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STATEMENT OF

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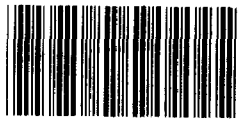
ON

QUALITY OF CARE ISSUES IN THE MEDICARE PROGRAM

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE



MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

It is a pleasure to be here today to share with this Committee some of the information we have developed on the quality of care provided by the Medicare program under the new prospective payment system (or PPS). In fiscal year 1985 Medicare spent approximately $37 billion under PPS for hospital care. More elderly Americans (over 27 million) are enrolled in Medicare than in any other federal program, including Social Security.

When the Social Security Act Amendments of 1983 were passed, the Congress recognized that incentives intended to cut costs could affect the quality of health care. Restraining costs by reducing services or lengths of stay could lead to greater efficiency, less inappropriate use of services, and better care for some patients. But if medically necessary and appropriate services were also curtailed, prospective payment incentives could have the unintended consequence of reducing the quality of care. A number of measures were taken at that time to minimize these potentially negative effects. The measures included the provision of supplementary payments for unusually complicated and costly "outlier" cases and the specific assignment of responsibility for oversight of quality of care to the Professional Review Organizations (or PROs). Our discussion today focuses on what we know about whether the quality review systems currently in place have effectively controlled the quality problems which could arise from the incentives built into the prospective payment system.

My comments will draw largely on the work we recently completed in which we examined the availability of information about the effects on post-hospital care of implementing the Medicare Prospective Payment System (PPS). In the course of doing this work, we came to the conclusion that some of the most important quality of care questions raised by the introduction of PPS can be addressed by focusing on two issues: the condition of Medicare patients when they are discharged from the hospital and the appropriateness of post-hospital placement for patients who require subacute care.

Today, I would like to focus on three concerns related to these points. The first has to do with the incentive structure, or the logic, of PPS. The second is the evidence about actual quality problems under PPS. The third involves reasons why more definitive information is not available.

Concerns About Quality of Care Posed by the Incentive Structure of PPS

Prior to PPS, when hospitals were reimbursed for individual services and days of hospital care, their financial interests could lead them to err on the side of providing too much health care. Even prior to PPS, there were problems in obtaining access to skilled nursing facilities for some patients. As a result, some of these patients remained in hospitals longer than

medically necessary.[1] Further, the limitations of Medicare coverage for post-hospital services reinforced incentives to extend hospital stays past the point where patients' acute care needs had been met. Some extended care provided in hospitals could have been covered by Medicare in post-hospital settings. In other cases the extended care was probably custodial or supportive care for chronically ill patients; this would not qualify for Medicare coverage.

Extended hospital stays could have had negative quality consequences, given the danger of complications and infection that accompany all medical interventions. The prime objection to this system, however, was its cost. Medicare was seen as paying for too much unnecessary and inappropriate care.

Incentives to Provide Less Rather than More Care. In shifting to a system of prospective payment based on diagnosis, Medicare suddenly removed the financial incentive to provide more health care services than needed in hospital settings. Rather, hospitals now stand to gain the most by curtailing both services and days of hospital care whenever possible. Under this system, hospitals can profit financially from cutting back on medically appropriate, as well as inappropriate, services. Thus, the discharging of patients still in need of hospital care has become a primary quality concern under PPS.

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[1]GAO, Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly, GAO/IPE-84-1 (Washington, D.C.: October 21, 1983), pp. 110-15.

Predictions of Increasing Need for Post-Hospital Care. A second concern relates to the ability of hospitals to respond to PPS incentives to shift the provision of subacute care to appropriate post-hospital settings. Patients who no longer require acute care should be discharged from the hospital, but some of these patients are still not sufficiently recovered to care for themselves at home. Such patients are likely to experience quality of care problems if they do not receive appropriate and competent post-hospital care. This is likely to have occurred much less frequently since PPS came into effect and transformed extensions of hospital stays from generally profitable to relatively unprofitable activities. Given a new level of demand, it will probably take some time before providers of post-hospital care can expand to accommodate it. Until they do, some patients are likely to have trouble obtaining access to the post-hospital care they need. This problem is probably accentuated for patients requiring the most intensive forms of post-hospital services, such as respirator care. Because it has only recently become feasible to provide relatively complex care of this sort outside the hospital setting, post-hospital care providers may not have the equipment or enough trained staff needed to furnish it. Moreover, when providers of post-hospital care are found, the complexity of these procedures and greater vulnerability of patients dependent on them increases the likelihood of problems of quality.

