

# Snapshot of Hospital Quality Reporting & P4P Under Medicare

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Policy Alternatives**

**Future Hospital Care: How Will We Pay the Bill?**

**July 15, 2005**

**Washington, DC**

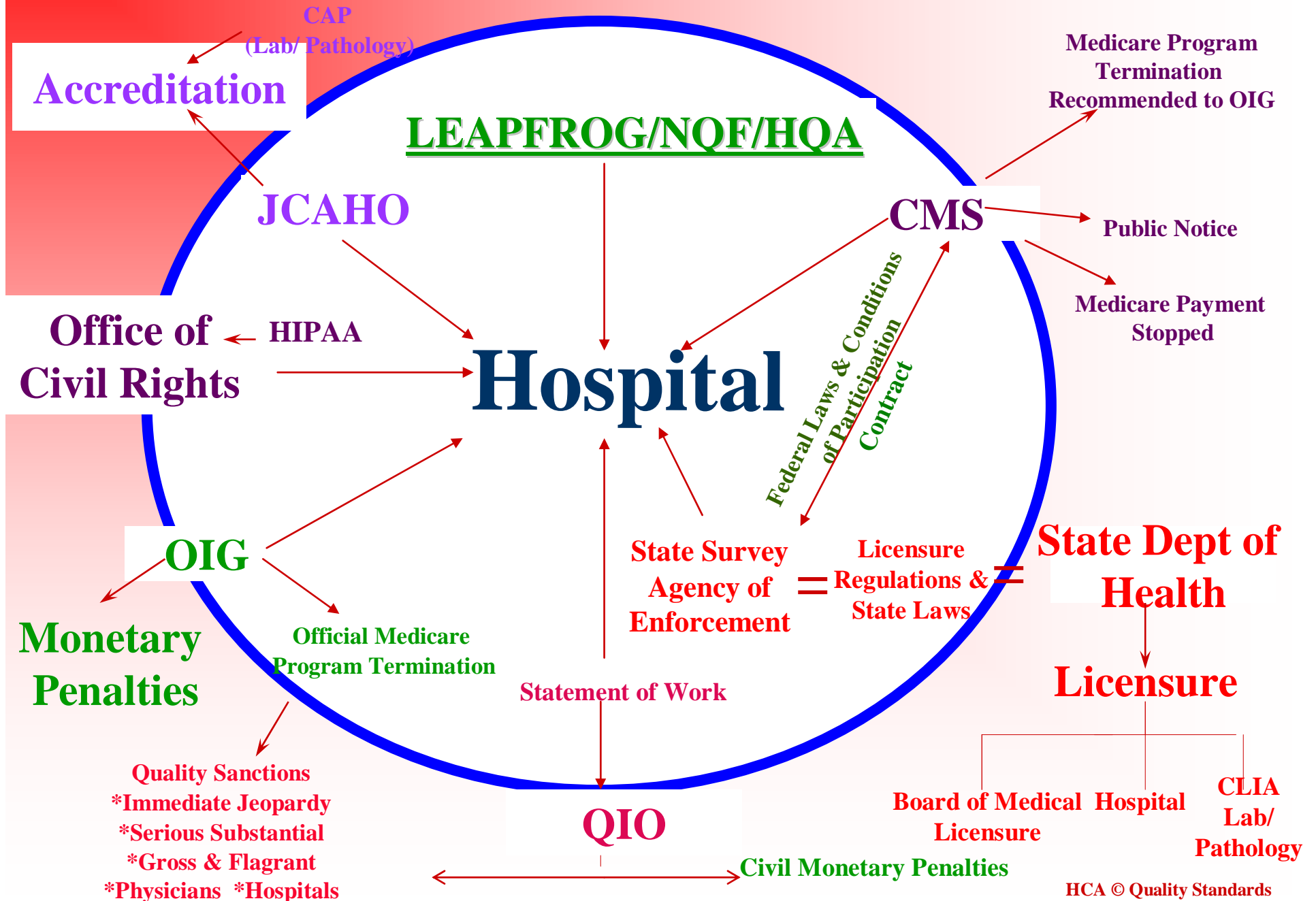
# Questioning Care & Safety

- **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 1<sup>st</sup> and 2<sup>nd</sup> quarters '04
  - 7 measures 2<sup>nd</sup> quarter '04
- **Hospital Demographics**
  - FY 2005 IPPS Final Rule Impact File
- **Discharges and Payment**
  - FY 2003 MEDPAR

