Massachusetts Leads the Way:
Pay for Performance to Reduce Racial/Ethnic Disparities

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Disparities in health and health care continue to exist

“Pay for Performance” (P4P) has become increasingly common among both private and public payers

Until now, P4P has not been utilized to reduce disparities in performance between racial-ethnic groups
Pay-for-Performance and Disparities

Pay-for-Performance (of P4P) is the practice of rewarding providers to meet quality goals and to improve outcomes of care, rather than paying for the volume of services they provide.

Questions have been raised about potential impact of P4P on racial-ethnic disparities
Research Questions

- Why and how was the MassHealth P4P/disparities program developed?
- How has the program been implemented?
- What are lessons learned?
Methods

- Review public documents
- Interview staff at Massachusetts’ Executive Office of Health and Human Services (Office of Medicaid), which was responsible for the P4P/disparities program.
- Analyze hospital performance data
- Speak to members of the hospital community about their experiences with the program.
Chapter 58 - The Massachusetts Universal Health Care Law Also Mandated Hospital P4P

- Institute of Medicine’s Unequal Treatment in 2003
- Boston Task Force to Eliminate Racial and Ethnic Disparities (2004-5)
- Section 25 of Chapter 58 (2006)
  - MassHealth hospital rate increases contingent on quality standards, including the reduction of racial and ethnic disparities.
P4P Measures

1) Clinical Measures - Reward Hospitals to report data by Race/Ethnicity & to reduce differences in clinical processes

2) Structural Measures - Reward Hospitals to improve organizational factors that may reduce racial/ethnic health disparities.
Clinical P4P Measures

1) Maternity/Newborn indicators
2) Pediatric Asthma indicators
3) Pneumonia indicators
4) Surgical Infection Prevention indicators

Criteria for Selection:

- Office of Medicaid
  - Relevant (high impact on population)
  - Actionable (scientifically sound; within provider control)
  - Feasible (existing technical specs, minimized collection burden, sufficient volume)

- NQF -- evidence of a quality gap
Structural Measures: Implementing CLAS – The CCOSA* (Selected Domains and Items)

HOSPITAL GOVERNANCE POLICY
Board adopted mission statement articulating cultural diversity as core value.
Board and senior management reflect the racial and ethnic mix of the actual population mix being served.

ADMINISTRATION & MANAGEMENT POLICY
Hospital provides diversity training for all clinical and nonclinical staff.
Hospital patient data is analyzed by race, ethnicity, and languages spoken.

SERVICE DELIVERY POLICY
Policies exist to include R/E communities in planning/design of services.
Hospital interpreter skill requirements are based on nationally recognized professional medical interpreter association standards.

CUSTOMER RELATIONS POLICY
Patient-satisfaction surveys are translated for non-English-speaking patients.
Interagency collaborative projects exist in racial/ethnic neighborhood communities in your service area.

* Cultural Competence Organizational Self-Assessment (CCOSA)
Financial Incentives

- Rate Year [RY] 2008
  - $4.5M was allocated for payments for performance on the structural measures;

- By RY 2010, this was set to increase to $20M for performance on the structural measures and $12M for disparities on the clinical measures.
  - >$300,000 per hospital for the structural measures, >$180,000 per hospital for the clinical measures.
  - Compare with Premier Hospital Quality Incentive Demonstration = ~$33,000 per hospital per year from 2003 through 2006
Care of minorities is relatively concentrated compared with whites.
Hospital-level Absolute Risk Differences (ARDs): White minus Black, RY 2009
Hospital-level Absolute Risk Differences (ARDs): White minus Latino, RY 2009
Hospital-level Between Group Variance (BGV) Values

- BGV: no difference
- BGV: sig lower
- BGV: sig higher

BGV 95% CI
Mean BGV Mean BGV 95% CI
Mixed Reactions from Hospital Community

- Hospitals Failing, 20
- Hospitals Passing, 45

- Strong stated support for the program’s goal
- Participation required extraordinary effort
- Frustration with the effort required to adapt to the clinical reporting system
- CCOSA checklist felt to be “ambiguous”
- Perceived focus on documentation at the expense of quality improvement

* Cultural Competence Organizational Self-Assessment (CCOSA)
Lessons

- Context Matters
- Sample size problems should be addressed up front
- Disparities indicators may need to be re-considered after examining the data
- Complex questions elicit nuanced answers
- The “between” problem should be examined along with the “within” problem.
We thank Terri Yannetti, Phyllis Peters, and Iris Garcia-Caban, PhD, the entire staff of the Massachusetts Office of Medicaid, and Anuj Goel from the Massachusetts Hospital Association (MHA), for their help and guidance.

