q & A

Practice Eligibility

- Participation in DOQ-IT program
 - Must meet all DOQ-IT requirements
- Small – Medium sized practices
 - ≤ 10 physicians (approx.)
- Focus on physicians providing primary care and/or care to patients with targeted conditions
- Minimum number of assigned FFS Medicare beneficiaries = 50

Beneficiary Assignment

- Beneficiary assigned to practice with greatest # primary care visits
- Algorithm uses retrospective (reporting period) Medicare claims data
 - Office/nursing home/home based E&M services
 - Only claims from primary care providers and some medical specialties included
- Beneficiaries assigned at the practice level (vs. individual physician)
- Beneficiaries assignment not 'fixed'
 - Assignment can vary each year based on where patient received most care during reporting period.

Beneficiary Eligibility

- Beneficiary must have had traditional Medicare Fee for Service coverage (A & B) for ≥ 6 months in the reporting year
 - Beneficiaries do NOT need to enroll
 - Beneficiaries remain free to see any Medicare provider
- Medicare must be primary insurer
- Not in hospice

Beneficiary Eligibility

- All assigned beneficiaries categorized based on diagnoses on claims:
 - Misc. chronic conditions*
 - Specific Chronic Condition
 - ❖ CHF
 - ❖ CAD
 - ❖ Diabetes

** Includes CHF, CAD, Other chronic cardiac or circulatory diseases, Diabetes, Alzheimer's and other mental health conditions, Kidney Disease, COPD and other chronic lung diseases, Cancer, Osteoporosis, and Arthritis*

Beneficiary Eligibility

- Categories not mutually exclusive.
 - Beneficiaries counted in each category for which they are eligible.
- Assignment process re-determined for each reporting year
 - Assignment in each year independent of previous/ future years

Incentive Payment

Three components:

1. One-time, Initial "Pay for Reporting" of baseline data
 - Payment not contingent upon performance scores
2. Annual "Pay for Performance"
 - Payment for achieving quality benchmarks during demonstration year
3. Annual EHR / Electronic Reporting Incentive
 - Bonus for reporting quality measures electronically from a CCHIT certified EHR

Clinical Quality Measures

- 26 measures
 - Diabetes – 8 measures
 - Congestive Heart Failure – 7 measures
 - Coronary Artery Disease – 6 measures
 - Preventive Services – 5 measures
- Goal- Consistency of measure specifications with NQF, DOQ-IT and other Medicare quality measures

Clinical Quality Measures

Diabetes	CHF	CAD	Preventive Care <i>(measured on population with specified chronic diseases)</i>
DM-1 HbA1c Management	HF-1 Left Ventricular Function Assessment	CAD-1 Antiplatelet Therapy	PC-1 Blood Pressure Measurement
DM-2 HbA1c Control	HF-2 Left Ventricular Ejection Fraction Testing	CAD-2 Drug Therapy for Lowering LDL Cholesterol	PC-5 Breast Cancer Screening
DM-3 Blood Pressure Management	HF-3 Weight Measurement	CAD-3 Beta Blocker Therapy – Prior MI	PC-6 Colorectal Cancer Screening
DM-4 Lipid Measurement	HF-5 Patient Education	CAD-5 Lipid Profile	PC-7 Influenza Vaccination
DM-5 LDL Cholesterol Level	HF-6 Beta Blocker Therapy	CAD-6 LDL Cholesterol Level	PC-8 Pneumonia Vaccination
DM-6 Urine Protein Testing	HF-7 Ace Inhibitor /ARB Therapy	CAD-7 Ace Inhibitor / ARB Therapy	
DM-7 Eye Exam	HF-8 Warfarin Therapy for Patients with AF		
DM-8 Foot Exam			

Clinical Quality Data Collection

- Claims based measures will be automatically calculated.
 - Practices will have ability to supplement with information from chart (e.g. 'denominator' exclusions)
- Chart based measures may be reported manually from paper chart or electronically from EHR
 - CMS will identify eligible patients
 - Practices may exclude patients for medical or other applicable reasons
 - Practices to submit data on all eligible patients unless number is large enough for valid sampling

Clinical Quality Data Collection

- CMS to provide electronic reporting tool
 - CMS will identify patients to report on.
 - Tool “pre-populated” with demographic and/or clinical information from claims on beneficiaries eligible for measure.
 - More detailed information on tool to be provided at kick off meetings
 - In-depth web-based training for practice staff during data submission periods.
 - QIOs available for technical assistance

Initial Incentive: Pay for Reporting (P4R)

- Payment contingent upon reporting clinical measures for eligible beneficiaries during baseline year (2006)
 - Opportunity for practices to use reporting tools / learn data collection & scoring methodology in risk free setting (scores will not affect initial incentive payment.)
- Per beneficiary per condition payment
 - Up to \$1000/physician; \$5000/practice
 - Measures may be submitted electronically but initial incentive (P4R) not eligible for 25% electronic reporting bonus
 - Data submission time frame: Aug-Sept '07

Pay for Reporting / Performance: Examples

- “Average” Physician*
 - Total patients assigned: 135 – 184
 - Patients with a range of chronic conditions: 129-172
 - Patients with one of target conditions:
 - Diabetes: 26-32 (17-19%)
 - CHF: 9-11 (7-11%)
 - CAD: 16-27 (11-15%)