# Data Base for Analysis

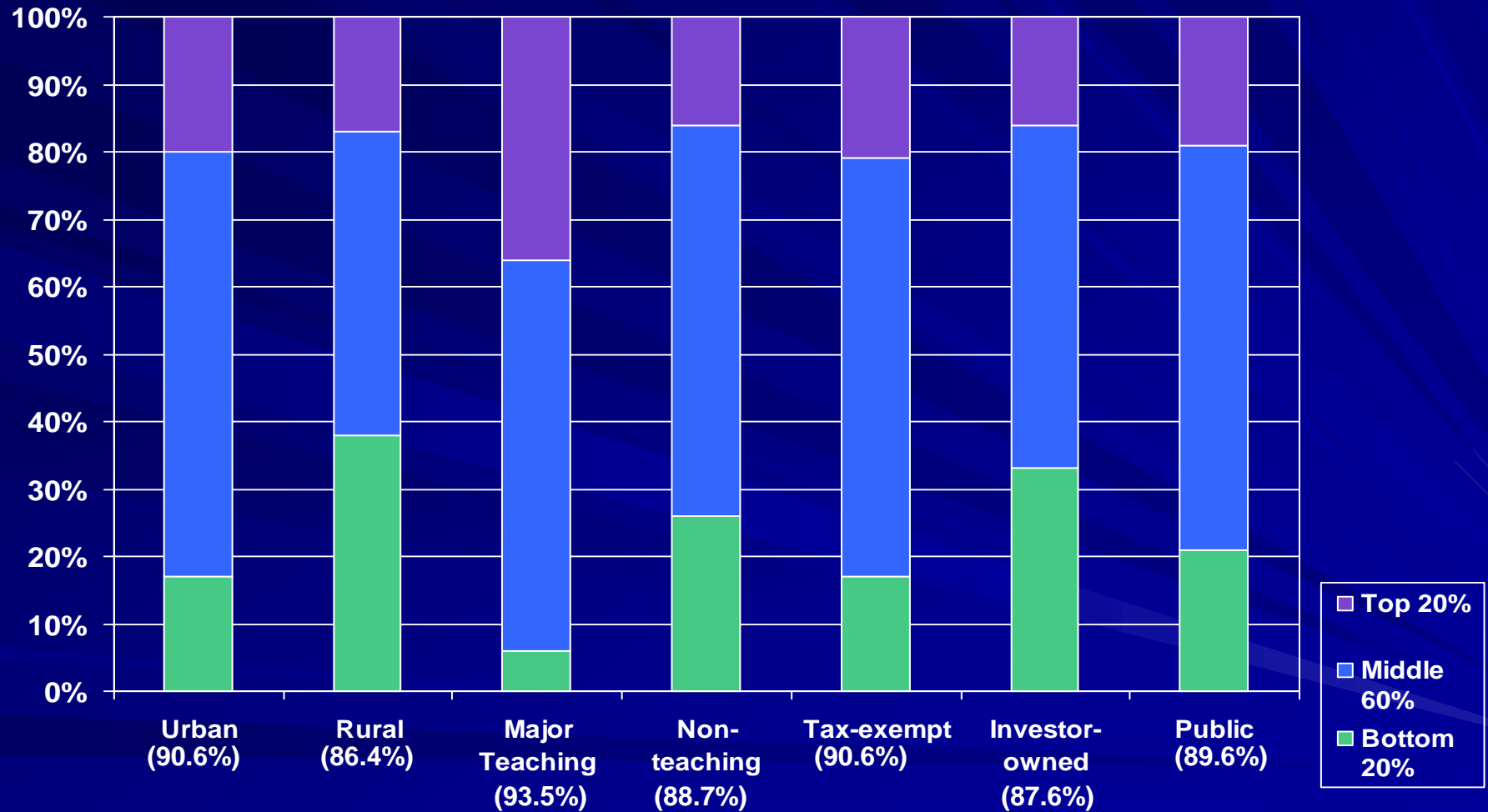
- Heart attack: 2,008 hospitals with a score
- Heart failure: 2,963 hospitals with a score
- Pneumonia: 3,393 hospitals with a score

