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Commentary

HCFA’s Agenda For Promoting High-Quality Care
by William L. Roper and Glenn M. Hackbarth

Medicare is now in its third decade, and its focus has shifted with the passing years. The first decade focused on improving access to health care. “Cost containment” was the rallying cry of the second decade. Medicare’s third decade is destined, we believe, to focus on the quality of care and the closely related concept of “value.”

Like any prudent shopper, the Health Care Financing Administration (HCFA) wants to purchase value, the optimal mix of high quality and reasonable cost. To use Walter McClure’s phrase, HCFA seeks to “buy right,” not “buy cheap.” The quality and cost of health care services are as tightly intertwined as fibers of fine silk. HCFA must be, therefore, more than a payer of bills; it must also be a quality assurance agency. In Medicare’s third decade, we hope HCFA will go one step beyond quality assurance to quality promotion.

The Medicare program, which is managed by HCFA, has 31 million elderly and disabled beneficiaries. In 1988, Medicare will spend roughly $85 billion. Medicare’s size, almost 20 percent of U.S. health care spending, gives HCFA a strong lever to move the health care system.

In this Commentary, we describe how we would like to see HCFA’s quality assurance efforts evolve. We also discuss how HCFA’s release of hospital mortality information and research efforts fit this new agenda. Finally, we discuss the link between quality promotion and Medicare’s Private Health Plan Option (PHPO), HCFA’s most important effort to reform health care financing.

Defining And Improving Quality

Medicare currently uses a two-tiered quality assurance system. To care
for Medicare patients, providers must meet certain conditions of participation, which establish minimum requirements for facilities and personnel. HCFA and state agencies monitor compliance through a system of survey and certification.

The second tier comprises review of care provided to individual Medicare beneficiaries. This review is performed primarily by peer-review organizations (PROs). PROs, state-level organizations of physicians, help assure that services provided in individual encounters with the health care system meet professionally recognized standards. Medicare’s quality assurance system has made important contributions to the well-being of Medicare patients. We can—and must—do better, however. We must preserve the best of the current system while developing new techniques to promote quality care.

Most experts agree that Medicare’s quality assurance efforts—indeed, all quality assurance programs—should focus more on the outcome of care and less on the process. The problem is figuring out how to do it. Because outcomes are difficult to measure, quality assurance efforts have focused, by necessity, on what is done to patients, not for patients. In the jargon of computers, quality has traditionally been defined by “input,” not “output.”

Measuring outcomes is complicated by the often subjective character of the benefits of health care. It is difficult, for example, to measure how much a given service has reduced a patient’s pain. Measuring outcomes also requires patience. The results of therapy may not be evident for weeks, months, or even years. Focusing on outcomes also requires a change in mindset. Even good physicians and hospitals often fail to cure their patients. Providers and patients know, intellectually, that failures are inevitable, but both find it disquieting. The myth of the invincible physician is comforting to patient and physician alike. By measuring quality through the process of care, we preserve at least the theoretical possibility that every case can be “successful”—for the provider if not for the patient.

Changing the national mindset about quality will be difficult but not impossible. The performance of a hospital or physician should be measured like the performance of a major league hitter or NFL quarterback—using averages. Good providers may not cure every patient, but their “batting averages” will be higher. Some providers may, of course, have high averages for treating some types of patients and low averages for others. Stressing “batting averages” would help lay to rest the myth of provider invincibility, but high-quality providers probably would benefit. A public accustomed to thinking in terms of “batting averages” might be less prone to equate poor results with negligence.

Not all outcome measures, of course, need take the form of “batting averages.” Quality medicine requires caring for patients, not just curing
them. Since providers have more control over caring than curing, we should establish a stricter standard. Patient surveys might be used to develop an outcome-based measure of caring.

