
Perspective

Aligning Quality and Payment for Heart Failure Care: Defining the Challenges

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ABSTRACT

Hospitals may not support programs that improve the quality of care delivered to heart failure patients because these programs lower readmission rates and empty beds, and therefore further diminish already-declining revenues. A conflict between the highest quality of care and financial solvency does not serve the interests of patients, physicians, hospitals, or payers. In principle, resolution of this conflict is simple: reimbursement systems should reward higher quality care. In practice, resolving the conflict is not simple. A recent roundtable discussion sponsored by the Heart Failure Society of America identified 4 major challenges to the design and implementation of reimbursement schemes that promote higher quality care for heart failure: defining quality, accounting for differences in disease severity, crafting novel payment mechanisms, and overcoming professional parochialism. This article describes each of these challenges in turn.

Key Words: Heart failure management, reimbursement, quality of care.

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During the 6th Annual Scientific Meeting of the Heart Failure Society of America held September 22–25, 2002, a roundtable discussion was held on the topic of “Aligning Quality and Payment for Heart Failure Care.” The purpose of the discussion was to identify barriers to linking reimbursement with quality and was intended to be a preliminary step to proposing changes. The meeting brought together heart failure specialists from a wide variety of practice and administrative settings, including academic and government institutions and managed care organizations, with a full range of clinical experiences including primary, secondary, and tertiary heart failure care and relevant academic interests, including health care economics and innovations in care delivery. This article represents a summary of that discussion and is intended to stimulate ongoing debate.

The Quality-Cost Conundrum

Consider this: Two different groups at two different academic centers designed and implemented multidisciplinary programs to provide higher quality care for their heart failure patients. Using randomized study designs, both groups demonstrated that their programs improved patient outcomes—including 6-month readmission rates—and did so at lower overall cost. Despite these benefits, both hospitals withdrew funding for the programs, yet, paradoxically, both hospitals acted rationally. This dynamic may best be described as the quality-cost conundrum.

How can this conundrum be explained? This question is not difficult to answer for most cardiologists, especially those whose practices focus on heart failure. The hospitals chose not to support these programs precisely *because* they decrease readmission rates. Lower readmission rates mean empty beds, which in turn lowers net revenues, leaving the hospital to absorb the overhead for the program.

For many health care institutions, there is tension in the current environment between financial solvency and the core value of providing the highest quality care. Many practitioners feel this same tension. As reimbursement declines, particularly from Medicare, it becomes increasingly difficult to spend time with heart failure patients discussing such things as medication compliance and side effects, diet, and exercise.

In principle, resolution of this conflict is simple: reimbursement systems should reward higher quality. In practice, resolving the conflict is not simple. An attempt to improve health care delivery without attention to financial realities is likely to fail. Recently there has been enthusiasm for public reporting of outcomes so that consumers can seek out the highest quality providers. This approach will not ultimately improve quality if the

result is that excellent providers are expected to accommodate increasing numbers of patients with poorly reimbursed conditions and find they are losing money, or if hospitals, faced with fewer admissions, withdraw support from excellent programs.

The Challenges

We identified 4 major challenges to the design and implementation of reimbursement schemes that promote higher quality care for heart failure: defining quality, accounting for differences in disease severity, crafting novel payment mechanisms, and overcoming professional parochialism.

Defining Quality

To reward high-quality heart failure care, one must first define high-quality care. Quality in health care has been typically defined in 3 domains¹: *structure* (a fixed characteristic of a provider, such as board certification of a physician or presence of a heart transplant program at a hospital), *process* (eg, did a heart failure patient receive a β -blocker), and *outcome* (eg, mortality rate). It is possible to define quality of heart failure care for reimbursement purposes in all 3 of these domains.

In a *structure*-based quality reimbursement scheme, providers with characteristics that have been associated with superior results would be reimbursed at higher rates. For instance, providers who have received accreditation or certification in heart failure management or who have electronic patient tracking systems in place might qualify. Measures of quality based on assessment of *process* are in widespread use. For example, both the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)² and the Centers for Medicare & Medicaid Services (CMS)³ currently evaluate provider quality by assessing rates of measurement of ejection fraction for patients with heart failure and prescription of angiotensin-converting enzyme (ACE) inhibitors for patients with heart failure resulting from left ventricular systolic dysfunction. In a *process*-based reimbursement scheme, providers demonstrating, for example, rates of ACE inhibitor prescription above prespecified thresholds might receive bonuses. Measuring the quality of heart failure care with *outcomes* such as mortality, functional status, and hospitalization rates is not generally in use, although some nascent efforts have appeared.⁴

Each of these three approaches has its advantages and disadvantages. With a *structure*-based definition, the measurement need only be made once instead of repeatedly for every patient. Problems with this approach are defining qualifications and structures precisely, and es-

establishing clear links with positive outcomes. Nevertheless, such interventions as disease management and patient education have repeatedly been shown to reduce adverse outcomes in patients with heart failure. Financial support for structures such as these might reasonably be expected to produce significant benefit. With a process-based definition, events are frequent enough that statistically meaningful inferences can be made,⁵ and process indicators on which almost all providers agree are generally available. The major disadvantage of a process-based approach is that measurement is not part of routine administrative processes in clinics or hospitals and can be cumbersome and time-consuming. Thus a reimbursement system tied to process performance would create the need for expensive data collection. This approach might also have unintended consequences—allocating resources to improve performance on the specified quality measures might divert resources from improving other key aspects of care. For heart failure, additional process measures such as rates of referral of selected patients for disease management or subspecialty care may need to be developed. The overriding advantage of an outcomes-based definition is its broad common sense appeal to patients and providers. Indeed, it may be difficult to find a definition of quality acceptable to all without including outcomes. The major disadvantages of an outcomes-based approach are that events, especially mortality, are often too infrequent to make statistically meaningful inferences for individual providers, and that it is necessary to adjust for baseline differences in patients' prognosis. This adjustment for risk, in addition to requiring expensive data collection such as that required for assessing processes, is in itself a complex issue.

