

Snapshot of Hospital Quality Reporting & P4P Under Medicare

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Policy Alternatives**

Future Hospital Care: How Will We Pay the Bill?

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Washington, DC

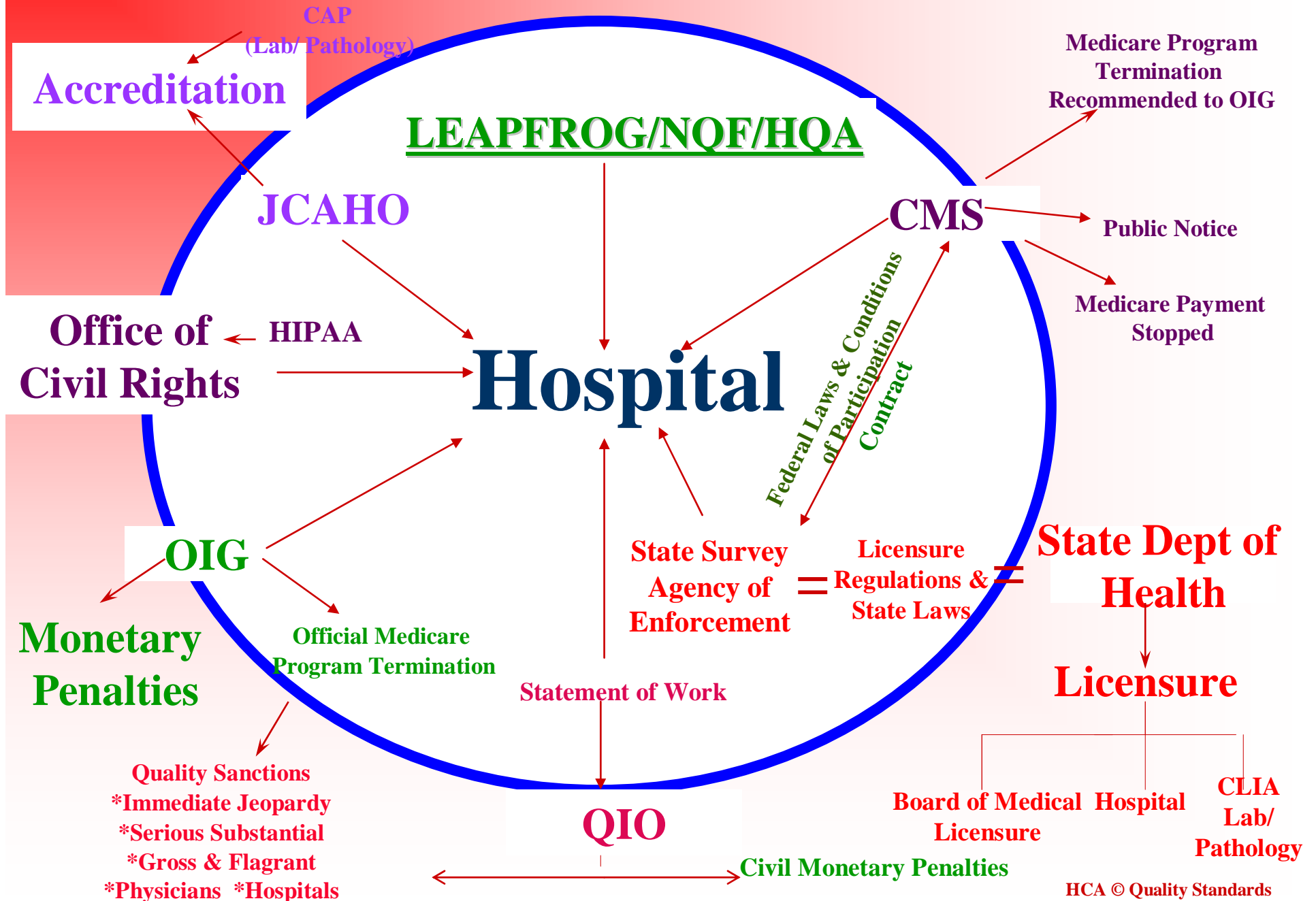
Questioning Care & Safety

- **Institute of Medicine (IOM): “To Err is Human” (1999); Ninety Eight Thousand Americans Dying Annually**
- **IOM: “Crossing the Quality Chasm” (2001); Health Care Delivery Fundamentally Flawed**
- **Doctors Wennberg & Brook**
 - **Thirty years of Findings Unexplained Variations in Practice & Apparent Unnecessary Care**
- **Key Questions Emerge:**
 - **Is Care Safe?**
 - **Does Care Meet Medical Standards?**
 - **Is Care Necessary?**

