

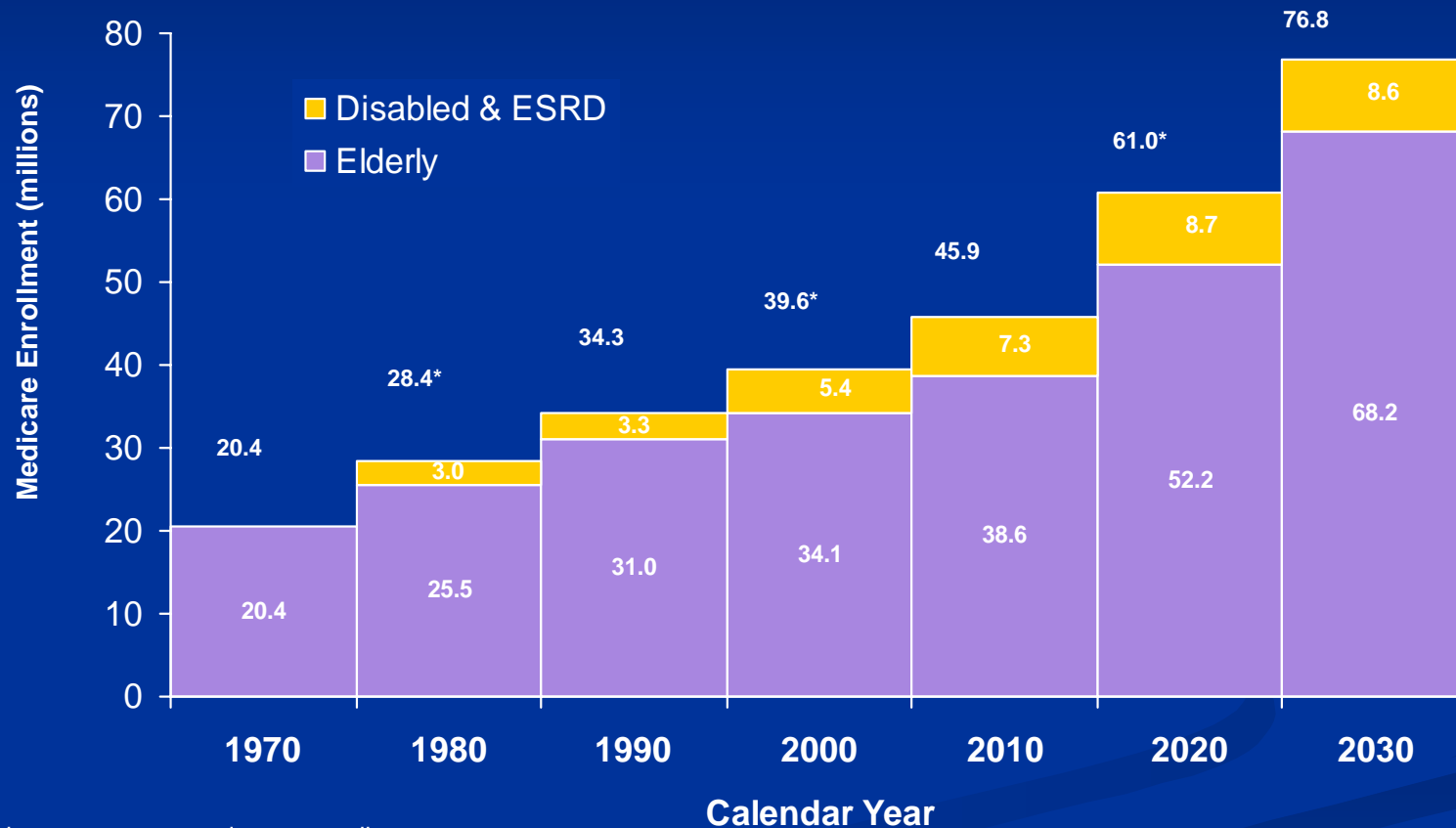
***Strategies Today for  
Superior Health Care  
Tomorrow***

**Trent T. Haywood, MD, JD**  
**Deputy Chief Medical Officer**

**CMS**

## Table 3.6 Number of Medicare Beneficiaries, 1970-2030

*The number of people Medicare serves will nearly double by 2030.*



\* Numbers may not sum due to rounding.

