

# Medicare Quality Improvement Program Re-design: potential implications for the ESRD Networks

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# The Healthcare Value Imperative

- US is most expensive health care (in the world)
- Quality is poor
- Variation in Quality & Cost
- CMS is at the “center of action” and scrutiny
- CMS & ESRD Community now in Leadership Role: MIPPA Sections 153a, 153b, 153c (2008)

# Congressional & Executive Branch Interests

- Increasing reimbursement for healthcare & quality improvement services leads to:
  - No widespread improvement in quality
  - Higher volume of services
  - Increased expenditures
- The Environment has Changed
- Demonstration / Measurement of Value is what is needed now

# CMS P4P Initiatives

- Dialysis Facilities
  - Hospitals
  - Nursing Homes
- Home Health Agencies
  - Physician Offices

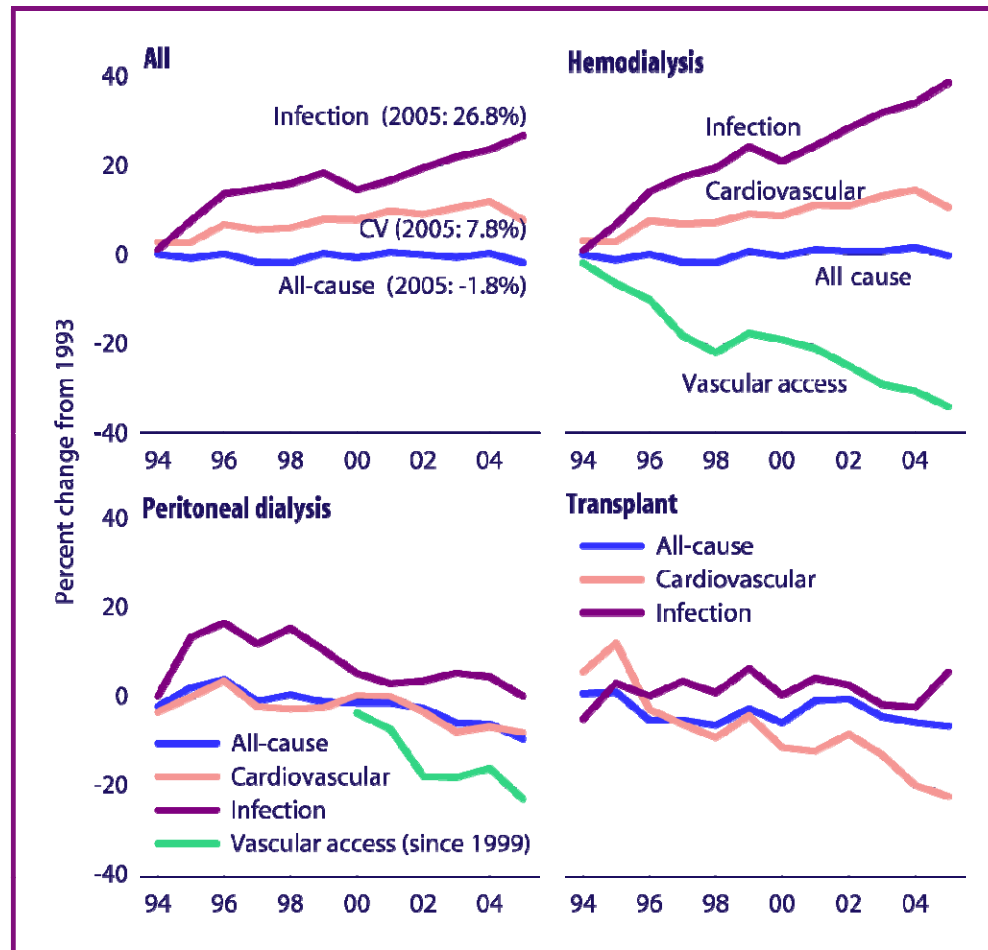
# What is Value?

