

ISSUE BRIEF

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TRENDS IN HEALTH CARE QUALITY

Pay for Performance: Are Hospitals Ready and Willing?

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This brief is based on Mathematica's study designed to examine hospital public reporting of quality information, conducted for the Centers for Medicare & Medicaid Services (CMS). The study included a nationally representative survey of acute care hospitals in summer 2005 that asked about hospital participation in pay-for-performance (P4P) programs and views on a future CMS initiative. Only about 20 percent of hospitals had participated in a P4P program at the time of the survey, but nearly all hospitals support CMS in moving forward with a P4P strategy that would encompass most U.S. acute care hospitals.

Setting the Stage

Public and private payers are developing hospital care P4P initiatives as part of a broader national movement to improve the quality and cost-effectiveness of health care services. These initiatives augment or reduce payments to a hospital on the basis of its performance on a predefined set of quality measures. The initiatives build on public reporting and pay-for-reporting efforts that have penetrated the hospital industry during the past few years, which have also improved hospital readiness for a system in which the payment level will depend on the quality of care provided.

The Hospital Quality Alliance (HQA)—a public-private collaborative for voluntary reporting established in 2002—and CMS's Hospital Compare website have spurred dramatic growth in public reporting of hospital quality data. Since 2002, increasing numbers of hospitals have participated in the HQA, which has

also increased the number of quality measures to be reported on CMS's website—from 10 in 2002 to 20 in 2006. At least 11 states, including large ones such as California and New York, have put statewide hospital quality public reporting initiatives into place. A review of hospital public reporting websites in 2005 by the Delmarva Foundation found that most of these efforts use the HQA measures (plus a few additional ones), promoting alignment in the areas the HQA has addressed.

Enacted in 2003, Medicare's Reporting Hospital Quality Data for Annual Payment Update (APU) has led to almost universal reporting by acute care hospitals of 10 HQA-defined measures on heart attack, heart failure, and community-acquired pneumonia. Most hospitals began to report data on these measures after the APU prompted full Medicare payment updates only for hospitals reporting these data. In August 2006, CMS expanded the number of required measures to 21, in order to receive the full payment update. The measures now also cover surgical care and influenza vaccinations (a measure Hospital Compare will begin reporting in 2007). CMS has also boosted the penalty for not reporting, so most acute care hospitals are expected to submit the full set of data.

On the Leading Edge

Over the years, some local health plans have undertaken P4P efforts, but more ambitious collaborations and public-sector pilot projects are a recent phenomenon. New and innovative initiatives include the following:

- **Premier Hospital Quality Incentive Demonstration.** This three-year project began in October 2004 and involves over 260 hospitals nationwide that are voluntarily participating in a CMS-sponsored

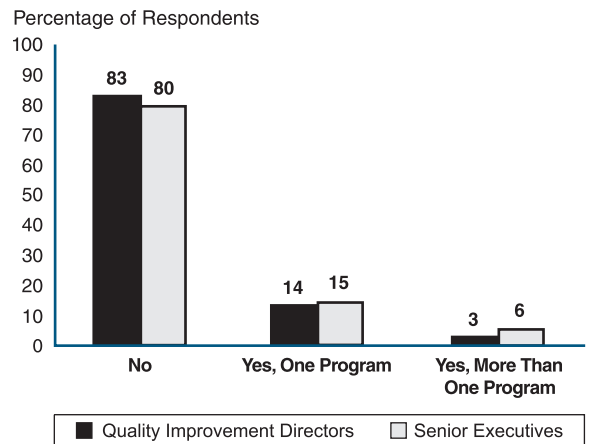
demonstration. Top-performing hospitals (those scoring in the top two deciles of participating hospitals each year) receive increased payments for Medicare patients. The 2006 incentive is based on a composite score for each of five clinical areas (heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacement). A total of 35 measures cover both process of care and outcomes. An August 2006 analysis by Premier Inc., the organization that implemented the demonstration with CMS, cites impressive improvements in quality and cost savings to hospitals. Analysis by an independent evaluator is ongoing.