Stress Of Unyielding Health Care Spending Curb

- **Medicare & Medicaid**
- **Employers**
- **Insurers & Health Plans**
- **More Empowered Consumer Patient**
- **Are the Premium Payers & Consumer Patients Receiving Value Per Health Care Dollar Spent?**

Quality Standards



Hospital Transparency & Accountability Mandate

- **Hospitals Face Cacophony**
- **Quality Improvement, Error Reduction, & Public Accountability Movement**
 - Accreditation Insufficient
 - Care Metrics Needed
 - Policy Makers, Regulators, Employers, & Insurers & Health Plans Engaged
- **HHS & Hospitals Respond with Hospital Quality Alliance (HQA) as Convener & Coordinator on Reporting**

Hospital Quality Alliance

- **HQA Hospital Reporting Program: Hospital Compare Database-Website**
- **Public-Private Sector Collaboration: CMS, AHRQ, Key Hospital and Health Care Organizations, & Health Care Quality and Consumer Groups**
- **HQA Purpose**
 - Useful & Valid Information
 - Predictability for Reporting
 - Standardized Data Priorities & collection Mechanisms
 - Enhance Efforts to Improve Care
- **Voluntary Participation Driven by MMA DRG Update**
- **Building on Seventeen Medical Process Measures**

CMS P4P Demonstration

- **Premier, Inc. Tapped by CMS for Pay-for-Performance Demonstration**
- **Two Hundred Seventy Four Hospitals Participating**
- **Bonus & Penalties for Meeting Certain Standards Over Three Years**
- **Thirty Four Medical Process & Outcomes Measures Re Five Conditions**

Methods For Snapshot Of Hospital Reporting & P4P

- **Premier Demonstration Methodology**
- **4203 Hospitals Reporting for HQA's Hospital Compare**
- **17 measures in three conditions**
 - heart attack, heart failure and pneumonia
 - account for 16 percent of Medicare discharges and payments
- **Calculated composite condition scores and examined performance by hospital type**
- **Estimated potential financial implications using two P4P scenarios**

Data Sources

- **Quality Data – Hospital Compare April 2005 database**
 - 10 measurers 1st and 2nd quarters '04
 - 7 measures 2nd quarter '04
- **Hospital Demographics**
 - FY 2005 IPPS Final Rule Impact File
- **Discharges and Payment**
 - FY 2003 MEDPAR