Differential PPS Effects on Quality are Likely. The concerns about quality of care raised by PPS are likely to affect

different groups of Medicare patients very unevenly. First, most Medicare patients have typically not used post-hospital care. For them, PPS incentives, at least in theory, pose fewer potential problems. However, the patients who do require post-hospital care tend to have had longer-than-average hospital stays. This could make them more likely to be targets of hospital cost-control efforts. Such patients are often frail or chronically ill, and have multiple health care problems. These conditions may render them less attractive for hospitals to admit, and harder to place in post-hospital care upon discharge.

Hospitals may respond by focusing more intensive discharge planning efforts on patients of this sort. To the extent that this will lead to appropriate post-hospital care, the results could be beneficial. Otherwise, the frail and chronically ill could experience disproportionate quality of care problems under PPS through a combination of premature discharges, inappropriate or substandard post-hospital care, or no care at all.

In addition, variations in hospital practice and health services resources across the country likely mean that there will be substantial differences in the way that PPS affects the quality of care. There are, for example, large variations in average lengths of stay in hospitals and in the availability of different types of post-hospital care. Hospitals which have relatively low lengths of stay or are located in areas with a relatively extensive networks of post-hospital care in place will probably have less difficulty adapting to the incentives of PPS without confronting major quality of care problems.

What Evidence Is There of Actual Problems in Quality of Care for Medicare Beneficiaries Under PPS?

Preliminary evidence from the U.S. Department of Health and Human Services indicates that hospitals have responded as they were expected to in terms of the incentives I have just described: average lengths of stay are down and the number of patients discharged to post-hospital care providers such as nursing homes and home health agencies appears to have increased sharply.[2] However, evidence of some quality of care problems stemming from these incentives has also emerged. There have been numerous reports of people having been discharged from the hospital in unstable medical condition, or without adequate provision for post-hospital care, or to inappropriate types of post-hospital care. We reported to the Senate Special Committee on Aging in February 1984 that there was substantial agreement among the hospital, nursing home, and home health care administrators and discharge planners and advocates for the elderly whom we met with in six communities across the nation that patients were being discharged sooner and in poorer states of health than before PPS. We were told that demand for post-hospital care had increased, and that patients in the post-PPS period required more intensive services after discharge from the hospital. At each site we visited, we were told of problems

[2]Department of Health and Human Services, Report to Congress: The Impact of the Medicare Prospective Payment System, 1984 Annual Report, (Washington, D.C.: November 1985), p. 6-13, and 8-6 to 8-12.

with obtaining appropriate subacute care for some patients, particularly those with extensive skilled nursing care needs.[3] Reports of similar problems have continued to surface since our preliminary report was issued.

Some work has begun on developing ways of measuring patients' level of dependency and their medical stability when they are discharged from the hospital. The early evidence seems to substantiate the common impression that patients are being discharged in less stable condition. However, we lack essential information on the extent to which patients are being discharged prematurely--that is, when they still require hospital care, or inappropriately--that is, when they no longer need acute care but have inadequate arrangements for post-hospital subacute care. We are currently examining some of the problems hospital discharge planners are experiencing in placing Medicare patients in post-hospital care. I expect the results of a national survey of more than 900 hospitals to be available this fall.

Premature Discharges. Physicians and hospital administrators testifying before both the House and Senate Aging Committees have reported that they have felt pressure to discharge patients earlier than is medically appropriate. However, the data on which to base any claims about the extent or severity of premature discharges under PPS are very limited. In October 1984, the Office of the Inspector General in HHS

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[3] Information Requirements for Evaluating the Impacts of Medicare Prospective Payment on Post-Hospital Long-Term Care Services: Preliminary Report, GAO/PEMD-85-8 (Washington, D.C.: December 7, 1985).

expressed concern about the possibility of a growing number of medically inappropriate discharges, transfers, and readmissions under PPS, but only limited reviews of a small number of cases were cited as evidence of this type of problem. While PROs have identified several thousand cases of premature discharge or incomplete care resulting in readmission within 7 days, the system of PRO review is not designed to produce uniform and comparable data. Therefore, PRO data cannot be used to estimate the incidence or extent of premature discharge experienced by the entire Medicare population.

Inappropriate Discharges. As with premature discharges, a great deal of testimony has been presented in House and Senate hearings describing instances of problems associated with patients' inability to obtain appropriate post-hospital subacute care. However, no systematic research has yet demonstrated the scope and magnitude of these problems.

PROs have no responsibility for reviewing post-hospital care services. Therefore, information on problems arising from lack of access to appropriate post-hospital care, or placement in inappropriate or substandard post-hospital care, cannot be obtained from PRO data. Most of the available information comes from providers and focuses on the increased demand for health care services perceived to be associated with earlier hospital discharges rather than on the direct assessment of the effect of earlier discharges on the quality of care. The available national, as well as regional and local studies show sizable increases in the provision of health-related services for elderly

persons in the community after PPS and increased demand for extensive skilled nursing services and "high-tech" services, in both nursing homes and home care. Studies that demonstrate the effects of either premature or inappropriate discharges on the outcomes of patient care, however, have yet to be done.