- Leapfrog Hospital Rewards Program.** The Leapfrog Group, comprised of large employers who purchase health care, launched this program in 2005 to speed evolution of hospital P4P programs in the private sector. Inspired by the Premier Hospital Quality Incentive Demonstration, and including many of the same National Quality Forum-endorsed measures, the program rewards hospitals that post gains in quality and efficiency in five clinical areas. Several health plans, including Horizon Blue Cross Blue Shield (BCBS) of Massachusetts and a multi-payer collaborative in Memphis, are implementing the program.
- BCBS Michigan Rewarding Results and Other BCBS Initiatives.** The Michigan BCBS program includes over 90 acute care hospitals and involves collaboration between the health plan, the Michigan Health and Hospitals Association, and the University of Michigan. This initiative is one of 14 BCBS P4P programs profiled on the Leapfrog Group's website (http://www.leapfroggroup.org/leapfrog_compendium).

Current Hospital Participation in P4P

Despite the increasing momentum of P4P, our survey found that only about 20 percent of hospitals were participating in these types of programs (Figure 1). Participation in BCBS initiatives (in 50 percent of hospitals participating in pay for performance), as well as the Premier Hospital Quality Incentive Demonstration (20 percent), was most common. Large hospitals accredited by the Joint Commission

Figure 1: Participation in P4P Programs or Demonstrations



on Accreditation of Healthcare Organizations (JCAHO) were more likely than other types of hospitals to have experience with pay for performance: 30 percent of these hospitals versus 6 percent of small non-JCAHO-accredited hospitals and 16 percent of other hospitals (mostly medium, JCAHO-accredited hospitals) took part in at least one P4P program in summer 2005. (All differences by hospital type discussed in this brief are statistically significant at the 95 percent level of confidence unless otherwise noted.)

Fewer than 6 percent of hospitals took part in more than one P4P program. We asked these hospitals whether multiple programs reinforced or interfered with each other. Three-fourths of senior executives (74 percent) and somewhat more than one-half of quality improvement (QI) directors (58 percent) said the programs reinforce each other. At this point, hospitals generally do not face a problem with various P4P programs differing from one another. However, 10 to 15 percent of those participating in more than one program said that the programs interfered with one another because of differing criteria or data collection procedures. This conflict can create reporting burden and varying quality improvement incentives within a hospital or between the hospital and staff physicians.

We asked the same question—do multiple programs reinforce or interfere with each other—of those who participated in multiple public reporting programs outside of JCAHO and HQA, and received a roughly similar response. About 20 percent stated that the

programs interfered with one another because of differing criteria or data collection procedures. As hospital pay for performance continues to expand, lack of coordination in measure selection, definition, and specification, as well as data collection and submission, are likely to become more problematic.

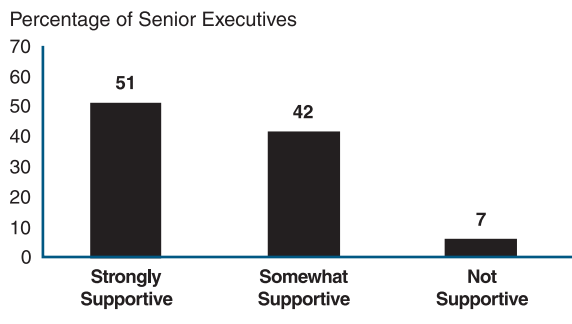
In response to an open-ended question about the most important reason they participated in pay for performance, many hospital executives said that their hospital viewed the programs as an opportunity for reaping financial benefits or for stimulating quality improvement. Almost 40 percent of those who participated cited the financial benefits; about 20 percent mentioned stimulation of quality improvement.

Hospital Views on a Future CMS Initiative

Ninety-three percent of hospitals supported CMS in moving forward with a P4P program over the next couple of years; half of the senior executives interviewed said their hospital's leadership would strongly support such an initiative. Support was strong among both senior executives in hospitals participating in pay for performance and those who did not participate.

