MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Improving quality through Medicare payment policy

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Statement of
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Committee on Ways and Means
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Chairman Johnson, Congressman Stark, distinguished Subcommittee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss improving quality in the Medicare program through Medicare payment policy, a subject that has been of particular interest to the Commission.

The quality of care for Medicare beneficiaries needs to be improved

Ensuring that Medicare beneficiaries have access to high quality care is the principal objective of the Medicare program. Yet Medicare beneficiaries receive care from a system known to have quality problems. While care is improving in several settings, as RAND, Jencks and others have reported, significant gaps remain between what is known to be good care and the care delivered. Studies documenting the gap between high-quality care and the care currently delivered have called attention to the need for improvement. As the Institute of Medicine reported, the safety of patients, particularly in hospital settings, is also of concern.

In our March report to the Congress, we document aspects of the quality of care for the Medicare population using quality indicators developed by the Agency for Healthcare Research and Quality (AHRQ) and results from CMS using other measures. We find that although some measures of quality show improvement over the last decade, many do not and improvement is possible in many more.

We find quality varies based on the indicators used. Hospital mortality rates are improving (table 1). The rate of in-hospital mortality—an indicator of effectiveness—generally decreased between 1995 and 2002 on all conditions and procedures measured. At the same time, many beneficiaries experience adverse events in hospitals. Measures of the safety of patients in the hospital reveal that 9 out of the 13 rates of adverse events we tracked for hospitalized Medicare beneficiaries increased between 1995 and 2002 (table 2). Beneficiaries are being admitted to hospitals for conditions that might have been prevented in ambulatory settings (table 3). Seven out of 12 indicators show increases in admissions between 1995 and 2002 for potentially avoidable admissions. For beneficiaries who are hospitalized, measures used by CMS's quality improvement organization program show improvement. Fourteen out of 16 measures of

appropriate provision of care in hospitals improved between the periods 1998 to 1999 and 2000 to 2001 as reported by Jencks. Although improving, gaps still exist between care delivered and optimum care.

Simply providing more care does not necessarily lead to improving quality. The amount of care Medicare beneficiaries receive varies widely across the nation. Yet, as noted in our June 2003 report to the Congress, higher use of care does not appear to lead to higher quality care; in fact it appears that states with the highest use tend to have lower quality than states with the lowest use. Wennberg, Cooper, Fisher and other researchers have found similar phenomena in smaller geographic areas—areas with the highest service use tend to have lower, not higher quality.

An approach to improving quality

Quality varies from low to high among providers. This implies both that high quality is achievable, and that a multi-faceted approach to quality is needed to account for the differing starting points of providers. For example, conditions for participating in the program can assure that all providers meet minimum standards but encouraging high-quality providers to maintain or improve their quality requires a different approach. The ultimate goal is to find ways to continually improve quality delivered by all providers. As a first step, quality has to be measured and evaluated.

Measures of quality and guidelines for appropriate care are becoming increasingly available. The Medicare program has been a leading force in these efforts to develop and use quality measures often leading initiatives to publicly disclose quality information, standardize data collection tools, and give feedback to providers for improvement. CMS has also revised its regulatory standards to require that providers, such as hospitals, home health agencies, and health plans, have quality improvement systems in place. By offering technical assistance to providers, the Quality Improvement Organizations have been a critical part of these efforts. In some sectors, these steps are showing results. The Commission views CMS's focus on quality as an important contribution and an excellent foundation for future initiatives.

The private sector also has taken steps to improve quality. In our June 2003 report, we document that most private sector organizations began their quality improvement efforts by

developing quality measures and then providing feedback to providers followed by public disclosure. This helped establish credibility and acceptance of the measures used as well as developed the process for data collection. But many organizations found that those steps alone did not achieve sufficient improvement and began designing financial incentives to tie payment to quality. Early experience has shown improved quality and in some cases cost savings.