Increasing emphasis on outcomes has a corollary: we should focus less on monitoring discrete encounters with the health care system, for example, hospital admissions, and more on how illnesses are treated. A given illness may span several hospital admissions and require large amounts of outpatient care. The quality of care provided to a cancer patient, therefore, is not the sum of the quality provided during the patient's hospital admissions. The care provided in the hospital may be fine, but the overall quality, poor. For many serious illnesses, proper medical management can significantly reduce the need for hospitalization. Numerous “high-quality” hospitalizations could then be a sign of poor care, not good care.

The current focus on discrete encounters is, at least in part, a reflection of Medicare’s fee-for-service payment system and the fragmented nature of the health care delivery system—two phenomena that are themselves closely related. Providers generally assume medical and financial responsibility for only small units of care, not the complete range of services. This fragmentation of responsibility makes little medical or financial sense. Comprehensive-care organizations, which assume the medical and financial responsibility for providing the full range of services, are preferable. As we will discuss later, capitation-based payment systems encourage the development of such organizations.

A sound quality assurance program also should reward high-quality providers, not simply punish poor-quality providers. That is what we mean by “quality promotion.” The existing system emphasizes the elimination of “bad apples.” The implicit assumption seems to be that all other providers are more or less equal. Yet intuition and data tell us that quality is best seen as a spectrum running from poor to outstanding. Finally, HCFA’s current quality assurance system produces too little information, for providers and patients alike. Patients, in particular, have been neglected. One of HCFA’s most important goals should be to increase the volume and quality of information available to the public, thus permitting—and encouraging—patients to ask probing questions. The best approach would be to publish outcome measures, for example, risk-adjusted mortality rates or patient-satisfaction surveys. Such information is an essential part of any strategy to reward good performers.

Our call for changes in HCFA’s quality assurance system should not be misconstrued as a repudiation of past efforts. Improving our ability to monitor outcomes does not preclude monitoring of process. Nor does monitoring episodes of illness preclude monitoring of discrete encounters. Our goal is not to discard old tools but to refine and supplement them. We are, in short, seeking to improve the tools applied in Medi-
care’s two-tiered quality assurance system and to add a third tier: dissemination of quality-related information to providers and the public. Pursuing this agenda will not be easy. Many experts agree with our recommendations, but there is less consensus on how to implement a new, improved program. Much research and planning must occur before major changes are made in the existing system.

One essential step is to develop objective measures of quality. To be sure, this is a complex task, but there is substantial agreement in the research community on its feasibility, if not on the specifics of methodology. During 1986 and 1987, HCFA has studied carefully how to measure quality. We also have developed an aggressive agenda for future research. Although we have not yet developed perfect measures of quality, we have made important progress. The release of information on hospital mortality rates for Medicare patients is an important step.

### Hospital Mortality Information: Lessons Learned

December 17, 1987, HCFA released information for 1986 on deaths within thirty days of admission for the roughly 6,000 hospitals caring for Medicare patients. The release culminated more than a year’s effort, with important contributions coming from both the research and provider communities. HCFA released information on deaths among Medicare patients in sixteen diagnostic categories. The release was designed to address the question: What is the actual death rate for each hospital compared to what would have been expected for that particular hospital, given what we know of the characteristics of its patients?

The mortality information for each hospital was adjusted to account for some of the factors known to affect the probability of death. HCFA calculated a range of expected mortality for each hospital, taking into account previous hospital admissions, whether the patient was transferred, age, sex, and presence of up to eight comorbid conditions (cancer, cardiovascular disease, cerebral degeneration/psychosis, pulmonary disease, renal disease, liver disease, diabetes, and hypertension).

HCFA cautioned against using the mortality information as a direct measure of a given hospital’s quality. We also warned that our methodology was not appropriate for comparing the mortality rates of different hospitals. The release did, nevertheless, provide important information. Hospitals with actual mortality rates exceeding the expected range are more likely than others to have quality problems. Hospital administrators, physicians, PROS, and patients, therefore, can use the mortality information as a basis for making more detailed inquiries. Not all high-mortality hospitals, it should be emphasized, suffer from poor quality. Mortality rates are best used as a screening tool to help focus more detailed review of individual cases.
Organizations representing hospitals and physicians opposed HCFA’s releasing hospital mortality information. They argued, correctly, that HCFA’s analysis did not fully adjust for differences in patient severity of illness. They drew, however, an erroneous conclusion: that no information is better than imperfect information.