Why Do We Not Know More About PPS Effects on Quality of Care Either in Hospitals or in Post-hospital Care?

PROs are the organizations charged with the responsibility of reviewing inpatient hospital care, and would seem to be the logical source of data on quality of care problems, including those associated with earlier discharges from the hospital. However PROs have not provided this information for a number of reasons.

Under their original scope of work, the specific types of discharge problems PROs reviewed were those that resulted in the subsequent readmission of a patient to the same hospital or readmission of a patient for care that could have been provided during the first admission.[4] Only readmissions to the same hospital within seven days were subject to mandatory review.

In addition, the case-by-case methodology PROs use to determine whether a premature discharge has occurred precludes the collection of uniform data on the incidence of such discharges nationwide. Each review rests ultimately on the individual professional judgment of the PRO personnel reviewing

[4]Health Care Financing Administration, "Peer Review Organization Manual," transmittal 5, Washington, D.C., August 1985, pp. 3-5.

the case. The criteria guiding this judgment are developed by each PRO in accordance with local medical practice. Therefore, similar cases could be assessed differently by different PROs.

Information on premature discharges has been limited also by the way in which PROs report their activities to the Health Care Financing Administration (HCFA). PRO review could lead to a variety of findings--inappropriate admission for the second hospitalization, readmission for legitimate reasons, or readmission needed because of inappropriate or poor quality care during the first hospitalization (which could include premature discharges). The reasons for readmissions were not routinely disaggregated in reports to HCFA. Consequently, summary statistics on readmissions and on payments approved or denied for readmissions would not provide information on premature discharges. Summary information provided to HCFA will be more extensive under the new round of PRO contracts, but data will not be available until these new contracts have been in effect long enough to conduct reviews, to record case findings, and to generate and analyze summary data tapes. Perhaps most significantly, PRO reviews do not provide information on cases of readmission resulting from premature discharge after the prescribed cut-off period (now 15 days) or on cases of premature discharge not resulting in readmission (including patients who were discharged and died without returning to the hospital).

PROs perform a valuable task in identifying and rectifying individual cases of poor quality care. The problems with PRO data that I have just discussed do not derive from poor

performance on their part. The difficulty is that the PROs were not designed to provide aggregate information on the nation-wide incidence of premature discharges under PPS.

The limitations of PROs in generating information on the quality of care are not, however, merely a function of design. They reflect, among other things, three major barriers to the development of an effective quality assurance system for the Medicare program: (1) conceptual problems in measuring the quality of care, (2) fragmented administration of health care services for the elderly, and (3) the magnitude of research and development efforts required.

Conceptual Problems Make Measuring Quality Very Difficult. An important reason for the collective lack of information about the quality of care provided to Medicare beneficiaries is that people do not agree on what is meant by "quality of care." Quality can be viewed from the perspective of the practitioner, the patient, or the persons who are charged with overseeing the programs that serve the public, and these perspectives are sometimes divergent. What may be state-of-the-art clinical medicine from a technical and scientific point of view may be unacceptable to a patient whose expectations about appropriate treatment are not met or who is dissatisfied with the interpersonal or environmental aspects of the health care encounter. Assessing the quality of care provided to beneficiaries of a health care financing program requires the consideration of trade-offs between available resources and expected benefits, which may not be as important in assessing the

quality of care rendered to an individual.

While there is no accepted standard definition of quality, there is some general agreement among experts that quality is a multidimensional construct, and that looking at different aspects of the structure, process and outcomes of care can produce meaningful and useful information. Clearly, the identification of deficiencies in physical plant and equipment (including technology) and the staffing, organization and professional training of persons working in health care facilities is essential to oversight, and so is the review of the activities performed in taking care of patients, including the gathering of information about diagnoses, procedures, therapy, follow-up visits, and so on. Under the pressures of cost-containment, however, a concern is growing about how these components of quality actually relate to the outcomes of care, as measured by changes in health status or patient satisfaction.

In attempts to make some overall judgments about quality, we have generally been limited to somewhat ambiguous proxy measures such as mortality rates and use rates, measures that are often difficult to interpret. For example, knowing that patients in a particular institution have a certain mortality rate is not useful in the absence of information on the complexity of cases treated in that institution and the expected mortality rates for similar groups of patients receiving appropriate care.

More comprehensive measures of quality would require linking variation in the process of care to differences in health outcomes or examining the quality of care provided in different

settings throughout an episode of illness. Research in these areas is in the early stage of development.