# Scores by Condition

	<b>Mean</b>	<b>20<sup>th</sup> Percentile</b>	<b>80<sup>th</sup> Percentile</b>
<b>Heart Attack</b>	<b>90.0%</b>	<b>85.0%</b>	<b>96.1%</b>
<b>Heart Failure</b>	<b>74.4%</b>	<b>63.5%</b>	<b>87.0%</b>
<b>Pneumonia</b>	<b>76.2%</b>	<b>69.2%</b>	<b>83.8%</b>

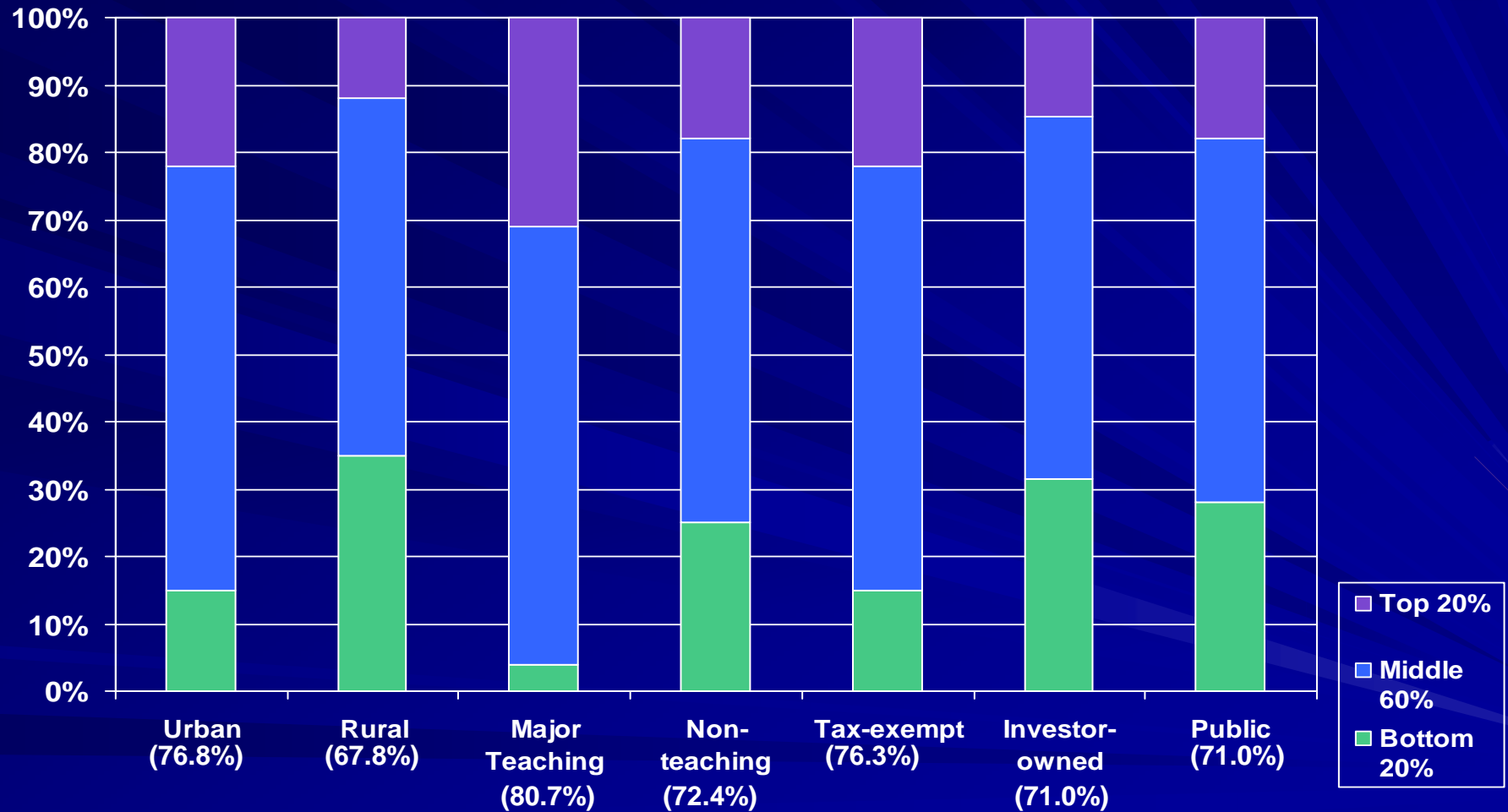
Source: Analysis of Hospital Compare data linked with the FY 2003 Medicare Provider Analysis and Review File