And how do we know when we  
get it? (or not)

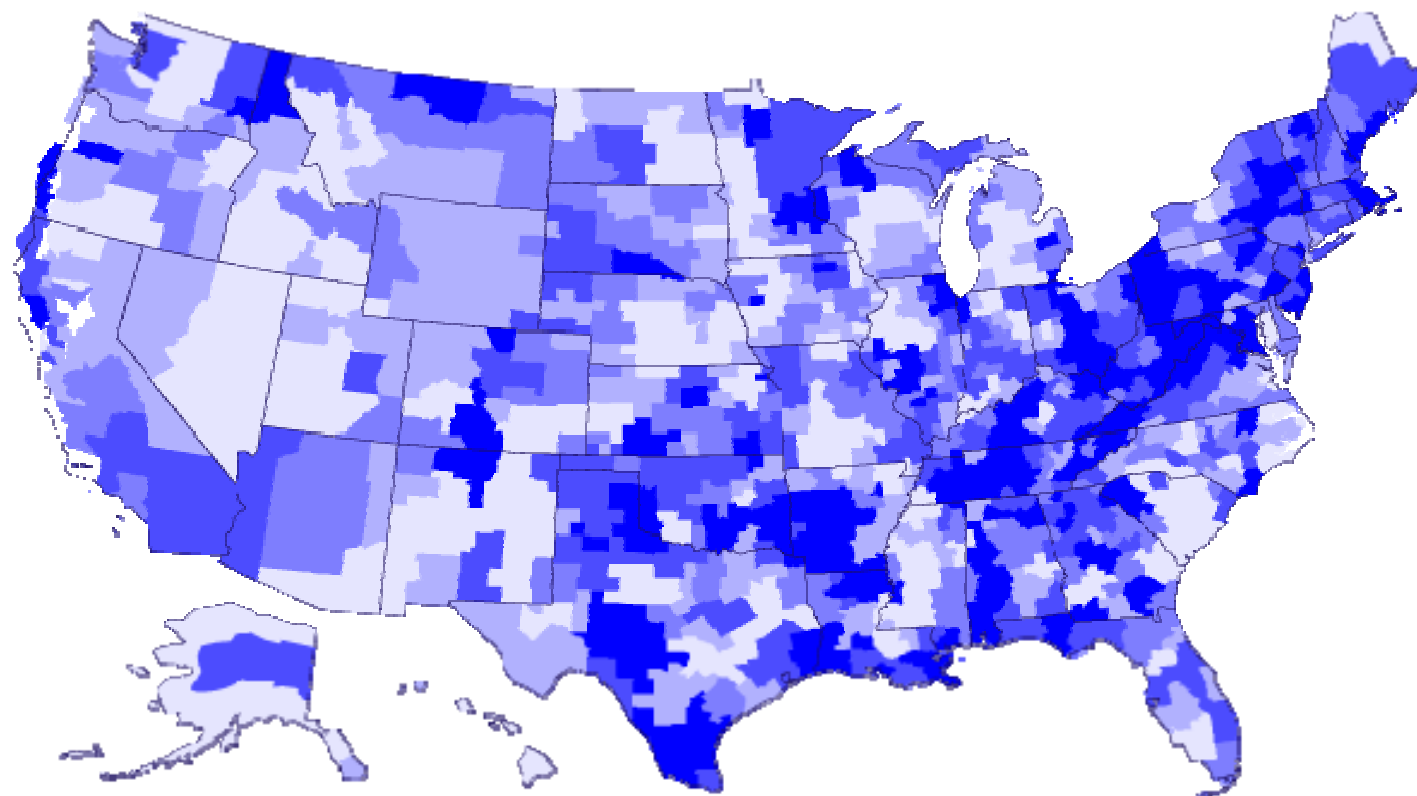
