The article by Havranek et al.1 eloquently outlines the challenges to achieving high-quality care for patients with heart failure and for those with other complex chronic conditions. We agree that payment needs to align in such a way that it allows and rewards the highest quality care. For the Medicare program, 70% of Medicare beneficiaries have at least 1 chronic condition, and the most expensive 10% of all beneficiaries account for 65% of Medicare spending. Medicare beneficiaries often receive care that is fragmented across multiple providers and sites. Many of them have heart failure. Thanks to researchers, including many of the authors of the Havranek paper, there is a growing evidence base regarding best care for patients with heart failure, yet clinicians and providers still have many opportunities to improve—one recent study in the inpatient setting showed by weighted national average for 2000-2001 that 34% of Medicare beneficiaries are not given angiotensin-converting enzyme inhibitors appropriately for heart failure, and 29% do not have an appropriate assessment of left ventricular systolic dysfunction.2 Heart failure is the leading reason for hospital admissions among Medicare beneficiaries,3 yet can often be successfully managed on an outpatient basis. For all these reasons, the Centers for Medicare and Medicaid Services (CMS) is highly motivated to find new ways to purchase higher quality care tomorrow than we are buying today. Toward this end, we have a number of initiatives and demonstration projects planned and ongoing, using heart failure as a prototype condition and investigating ways to improve and coordinate treatment plans, reduce avoidable hospital admissions, and promote desirable health outcomes. All of these projects use performance measurement to evaluate the projects, may apply incentive payments, and generally seek to accomplish their goals without increasing overall health care costs.

CMS makes use of multiple interventions to stimulate and support clinicians and providers in delivering high quality care. As a regulator, we structure coverage and payment to allow clinicians to provide appropriate care, and establish and enforce standards. And, as a purchaser and facilitator, we forge collaborations and partnerships, provide economic and non-economic incentives and rewards, provide technical assistance, and give consumers information to make choices. The necessary tools for this work are data and quality measures; and CMS has for a number of years collected and analyzed data on priority conditions (including heart failure), working closely with full-time clinicians and academic researchers to create and use validated process, outcome, and structural measures of quality.

Technical Assistance to Clinicians, Health Plans, and Providers

Through our quality improvement organizations (QIOs), we have provided technical assistance to health plans, doctors, and hospitals to use these measures to identify improvement opportunities and institute improvements. Most recently, the QIOs have expanded their work to include new settings of care, such as home health agencies and nursing homes. A recent report of these activities in the inpatient setting2 showed that care for fee-for-service Medicare beneficiaries has improved.
over recent years, though a large opportunity for further quality improvement remains. Our QIOs work with clinicians and providers on four measures of heart failure care, and, in 2001, our national quality improvement project with Medicare+Choice plans focused on improving heart failure care.

**Consumer Information Coupled With Quality Improvement Support**

CMS believes strongly in the value and power of consumer information. We are currently sharing measures of quality on our Web site at [www.medicare.gov](http://www.medicare.gov) for dialysis facilities, Medicare+Choice plans, home health agencies, and nursing homes. Regarding hospital care, we expect to publicly report on 10 hospital-level quality indicators (including 2 on heart failure) in summer 2003 as part of The Quality Initiative: A Public Resource on Hospital Performance, a voluntary initiative of the American Hospital Association, Federation of American Hospitals, and the Association of American Medical Colleges. These public reporting initiatives are intended to fast-track quality improvement through their impact on provider accountability and consumer choice and engagement.

**Rewarding Highest Quality Care**

In a 2-year special project in 2002 and 2003, Medicare+Choice (M+C) organizations that meet specific rates of performance on 2 quality indicators for heart failure care received extra payments to recognize the costs of successful outpatient management of heart failure. CMS more than doubled the extra payment amount to qualifying M+C Organizations for 2003. Each year, about 95 M+C organizations reported their heart failure quality measures and received extra payments. (For more information, visit [http://www.cms.hhs.gov/healthplans/chf](http://www.cms.hhs.gov/healthplans/chf).

**Aligning Payment and Quality Incentives Through Demonstration Projects**

Additionally, there are 5 demonstration projects that target heart failure patients, among others, with complex chronic conditions (for more information on the demonstration projects: [http://www.cms.hhs.gov/healthplans/research](http://www.cms.hhs.gov/healthplans/research)).

The Coordinated Care Demonstration, authorized by Section 4016 of the Balanced Budget Act of 1997, uses both case management and disease management interventions to test whether providing coordinated care services to Medicare fee-for-service beneficiaries with complex chronic conditions can yield better patient outcomes without increasing program costs. The Health and Human Services Secretary, through regulations, can make components of the demonstration that are found to be cost-effective a permanent part of the Medicare program. Five of the 15 participating sites target heart failure.

The Physician Group Practice Demonstration was authorized by Section 412 of the Medicare, Medicaid, and State Children’s Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA). This tests a hybrid payment methodology for paying physician-driven organizations that combines Medicare fee-for-service payments with a bonus pool derived from savings achieved through improvements in the management of patient care and services. A core set of process and outcome measures will be established for use in measuring performance and allocating quality bonuses under the demonstration. Four of the 8 proposed process and outcome measures are applicable to patients with heart failure. We anticipate that the quality bonus can be obtained with a 10% improvement over the prior year or a predetermined performance threshold.

The Demonstration Project for Disease Management is expected to begin enrolling patients in March 2003. This demonstration was authorized by Section 121 of BIPA to evaluate how disease management organizations can improve the health outcomes of Medicare beneficiaries diagnosed with advanced stage heart failure, diabetes, or coronary heart disease, while providing sufficient savings to at least cover the expense of the disease management services and payment of all costs for prescription drugs whether or not they relate to the chronic health condition. All 3 selected disease management organizations will serve Medicare beneficiaries with heart failure.

The Case Management Demonstration has one site that is providing coordinated care services specifically for patients with heart failure. The program began enrolling Medicare beneficiaries in November 2001.

Recently announced on February 27, 2003, and open for submission of proposals until May 29 is the Capitated Disease Management Demonstration. This demonstration uses disease management interventions and payment for services based on full capitation of select chronic diseases (including heart failure). The payment methodology, which includes full risk adjustment and risk sharing options, aims to encourage the formation of specialty plans that market directly to Medicare’s sickest beneficiaries.

In summary, CMS has a large quality agenda intended to align quality and payment for complex chronic diseases like heart failure. Indeed, the extra payment that CMS is paying qualified M+C organizations is the first time that CMS has linked extra payment to the reporting and attainment of high performance. These initiatives and demonstrations are just a few of the ways we are working to “Cross the Quality Chasm” and pay for care that meets the quality domains defined by the Institute of Medicine: safe, effective, patient-centered, timely, equitable, and efficient.\(^5\)
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References