Aligning Payment Systems with High-Quality Care in ESRD

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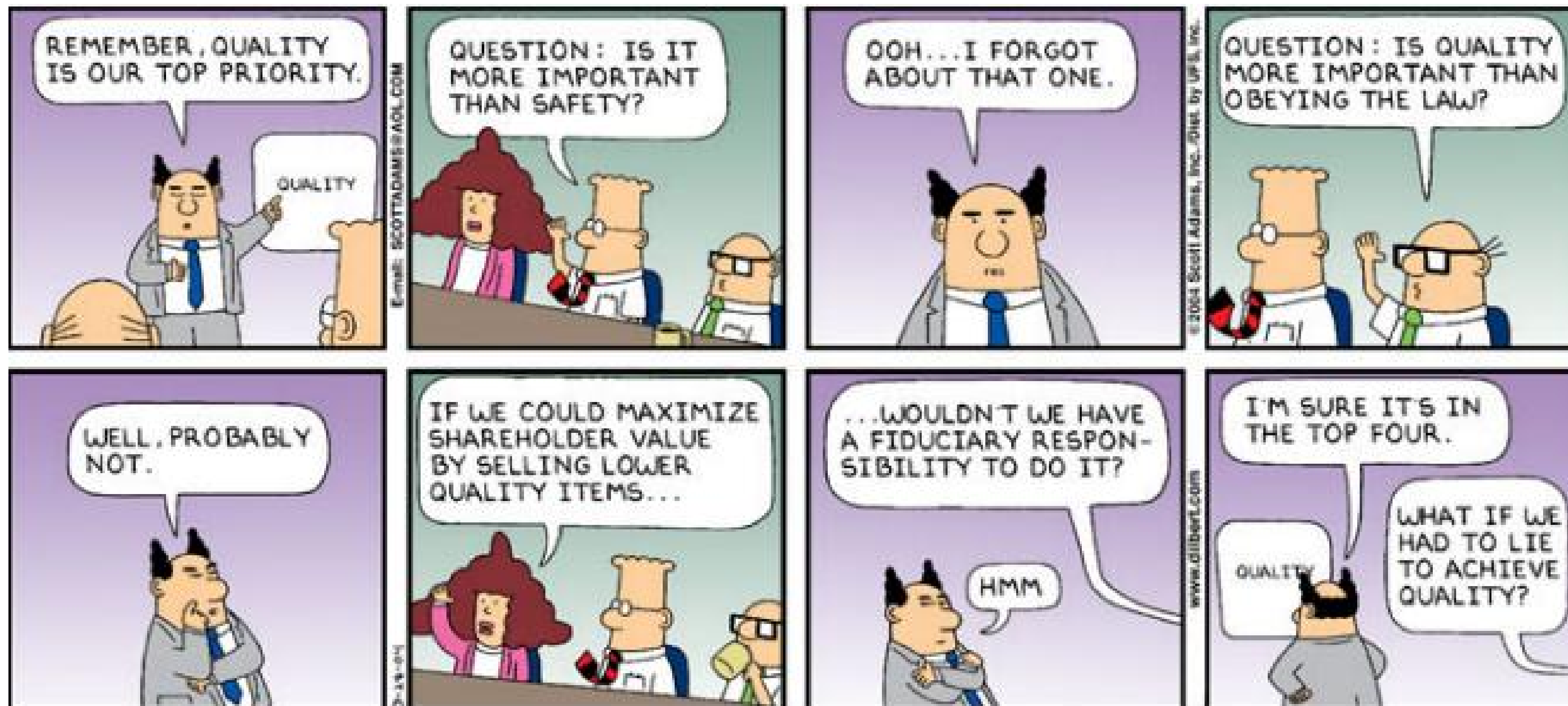
Dilbert System Change

