



# Value Driven Health Care

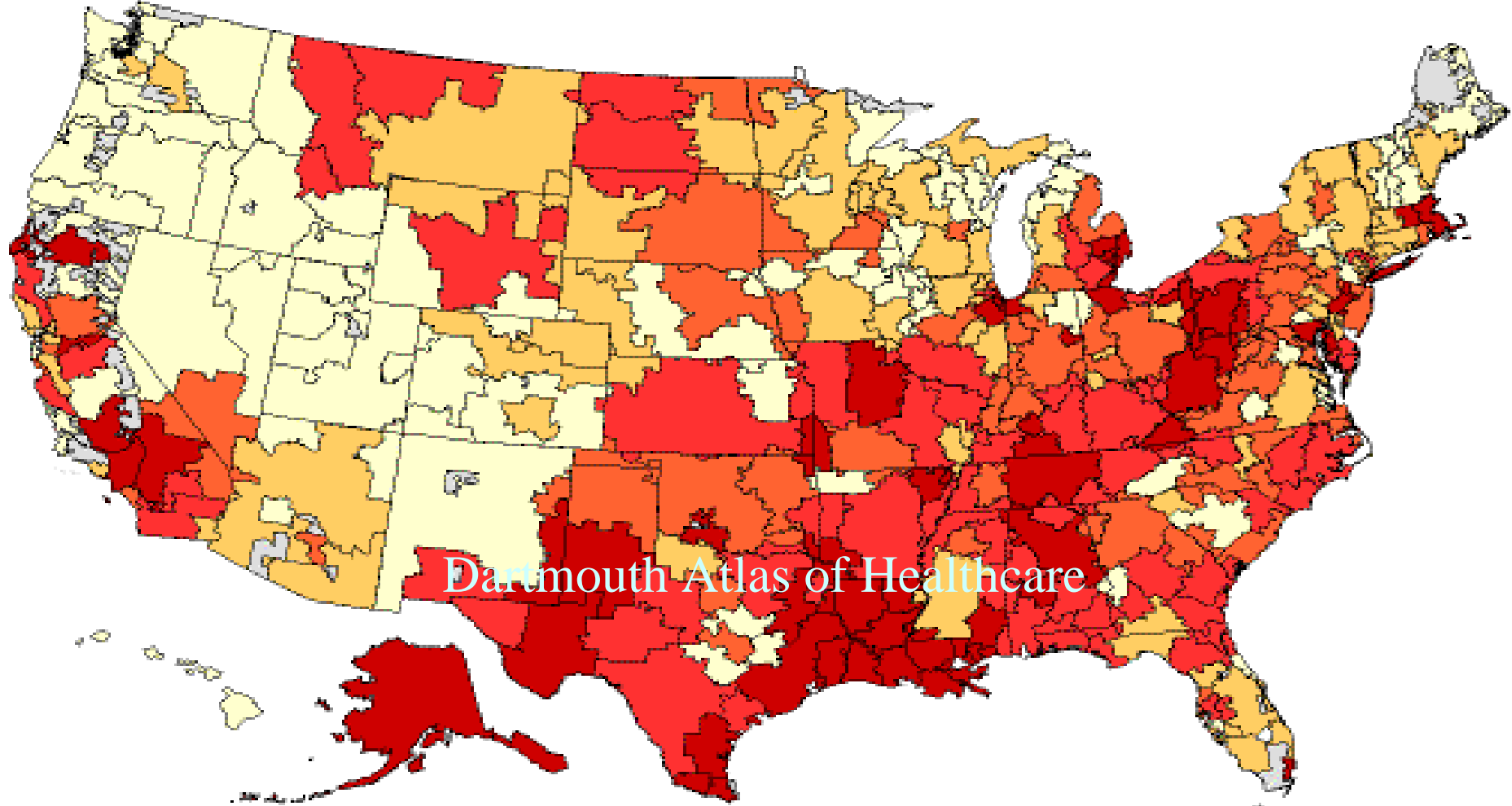
Division of Quality, Evaluation,  
and Health Outcomes