The views expressed in this presentation are those of the authors and no official endorsement by the Executive Office of Health and Human Services, the Office of Medicaid, or the MHA is intended or should be inferred.
“In order to eliminate disparities in health, we need leaders who care enough, know enough, will do enough and are persistent enough.”

- David Satcher, M.D., Ph.D.
- Former Surgeon General of the U.S.
End of Presentation
Extra Unused Slides Follow
### Health Disparities Measurement & Incentive Strategy

<table>
<thead>
<tr>
<th>Strategy</th>
<th>RFA08 (Yr.1) HD-1 Structural Measure</th>
<th>RFA09 (Yr. 2) HD-2 Clinical Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Approach</strong></td>
<td>Reward Hospitals to improve organizational factors that reduce racial/ethnic health disparities.</td>
<td>Reward Hospitals to report data by Race/Ethnicity &amp; reduce disparities in clinical quality measures</td>
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</tbody>
</table>
| **Performance Measure** | Require Hospitals to implement CLAS standards regardless of patient R/E/L mix served. | Clinical Quality Measures:  
  - Maternity/Newborn indicators  
  - Pediatric Asthma indicators  
  - Pneumonia indicators  
  - Surgical Infxn Prevention indicators |
| **Performance Assessment Method** | CLAS Validation Rate  
  - CLAS Best Practice Rating  
  - CLAS Measure Score | Data Validation Rate (RY09)  
  - Clinical Disparity Measure Score (RY2010) |
| **Bonus Payment Approach** | Earn payments for meeting performance thresholds on organizational factors (implementing CLAS). | Earn payments for meeting performance thresholds on clinical disparities measures |
### MassHealth Acute Hospital Clinical Quality Measures Set*

<table>
<thead>
<tr>
<th>MATERNITY &amp; NEWBORN</th>
<th>PEDIATRIC ASTHMA</th>
<th>SURGICAL INFECTION PREVENTION</th>
<th>COMMUNITY ACQUIRED PNEUMONIA</th>
<th>HEALTH DISPARITIES</th>
</tr>
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<tbody>
<tr>
<td>MAT-1: Intrapartum Antibiotic prophylaxis for Group B Streptococcus</td>
<td>CAC-1: Children’s Asthma Care - Inpatient use of relievers</td>
<td>SCIP-1a: Prophylactic Antibiotic w/in 1hr prior to surgical incision</td>
<td>PN-1: Oxygenation Assessment (RETIRED)</td>
<td>HD-1: (RY09+RY10) Cultural &amp; Linguistic Appropriate Service (CLAS) Standards</td>
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<td>PN-5c: Initial Antibiotic received within 6 hrs of arrival</td>
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<td>PN-6: Appropriate Antibiotic selection for immuno-competent patients</td>
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*MassHealth Presentation to Health Care Quality and Cost Council, Expert Panel on Performance Measurement, January 8, 2010 Meeting*
Jan/Andy – Any chance we could make a graph out of this, e.g., a cumulative distribution graph? y access = % of care; x access = number of hospitals

From text:
...2/3 of the opportunities from African-American patients emanated from 10 hospitals; 89% came from 20 hospitals; and 96% came from 30 hospitals. Similarly, for Latino patients, 2/3 of the opportunities emanated from just 10 hospitals; 88% came from 20 hospitals, and 95% came from 30 hospitals. In contrast, for white patients 40% of opportunities came from 10 hospitals, 63% came from 20 hospitals, and 79% came from 30 hospitals. Eight of the state’s hospitals reported zero opportunities for non-white patients.
Care of minorities relatively concentrated

- **Blacks**
  - 66% of opportunities from 10 hospitals
  - 89% of opportunities from 20 hospitals

- **Hispanics**
  - 66% from 10 hospitals;
  - 88% from 20 hospitals

- **Whites**
  - 40% from 10 hospitals,
  - 63% from 20 hospitals