Medicare payment systems do not incorporate financial incentives tying payment directly to quality. Current payment systems in Medicare are at best neutral and at worst negative toward quality. All providers meeting basic requirements are paid the same regardless of the quality of service provided. At times providers are paid even more when quality is worse, such as when complications occur as a result of error. It is time for Medicare to take the next step in quality improvement and put financial incentives for quality directly into its payment systems. Linking payment to quality holds providers accountable for the care they furnish. In addition, financial rewards would accrue to providers investing in the processes that improve care encouraging investment in such improvements. Through its actions Medicare can act as a catalyst for improvement throughout the health delivery system.

In our June 2003 report to the Congress, the Commission recommended that CMS move toward using financial incentives for all types of providers and plans participating in Medicare. We also developed the following criteria for choosing the most promising settings for introducing payment for quality performance:

- To be credible, measures must be evidence based to the extent possible, broadly understood, and accepted.
- Most providers and plans must be able to improve upon the measures; otherwise care may be improved for only a few beneficiaries.
- Incentives should not discourage providers from taking riskier or more complex patients.
- Information to measure the quality of a plan or provider should be collected in a standardized format without excessive burden on the parties involved.

Building on this analysis, in our March 2004 report to the Congress, we develop as a general design principle that a system linking payments to quality should:

- reward providers based on both improving the care they furnish and exceeding thresholds,
- be funded by setting aside a small proportion of total payments, and
- be budget neutral and distribute all payments that are set aside for quality to providers achieving the quality criteria.

We also analyze and make specific recommendations on linking payment to quality for two sectors judged the most ready for financial incentives: providers of dialysis services, and private plans in Medicare.

Using payment incentives to improve dialysis quality. The Commission recommends that the Congress establish a quality incentive payment policy for physicians and facilities providing outpatient dialysis services. Although quality of outpatient dialysis services has improved for some measures, it has not for others. Despite some improvement in dialysis adequacy and anemia status, patients and policymakers remain concerned about the unchanged rates of hospitalization during the past 10 years and the poor long-term survival of dialysis patients. By directly rewarding quality, Medicare will encourage investments in quality and improve the care beneficiaries receive. The recommendation would reward both the dialysis facilities and physicians who are paid a monthly capitated payment to treat dialysis patients. Physicians are responsible for prescribing dialysis care and facilities are responsible for delivering it; only together can they improve quality in the long term.

The outpatient dialysis sector is a ready environment for linking payment to quality. It meets all of our criteria. Credible measures are available that are broadly understood and accepted. All dialysis facilities and physicians should be able to improve upon the measures. Obtaining information to measure quality will not pose an excessive burden on dialysis facilities and physicians, and measures can be adjusted for case mix so that dialysis facilities and physicians are not discouraged from taking riskier or more complex patients.

In keeping with our general design, MedPAC recommends a system linking payments to quality that would:

- reward facilities and physicians based on both improving the care they furnish and meeting thresholds,
- be funded by setting aside a small proportion of total payments, and
- distribute all payments that are set aside for quality to facilities and physicians achieving the quality criteria.

Measuring the quality of care and holding providers financially accountable will take on additional importance if Medicare broadens the dialysis payment bundle to include commonly used injectable drugs and laboratory services.

CMS is already planning to use quality incentives in the agency's new end-stage renal disease management demonstration. Medicare will pay program participants—dialysis facilities and private health plans—an incentive payment if they improve quality of care and if they demonstrate high levels of care compared with the national average. We applaud CMS for linking payment to quality in the demonstration. Quality incentives should not, however, be limited to demonstration efforts, but rather should apply to all fee-for-service dialysis providers so care for as many patients as possible will improve. In addition, when using quality incentives only in a demonstration, bidders may primarily consist of high-quality facilities and not be representative of all facilities. By contrast, we recommend incentives that are part of the outpatient dialysis payment system and will affect both low- and high-quality providers.

Using payment incentives to improve the quality of care in private plans. To reward improvements in quality for beneficiaries enrolled in private plans we recommend that the Congress establish a quality incentive payment policy for all private Medicare plans. This program is a promising sector for applying payment incentives to provide high-quality care because it meets the criteria for successful implementation. Private Medicare plans already report to CMS on a host of well-accepted quality measures. Plans vary in performance on the reported quality measures and room for improvement exists on almost all measures. Because plans are responsible for the whole spectrum of Medicare benefits, they have unique incentives to coordinate care among providers which is an important aspect of quality.