Center for Medicaid and State Operations  
Centers for Medicare & Medicaid Services

# CMS Quality Improvement Roadmap

Released in August 2005

- **Vision: The right care for every person every time**
  
- **Aims: Make care safe, effective, efficient, person-centered, timely; and equitable**



Dartmouth Atlas of Healthcare

**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



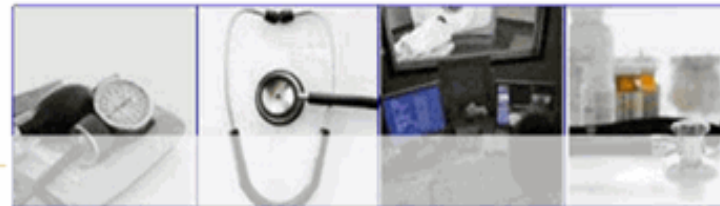
# Medicaid/SCHIP Quality Strategy

- Developed the Medicaid/SCHIP Quality Strategy in August 2005 with updates in July 2006
- Strategy builds upon the CMS Quality Roadmap and is structured to recognize the unique relationship between the Federal Government and States.
- The pillars of the Medicaid/SCHIP framework are:
  - Evidenced-Based Care and Quality Measurement
  - Supporting Value Based Payment methodologies
  - Health Information Technology
  - Partnerships
  - Information Dissemination and Technical Assistance



## Value-Driven Health Care

*Transparency: Better Care Lower Cost*



- Secretary Leavitt challenged State Medicaid programs to partner in a value driven health-care initiatives centering around four cornerstones:
  - Intraoperatable health information technology
  - Measuring and publishing quality information
  - Measuring and publishing price information
  - Creating positive incentives for high quality health care purchasers

# Transparency of Quality

- Request that health plans use and publicly report measures adopted by AQA, HQA, NQF and other national bodies.
- Request that plans and EQROs participate in AQA, HQA, NQF or another national quality transparency collaborative.
- Participate in national public-private collaborative committees or workgroups to establish and support standards in measuring or reporting quality.
- Become a member of NQF
- Collaborate with other state Medicaid agencies and CMS to share your success and challenges

# The Guide to Quality Measures: A Compendium

## Medicaid and SCHIP Quality Improvement

Volume 1.0

Compiled by the  
Division of Quality, Evaluation and Health Outcomes



Family and Children's Health Programs Group  
Center for Medicaid and State Operations

September 2006



Other organizations are interested in partnering to support efforts to increase the availability of performance measures for underrepresented domains and populations. Specifically organizations are interested in partnering with CMS to establish a national agenda for the development of pediatric measures. The National Association of Children's Hospitals and Related Institutions (NACHRI), the National Initiative for Children's Healthcare Quality (NICHQ) and the American Academy of Pediatrics (AAP) have approached CMS to expand the selection of measures relevant for pediatric populations.

### AHRQ - Agency of Healthcare Research and Quality

The Agency of Healthcare Research and Quality (AHRQ) developed the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey; originally a tool to assess and report satisfaction of enrollees with health plans, it has evolved into a suite of satisfaction tools across care settings. In addition to the health plan survey, satisfaction tools are available for the hospital, behavioral health care services, in-center hemodialysis, and nursing home settings. A nursing home satisfaction tool is currently under development to determine and report patient satisfaction with nursing home quality. The Quality Indicators (QIs) were also developed by AHRQ; these measures use readily available administrative data for measurement of various aspects of quality—prevention, inpatient care, pediatric inpatient care and patient safety.

### AMA - American Medical Association

The Physician Consortium for Performance Improvement (PCPI) is a workgroup of interdisciplinary specialist of the American Medical Association involved in performance measure development. The group supports and advances measure sets that facilitate clinical performance improvement among physicians for a number of select conditions. Measures are available for conditions such as bone conditions, diabetes, hypertension and mental health.