Source: CMS, Office of the Actuary.

CHAPTER TWO

## How Well do Health Systems Perform?

Better health is unquestionably the primary goal of a health system. But because health care can be catastrophically costly and the need for it unpredictable, mechanisms for sharing risk and providing financial protection are important. A second goal of health systems is therefore fairness in financial contribution. A third goal – responsiveness to people's expectations in regard to non-health matters – reflects the importance of respecting people's dignity, autonomy and the confidentiality of information. WHO has engaged in a major exercise to obtain and analyse data in order to assess how far health systems in WHO Member States are achieving these goals for which they should be accountable, and how efficiently they are using their resources in doing so. By focusing on a few universal functions that health systems undertake, this report provides an evidence base to assist policy-makers improve health system performance.

Member State	ATTAINMENT OF GOALS						Health expenditure per capita in international dollars	PERFORMANCE	
	Health		Responsiveness		Fairness in financial contribution	Overall goal attainment		On level of health	Overall health system performance
	Level (DALE)	Distribution	Level	Distribution					
Syrian Arab Republic	114	107	69 – 72	79 – 81	142 – 143	112	119	91	108
Tajikistan	120	124	125	136	112 – 113	127	126	145	154
Thailand	99	74	33	50 – 52	128 – 130	57	64	102	47
The former Yugoslav Republic of Macedonia	64	85	111	95	116 – 120	89	106	69	89
Togo	159	170	155	162	152	156	180	159	152
Tonga	75	84	61	97	108 – 111	85	73	114	116
Trinidad and Tobago	57	75	141	108 – 109	69	56	65	79	67
Tunisia	90	114	94	60 – 61	108 – 111	77	79	46	52
Turkey	73	109	93	66	49 – 50	96	82	33	70
Turkmenistan	128	131	88 – 89	113	121	130	128	152	153
Tuvalu	119	116	132 – 135	153 – 155	26 – 29	120	151	128	136
Uganda	186	138	187 – 188	165	128 – 130	162	168	179	149
Ukraine	70	47	96	63 – 64	140 – 141	60	111	101	79
United Arab Emirates	50	62	30	1	20 – 22	44	35	16	27
United Kingdom	14	2	26 – 27	3 – 38	8 – 11	9	26	24	18
United Republic of Tanzania	176	172	157 – 160	150	48	158	174	180	156
United States of America	24	32	1	3 – 38	54 – 55	15	1	72	37
Uruguay	37	68	41	53 – 57	35 – 36	50	33	50	65
Uzbekistan	100	144	105 – 107	71	131 – 133	109	120	112	117
Vanuatu	135	127	127	132	62 – 63	134	132	120	127
Venezuela, Bolivarian Republic of	52	76	69 – 72	92	98	65	68	29	54
Viet Nam	116	104	51	121	187	140	147	130	160
Yemen	141	165	180	189	135	146	182	82	120
Yugoslavia	46	90	115 – 117	116	158	95	113	47	106
Zambia	188	171	132 – 135	171	155	174	148	190	182
Zimbabwe	184	98	122	166 – 167	175	147	110	191	155

Source: Annex Tables 5–10.