- **Hospitalizations**

- **Geographic Variations**

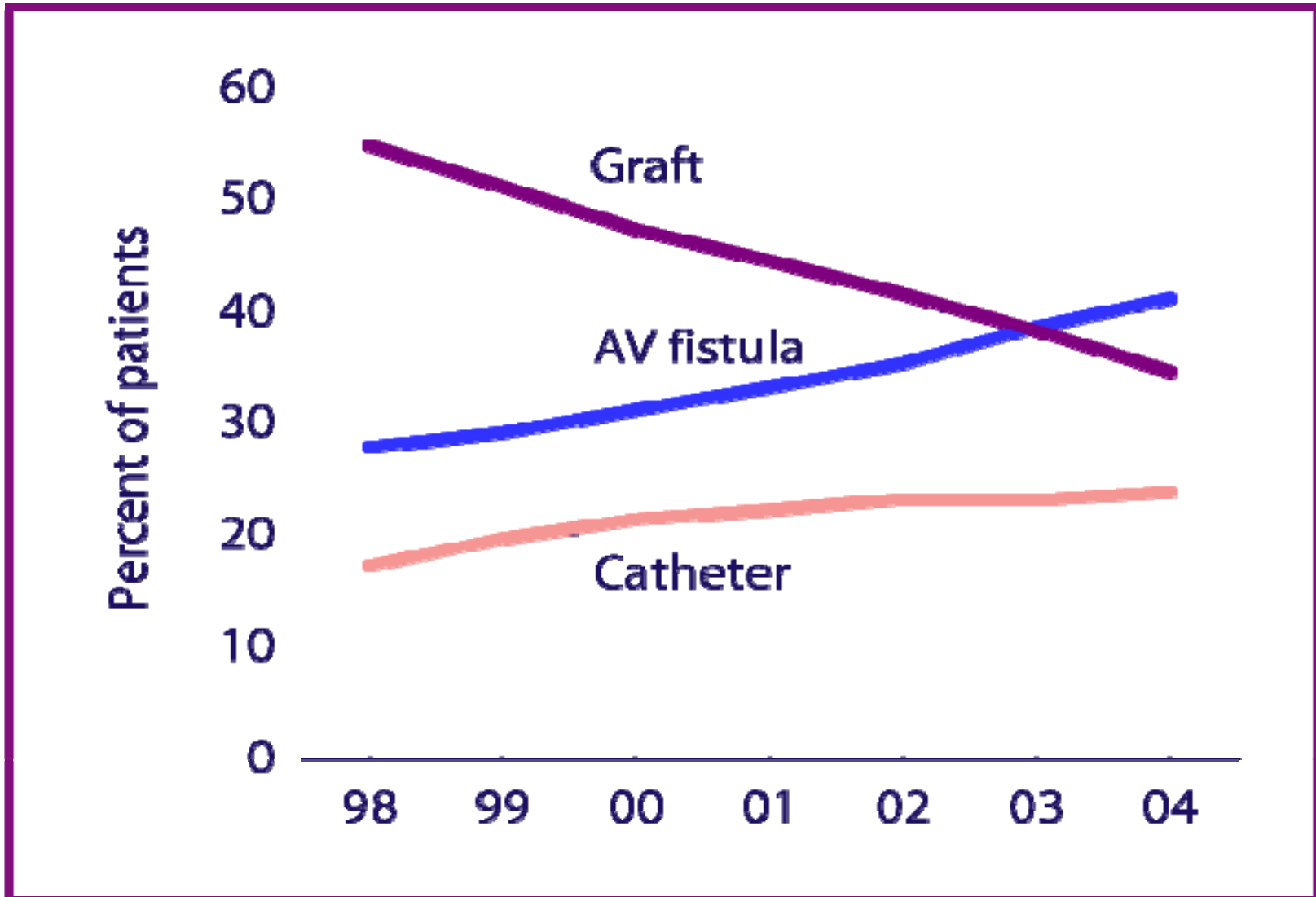