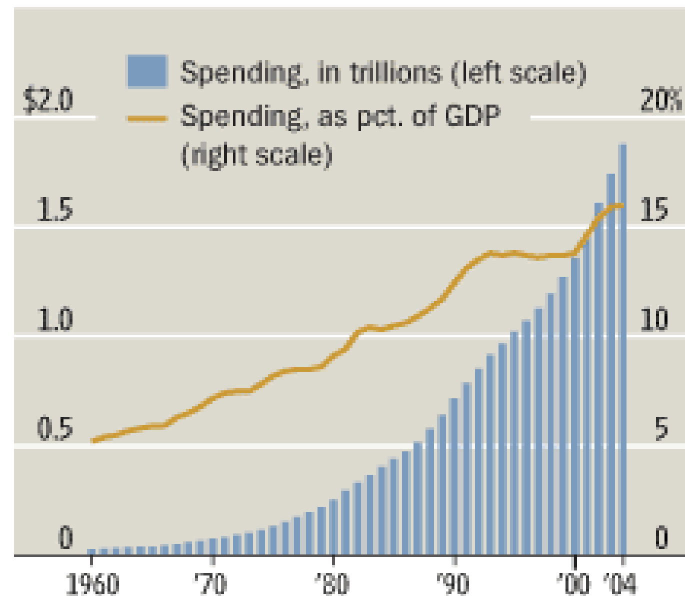


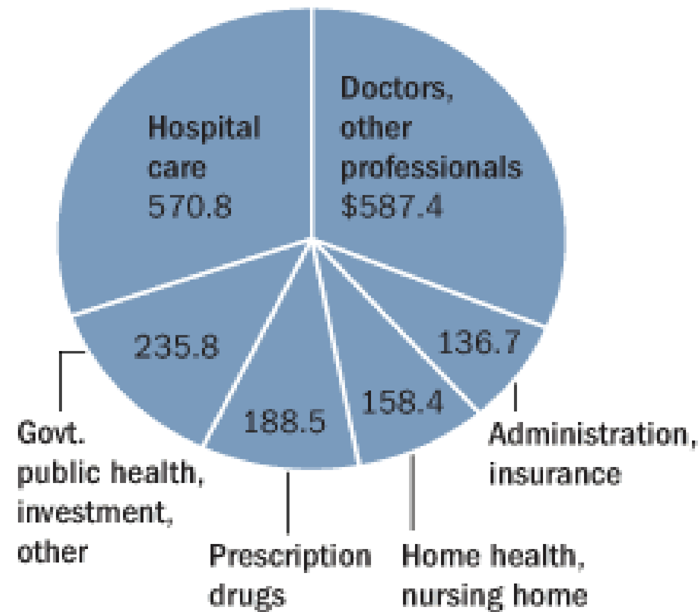
…is quality really our top priority?

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

What we know…

Health-Care Spending, American-Style





Source: Centers for Medicare & Medicaid Services

By 2014, total health spending is projected to constitute 18.7% of gross domestic product, from 15.3% in 2003. (CMS, 2005)

What we know…

U.S. Health Care Spending In An International Context

Why is U.S. spending so high, and can we afford it?

by Uwe E. Reinhardt, Peter S. Hussey, and Gerard F. Anderson

ABSTRACT: Using the most recent data on health spending published by the Organization for Economic Cooperation and Development (OECD), we explore reasons why U.S. health spending towers over that of other countries with much older populations. Prominent among the reasons are higher U.S. per capita gross domestic product (GDP) as well as a highly complex and fragmented payment system that weakens the demand side of the health sector and entails high administrative costs. We examine the economic burden that health spending places on the U.S. economy. We comment on attempts by U.S. policymakers to increase the prices foreign health systems pay for U.S. prescription drugs.

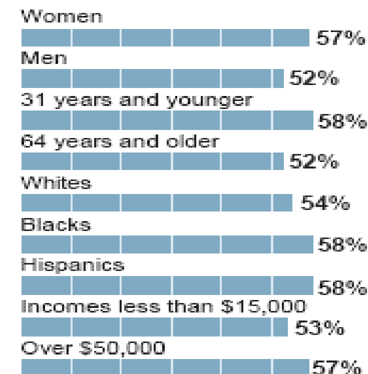
What we know…

U.S. health care mediocre across the board

Rich or poor, black or white, Americans get equally shoddy treatment

Associated Press (March 15, 2006)