Voltaire wisely cautioned against making the best the enemy of the good. It is odd that health care organizations have fallen prey to that temptation. Physicians often use information that is less than perfect. They routinely collect information from a wide range of tests, none of which individually may lead to the precise diagnosis. Physicians even accept the inevitability of false positives and negatives. After reviewing the evidence, they reach a conclusion about the illness. To argue that mortality information should not be used until it is perfect is inconsistent with what physicians do every day.

The release of hospital mortality information is a significant step toward the quality promotion effort described earlier. Mortality statistics measure outcomes, not inputs. Moreover, mortality information acquaints the public with thinking in terms of “batting averages,” not only the results for individual patients. HCFA’s release of mortality information also highlights that some institutions do better than predicted; it therefore advances the cause of rewarding good providers, not just punishing the “bad apples.” Finally, releasing hospital mortality information stimulates the public’s interest in health care information.

We believe the release of hospital mortality information was a major success. Through careful attention to detail, both in methodology and communications, we were able to provide the public with appropriate and useful information. Because of this achievement, the release of such information is now institutionalized in HCFA. HCFA plans to release more and better information every year, eventually including information on physicians, nursing homes, health maintenance organizations (HMOs), and other providers. As in the case of hospital mortality statistics, we plan to proceed deliberately and after due consultation with the affected parties and experts.

**HCFA’s Quality Research Agenda**

HCFA devotes a large portion of its research budget to improving its ability to measure quality. Major investments also are being made in the agency’s data systems, which will improve HCFA’s ability to collect and synthesize information about quality. We expect to spend still more on both areas in future years. The Omnibus Budget Reconciliation Act of 1986 required the Secretary of the Department of Health and Human Services to “arrange for a study to design a strategy for reviewing and assessing the quality of care purchased by Medicare.” HCFA has signed a
cooperative agreement with the Institute of Medicine of the National Academy of Sciences to develop this strategy.

To help structure its agenda, HCFA sponsored a quality of care symposium in June 1987. We also have held smaller, less formal discussions on refining quality measures with health services researchers and representatives of providers and consumers. Based on these discussions, we have identified key issues for intensive research and development. In developing mortality statistics, HCFA will be studying ways to identify “preventable deaths,” as opposed to deaths in general. A critical part of this effort is improving our ability to adjust mortality statistics for differences in severity of illness. In 1988, we plan to develop instruments that will allow hospitals and PROs to adjust mortality rates for differences in the patient’s severity of illness at admission. Initially, we will concentrate on stroke, pneumonia, myocardial infarction, and congestive heart failure. These conditions account for almost a third of deaths among Medicare patients. Risk-adjustment tools are currently available (for example, the APACHE and MEDISGroups systems), but they have not been calibrated using nationally representative data.

HCFA also is exploring new outcome measures and quality indicators, including readmissions for the same condition and nosocomial infections. Similarly, we are studying how Medicare Part A and Part B data may be linked to identify certain outpatient services that may indicate poor-quality care in a previous hospital admission even where there is no death or readmission.

### Quality Enhancement Through Effectiveness

HCFA will be exploring steps to promote more effective treatment. Unlike quality assurance, which focuses primarily on benefit (or harm) to the patient, effectiveness relates to value, or the combination of quality and cost. Our goal is to assure that any given patient receives the maximum benefit in improved health for any given level of health care expenditure. Unlike cost/benefit analysis, effectiveness analysis does not address the question whether a given patient is “worth” the expenditure.

HCFA has only begun studying effectiveness, and we do not yet know what our role should be. A meeting with outside experts produced a lengthy list of suggestions including “consciousness raising,” creating an institutional home for analysis of effectiveness, funding randomized clinical trials, and establishing a federal repository for claims data useful in analyzing effectiveness. We have not yet decided which of these suggestions to pursue.