# Hospitalization Rates



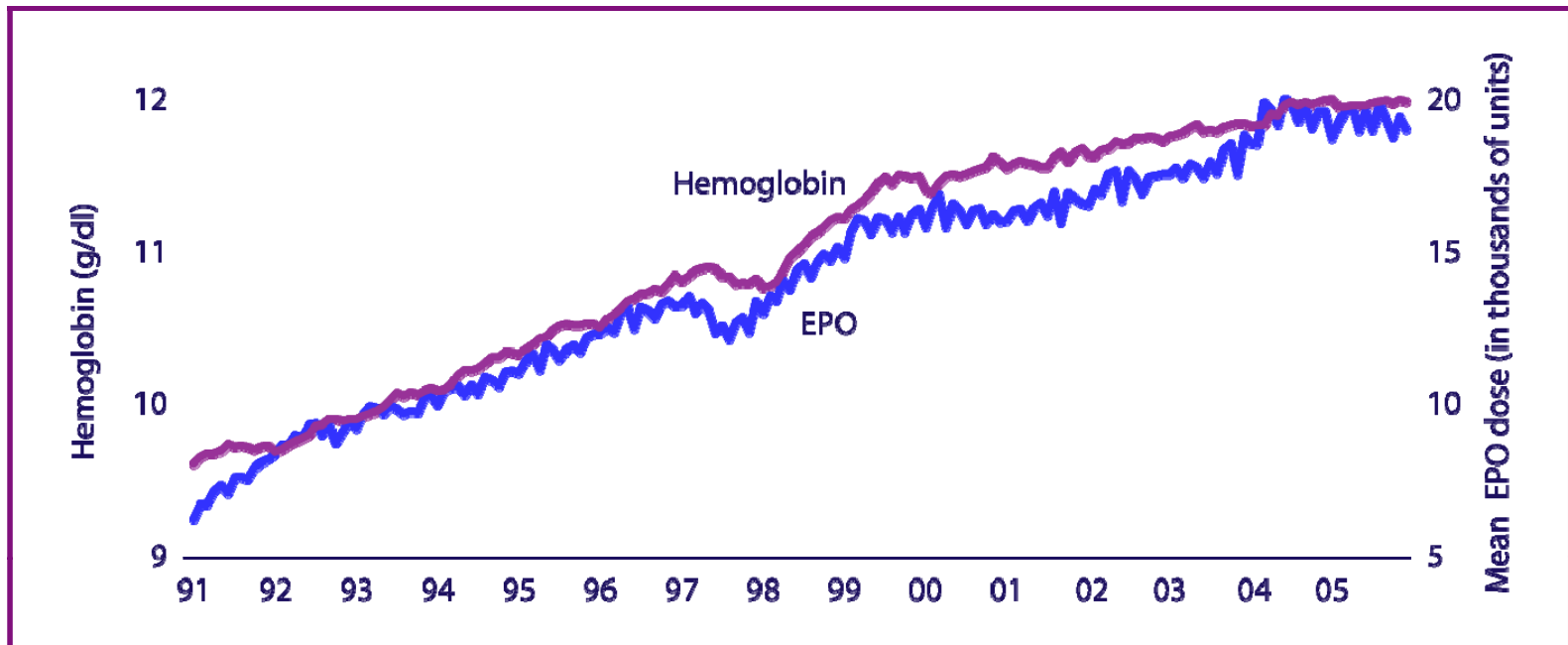
# Geographic Variation in Hospitalization