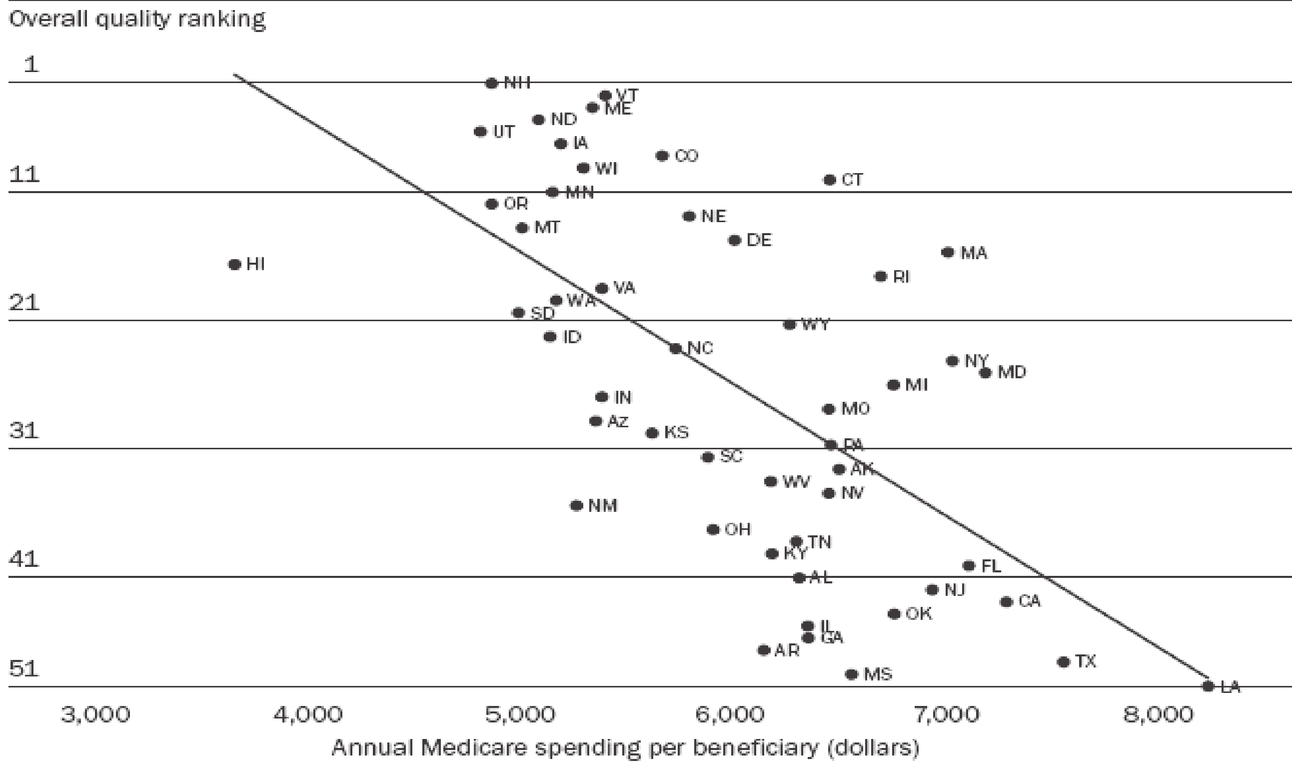
"Overall, patients received only 55 percent of recommended steps for top-quality care — and no group did much better or worse than that."



What we know…

EXHIBIT 1

Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001



SOURCES: Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.
NOTE: For quality ranking, smaller values equal higher quality.

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What we know…

Health care quality is improving but the quality chasm is still very wide and more money for more services is not the solution…

"You can always count on Americans to do the right thing - after they've tried everything else." Winston Churchill

…but more money for the *right* services will help accelerate improvement.

Paying For Performance: Medicare Should Lead

We the undersigned are united in our belief that a unique opportunity now exists to address the crisis of quality facing the nation's health system. The human and financial costs of medical error and substandard care have been exhaustively documented. A robust inventory of measures and standards for quality improvement has been developed and continues to grow. The strategic concept of paying for performance—a bedrock principle in most industries—has begun to emerge in health care in a variety of experiments in both the private and public sectors. But further progress is by no means assured.

Despite a few initial successes, the inertia of the health system could easily overwhelm nascent efforts to raise average performance levels out of mediocrity. At issue is not the dedication of health professionals but the lack of systems—including information systems—that reduce error and reinforce best practices, as such systems do in other industries such as aviation and nuclear power. We have concluded that such systematic changes will not come forth quickly enough unless strong financial incentives are offered to get the attention of managers and governing boards. As the biggest purchaser in the system, the Medicare program should take the lead in this regard. Decisive change will occur only when Medicare, with the full support of the administration and Congress, creates financial incentives that promote pursuit of improved quality.

Quality is not an issue for partisanship. Nor, in urging that Medicare take a leading role, are we suggesting that such an initiative be dominated by government. Indeed, both private payers and public agencies have made important strides in recent years in tackling the quality challenge. The National Committee for Quality Assurance has promulgated widely used performance indicators for health plans. The National Quality Forum has brought public and private payers together with consumers, researchers, and clinicians to broaden consensus on performance measures and best practices for a growing portfolio of health care settings, conditions, and treatments. The Agency for Healthcare Research and Quality (AHRQ) has established itself as an honest broker of evidence-based treatment standards. The self-insured employers in the Leapfrog Group have moved boldly to tie provider payment to selected performance indicators; and many insurers, health plans, and provider systems are testing new disease management models and other approaches that tie payment to performance.