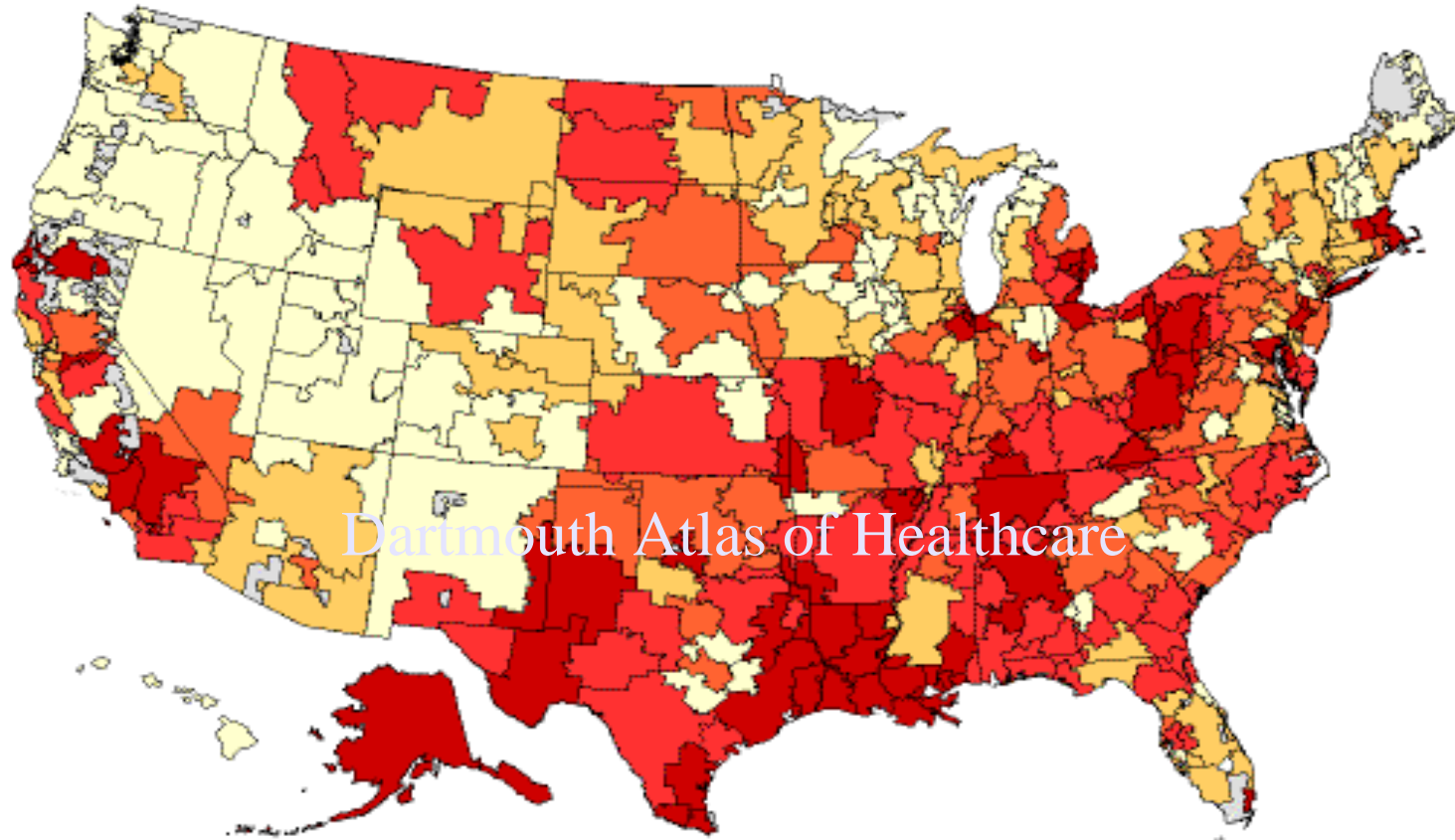
# Another Payment Problem

## TOTAL MEDICARE PAYMENTS FOR PQI HOSPITALIZATIONS, 1995 AND 2001

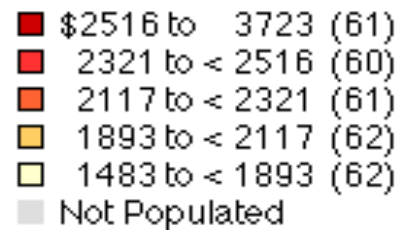
	Year 2001 Payments	5% Saving	10% Saving	20% Saving
CONGESTIVE HEART FAILURE	3,829,131,296	191,456,565	382,913,130	765,826,259
BACTERIAL PNEUMONIA	3,083,086,363	154,154,318	308,308,636	616,617,273
COPD	1,767,023,938	88,351,197	176,702,394	353,404,788
DIABETES LONG TERM COMPLICATION	947,957,162	47,397,858	94,795,716	189,591,432
URINARY INFECTION	869,616,059	43,480,803	86,961,606	173,923,212
DEHYDRATION	755,833,815	37,791,691	75,583,382	151,166,763
LOWER EXTREMITY AMPUTATION	643,469,317	32,173,466	64,346,932	128,693,863
ADULT ASTHMA	308,802,016	15,440,101	30,880,202	61,760,403
PERFORATED APPENDIX	129,726,461	6,486,323	12,972,646	25,945,292
ANGINA	120,711,633	6,035,582	12,071,163	24,142,327
HYPERTENSION	120,096,630	6,004,832	12,009,663	24,019,326
DIABETES SHORT TERM COMPLICATION	109,323,970	5,466,199	10,932,397	21,864,794
DIABETES UNCONTROLLED	77,422,587	3,871,129	7,742,259	15,484,517
<b>Total</b>	<b>12,762,201,247</b>	<b>638,110,062</b>	<b>1,276,220,125</b>	<b>2,552,440,249</b>

Notes: Includes hospitalizations among FFS Medicare beneficiaries for AHRQ PQI measures. Dollars are nominal dollars.