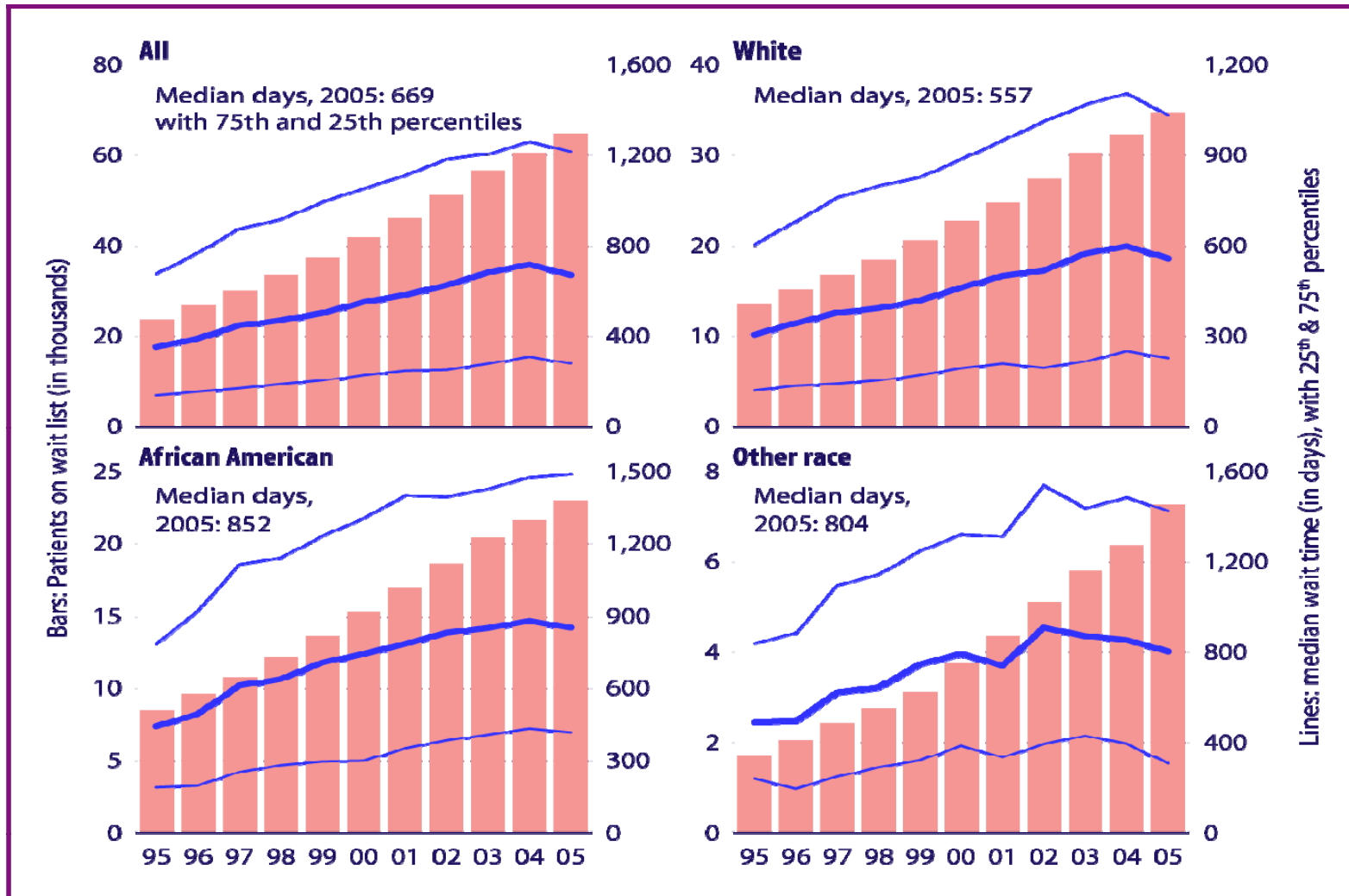
# Vascular Access Use



# Mean Monthly Hb & Epo Dose



# Transplant Wait List & Times by Race

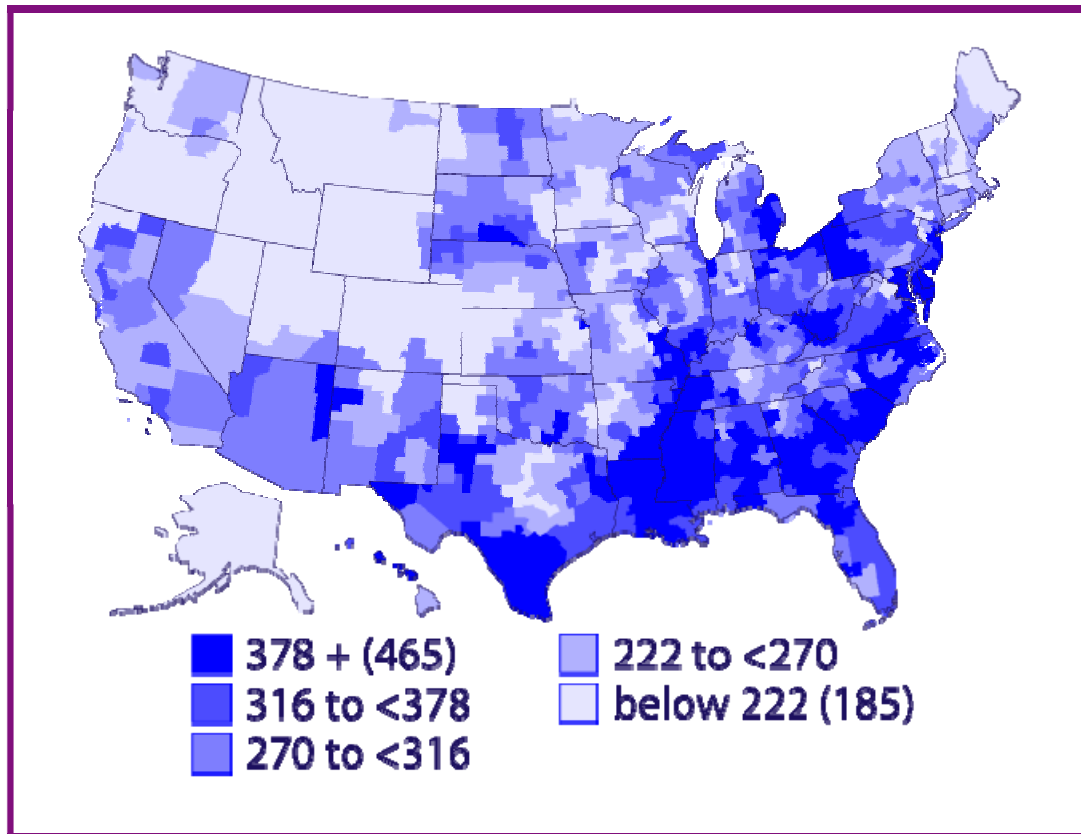


# CKD/ESRD Value Imperative

## PREVENTION: Overlap with QIO Program

- Growing number of patients needing renal replacement therapy
  - Epidemic of CKD: 26 Million Americans
  - Increasing shortfall of donor kidneys
  - Unless we can mitigate progression of CKD, increasing need for dialytic services

# Geographic Variations by Incident Rates-Hemodialysis



**Opportunities to Show  
Value are Abundant in  
CKD/ESRD**

# IOM Pathways to Quality Healthcare

- Performance Measurement: Accelerating Improvement (1 December 2005)
- Medicare's Quality Improvement Organization Program: Maximizing Potential (9 March 2006)
- Rewarding Provider Performance: Aligning Incentives in Medicare(21 September 2006)

# IOM Reports: Key Conclusions

- There has been improved quality over time
- The existing evidence is inadequate to determine the extent to which the QIO Program has contributed directly to those improvements
- The QIO Program provides a potentially valuable nationwide infrastructure dedicated to promoting quality health care

# IOM Report: Key Conclusions

- **Focus** the attention on provision of technical assistance in support of quality improvement
- Broaden the **governance** base and structure & address perceived conflicts of interest
- Improve **CMS's management** of related data systems and program evaluations
- Demonstrate **attribution** of QIO initiatives to actual quality improvement

# Summary of Concerns (QIOs)

- Specific outcomes not clearly defined
- Competition
- Accountability for poor performance
- Variable efficiency (contractor to contractor)
- Geographic variation

