

## DEMONSTRATIONS AND PILOT PROGRAMS

Premier Hospital Quality Incentive Demonstration. CMS has partnered with Premier Inc., a nationwide alliance of not-for-profit hospitals, to conduct a demonstration program that is designed to improve the quality of inpatient care for Medicare beneficiaries by providing financial incentives. Under the Premier Hospital Quality Incentive Demonstration, about 270 hospitals are voluntarily providing data on 34 quality measures related to five clinical conditions: heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements. Using the quality measures, we will identify hospitals in the demonstration with the highest clinical quality performance for each of the five clinical areas. Hospitals scoring in the top ten percent for a given set of quality measures will receive a 2 percent bonus payment in addition to the normal payment for the service provided for Medicare discharges in the corresponding diagnosis-related groups (DRGs). Hospitals in the next highest ten percent will receive a 1 percent bonus payment. In the third year of the demonstration project, hospitals that do not achieve absolute improvements above the demonstration baseline will be subject to reductions in payments. Preliminary results show that the modest financial incentives under the demonstration are sufficient to drive quality improvement.

Physician Group Practice Demonstration. CMS recently announced a demonstration project to test pay-for-performance in Medicare's fee-for-service payment system for physicians. The Physician Group Practice Demonstration will assess the ability of large physician groups to improve care that could result in better patient outcomes and efficiencies. Ten large (200+ physicians), multi-specialty physician groups in various communities across the nation will participate in the demonstration, which began operations in April 2005. Participating physician groups will continue to be paid on a fee-for-service basis, but they will be able to earn performance-based payments for implementing care management strategies that anticipate patients' needs, prevent chronic disease complications, avoid hospitalizations, and improve the quality of care. The performance payment will be derived from savings in total Medicare benefits achieved by the physician group for its patient population and paid out in part based on the quality results, which we will assess.

Medicare Care Management Performance Demonstration. CMS also plans to test a pay-for-performance system to promote the adoption and use of health information technology to improve the quality and efficiency of care for chronically ill Medicare beneficiaries treated in small- and medium-sized physician practices. The Medicare Care Management Performance Demonstration will provide performance payments for physicians who meet or exceed performance standards in clinical delivery systems and patient outcomes, and will reflect the special circumstances of smaller practices. This demonstration is under development and will be implemented in Arkansas, California, Massachusetts, and Utah. Participating practices will receive technical assistance from the Quality Improvement Organizations in their areas, as well as bonus payments for achieving the project's objectives.

Medicare Health Care Quality Demonstration. CMS is also investigating how to enhance quality and safety in the Medicare Health Care Quality Demonstration. This demonstration program, which was mandated by the MMA, is a five-year program designed to reduce the variation in utilization of health care services, and to increase quality and efficiency of care by encouraging

area-level collaboration and coordination to improve the use of evidence-based care and overall area quality. We have sought public comment on the design of this demonstration and will consider these comments in a request for proposals. The project will be open to physician groups and other providers that are involved in integrated health care delivery, for example using effective interoperable electronic health information systems that improve quality and avoid unnecessary costs.

Chronic Care Improvement Program. This pilot program will test a population-based model of disease management. Under the program, participating organizations will be paid a monthly per beneficiary fee for managing a population of beneficiaries with advanced congestive heart failure and/or complex diabetes. These organizations must guarantee CMS a savings of at least five percent plus the cost of the monthly fees compared to a similar population of beneficiaries. Payment also is contingent upon performance on quality measures and beneficiaries and provider satisfaction. The program will generate data on performance measures that will be useful in improving the Medicare program as a whole.

Disease Management Demonstration for Severely Chronically Ill Medicare Beneficiaries. 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. Participating disease management organizations 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. To measure quality, the organizations must submit data on a number of relevant clinical measures.

Disease Management Demonstration for Chronically Ill Dual-Eligible Beneficiaries. Under this demonstration, disease management services are being provided to full-benefit dual 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. The demonstration organization is being paid a fixed monthly amount per beneficiary and is at risk for 100 percent of its fees if performance targets are not met. Savings above the targeted amount will be shared equally between CMS and the demonstration organization. Submission of data on a variety of relevant clinical measures is required to permit evaluation of the demonstration's impact on quality.

End Stage Renal Disease (ESRD) Disease Management Demonstration. This demonstration is scheduled to begin later this year and extend for four years. Under this demonstration, organizations serving ESRD patients will receive a capitated payment to test the effectiveness of disease management models in increasing quality of care and containing costs. Eligible organizations will receive capitated payments and accept risk to provide a coordinated care benefit plan to ESRD enrollees. Incentive payments of up to five percent will also be made to plans for achieving quality improvements over the course of the demonstration. Quality measurement will be based on a quarterly submission of patient-level data on five key clinical

indicators profiled in the CMS ESRD Clinical Performance Measures (CPM) Project. Initiated in 1998, the CPM Project currently monitors 16 quality measures that are based on the National Kidney Foundation's Kidney Disease Outcomes Quality Initiative (K-DOQI) Clinical Practice Guidelines. These measures report the quality of dialysis services provided under Medicare in the areas of adequacy of hemodialysis and peritoneal dialysis, anemia management, and vascular access management. In addition to the CPMs, CMS will collect data on patient nutrition and develop additional measures related to kidney transplant referral and ESRD bone metabolism.

Care Management Demonstration for High Cost Beneficiaries. This demonstration, which is approaching implementation, will test models of care management in a Medicare fee-for-service population. The project 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 we accepted applications through January 2005. The payment methodology will be similar to that implemented in the Chronic Care Improvement Program, with participating organizations required to meet relevant clinical quality standards for the specific populations they target as well as guarantee savings to the Medicare program.