### AQA Alliance

Collaborative organizations perform an important role in consensus building across multiple stakeholder organizations. Such organizations bring together stakeholders on particular domains of health care. For example, the AQA alliance (formerly the Ambulatory Quality Care Alliance) convenes a national coalition of more than 125 organizations to improve health care quality through a process in which stakeholders agree on a performance measurement strategy for physician level reporting. Through this effort a starter set of 26 measures relevant to the ambulatory care setting were endorsed meeting the group's criteria for clinical importance, physician accountability, feasibility and consumer and purchaser relevance.

	A	B	C	D	E	F	G	H	I	J
1	<b>The Guide to Quality Measures: A Compendium Version 1.0</b>									
2										
3	Category	Measure	Description	Measure Setting	Population	Source	Type	Data Source	Endorsement	RIFA
304	Preventive	Discussion of Smoking Cessation Medication	% of patients whose practitioner recommended or discussed smoking cessation medications	Ambulatory	adult	NQQA	process	administrative		A
305	Preventive	Influenza Vaccination	% of patients who received an influenza vaccine	Ambulatory	adult	CMS, NQQA, AQA	process	administrative	Pending	A
306	Preventive	Pneumonia Vaccination	% of patients who ever received a pneumococcal vaccine; (age ≥ 65 years)	Ambulatory	adult	NQQA, CMS	process	administrative	Y	A
307	Preventive	Childhood Immunization	% of patients who turned 2 years old during the measurement year who had four DTsP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B and one chicken pox vaccine (VZV) by the time period specified and by the child's second birthday	ambulatory	pediatric	NQQA	process	administrative		A
308	Preventive	Well Child Visits	% of members who received zero, one, two, three, four, five, and six or more well child visits with a primary care practitioner during their first 15 months of life	ambulatory	pediatric	NQQA	process	administrative		A
309	Preventive	Well Child Visits in 3rd, 4th, 5th and 6th Year	% of members age 3 to 6 years old who received one or more well-child visits with a primary care practitioner during the measurement year	ambulatory	pediatric	NQQA	process	administrative		A
310	Preventive	Adolescent Well Care Visit	% of members age 12 through 21 years who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.	ambulatory	pediatric	NQQA	process	administrative		A

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# Incentives for High-Value Health Care

- Encourage beneficiaries to use providers with the highest quality and lowest cost.
- Offer providers incentives and rewards for delivering high-value care
- Provide direct financial incentives and/or public recognition to providers who demonstrate superior performance
- Provide employees the option of consumer-directed health plan with a health savings account or high reimbursement account.
- Implement incentive programs to encourage provider adoption on electronic health records and health information exchange
- Provide beneficiaries with incentives for prevention and wellness
- Provide beneficiaries with incentives for self-management of chronic illness

# Supporting Efforts in Value Based Purchasing

A quality improvement and reimbursement methodology which is aimed at moving towards payments that create much stronger financial support for person focused, high value care.

- National Medicare pay-for-performance efforts underway
- At least 28 States have 35 Medicaid value-based purchasing initiatives
- In the next two years, at least 34 states are planning 47 new activities
- Important that evolving programs include an evaluation component to answer the question of effectiveness
- Considerations related to the approach a State uses to implement program (e.g. State Plan, Waiver, etc.)

# IOM: Rewarding Provider Performance

- Payment incentives to reward quality “can serve as a powerful stimulus to drive institutional and provider behavior toward better quality”
- Incentives alone would be insufficient without certain conditions such as public reporting, beneficiary incentives, and education of boards of directors.”

# Overarching Principles: Medicaid P4P programs should be:

- Data driven
- Beneficiary-centered
- Transparent
- Developed through partnerships
- Administratively flexible

# Incentive Structure: P4P incentives consideration:

- Equitable and fair to program participants including the beneficiary
- Timely
- Sufficient to motivate improvement
- Flexible enough to provide payment for innovative care processes
- Structured to avoid unintended consequences

# Incentives Currently Used in the Industry

- Public reporting of quality information
- Performance based rate adjustments
- Performance based bonuses
- Competitive payment schedule
- Tiered payment levels
- Performance based fee schedules
- Performance based payment withholds
- Quality Grants
- Autoassignments

# New York State P4P

- State contracts with 28 fully capitated plans (2.6 million enrollees)
- 1115 Waiver (began 1997)
- Began P4P in the fall of 2002 to begin to make the business case for investing in quality, to accelerate improvement, and to align with other P4P initiatives (health plan initiated or private payor initiated)
- Methodology includes awarding 2/3 points for meeting goals in the HEDIS/QARR measures and 1/3 for meeting CAHPS goals.
- Plans can earn 3%, 2.25%, 1.5%, .75% or no additional premium depending on overall score. Also uses autoassignment as an incentive.