# Heart Attack



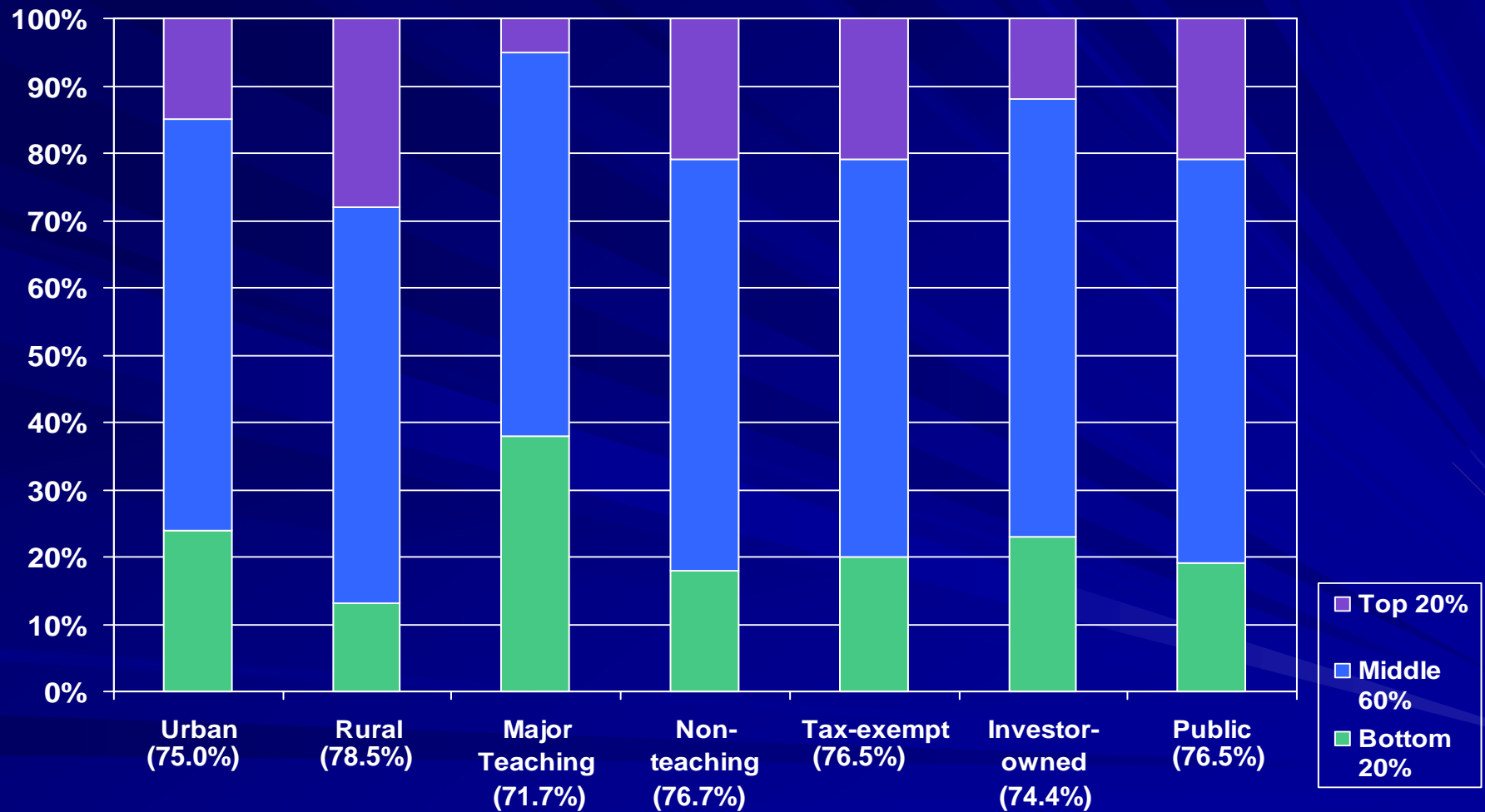
Source: Analysis of Hospital Compare data linked with FY2005 Final Rule Impact File and the FY 2003 Medicare Provider Analysis and Review File

# 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>
<b>All Hospitals</b>	39.4	30.5	139.8	-139.8
<b>Urban</b>	34.0	25.2	117.2	-119.8
<b>Rural</b>	5.3	5.1	21.6	-18.8
<b>Tax-exempt</b>	32.6	20.0	114.8	-105.6
<b>Investor-owned</b>	3.0	6.3	10.7	-17.5
<b>Government</b>	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**