The Centers for Medicare and Medicaid Services (CMS) has taken significant steps toward a quality strategy based on quality measurement and incentives. The agency's publication of performance data on nursing homes and home health agencies has heightened public awareness of the value of information on quality

November/December 2005

Current Climate

- Public sector interest
  - Both at national and state levels
- Private sector initiatives
  - Leapfrog group
  - Private insurers
- MedPAC reports
- IOM reports
- International comparisons
  - NHS P4P for primary care since 2003

Mark McClellan, M.D., Ph.D.

Problem

- "…physicians who want to improve quality of care find that Medicare's payment systems often do not provide them with the resources or flexibility needed to do so."

Testimony to House Committee on Ways and Means (Jul 21, 2005)

Mark McClellan, M.D., Ph.D.

Solution

- " Linking a portion of Medicare payments to valid measures of quality and effective use of resources would give physicians more direct incentives to implement the innovative ideas and approaches that actually result in improvements…"

Testimony to House Committee on Ways and Means (Jul 21, 2005)

CMS Quality Vision

- Provide leadership in improving health care
- The right care for every person every time
- Safe, effective, timely, patient-centered, efficient and equitable (IOM recommendations)
- Partnerships are key

CMS Quality Council (CQC)

- CMS Quality Council is charged with leading efforts to achieve the Quality Vision
- Council Structure
  - Chair: CMS Administrator
  - Members: Senior management and staff
- Six quality council forums

CMS Quality Roadmap

VISION: *The right care for every person every time.*

AIMS: *Make care safe, effective, efficient, patient-centered, timely, and equitable.*

CMS is focusing on emerging opportunities because its size and broad impact make it a public health agency.

CMS intends to…achieve the quality aims through a set of system strategies linked to specific, clear steps to achieve transformational improvements in health care.

CMS System Strategies

- Work through partnerships
- Publish quality measurements and information
- Pay in a way that expresses our commitment to supporting providers and practitioners for doing the right thing
- Assist practitioners and providers
- Become an active partner in driving the creation and use of information about the effectiveness of healthcare technologies

CMS P4P Strategy

- Focus (five major settings)
  - Physician offices, hospitals, nursing homes, home health and dialysis facilities
- Framework
  - Organize Short-term Efforts, Patient Centered, and Long Term Approach Desirable
- Five Steps
  - Quality and Performance, Data Infrastructure, Payment System and Mechanics, Validation, and Value

Issues to Consider

- Vehicles for encouraging quality
  – Information collection
  – Information dissemination
  – Financial rewards
  (provide incentives, remove hindrances)

Issues to Consider

- What to Reward
  - Relative quality
  - Absolute threshold
  - Improvement
- How to Finance Incentives
  - Across-the-board reduction to create pool
  - Offsetting penalties
  - Offsetting savings

CMS P4P Demonstrations

- Premier Hospital Quality Incentive Demo.
- Medicaid/SCHIP demonstrations
- Physician Group Practice Demonstration
- Section 649 MCMP Demonstration
- Nursing Home P4P Demonstration
- Section 646 Medicare Health Care Quality Demo.
- Medicare Health Support Pilot
- Home Health P4P Demo.

CMS P4P Demos in CKD

- ESRD Managed Care Demonstration
- ESRD Disease Management Demo.
- ESRD Bundled Payment Demonstration
- Care Management for High Cost Beneficiaries Demonstration

Next Steps

- Design, for each major setting, modifications to payment systems that encourage the right care and modify them as laws allow.
  - Deficit Reduction Act of 2005: increases payment incentive for hospitals
- Create and maintain equitable partnerships.
  - White Paper
- Collection and Public reporting of performance data regarding the 5 settings related to P4P.
- Promote data exchange and the use of effective electronic health record systems

Conclusion

- Medicare increasing focus on quality
- P4P is here to stay - widespread support
- Multiple demonstration projects underway / in development
- Early results confirm improved quality outcomes using P4P
- P4P creates value

"We are seeing that pay-for-performance works. We are seeing increased quality of care for patients, which will mean fewer costly complications – exactly what we should be paying for in Medicare."

Mark B. McClellan, MD, PhD

CMS Administrator