Data Base for Analysis

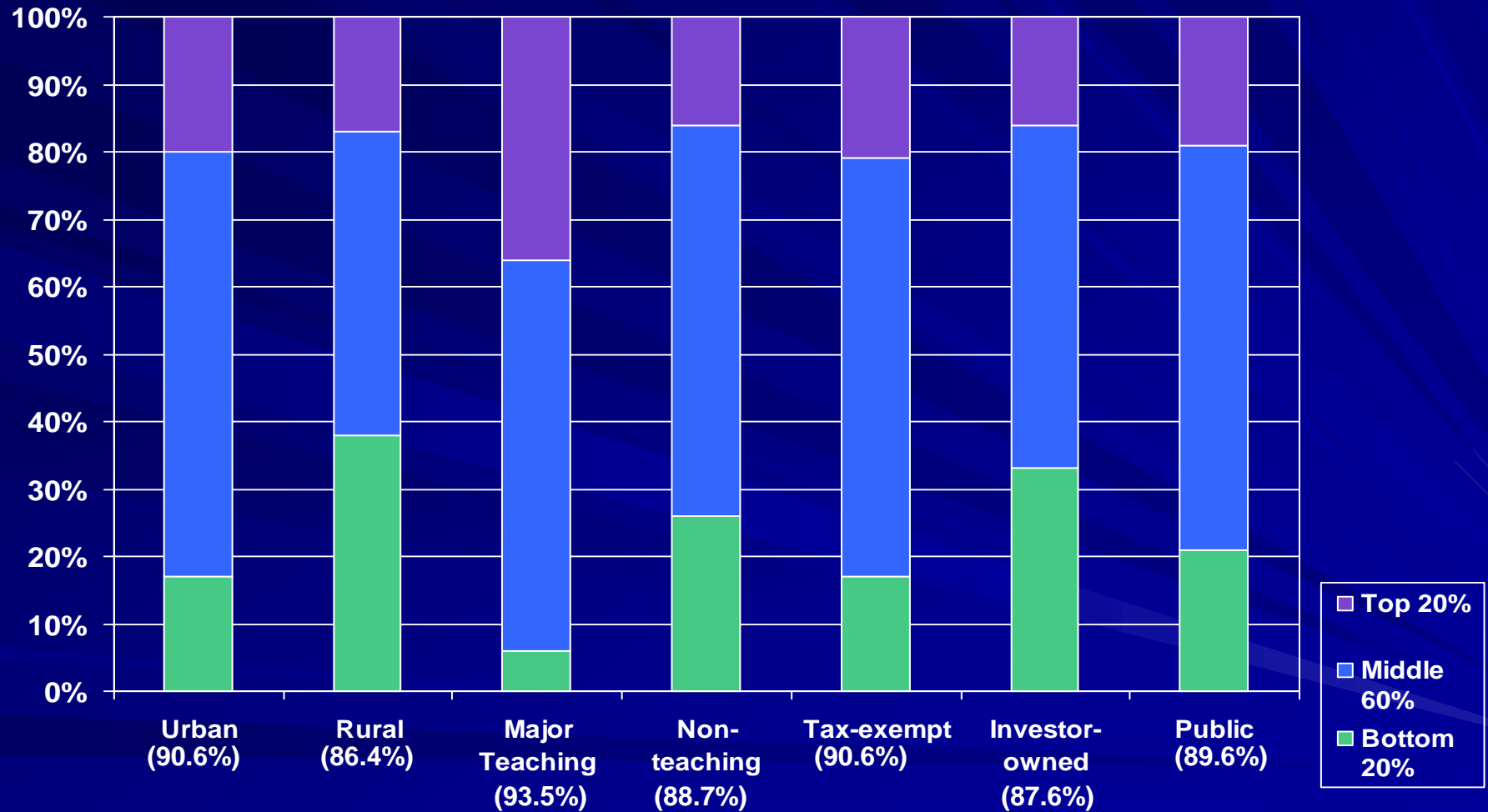
- Heart attack: 2,008 hospitals with a score
- Heart failure: 2,963 hospitals with a score
- Pneumonia: 3,393 hospitals with a score

Scores by Condition

	Mean	20th Percentile	80th Percentile
Heart Attack	90.0%	85.0%	96.1%
Heart Failure	74.4%	63.5%	87.0%
Pneumonia	76.2%	69.2%	83.8%

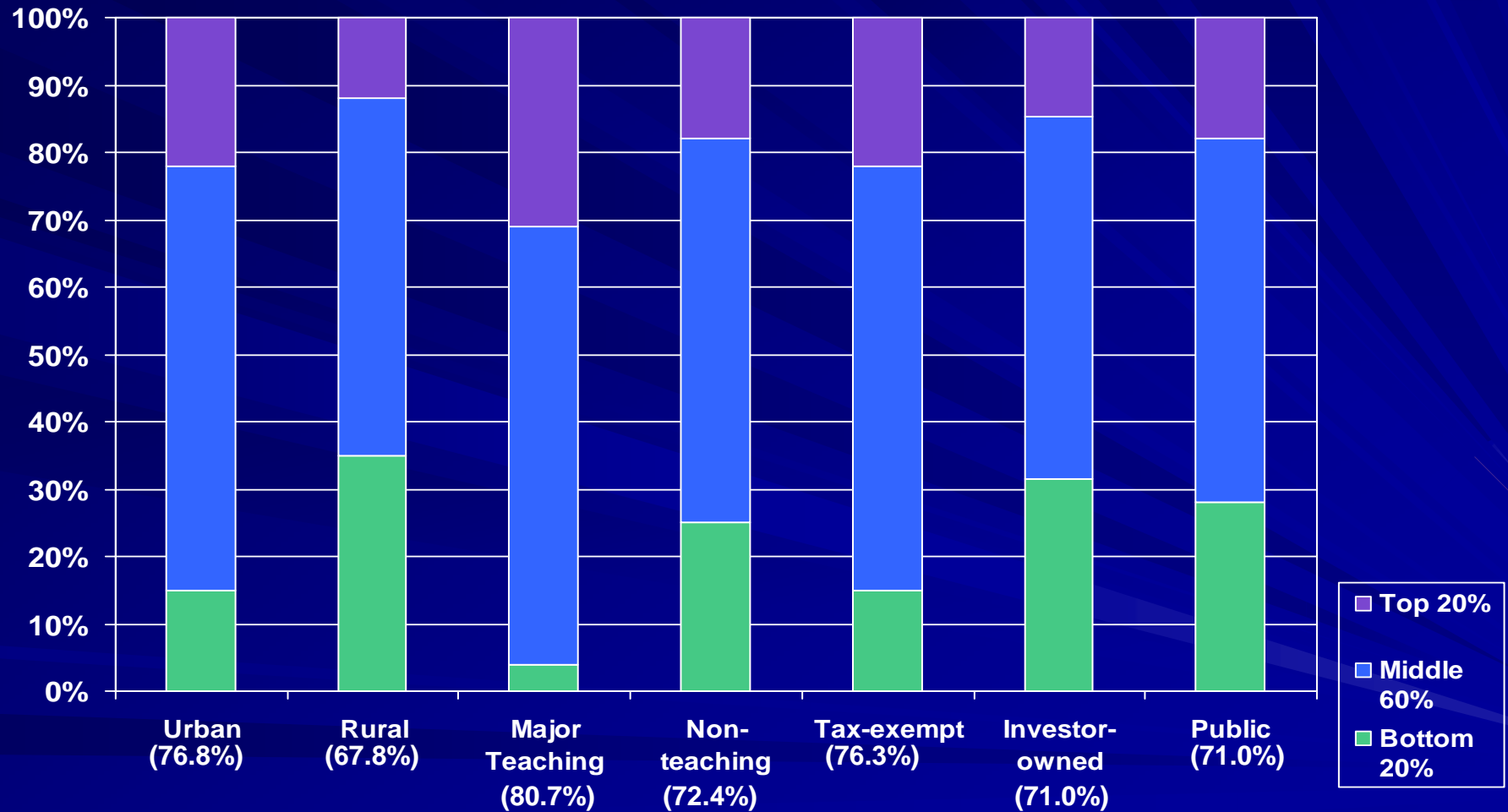
Source: Analysis of Hospital Compare data linked with the FY 2003 Medicare Provider Analysis and Review File