# CMS Responses (QIOs)

- Clear and specific metrics
  - Evidence-based: both metrics and interventions
  - Quarterly monitoring for progress
  - 18 month and 28 month major checkpoints
    - Can redirect contract at 18 months if not achieving goals
- Competition
  - Some tasks subnational, not all QIOs obtain a contract
  - Non-QIOs can compete for some contracts
- Governance and Conflict of Interest specifics part of the contract
- CMS oversight markedly strengthened
  - Management information system is operational

# CMS Responses (2)

- Some of case review functions reassigned to outside the QIO program
- Occurs in context of broader “Medicare Contractor Reform” (A/B MACs)
- Targeted technical assistance introduced to focus QIOs on providers with the most opportunities for improvement

**How will we respond to these  
issues in the ESRD NW  
Program?**

**As the health care system  
changes, how will the  
role(s) of the networks  
adapt?**

# ESRD NW Re-design

- Process
- Context
- Guiding Principles
- Data
- Practical Aspects

# ESRD NW Re-design: Process

- Educational sessions, data gathering (“as-is”)
- Environmental Scan
- Stakeholder input (what “could-be”)
- Analysis of Findings: Synthesis
- Recommendation Plan
- Check with Stakeholder Communities again
- Using Principles, Develop Contract
- Complete “clearance & funding” process
- Procurement Phase

# ESRD NW Re-design: Context

- Re-design for greater efficiency, higher performance
- Changing administration
- Changing Congressional priorities
  - MIPPA Section 153 (2008)
- New Conditions for Coverage
- Bundled Payment, P4P, CROWN-Web
- Change in National & Federal Economic Conditions
- OMB/HHS/SFC experience with QIO Re-design
- New GAO mandates (MIPPA 153d)
- CMS Health Disparities Forum
- ARRA (2009) attention to Preventive Health

# ESRD NW Re-design: Guiding Principles

- Increase Competition
- Demonstrate Value
- Demonstrate Attribution
- Improve Dissemination and Coordination of a Quality Improvement Culture
- Improve CMS Oversight
- Contribute to Improved Outcomes

# ESRD NW Re-design: Data

- Patient Education and Self-Empowerment
- Access to Care
- Physical Environment
- Quality Measures
- Grievances/Complaints
- Involuntary Discharge
- Disparities
- ESRD NWs: Role & Customers
- Role of Special Projects

# Stakeholder Data

- *Patient Education & Self-Empowerment*
  - IOM quality dimension: “Pt-Centeredness”
  - Emphasis on self-care
  - Emphasis on Chronic Disease Self Management (CDSMP for ESRD, diabetes, CAD/CHF, hypertension)
  - Emphasis on Vocational Rehab, if desired
    - (better data, e.g., on number of shifts after 5pm)

# Stakeholder Data

- Access to Care
  - IOM quality dimension: Timeliness/Equity
  - Overnight dialysis
  - Multi-modality access
  - More frequent dialysis
  - Transportation
- Physical Environment
  - IOM: Pt-centeredness
  - Comfort: temperature
  - Equipment
  - space

# Stakeholder Data

- Quality Measures
  - 3 measures in MIPPA
  - CPMs increase from 17 to 26 (2008)
  - IOM Category: Effectiveness, Safety, Efficiency
  - Many new suggested measure topics:  
Nutrition, vaccination, medication, lipids, bone/mineral metabolism, HgbA1c, hypertension, diabetes, sleep/insomnia, amputation, infection

# Stakeholder Data

- *Grievances/Complaints*
  - System itself needs re-design (like QIOs)
  - Need better data, standardized data
  - ESRD CAHPS
- *Involuntary Discharge*
  - Impact on CROWN-Web?
  - If younger population, employment concerns an issue

# Stakeholder Data

- *Disparities in Health Care*
  - Widespread Issue, in all settings
  - Exist even before pts enter ESRD
  - Physician Community is an important part of the solution, but not the only part (CLAS)
  - Education and Health Literacy is important
  - Rural / Inner City: important environments
  - CMS Health Care Disparities Forum