** Based on 2005 claims data from 4 demonstration states*

Pay for Performance (P4P): Example – Initial Incentive

Payment Tied to # beneficiaries in each category, not performance scores

	DM	CHF	CAD	PC
# Medicare Patients	30	10	20	150
Patients Reported On	30	10	0	150
Payment Per Patient	\$20	\$20	\$20	\$20
% Incentive Earned	100 %	100 %	0 %	100 %
Total Payment	$\$20 \times 100\% \times 30 = \600	$\$20 \times 100\% \times 10 = \200	\$ 0	$\$20 \times 100\% \times 150 = \3000
Total Payment for Clinical Performance	$\$600.00 + \$200.00 + \$0 + \$3000 = \underline{\underline{\$3,600}}$ <u>(If practice has 1 physician, payment = \$1,000)</u> <u>If practice has 3 physicians, payment = \$3,000</u> <u>If practice has >= 4 physicians, payment = \$3,600</u>			

Annual Incentive: Pay for Performance (P4P)

- Performance on clinical measures determines payment
- Bonus for electronic reporting
- Key issues
 - Scoring
 - Rewarding Improvement vs. Absolute scores
- Three annual performance years
 - July – June

Pay for Performance (P4P): Scoring

- 0-5 points given for performance on each measure depending upon score
- Individual measure scoring based on Medicare HEDIS (where available)
 - Scores \geq HEDIS 75th percentile = 5 points
 - If not a HEDIS measure, 75% = 5 points
 - Scores below 75%: 0-4 points (depending upon score)
- Points within each category (DM, CHF, CAD, PC) summed

Pay for Performance (P4P): Payment

- Composite % calculated based on total possible points in each category
 - Diabetes – 40 points
 - CHF - 35 points
 - CAD – 30 points
 - Preventive Services -25 points
- Payment proportional to composite % score
 - Minimum score required for payment increases each year (30%, 40%, 50%)
 - Composite score $\geq 90\%$ gets full payment
- Separate payment for each category (DM, CHF, CAD, PS) based on number of beneficiaries with condition or, for preventive care, any chronic condition

Pay for Performance (P4P): Example – Annual Payment

Payment tied to # beneficiaries in each category AND performance scores.

	DM	CHF	CAD	PC
# Medicare Patients	30	10	20	150
Payment Per Patient *	\$70	\$70	\$70	\$25
Maximum Possible Points	40	35	30	25
Full (90%) / Minimum (30%) Payment Level	36 / 12	31.5 / 10.5	27 / 9	22.5 / 7.5
Points earned	38	25	8	18
Composite Quality Score	95 %	71 %	27 %	72 %
% Incentive Earned	100 %	79.4 %	0 %	80 %
Total Payment	$\$70 \times 100 \% \times 30 = \2100	$\$70 \times 79.4 \% \times 10 = \555.80	\$ 0	$\$25 \times 80 \% \times 150 = \3000
Total Payment for Clinical Performance	$\$2100.00 + \$555.80 + \$3000.00 = \underline{\underline{\$5655.80}}$			

Pay for Performance (P4P): Clinical Performance Incentive

- Maximum payment each year for clinical performance incentive
(3 year demonstration)
 - Up to \$10,000 per physician / year
 - Up to \$50,000 per practice / year

Incentive for Electronic Reporting

- Demonstration goal to encourage implementation and adoption of HIT.
- Measures must be reported from a CCHIT certified EHR
 - Up to 25% bonus over clinical performance incentive (% determined by # measures reported electronically)
 - No bonus if clinical measure scores too low
- CMS will provide vendors specifications to encourage development of functionality to support reporting.

Summary:

Total Potential Payments

1. Initial "Pay for Reporting" Incentive:
 - Up to \$1,000/physician; \$5,000/practice
2. Annual "Pay for Performance" Incentive:
 - Up to \$10,000/physician; \$50,000/practice *per year*
3. Annual Bonus for Electronic Reporting:
 - Up to 25% of clinical "pay for performance" payment tied to # measures reported electronically
 - Up to \$2,500 per physician; \$12,500/practice *per year*

Maximum potential payment over 3 years:
\$38,500 per physician; \$192,500/practice

Evaluation

- Report to Congress due 12 months after demonstration
- CMS & AHRQ jointly funded contract with Mathematica Policy Research, Inc. (MPR)
- Evaluation design:
 - Non randomized, matched comparison group
 - DOQ-IT practices in non demonstration states
 - Use of Medicare claims data, patient & physician surveys, DOQ-IT office systems survey

Time Frame

- Late 2006 / Jan. 2007
 - Applications mailed to DOQ-IT practices
- *APPLICATIONS SHOULD BE SUBMITTED EARLY TO GET FULL CONSIDERATION*
- April 15, 2007
 - Last date to submit applications
- May / June 2007
 - Kick off meetings in demonstration states
 - Follow up conference calls for additional Q & A

Time Frame

- July 1, 2007
 - Demonstration begins
- July – Sept. 2007
 - Data collection for baseline reporting year (2006)
 - QIOs provide T & A to practices / serve as primary contact point
- Winter 2007/2008
 - Payment for baseline reporting to practices

Time Frame

- Three year demonstration period
 - Year 1: July 2007 – June 2008
 - Year 2: July 2008 – June 2009
 - Year 3: July 2009 – June 2010
- Clinical Data Collection
 - Year 1: Fall 2008 /Winter 2009
 - Year 2: Fall 2009 /Winter 2010
 - Year 1: Fall 2010 /Winter 2011

Questions



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Demonstration website:

<http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=ascending&itemID=CMS057286>

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