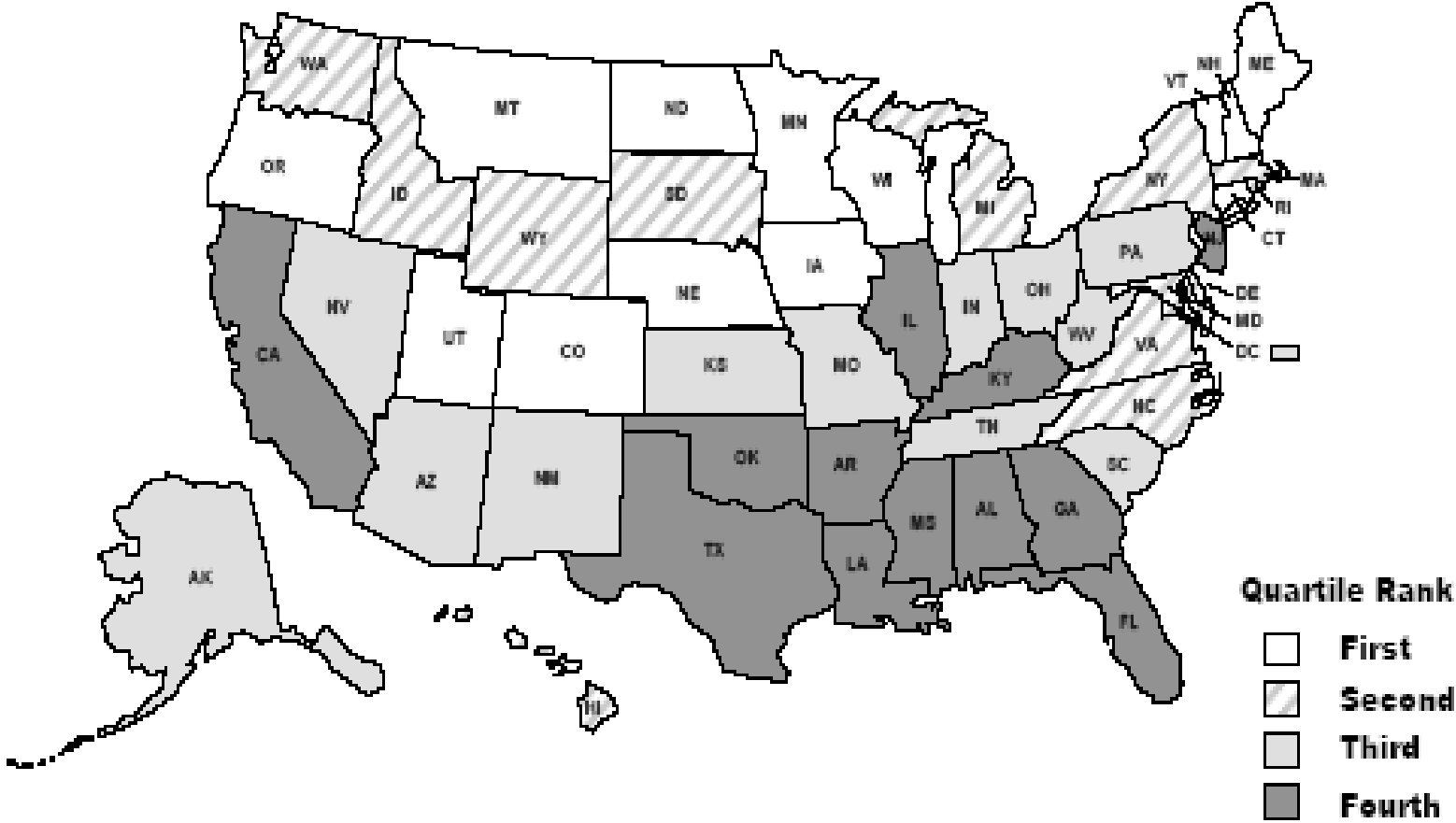
# A Variation Problem



**Map 2.5. Inpatient Hospital Services per Medicare Enrollee  
by Hospital Referral Region (1995)**



# Performance on Medicare Quality Indicators, 2000-2001



Source: S. F. Jencks, E. D. Huff, and T. Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001," *Journal of the American Medical Association* 289 (Jan. 15, 2003): 305-312.

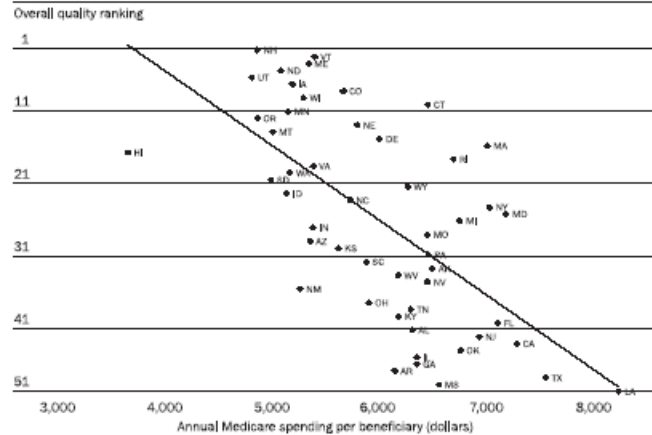
## Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Care

Areas with a high concentration of specialists also show higher spending and less use of high-quality, effective care.

by Katherine Baicker and Amitabh Chandra

**ABSTRACT:** The quality of care received by Medicare beneficiaries varies across areas. We find that states with higher Medicare spending have lower-quality care. This negative relationship may be driven by the use of intensive, costly care that crowds out the use of more effective care. One mechanism for this trade-off may be the mix of the provider workforce: States with more general practitioners use more effective care and have lower spending, while those with more specialists have higher costs and lower quality. Improving the quality of beneficiaries' care could be accomplished with more effective use of existing dollars.

**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.

CHAPTER 2

Quality of care for Medicare beneficiaries

CHAPTER 4

Strategies to improve care: Pay for performance and information technology

Strategies to improve care: Pay for performance and information technology

**M**edicare payment systems are neutral and sometimes negative toward quality. The Congress should adopt pay-for-performance programs for hospitals, home health agencies, and physicians.

We earlier recommended pay-for-performance programs for Medicare Advantage plans and dialysis providers. The amount of payment should be small at first, but increase over time. Quality measurement can begin for hospitals—with process, structural, and outcomes measures; for home health agencies—with outcomes measures; and for physicians—with structural and, after a transition, process measures. We recommend several approaches to broaden measure sets for these programs, including reporting lab values. The measure sets should evolve over time. To accelerate adoption of information technology (IT), pay-for-performance programs should include measures of quality-enhancing activities supported by IT. A standard vocabulary to report lab values would increase electronic sharing of clinical data.