# Stakeholder Data

- ESRD NWs: Role? “Customers”?
  - Who do the NWs “work for”?
    - Pt-centeredness = the patient
    - Practical realities = the facility
    - Business sense = CMS
  - Lack of awareness/knowledge about the Program
  - ? Care Coordination / ? Care Transitions
  - Access / Transportation
  - True value requires real-time data access
- Special Projects
  - Do they add value?
  - Concept of “centralized functions”: NCC, IT support, annual meeting

# Attribution of Effect

- Forum Definition: “correlating or associating an outcome with an intervention”
- Interventions, and ultimate goals, are key to designing a system of attribution
- Interventions need to be evidence based
- The ultimate goal is to help the beneficiary

# Example from 9<sup>th</sup> SoW: Care Transitions Theme

- See Jencks, Williams, Coleman.  
“Rehospitalizations among Patients in the Medicare Fee-for-Service Program”.  
NEJM 360(14): 1418-28; 2 April 2009
- Studied 11.9M hospital discharges in 2003-2004. Of these, 19.6% were re-admitted within 30d.
- QIO “Care Transitions” Theme attempts to address this issue (subnational 7.2)

# Care Transitions Example

- Possible causes:
  - Not seeing a physician after discharge (50%)
  - Incomplete understanding, or misunderstanding, of discharge medications
  - Inadequate follow up arrangements
  - Poor health literacy / understanding of chronic disease
  - No emergency plan
  - Unrecognized cognitive impairment
  - No “medical home”

# Evidence-Based Interventions

- For each cause, there are evidence-based interventions (see Coleman, et al.)
- QIOs are charged with organizing a community coalition of providers willing to work to implement evidence-based interventions
- “Structural Measures” are tracked
- QIOs are held accountable for Outcome results (measure O-4).
- The Medicare Program is paying for good outcomes, not adequate structure.

# Attribution of Effect

- Just like QIOs, NWs cannot work with every provider (not enough resources)
- Provides opportunity to compare an “intervention group” with a “comparison group”
- Raises issues of “case-mix adjustment”
- HHS/OHRP has ruled that most such projects do not require IRB approval  
(see: [www.hhs.gov/ohrp/qualityfaq.html](http://www.hhs.gov/ohrp/qualityfaq.html))

# Attribution: NW Forum Draft

1. RCTs are impractical
2. Assessment of “change readiness”
3. Structural Measures
4. Survey of “provider perception and satisfaction”
5. “generalized, linear, hierarchical models”

# Example of “Value-Proposition”

- **By the end of the three year contract period, the evidence will show that QIO projects have resulted in:**
  - **18,000 more pneumococcal vaccinations**
  - **39,000 less pressure ulcers**
  - **10,000 more beneficiaries with recommended screening for colon cancer**
  - **6,000 more minority diabetics with proper diabetes treatment**
  - **Reduction of 2,500 unnecessary acute care hospitalizations**

# The Environment is Shifting

- Pay For Performance
- Bundled Payment
- Increasing importance and prevalence of “vulnerable populations”
- Increasing concern about the unintended consequences of restructured payment on “undercapitalized” providers
- Attention to “benchmark performance” of providers on measures of quality

# ESRD NW Re-design: Practical Aspects

- A formal report is being prepared
- The report will be approved, as a re-design report, by CMS
- The report will make specific recommendations for change
- The report will be shared with stakeholders, comments will be accepted
- The final report will form the basis for the creation of the next contract
- Usual Procurement Regulations will apply to this phase

# SUMMARY

- The ESRD Program is an important and growing part of Medicare
- Many changes are underway, both in ESRD, but also in health care in general
  - MIPPA 153a, 153b, 153c
  - Implementation of new CoCoverage
  - CROWN Web Implementation
  - Dialysis Facility Compare and public reporting
- The Network Program will play a vital role in all of this system change
- CMS is committed to keeping communication open during this time of change

**QUESTIONS?**