Although CMS would have work to do before it would be ready to administer any incentive program, in keeping with our general design principles we recommend creating a reward pool from a small percentage of current plan payments and redistributing it based on plans' performance on quality indicators. To reach the most beneficiaries, Medicare should reward plans that meet a certain threshold on the relevant performance measures and plans that improve their scores. The program should be budget neutral and CMS would need to create a mechanism that insured budget neutrality.

Next steps to link payment to quality

The Commission seeks opportunities to improve the quality of care all Medicare beneficiaries receive. As we have discussed, beginning in 2005 we recommend paying for quality in two sectors where there is consensus on measures and they are regularly collected—outpatient dialysis and Medicare private plans. We anticipate expanding recommendations on payment for quality to other sectors in the future as better measures become available.

To help target quality improvement initiatives, we will continue to analyze the quality of care in hospitals, ambulatory settings, post-acute care settings, and private plans using a range of available indicators. The hospital and ambulatory settings affect a large number of beneficiaries and thus quality in those settings is critical to the program. This work will raise questions for further research, but may also point to where payment incentives are most needed. The Commission will also investigate the relationship between cost and quality. Work in the dialysis sector showed no correlation between cost and quality for services paid prospectively under the composite payment. It also found a negative correlation under the fee-for-service payment for the sector—beneficiaries' outcomes were poorer for facilities with higher than average costs. This correlation could, to some extent, be a reflection of unmeasured case mix complexity.

We will also investigate how care coordination and rewarding improvements in quality across settings can be addressed given the fragmented nature of the current health care system. In fee-for-service Medicare, rewarding the providers in one sector when savings from their actions accrue in other sectors is a challenge. It is also difficult to provide incentives to coordinate care across settings, for example, through mechanisms such as disease management, when no single

provider is responsible. Such considerations have led many private purchasers and plans to target their incentive initiatives at organizations—either group practices, networks, or health plans that use some form of risk sharing—that they believe are more effective at improving quality. Finding effective approaches to these issues will be a major challenge for the Medicare program.

Conclusion, the time is now

The Medicare program can no longer afford for its payment systems to be neutral or negative to quality. Although there are risks in paying for quality—providers avoiding high-risk patients and concentrating on the measured quality elements to the exclusion of others—good design can ameliorate them. The risk from maintaining the status quo is much greater. No beneficiary should be fearful for her safety going into a hospital because of medical errors. No beneficiary should be hospitalized when it could have been avoided through better ambulatory care. It would be impossible to reduce medical errors or preventable hospitalizations to zero, but evidence suggests we are far from a tolerable level now and many improvements are possible and needed.

In June 2003, MedPAC expressed an urgent need to improve quality in fee-for-service Medicare and in care furnished by private plans. In our March report we have recommended two sectors where the Congress can act now—rewarding quality care in outpatient dialysis and Medicare Advantage. Linking payment to quality in other sectors could encourage broader use of best practices and thus, improve the quality of care for more beneficiaries. A Medicare program that rewards quality would send the strong message that it cares about the value of care beneficiaries receive and encourages investments in improving care.

Table 1. Effectiveness of care: Hospital mortality decreased from 1995–2002

Diagnosis or procedure	Risk-adjusted rate per 10,000 discharges 1995	1998	2000	2002	Percent change 1995–2002	Observed deaths in 2000
In-hospital mortality						
Pneumonia	1,122	1,032	1,012	949	–15.4	78,999
AMI	1,670	1,477	1,414	1,309	–21.6	43,750
Stroke	1,357	1,240	1,212	1,159	–14.6	39,099
CHF	689	585	541	474	–31.2	38,828
GI hemorrhage	504	434	400	355	–29.5	11,155
CABG	580	522	482	427	–26.3	8,669
Craniotomy	1,033	963	986	931	–9.9	3,216
AAA repair	1,258	1,178	1,161	1,130	–10.2	2,632
30-day mortality						
Pneumonia	1,525	1,531	1,377	1,557	2.1	107,502
CHF	1,063	1,006	818	907	–14.6	58,678
Stroke	1,816	1,808	1,620	1,807	–0.5	52,263
AMI	1,899	1,792	1,627	1,690	–11.0	50,367
GI hemorrhage	757	718	590	649	–14.3	16,438
CABG	532	496	441	412	–22.5	7,932
Craniotomy	1,164	1,158	1,123	1,182	1.6	3,666
AAA repair	1,158	1,116	1,069	1,072	–7.4	2,423