Heart Attack



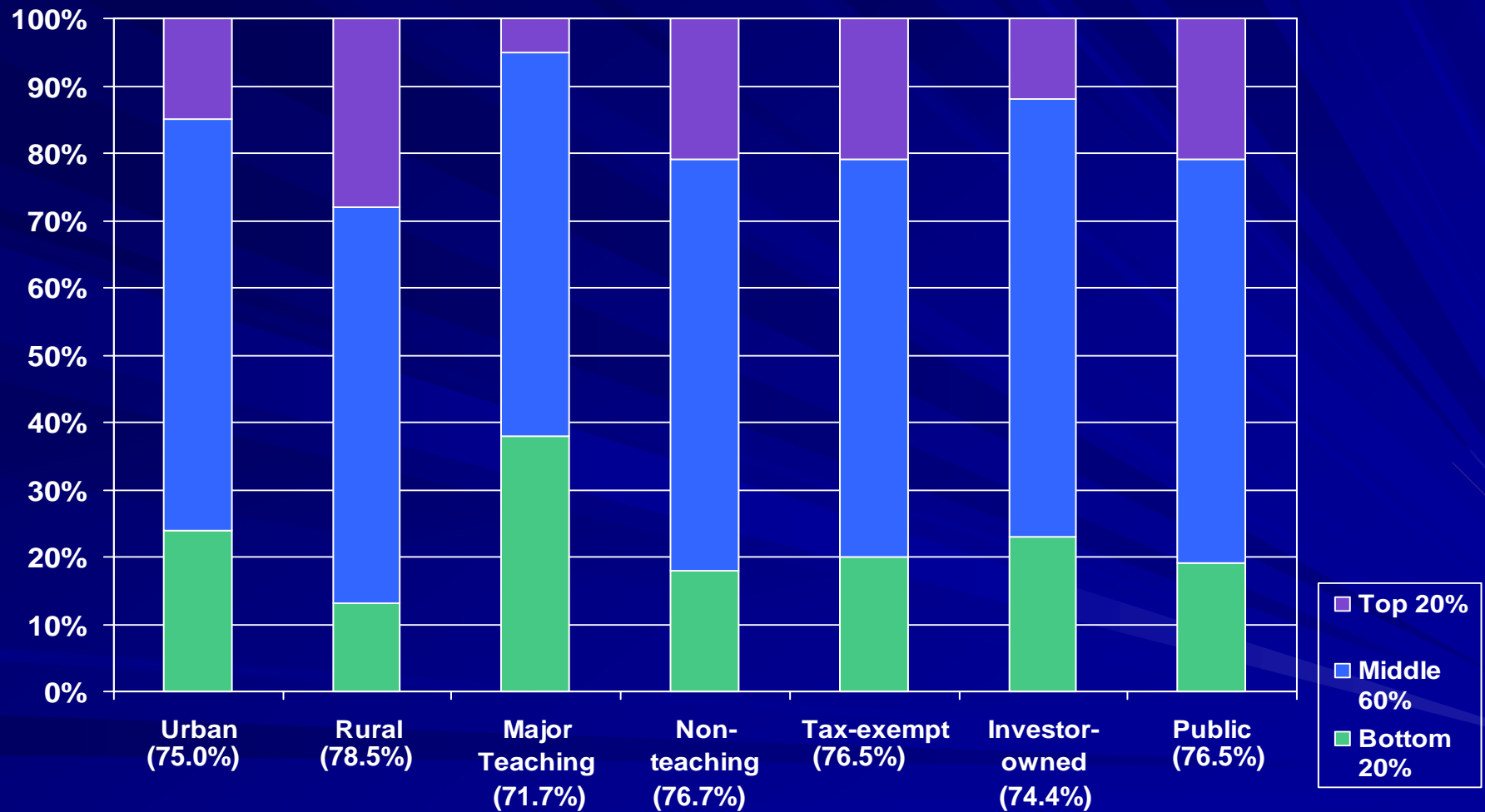
Source: Analysis of Hospital Compare data linked with FY2005 Final Rule Impact File and the FY 2003 Medicare Provider Analysis and Review File