# New York State P4P

- 2005 results:
  - Over \$13 million distributed to high performing plans in the first two years (02/03 and 03/04) of the program.
  - Estimated \$9.3 million to be distributed in '05
  - A pool of approximately 105,000 autoassignees who could provide high performing plans with an additional \$55 million in premium payments.
- Anticipating a grant from the Commonwealth Fund this fall for:
  - Qualitative evaluation (interviews with health plan executive staff)
  - Quantitative evaluation (using plan data to try to discern any trends)
  - Generate a report that can be used by other states/purchasers to shape their program

# MARYLAND STATE PAY FOR PERFORMANCE

Table 2. Performance Summary

Performance Measure	2004 Target	MCO					
		AGM	HFC	JMS	MPC	PPMCO	UHC
		Incentive (I); Neutral (N); Disincentive (D)					
Well-child visits for children ages 3–6	Incentive: >68% Neutral: 61%–68% Disincentive: <61%	78.8% (I)	75.3% (I)	79.1% (I)	67.8% (N)	70.8% (I)	68.4% (I)
Dental services for children ages 4–20	Incentive: >60% Neutral: 40%–60% Disincentive: <40%	38.4% (D)	46.8% (N)	33.3% (D)	44.4% (N)	48.0% (N)	44.4% (N)
Ambulatory care services for SSI adults	Incentive: >86% Neutral: 72%–86% Disincentive: <72%	74.8% (N)	80.9% (N)	82.4% (N)	80.7% (N)	81.0% (N)	79.7% (N)
Ambulatory care services for SSI children	Incentive: >77% Neutral: 63%–77% Disincentive: <63%	68.0% (N)	76.3% (N)	61.0% (D)	72.8% (N)	70.6% (N)	67.4% (N)
Timeliness of prenatal care	Incentive: >89% Neutral: 72%–89% Disincentive: <72%	93.9% (I)	90.3% (I)	82.7% (N)	86.0% (N)	81.5% (N)	87.1% (N)
Cervical cancer screening for women ages 21–64	Incentive: >77% Neutral: 47%–77% Disincentive: <47%	64.5% (N)	62.8% (N)	60.1% (N)	62.8% (N)	69.1% (N)	53.5% (N)
Lead screenings for children ages 12–23 months	Incentive: >53% Neutral: 41%–53% Disincentive: <41%	50.8% (N)	54.0% (I)	48.4% (N)	50.7% (N)	51.6% (N)	43.1% (N)
Eye exams for diabetics	Incentive: >64% Neutral: 42%–64% Disincentive: <42%	50.3% (N)	38.9% (D)	62.5% (N)	41.1% (D)	40.4% (D)	50.1% (N)
Childhood immunization status—Combo 2	Incentive: >68% Neutral: 50%–68% Disincentive: <50%	80.1% (I)	73.1% (I)	75.8% (I)	66.1% (N)	75.7% (I)	65.2% (N)
Practitioner turnover	N/A	6.8%	9.2%	6.5%	2.6%	1.5%	9.4%

# Medicare VBP Legislative Background

- Deficit Reduction Act (DRA) Section 5001(b) authorized CMS to develop a Medicare Hospital Value-Based Purchasing (VBP) Report

Based on assumption of implementation in FY 2009; implementation will require additional statutory authority

Must consider

- Measures
- Data Infrastructure and Validation
- Incentive Structure
- Public Reporting

Must consult relevant stakeholders and consider experience with relevant P4P demonstrations and private-sector programs

# Transparency of Price

- Make available to beneficiaries the cost or price of care.
- Assure that cost or price information is made available with quality information to the maximum extent possible.
- Participate in broad-based public-private collaborative efforts to develop strategies to measure the overall cost of services.
- Participate in regional or national public-private collaborative committees or workgroups to establish and support uniform standards for measuring or reporting quality information.

