

# Pay-for-Performance to Reduce Racial and Ethnic Disparities in Health Care in the Massachusetts Medicaid Program

Recommendations of the  
Massachusetts Medicaid Disparities Policy Roundtable

July 2007



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All acute hospitals in the state were invited to comment on the Roundtable's deliberations. The contents of this paper represent the collective opinions and recommendations only of the Roundtable members. Except where noted, they are not intended to represent the opinions or recommendations of any member's employing organization or the funding organizations.

## **About the Massachusetts Medicaid Policy Institute**

The Massachusetts Medicaid Policy Institute (MMPI) is an independent and nonpartisan source for information and analysis about the Massachusetts Medicaid program, "MassHealth." MMPI promotes broader understanding of MassHealth and its interrelatedness with other health care programs for low-income people, and a more rigorous and thoughtful public discussion of the program's successes and the challenges ahead.

## **About the MetroWest Community Health Care Foundation**

The MetroWest Community Health Care Foundation is an independent philanthropy addressing the health needs of twenty-five communities in the MetroWest area of Massachusetts. The Foundation meets the health care needs of the region's residents by supporting community-based and community driven programs, and by encouraging and fostering leadership on critical health issues.

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# Acronyms and Definitions

<b>Appendix G</b>	An appendix to the annual MassHealth request for applications which contains measures relevant to the structure of health care for racial and ethnic minority patients
<b>CMS</b>	Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services
<b>DHCFP</b>	Division of Health Care Finance and Policy, Executive Office of Health and Human Services, Commonwealth of Massachusetts
<b>DPH</b>	Department of Public Health, Executive Office of Health and Human Services, Commonwealth of Massachusetts
<b>MassHealth</b>	The Massachusetts Medicaid Program
<b>MHA</b>	Massachusetts Hospital Association
<b>PAPE</b>	Payment Amount Per Episode, the MassHealth payment methodology applied to acute hospital outpatient departments and hospital-licensed health centers
<b>PCCP</b>	Primary Care Clinician Plan, a primary care case management program administered by MassHealth
<b>RFA</b>	Request for Applications, the annual Medicaid provider agreement for acute care hospitals, which includes MassHealth rates and payment methodologies
<b>SPAD</b>	Standard Payment Amount per Discharge, the MassHealth payment methodology applied to acute hospital inpatient services

# Executive Summary

The 2006 Massachusetts health care reform legislation included a provision to make Medicaid hospital rate increases contingent upon quality measures, including measures of the reduction of racial and ethnic disparities in health care. While the use of pay-for-performance incentives is growing rapidly across the nation, most initiatives are relatively new, and experience with measurement and target setting is comparatively limited. To date, no other pay-for-performance programs have incorporated measures of the reduction of racial and ethnic disparities into their incentives, making the Massachusetts initiative a first test of the feasibility and impact of this approach.

A variety of concerns have been raised about the ways in which pay-for-performance quality incentives may result in increasing racial and ethnic disparities in care. For example, incentive programs have the potential to result in providers selecting patients with more favorable characteristics, and rate increases designed to reduce disparities could inadvertently penalize institutions serving larger minority populations. Such programs could have a host of other unintended consequences as well. As a result, close consideration to the design of the Massachusetts program will be crucial to success.

In response, the Massachusetts Medicaid Policy Institute organized the Massachusetts Medicaid Disparities Policy Roundtable to bring together a variety of experts to develop and recommend an accurate and fair approach to implementing the program. MetroWest Community Health Care Foundation provided additional grant support to the Roundtable, which considered a broad array of issues that could affect program design and its likelihood of success.

This paper documents the issues the Roundtable considered and its recommendations to the Commonwealth regarding program implementation. These are summarized in Table ES-1.

At the time this paper is being released, MassHealth is preparing for the fiscal year 2008 implementation of the program, which will begin October 1, 2007.

**Table ES-1. Summary of Recommendations**

Issue	Summary of main recommendation	Is this a consensus recommendation?
1. Should Medicaid hospital rate increases be contingent solely on inpatient measures, or on both inpatient and outpatient measures?	Measures should focus solely on the inpatient and emergency department settings.	Yes.
2. What criteria should be used in measure selection?	10 criteria are recommended.	Yes.
3. What measures beyond those specifically mentioned in the legislation should be considered? What measures should the Roundtable recommend to the state?	Measures should focus on 5 areas in addition to the measures included in Appendix G of the MassHealth RFA: <ul style="list-style-type: none"> <li>• Pediatric asthma;</li> <li>• Obstetrical care;</li> <li>• Patient safety, adverse events, and serious reportable events;</li> <li>• National Hospital Quality Measures for pneumonia and Surgical Care Improvement/Surgical Infection Prevention; and</li> <li>• Patient experiences with care</li> </ul>	Yes, except for the obstetrical care measures.
4. Should the measures in Appendix G of the MassHealth RFA be included in the measure set?	A subset of measures are recommended for inclusion.	Yes, with one concern raised.
5. Should the state have a list of measures from which hospitals can choose?	No recommendation is made. Guidance is offered if the state decides to have a list of measures from which hospitals can choose.	No.
6. Should MassHealth use a single composite measure in the rate setting process?	The development of a composite measure should not be considered until the Commonwealth has at least one year of experience with collecting the initial measure set from hospitals.	Yes.
7. Should the state reward the achievement of fixed performance goals, improvement over time, or on a per-patient basis?	The state should use an approach that incorporates rewards for improvement over time, conditional on reaching a minimum acceptable level of achievement.	Yes.
8. Should performance be measured in terms of the disparity between “advantaged” and “disadvantaged” groups, or in terms of performance level/ level of improvement for the disadvantaged group?	The state should measure both changes in performance level for disadvantaged groups and changes in disparities between advantaged and disadvantaged groups.	Yes.