We will be cautious about expanding HCFA’s efforts in this area. If HCFA were to enforce “effectiveness” standards by denying payment, we would be criticized, no doubt, for “dictating the practice of medi-
cine.” We would prefer to avoid such controversy, particularly since there will inevitably be large areas of uncertainty. A sounder approach, in our view, would be to give physicians better information about what works. The vast majority of physicians are anxious to get such information and would gladly act on it. Payment denials remain an option, but they should be used as a last resort, not the first.

So long as the federal government remains an open-ended, fee-for-service insurer for the elderly and disabled, HCFA has an obligation to ensure that our beneficiaries—and the taxpayers—get the best value for the government’s money. Research suggests that a significant portion of the surgical procedures performed on Medicare beneficiaries are questionable, if not totally inappropriate. Moreover, the scientific basis for some well-established medical practices has been called into question. Given the medical and financial consequences of these problems, HCFA cannot afford to be passive.

Quality Promotion And The PHPO

Medicare’s Private Health Plan Option (PHPO) gives beneficiaries and providers an alternative to the traditional fee-for-service program. Under PHPO, the government makes a monthly capitation payment on behalf of Medicare beneficiaries who elect to enroll in qualified private health plans. The plan assumes the financial and medical responsibility for providing the full range of Medicare-covered services. Within broad constraints, the plan is free to decide which providers to contract with, how much to pay, and what to pay for. In short, PHPO establishes a financial framework for the government to delegate key decisions to private, comprehensive-care organizations.

PHPO is widely viewed as a means to control government expenditures and to create incentives for efficiency—and appropriately so. But PHPO is more. PHPO establishes an appropriate framework for assuring, and promoting, high-quality care.

Comprehensive-care organizations are better suited to assuring continuity and quality of care. Because a single organization has responsibility for the full range of services, there is an incentive to treat illnesses, not simply to provide episodic care. The prospective payment system (PPS) for hospitals, in contrast, encourages fragmentation. Payment is per admission, which creates an incentive for early discharge but no incentive to avoid future admissions through effective management of outpatient care. This problem may be aggravated if Medicare subsequently adds incentive payment systems for nonhospital care alongside PPS. In the worst case, incentive payment systems laid side-by-side could create payment “seams” threatening the continuity of care.

Comprehensive-care organizations also facilitate population-based
measurement of outcomes. Medicare’s current quality assurance system tends to emphasize discrete encounters with the health care system. This complicates measuring outcomes, for example, through mortality statistics. Hospitals, with some validity, complain about being held responsible for postdischarge mortality. Yet measuring only inpatient mortality presents even more severe problems. Measures of performance should comport with the reality of health care; effective treatment often involves a wide range of services, not isolated units.

Finally, comprehensive-care arrangements permit monitoring of whether organizations keep people well, not just their ability to cure the ill. From both a medical and financial perspective, we should be rewarding organizations that preserve good health.

Conclusion

HCFA will face unprecedented challenges and opportunities during Medicare’s third decade. Continuing pressure on the federal budget combined with the aging of the population will dictate still greater efforts to stem the increase in Medicare expenditures. Those efforts will, in turn, fuel still more concern about protecting the quality of care. Within reasonable bounds, demands for improved efficiency and quality are compatible. Indeed, HCFA’s efforts to promote quality and efficiency can be mutually reinforcing. The Private Health Plan Option will encourage changes in health care delivery that facilitate the development and use of quality measures based on outcome.

Even though Medicare will remain predominately fee-for-service for the foreseeable future, HCFA must begin refocusing its quality assurance efforts. Our goal should be quality promotion, not just quality assurance. The guiding principles of HCFA’s effort should include: more emphasis on outcomes and less on process; more emphasis on treatment of illnesses and less on discrete encounters; rewarding good providers as well as punishing poor providers; and increasing the amount and quality of information available to providers and patients. This new effort should not supplant existing quality assurance mechanisms but, rather, complement them.