In this chapter

- Pay for performance in Medicare
- Hospitals
- Home health agencies
- Physicians
- Implementation issues
- Accelerate adoption of health information technology
- Provide financial incentives
- Help providers navigate the IT market and implement systems
- Promote sharing of information across providers and patients



## NEWS RELEASE

12:01 a.m.,  
Friday, May 13, 2005

For further information, contact:  
Mary Mahon: (212) 606-3853 / [mm@cmwf.org](mailto:mm@cmwf.org)  
cell phone (917) 225-2314  
Kari Root: (301) 652-1558, ext. 112

### HEALTH CARE LEADERS: PAY-FOR-PERFORMANCE MOST EFFECTIVE WAY TO REDUCE HEALTH CARE COSTS

Disease Management for High-Cost Conditions, Primary Care Case Management  
Best Ways to Reduce Unnecessary Care

*Shifting More Costs to Patients Seen as Least Effective Way to Cut Unneeded Services*

#### HOW EFFECTIVE DO YOU THINK EACH OF THESE POSSIBLE ACTIONS WOULD BE TO REDUCE HEALTH CARE COSTS?

(Percent saying extremely or very effective)

Reward more efficient and high-quality medical-care providers	57%
Improve disease management and primary care case management	56%
Use evidence-based guidelines to determine when a test or procedure should be done	52%
Expand the use of information technology	46%
Have all payers, including private insurers, Medicare, and Medicaid, adopt common payment methods and rates	44%
Have patients pay a substantially higher share of their health care costs	31%

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

**Winston Churchill**

# CMS Quality Roadmap

- **VISION:** *The right care for every person every time*
  - *Make care:*
    - *Safe*
    - *Effective*
    - *Efficient*
    - *Patient-centered*
    - *Timely*
    - *Equitable*

# CMS Quality Roadmap: Strategies

1. Work through partnerships to achieve specific quality goals
2. Publish quality measurements and information as a basis for supporting more effective quality improvement efforts
3. Pay in a way that expresses our commitment to quality, and that helps providers and patients to take steps to improve health and avoid unnecessary costs

# CMS Quality Roadmap: Strategies for QI

4. Assist practitioners in making care more effective and less costly, especially by promoting the adoption of HIT
5. Bring effective new treatments to patients more rapidly and help develop better evidence so that doctors and patients can use medical technologies and treatments more effectively, improve quality and avoid unnecessary complications and costs

# CMS Quality Initiative Components

- Broad National Quality Alliances
- Quality data collection & public reporting
  - Medicare.gov Compare websites
- Linking payment to quality: Pay-for-Performance (P4P)
- Multiple Demonstrations
  - Physician-patient partnerships
  - Physician group practices and integrated delivery systems
  - Chronic illness management, prevention
  - High Cost Beneficiaries, Special Needs populations
  - Efficiency and value through coordinated care
  - New payment models: P4P, Value-based purchasing, gainsharing
  - HIT adoption and use, practice redesign
  - Evidence-based medicine decisions and processes

# Congressional & Payment Reform

- Many opportunities for improving the quality of healthcare services, outcomes and efficiency
- Increasing reimbursement for healthcare services leads to:
  - No uniform or widespread improvement in quality
  - Increased utilization of some services
  - Net increase in overall healthcare expenditures
- Congress looking to CMS and healthcare providers to demonstrate ability to improve quality, avoid unnecessary complications and costs
  - Overall Medicare payment reform contingent linked

# ESRD Conditions for Coverage

- Current conditions not revised in their entirety since 1976
- Applicable to 4,700 Medicare-approved dialysis facilities
  - 325,000 patients with ESRD treated with dialysis
- NPRM on display February 4, 2005, followed by 90 day comment period

# ESRD Conditions for Coverage

- Patient-centered rule
  - Reflects current clinical & scientific advances in dialysis technology and standard care practices
  - Includes clinical practice guidelines developed by the National Kidney Foundation's Kidney Disease Outcomes Quality Initiative (NKF-K/DOQI)
- Must be integrated and align with OPO and Transplant Center Conditions for Coverage
- Currently all three NPRMs are undergoing comment reviews and rewrites for final rule publication

# ESRD CfCs: New Components

- Patient Safety
  - Incorporation of current CDC infection control guidelines
  - Incorporation of current Association for the Advancement of Medical Instrumentation (AAMI) guidelines for water quality and hemodialyzer reuse
  - Additional patient safety protections such as defibrillators in the emergency equipment list and updated fire safety code provisions
  - Additional patient rights, such as advance directives, 30 day notice to involuntary discharge, posting of external grievance mechanisms, and an internal patient grievance process