# Linking Quality and Cost: Pay for Performance and Efficiency

- **Efficiency** Is One of the Institute of Medicine's Key Dimensions of **Quality**
  - Safety
  - Effectiveness
  - Patient-Centeredness
  - Timeliness
  - **Efficiency: absence of waste, overuse, misuse, and errors**
  - Equity

Institute of Medicine: Crossing the Quality Chasm:  
A New Health System for the 21st Century, March,  
2001.

# Interoperable Health Information Technology

- Request health insurance plans, TPAs, and others involved with HIT monitor activities of national standard setting bodies
- Encourage providers to utilize EHRs that have been certified by national certification bodies
- Encourage participation in HIE
- Utilize the national RFI to measure health plan performance.
- Self-assess the PCCM program
- Develop expertise regarding MITA

# IT and Quality

- Supports Strategies for achieving Quality in a *transformed health care system*
  - Changing organizational culture
  - Developing systems that support clinical processes as well as payment processes
  - Using information technology more effectively to improve safety, outcomes, and health care policy
  - Transforming data into information for providers and consumers

# Challenge ahead of us includes using HIT to support care coordination that are different

- *But all need Interoperability*
- Nursing home
- Home health
- Hospital
- Critical access rural hospital
- Physician practice
- Physician practice underserved
- Physician practice pharmacy

# FY07 and Beyond in Medicaid Quality:

## White House Releases Medicaid PART Information on ExpectMore.Gov. Quality Goal is highlighted

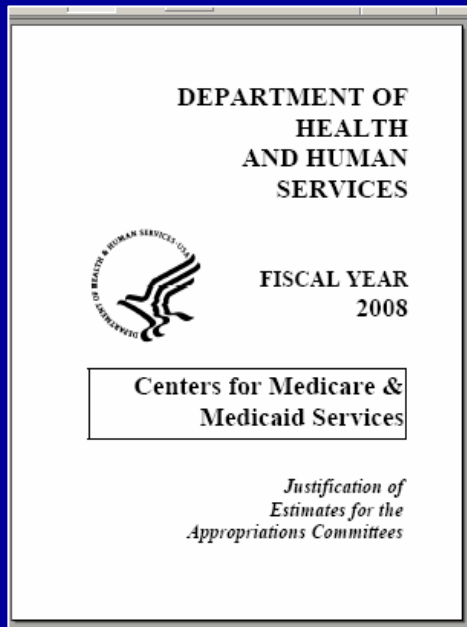
The screenshot shows the ExpectMore.gov website. The header includes navigation links for Home, About Us, Contact, and What's New. The main content area is titled "PROGRAM ASSESSMENT" and features a "Show Me Programs" button. The "PROGRAM" section is titled "Medicaid" and includes a description: "Medicaid is a means-tested, Federal-State funded entitlement program that provides medical assistance, including acute and long-term care, to families with dependent children as well as aged, blind, or disabled individuals. The Centers for Medicare and Medicaid Services (CMS) provides Federal oversight of this program." The "RATING" section is titled "PERFORMING" and "Adequate". It includes two bullet points: "Medicaid provides health insurance to millions of targeted individuals. In 2005, the number of Medicaid enrollees was 49.1 million. Nearly one in every four children in America relies on Medicaid for health coverage. Two-thirds of all Medicaid enrollees are in low-wage working families. Medicaid also pays for six out of every ten beds in nursing homes." and "New performance measures assess program effectiveness. Center for Medicare and Medicaid Services (CMS) created new performance measures that assess health quality and focus on improving program management. More work needs to be done; CMS is working on a national strategy to improve the quality of care across State Medicaid programs and is developing a national payment error rate for Medicaid."