Heart Failure



Source: Analysis of Hospital Compare data linked with FY2005 Final Rule Impact File and the FY 2003 Medicare Provider Analysis and Review File

Pneumonia



Source: Analysis of Hospital Compare data linked with FY2005 Final Rule Impact File and the FY 2003 Medicare Provider Analysis and Review File

Difference Between Best and Worst Performers on Heart Attack: Average Measure Scores

	<u>Top 20%</u>	<u>Bottom 20%</u>	<u>Difference</u>
Aspirin @ Arrival	98.5%	87.7%	10.8%
Aspirin @ Discharge	98.6%	80.5%	18.1%
ACE Inhibitor LVSD	90.9%	60.8%	30.1%
Beta B @ Discharge	98.1%	75.2%	23.0%
Beta B @ Arrival	97.5%	75.7%	21.8%

Difference Between Best and Worst Performers, Heart Failure and Pneumonia: Average Measure Scores

	<u>Top 20%</u>	<u>Bottom 20%</u>	<u>Difference</u>
Left Vent Assessment	95.3%	62.2%	33.1%
ACE Inhibitor LVSD	86.7%	61.8%	24.9%
Discharge Instructions	83.6%	16.0%	67.6%
Left Vent Assessment	95.3%	62.2%	33.1%
Oxygenation Assessment	99.2%	95.1%	4.1%
Pneumococcal Vaccine	76.0%	14.7%	61.3%
Antibiotic Timing	83.4%	57.6%	25.9%

Comparison of P4P Scenarios

(\$ in millions)

	<u>PREMIER</u>		<u>MEDPAC</u>	
	<u>Total Bonus</u>	<u>Total Penalty</u>	<u>Total Bonus</u>	<u>Total Pool Contribution</u>
All Hospitals	39.4	30.5	139.8	-139.8
Urban	34.0	25.2	117.2	-119.8
Rural	5.3	5.1	21.6	-18.8
Tax-exempt	32.6	20.0	114.8	-105.6
Investor-owned	3.0	6.3	10.7	-17.5
Government	3.7	4.1	14.2	-16.6

Source: Analysis of Hospital Compare data linked with FY2005 Final Rule Impact File and the FY 2003 Medicare Provider Analysis and Review File

Conclusions and Parting Thoughts

- Results are initial snapshot only
 - Both performance and reporting will improve
 - No financial consequences
 - No period to improve to attain standard
- Measures are clinically-based
- But composite score methodology and P4P policies are more policy preference and judgment than science
- Do we really know comparative impact of P4P with reporting/management improvement only?

How Far Should P4P Go?

- **Changing Medical Practice, Practice Culture Aim of Reporting & P4P Proposals**
- **Reporting & P4P in Formative Stages**
- **Should P4P Aim at Actual Pay for Performance?**
 - **No Pay for Failure to Meet Standards**
 - **No Pay for Never Events**
 - **Pay Per Patient Based on Risk-adjusted Outcome**