The Complexities of Adjusting for Differences in Disease Severity

Even if one commits to a reimbursement system that focuses on improving quality, establishing incentives that are consistent with patients' and providers' desires will not be easy. Consider, for instance, a proposal that hospitals with the lowest unadjusted 30-day mortality rates after discharge for heart failure be reimbursed at a higher rate. At least 3 unintended consequences are likely. Hospitals that provide excellent outpatient care and hence prevent admissions except among those patients least responsive to therapy would be overburdened. Hospitals might also seek to avoid caring for higher acuity patients. Finally, some facilities might admit lower acuity patients rather than care for them as outpatients. To avoid such consequences, it is crucial that statistical methods to adjust for "case mix" or "risk" are applied to outcomes.

Retrospective statistical adjustment can never produce a perfectly level playing field, and agreeing on how good is good enough for a model that affects payment is a major challenge. Case mix adjustment models published to date for heart failure, generally based on administrative data, are probably insufficiently discriminative for payment purposes.⁶⁻⁸ Developing models with better operating characteristics is therefore another important challenge, and one that is unlikely to be met without considerable investment of resources.

Novel Reimbursement Mechanisms

Much of the energy behind the movement to improve quality of care has come from outside the health care community. Government, community, and business groups have demanded that the U.S. health care system be accountable for quality and safety. If accountability demands are translated into new reimbursement schemes, provider payments will rise or fall as their measured performance rises or falls. It is therefore imperative that provider specialty societies, while taking leadership roles in the development of specialty-specific quality indicators, acknowledge the roles of patients and purchasers.

Patients and purchasers view prepayment for all services (eg, inpatient, outpatient, pharmacy) as a means to allow physicians to allocate resources with maximum flexibility in the pursuit of higher quality. Although conceptually appealing, prepayment faces many challenges as a means to improving quality because it would require integration of traditionally independent entities. In heart failure care, a prepayment approach would require that several types of physicians (eg, primary care, heart failure cardiologists, interventional cardiologists) work with a hospital and home health providers to allocate the prepaid resources. There are currently few mechanisms in place by which this could be accomplished. Furthermore, even if integrated systems receiving prepayments can produce high-quality care, it is likely that some services would still need to be reimbursed on a fee-for-service basis. For instance, it may not make sense to include a necessary preventive service such as flu vaccination for heart failure patients in prepayment, because every provider would receive the payment whether they actually gave the vaccine or not. As a general rule, when there is complete consensus that an action should be taken (eg, measuring ejection fraction), paying only when the service is provided (fee-for-service) is more likely to improve quality than including the cost of the service in prepayments (whether their ejection fraction is measured or not).

Another problem with prepayment as a route to quality improvement is that it favors cost-effective measures

over measures that serve society's values. In general, society has assigned disproportionately high value to preventive, prenatal, and pediatric care, and has given special consideration to immediately life-saving treatments, such as transplantation. An illustration of this is the experience with the Oregon Health Plan.⁹ In 1989 the state of Oregon proposed universal access to a package of basic health care services for its poor. The list of contents of the package was initially based on cost-benefit analysis, but was changed in response to public opposition to one based on a community survey of citizen's perceptions of the values of treatments. The list was changed yet again in response to political pressure from disability advocates. The net result of the community survey was an increased emphasis on preventive care and maternal services, and the net result of pressure from disability groups was a focus on life-saving rather than symptom-limiting treatments. For heart failure care, this likely means that preventive services for patients with heart failure will need to be guaranteed, and that cardiac transplantation may need to be excluded from prepayment and remain in a fee-for-service realm. Agreeing on which services are essential is another challenge.

Overcoming Professional Parochialism

Finally, physicians are trained to be advocates for individual patients and have little training or experience in public policy. As a group, physicians have difficulty seeing policy issues from other perspectives. Thus teaching physicians to approach broad solutions to problems is another challenge. Physicians must come to understand that there will be little or no sympathy for schemes that propose extra payment for providing high-quality care—public expectation is that if treatments such as ACE inhibitors and β -blockers benefit heart failure patients, doctors should not need rewards to prescribe them. Reimbursing quality must be a “zero sum game,” with no net increase in health care costs for the system. Physicians must understand that the public generally sees them as well-rewarded by the current system. On the other hand, changing a system as complex as health care is difficult and will require capital investment in infrastructure. Any system that provides an appearance of being subject to gaming or fraud will be poorly received.

Conclusions

There are major challenges to designing and implementing a system that rewards high-quality heart failure

care, yet it may be difficult to fully achieve high-quality care without such a system in place. Although reimbursement for providers with the best heart failure outcomes is the most conceptually appealing approach, incremental change with reimbursement for basic structural elements of high-quality heart failure care such as effective patient education or group visits for β -blocker initiation may be preferable. There is ample justification for advocating improved reimbursement for select structures of disease-management programs. Incremental gain may also be achieved through incentives for therapies of proven benefit such as β -blockers. Finally, physicians must understand societal expectations for the services that are considered essential and must learn to see solutions to problems from the viewpoint of policy makers and the public at large. Despite these challenges, putting quality of care into the reimbursement equation is ultimately in the best interest of both patients and providers. It is therefore essential to address these challenges in order to develop an equitable system for aligning quality and payment for heart failure care.

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