The Fragmented Administration of Health Care Services Leads to Data and Accountability Problems. Assessing the quality of care is complicated further by the fragmentation of responsibility for quality oversight among different segments of the health care system. For example, Medicare covers acute and subacute care for the elderly; private payment and Medicaid cover most long-term care for the frail elderly and chronically ill and disabled. Therefore, federal programs have responsibility for the oversight of quality in different sites--hospitals and nursing homes, for example--and for different populations of beneficiaries--the acutely versus chronically ill. This fragmentation is exacerbated within the Medicare program itself, which covers a wide range of services under two separate insurance funds, and uses a variety of payment mechanisms--each with its own billing and administrative data--to reimburse providers of care.

As a result of divided responsibilities and diverse payment and administrative systems, the measures and mechanisms that have been developed for monitoring quality of care have tended to focus on different types of information and different aspects of quality. These various elements have not been tied together into a unified conceptualization of quality extending throughout an episode of illness. The immediate case in point is the system of PRO review, in which responsibility is limited by the parameters of the specific prospective payment system in place. PROs are

responsible only for reviewing the quality of inpatient hospital care; they have no responsibility for monitoring other Medicare services or non-Medicare services received by beneficiaries.

Developing Stronger Information on Quality of Care Requires a Concerted Effort. To overcome barriers to the assessment of quality, significant efforts will be needed in both measuring quality and collecting relevant information. A first task is to clarify what is meant by "quality health care," particularly in the light of changing payment mechanisms and their associated incentives. Measurement development should be linked to improvements in the Medicare data collection system that would make it possible to apply comprehensive measures of quality throughout episodes of illness. At the same time, we need (1) to improve the system of PRO review so that it can generate valid and nationally representative information on quality problems, and (2) to devise ways to use this information to make systematic improvements in quality of care.

We have begun a study that will take some initial steps towards these ends. Our work will focus on relatively short-term approaches for assessing the quality of care that can use Medicare administrative data. Given the scope and complexity of the issues involved, however, a major research and evaluation effort will be required from HHS and others if the full range of quality of care issues is to be adequately addressed.

It should be noted that the development and refinement of many existing quality assurance methods was accomplished, in part, by the availability of federal research funds throughout

the 1970s. As policy concerns for health care costs increased, these concerns were reflected in shifts in priorities and agendas for funding research, and this resulted in decreased emphasis on quality-related studies. The present congressional hearing and the increased attention devoted to problems of health care quality suggest a need to reassess priorities for health services research. Greater attention to developing appropriate quality measures is essential. Studies to delineate the magnitude and types of health care quality problems occurring in the Medicare program and to develop systematic approaches for improving quality depend upon such basic developmental efforts.

Conclusions

To summarize, we have three major concerns about assessing the quality of care in the Medicare program under PPS:

First, the incentives created by prospective payment are such that providers could profit by cutting back on medically necessary care. However, these incentives operate more or less strongly for different types of patients and providers. Analyses based on individual cases or local or regional studies could be misleading. Therefore, it is critically important to develop information on quality of care that is national in scope and represents the population as a whole.

Second, virtually every source we have reviewed reports some problems of quality under PPS that are consistent with the logic of these incentives. The numerous descriptions of individual cases which have emerged since PPS came into effect are also

consistent with this logic. Further, as I previously testified before the Senate Special Committee on Aging, our work has uncovered no systematic research demonstrating that such quality of care problems are not significant. Based on the available evidence, we believe that there are some instances of serious problems with the quality of care provided to Medicare beneficiaries under PPS. However we do not know the extent, distribution, or intensity of these problems.

Third, significant barriers to obtaining better information derive from a combination of measurement problems, fragmented administrative responsibilities, and decreased emphasis on essential research and development. These barriers will not be overcome unless a systematic and extensive effort--and the resources to support this effort--are directed to the task.

The current gaps in information should not, however, preclude consideration of the genuine instances of problems of quality that have arisen under PPS. Although we cannot yet determine the distribution and intensity of these problems, some interim measures to remedy cases of premature discharge and seriously deficient post-hospital care as they occur are clearly justified. There should be effective mechanisms to provide patients with full and accurate information about their rights; procedures to deal immediately with Medicare patients' urgent problems related to hospital discharge decisions and placement in post-hospital care are also needed. Without better information on the nature of the quality of care problems occurring in the Medicare program, however, the basis is lacking for considering

more extensive policy changes intended to adjust the basic incentive structure of PPS, or substantively change Medicare eligibility criteria or its coverage of subacute health care services.

This concludes my prepared statement. I will be happy to answer any questions you or any other members of the Committee have.