Note: AMI (acute myocardial infarction), CHF (congestive heart failure), GI (gastrointestinal), CABG (coronary artery bypass graft), AAA (abdominal aortic aneurysm). Rate is for discharges eligible to be considered in the measure.

Source: MedPAC analysis of 100 percent of MEDPAR data using Agency for Healthcare Research and Quality indicators and methods.

Table 2. Safety of care: Adverse events affect many beneficiaries

Patient safety indicator	1995	1998	2000	2002	Change in rate 1995–2002	Percent change 1995–2002	Observed adverse events 2000
	Risk-adjusted rate per 10,000 discharges eligible						
Decubitus ulcer	237	273	297	319	82	34.5	128,774
Failure to rescue	1,772	1,683	1,652	1,511	–261	–14.7	57,491
Postoperative PE or DVT	98	108	120	123	25	24.5	36,795
Accidental puncture/laceration	28	31	32	36	8	30.7	34,171
Infection due to medical care	24	27	28	30	6	28.5	24,524
Iatrogenic pneumothorax	10	12	11	11	1	4.8	10,985
Postoperative respiratory failure	43	66	75	87	44	99.6[b]	8,184
Postoperative hemorrhage or hematoma	N/A	27	26	24	–3[a]	–11.2	8,056
Postoperative sepsis	89	112	127	135	46	50.7	6,739
Postoperative hip fracture	18	18	18	13	–5	–24.2	3,707
Death in low-mortality DRGs	39	30	31	30	–9	–23.6[c]	3,453
Postoperative wound dehiscence	38	41	37	38	0	0.4	2,043
Postoperative physiologic and metabolic derangement	11	12	13	14	3	31.8	1,952

Note: PE (pulmonary embolism), DVT (deep vein thrombosis), N/A (not available), DRG (diagnosis related group).
[a] change from 1998–2002.
[b] Some of this increase may be due to the introduction of a new code in 1998 for acute and respiratory failure.
[c] Agency for Healthcare Research and Quality researchers identified low-mortality DRGs for all-payers, not Medicare beneficiaries only.
Source: MedPAC analysis of 100 percent of MEDPAR data using Agency for Healthcare Research and Quality indicators and methods.

Table 3. Effectiveness and timeliness of care outside the hospital: The change in the rate of potentially avoidable hospital admissions is mixed, 1995–2002

Conditions	1995	1998	2000	2002	Percent change 1995–2002	Observed admissions in 2000
	Risk-adjusted rate per 10,000 beneficiaries					
Congestive heart failure	241	257	244	238	–1.0	703,012
Bacterial pneumonia	154	182	193	192	24.1	567,995
COPD	104	121	122	118	13.6	368,674
Urinary infection	60	64	67	66	9.4	209,550
Dehydration	50	55	58	65	30.2	181,785
Diabetes long-term complication	35	38	39	41	18.5	125,053
Adult asthma	24	21	20	23	–6.3	65,680
Angina without procedure	50	24	19	14	–71.4	59,983
Hypertension	9	10	11	13	38.3	37,334
Lower extremity amputation	15	16	15	14	–2.1	24,224
Diabetes short-term complication	7	7	7	7	2.1	22,425
Diabetes uncontrolled	10	8	7	6	–38.1	22,416

Note: COPD (chronic obstructive pulmonary disease).
Source: MedPAC analysis of 100 percent of MEDPAR data using Agency for Healthcare Research and Quality indicators and methods.