Selecting the right measures will be a critical element of future success in the P4P arena. In choosing measures, CMS will need to strike a balance between including a large number of measures to estimate hospital quality accurately in important clinical areas, and overwhelming hospitals with new measures they have not been reporting. We explored hospitals' views on this issue in two ways. For hospitals that reported the 10 initial HQA-defined measures, we asked senior executives whether these measures

Figure 2: Support for a CMS Pay-for-Quality Initiative



ABOUT THE SURVEY

In summer 2005, Mathematica conducted telephone interviews with QI directors and senior executives involved in quality improvement (typically the chief medical officer or vice president of medical affairs). The target population was short-term acute care general and critical access hospitals in the 50 states and the District of Columbia that submitted hospital quality data for Hospital Compare, a major CMS quality initiative, in 2005. Mathematica selected a stratified random sample based on hospital size (small—1 to 99 beds; medium—100 to 299 beds; and large—300 or more beds), participation in CMS's Premier Hospital Quality Incentive Demonstration, and accreditation by the JCAHO. The sample for QI director responses discussed in this issue brief includes 172 large JCAHO-accredited hospitals; 140 small non-JCAHO-accredited hospitals; and 341 other hospitals, mostly medium size and JCAHO accredited. For the senior quality executives, the samples are 171, 133, and 334, respectively. The survey weighted response rates were 89 percent for senior hospital executives and 95 percent for QI directors.

should be expanded, reduced, or stay the same for a national CMS P4P initiative. For hospitals that participated in the Premier Hospital Quality Incentive Demonstration, we asked the same question about the demonstration's set of measures, consisting of the 10 initial HQA measures plus 25 additional ones.

Senior executives in the first group were about evenly split between those who felt the measures were appropriate as is, and those who felt they should be expanded (43 percent and 41 percent, respectively). Only 16 percent felt the set should be reduced or should include different measures, although this percentage was higher (27 percent) for small non-JCAHO-accredited hospitals compared with other hospital types. The most popular candidates for elimination were the pneumonia measures (particularly

the pneumococcal vaccination) and the heart attack measures. Of those that wanted different measures, the most frequent suggestion was to add measures with sufficient volume per year so that real differences between hospitals could be detected. Hospitals were wary of large expansions, with only 10 percent in favor of substantially expanding the original set. However, more of the large JCAHO-accredited hospitals favored large expansion, with 22 percent supporting it, compared with 15 percent of small non-JCAHO-accredited hospitals and 6 percent of other hospital types.

Hospitals participating in the Premier Hospital Quality Incentive Demonstration, accustomed to measuring their quality against a larger set of 35 measures, were again about evenly split between those in favor of using that measure set as is (42 percent) or expanding it for use in a future national CMS P4P program (38 percent). Twenty percent felt some measures should be eliminated or changed before being used in a pay-for-quality initiative. The most frequent suggestions included a general cutback in measures for (1) influenza and pneumonia vaccines; (2) administration, timing, and selection of antibiotics for all measured conditions; and (3) heart attack.

Moving Ahead

Most hospitals appear to be ready and willing to move forward into a P4P environment. As CMS and other payers and purchasers of health care develop additional programs, our survey suggests they keep the following in mind:

- While supportive of the P4P concept, few hospitals have experience with programs to date. This suggests new initiatives should include a “ramp-up”

period to allow hospitals to become more sophisticated in responding to the new programs, before a large portion of their dollars is at stake.

- The positive signals about moving forward from hospitals with P4P experience suggest that, as of summer 2005, they viewed models such as the Premier Hospital Quality Incentive Demonstration as on track.
- Hospitals appear comfortable with the measure sets they use. Although the original 10 HQA-defined measures offer a relatively narrow assessment of hospital quality, most participating hospitals supported either using this set of measures as is or implementing a modest expansion. Most hospitals participating in the Premier Hospital Quality Incentive Demonstration expressed similar views about expanding that 35-measure set to additional hospitals in the future. If this existing pattern of comfort continues, then hospitals may feel more at ease with a larger set of P4P measures (21 or more) in another year or two, given the increase underway in the number of measures required for the full Medicare annual payment update.
- Most hospitals have not faced the challenge of responding to multiple P4P programs from different payers. As momentum increases, multiple P4P programs will be an issue to watch, and one that payers must consider as they design and implement new programs.

For more information about this study, funded by CMS through the Delmarva Foundation, please contact Myles Maxfield, vice president and director of health research, at mmaxfield@mathematica-mpr.com, (202) 484-4682. To read more about Mathematica’s quality of care research, go to www.mathematica-mpr.com/healthofcare.asp.

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