The screenshot shows the "RATING" section of the ExpectMore.gov website. The "RATING" is "PERFORMING" and "Adequate". The "IMPROVEMENT PLAN" section is titled "What This Rating Means" and includes the following text: "We are taking the following actions to improve the performance of the program:" followed by three bullet points: "Working with the States to measure, track, and improve quality of care in Medicaid and moving toward a national framework for Medicaid quality.", "Reducing fraud, waste, and abuse in the Medicaid program, and improving overall program integrity.", and "Working with States to establish baseline data for the newly developed Medicaid performance measures." The "LEARN MORE" section includes three links: "View Similar Programs.", "How all Federal programs are assessed.", and "Learn more about Medicaid."

We are taking the following actions to improve the performance of the program:  
Working with the States to measure, track, and improve quality of care in Medicaid and moving toward a national framework for Medicaid quality.

# FY07 and Beyond in Medicaid Quality:

## CMS Budget Reports New GPRA Goal and Funding for Goal



Medicaid Quality Improvement Program			
Long Term Goal: The Medicaid Quality Improvement Program process will demonstrate improvement in State's assessment of Medicaid beneficiary access to and quality of health care.			
Long-Term Measure	FY	Target	Result
The number of States that demonstrate improvement related to access and quality of health care. (outcome) Long-term: Output Performance Measure	2013	25% of the States (13 States)	Mar -14
	2010	20% of the States (10 States)	Mar-11
	2008	15% of the States (8 States)	Mar-09
	2007	Baseline – number of States = 0	Feb-08
<b>Data Source:</b> States report quality improvement efforts via several vehicles including the State quality improvement strategies (CFR 438.204 Subpart D), External Quality Review Organizations (EQRO) Reports (CFR 438.310-438.70 Subpart E), Medicaid Demonstration evaluation reports, performance measurement reporting, state report cards, clinical studies, targeted Performance Improvement Projects, and other vehicles. A combination of these data sources will be analyzed, when available and appropriate, to ensure a comprehensive review of State quality improvement activities.			
<b>Data Validation:</b> CMS has developed templates, assessment tools and protocols for review and validation of quality improvement strategies, selected EQRO requirements, and program evaluations.			

# Deliverables Required as a Result of Recent Activity

- Engage States in the Value Driven Health Care Initiative
- Begin the Process of Developing a National Framework for Medicaid Quality
- Demonstrate Improvement in 8 States by 2008 and 13 States by 2013

# Meeting the Deliverables

- Demonstrate Improvement in 8 States by 2008 and 13 States by 2013
  - Develop metrics and workplan for assess quality using:
    - State Quality Strategies
    - HCBS Quality Strategies
    - External Quality Review Reports
    - State Demonstration Evaluations
  - Announce activities via an SMD and presentations and then provide individual feedback on State Quality Strategies within next four months to all States.
  - Develop State Quality Summaries that provide a snap shop of State activities that have the cornerstones of the Secretary's Value Drive Health Care Initiative
    - Connecting to the system – system for health records
    - Measuring and Publishing Quality
    - Measuring and Publishing Cost
    - Creating Positive Incentives

# Progress to Date

- Published a compendium of measures available on the CMS website
- AHRQ and CMS are collaborating to develop performance indicators for HCBS
- 18 states and the District of Columbia have committed in writing to the VDHC initiative
- 12 State Medicaid agencies have implemented a total of 16 HIT initiatives (five of the states are currently receive some support from Medicaid Transformation Grants)
- 25 State Medicaid agencies are involved in planning and developing statewide HIE networks.
- 13 State Medicaid agencies include MITA as a part of their HIT and HIE planning.

# Progress to Date

- 28 States have 35 value-based purchasing programs
- 12 States with transformation grants have formed a coalition on HIT coordination, standards harmonization and joint planning
- At least 2 States plan to apply to serve as a CVE
- 2 States are pursuing the relationship of consumer incentives and personal responsibility which has a similar correlation to the goals of the price transparency or getting consumers engaged based on the value of care.

*The Right Care for Every  
Person Every Time*