# ESRD CfCs: New Components

## ■ Preamble

- Detailed discussion regarding the possible use of minimum facility-wide standards
- Request for public comment regarding whether to immediately adopt certain widely-accepted NKF-K/DOQI clinical practice guidelines as minimum facility-wide standards
- Discussion and request for public comment on issue of how care and services should be provided to hemodialysis patients in nursing homes,

# ESRD CoCs: Public Comments

370 total Commenters

2700 total comments

## Organizations

- ANNA
- LDOs
- NKF
- RPA
- ASN
- KCP
- NRRA
- AKF
- AAKP
- Many others

## Professionals

- 53 Social Workers
- 42 Pharmacists
- 24 Dietitians/Nutritionists
- 22 Nurses
- 18 Physicians
- 12 ESRD Networks
- 8 States

# ESRD CoCs: Public Comments

- Many commenters support a proactive approach to patient care as embodied in the proposed QAPI requirement
- Significant concern and anxiety about proposals for regulating dialysis in nursing facilities
  - Dialysis providers
  - Long term care facilities and Hospital-based SNFs
- Final rule must be published on or before 2/7/2008 under MMA; Target: March 23, 2007

# ESRD Bundled Payment Demo: Statutory Background

- Current Policy
  - Composite Rate with basic case mix adjustment
  - Separately billed services under fee-for-service
- MMA §623(e): Demonstration of
  - A ‘fully case-mix adjusted’ payment system
  - An expanded bundle including drugs and biologicals
  - Related laboratory tests

# ESRD Bundled Payment Demonstration

- 2005 Advisory Board input
  - Substantial P4P component recommended
  - Better alignment of incentives among facilities, physicians, other providers/suppliers
  - Modality & home therapy issues should be addressed
    - Financial incentives should not favor in-center hemodialysis
  - Limited availability of data and analytic methods to account for variation in the use of separately billed drugs and other services
  - Recommended that any prospective payment method employ a measure of prior use as a case mix adjuster

# ESRD Bundled Payment Demonstration

- Solicitation for demo being developed will likely include
  - Bundled payment component
  - P4P component
- Demonstration onset delayed

# ESRD 2005 CPM Project

<u>Measure</u>	<u>2004 Results</u>	<u>2005 Results</u>
% Adult HD Pts with mean Kt/V $\geq 1.2$	91%	91%
% Adult HD Pts with mean Hb $\geq 11$ gm/dl	80%	83%
% Prevalent Adult HD Pts with AVF	35%	39%
% Incident Adult HD Pts with AVF	35%	37%
% Adult HD Pts Serum Albumin $\geq 4.0/3.7$ gm/dl	81%	82%

# CKD/ESRD Medication Measures

- Medicare Prescription Drug Benefit implemented!
- Draft set of candidate CKD/ESRD Medication Measures on December 28th for CMS review
- CKD/ESRD Medication Measures Technical Expert Panel Meeting was held January 26th-27th in Baltimore
- Draft TEP Summary Report including TEP feedback on February 17th with CMS review and comments returned on March 10th
- TEP Summary Report being revised and as well as a CKD/ESRD Medication Measures Input Document that will contain a revised list of candidate measures
- Web posting mid-May, 2006
  - Public comment period

# In-Center Hemodialysis CAHPS

- Currently available for facilities that want to use it
- Core survey
  - Nephrologist(s)
  - Dialysis center and staff
  - Treatment
- Supplemental items
  - Quality improvement
- Feedback & Pilot projects
- AHRQ contact: [cdarby@ahrq.hhs.gov](mailto:cdarby@ahrq.hhs.gov)

# Contact Information

Barry M. Straube, M.D.

Acting Chief Medical Officer

Acting Director, Office of Clinical Standards & Quality

Centers for Medicare & Medicaid Services

7500 Security Boulevard

Baltimore, MD 21244

Email: [Barry.Straube@cms.hhs.gov](mailto:Barry.Straube@cms.hhs.gov)

Phone: (410) 786-6841