Issue	Summary of main recommendation	Is this a consensus recommendation?
9. Which racial or ethnic groups should be included? What is the minimum sample size? Which racial or ethnic groups should be combined due to sample size considerations?	The state should look to the minimum sample size recommended for use with each measure that is selected for guidance on sample size. The state should require hospitals to produce measures for all racial and ethnic groups for which they meet the minimum sample size requirement.	Yes.
10. Is risk- or case-mix adjustment for health differences between racial and ethnic groups needed, and if so, when? Should this include some form of socioeconomic risk adjustment?	The state should consider some form of risk or case-mix adjustment for outcome measures, but should not do so until there is at least one year of experience with collecting the initial measure set from hospitals.	Yes.
11. Should the state measure disparities only within the Medicaid population, or among all of a hospital's patients?	Rate increases should be based on all-payer data, while emphasizing measures that are of particular importance for the Medicaid population.	No.
12. How can the measurement system be designed so that hospitals with large minority patient populations are held accountable but are not disadvantaged by the large number of patients they would need to work with in order to reduce disparities?	The design of the payment program should account for the size of the minority patient population served by each hospital.	Yes.
13. Should disparities measures be publicly reported?	The state should develop a public report card to annually assess the current state and trends in racial and ethnic disparities in care in Massachusetts. This report should include data from all hospitals combined, but should not include information on individual hospitals' performance. The report card should include data from sources beyond the MassHealth pay-for-performance program.	Yes.

Issue	Summary of main recommendation	Is this a consensus recommendation?
14. How can MassHealth improve its access to data on the race and ethnicity of its members?	MassHealth should work with DHCFP to use the race and ethnicity data that are reported to DHCFP on the hospital discharge data in order to improve race and ethnicity information in the MassHealth enrollment database.	Yes.
15. What strategies could MassHealth employ to expand the measures available for the pay-for-performance program and minimize the burden of measurement on hospitals?	MassHealth should work with DHCFP to use submitted hospital discharge data to supplement the measures used in the pay-for-performance/disparities reduction program. MassHealth should work with DPH to develop additional measures for this program.	Yes.

## A. Introduction

On April 4, 2006 the Massachusetts House and Senate approved a comprehensive health care reform bill by overwhelming margins; it was signed by the Governor on April 12, and vetoed sections were subsequently overridden by the legislature. The bill not only extended health insurance coverage to hundreds of thousands of Massachusetts residents, but also included provisions to address racial and ethnic disparities in health care. Among these was a provision to make Medicaid hospital rate increases contingent upon quality measures, including measures of the reduction of racial and ethnic disparities in health care.<sup>1</sup>

While the use of pay-for-performance incentives is growing rapidly across the nation, most initiatives are relatively new, and experience with measurement and target setting is comparatively limited.<sup>2</sup> As of July 1, 2006, more than half of state Medicaid programs were running pay-for-performance programs, and within the next 5 years, that number is expected to rise to 85 percent.<sup>3</sup> Despite the prevalence of pay-for-performance initiatives in state Medicaid programs, the Massachusetts effort is the first known to set pay-for-performance targets in health care based on the race and ethnicity of patients, and it provides an innovative financial approach to incentivizing the reduction of disparities. To date, Medicare and commercial insurers' pay-for-performance programs have not incorporated measures of the reduction of racial and ethnic disparities, making the Massachusetts initiative a first test of the feasibility and impact of this approach.

Concerns have been raised that pay-for-performance quality incentives may result in increasing racial and ethnic disparities in care.<sup>4</sup> For example, incentive programs have the potential to result in providers selecting patients with more favorable characteristics, and one public reporting program has been associated with increases in racial and ethnic disparities as a result.<sup>5</sup> It is also possible that rate increases designed to reduce disparities could inadvertently penalize institutions serving larger minority populations if they need to reach a larger number of patients to achieve a given performance target. Another potential effect is that the tendency to “teach to the test” – that is, to increase the focus on the areas being measured, while deemphasizing other areas – might disproportionately affect minority patients.<sup>6</sup> Such programs could have a host of other unintended consequences as well. As a result, close consideration to the design of the Massachusetts program will be crucial to success not only in the Commonwealth, but potentially in other programs elsewhere in the nation.

In response, the Massachusetts Medicaid Disparities Policy Roundtable was organized to bring together a variety of experts to develop and recommend an accurate and fair approach to implementing the program. The work of the Roundtable was sponsored by the Massachusetts Medicaid Policy Institute and the MetroWest Community Health Care Foundation. Although this project was independent of state efforts, MassHealth had representatives at each of the Roundtable meetings. The 15 Roundtable members represented hospitals, Medicaid and commercial insurers, researchers, community based organizations, and health care quality and quality measurement organizations.

The Roundtable considered a broad array of issues that could affect program design and its likelihood of success. Although consensus was not the goal of the Roundtable's efforts, deliberations on most issues did result in consensus recommendations. For the remaining issues, a diversity of opinions is represented. This paper documents the Roundtable's recommendations to the Commonwealth regarding program implementation.

## B. Improving Racial and Ethnic Disparities

### **Health care and health disparities**

A significant proportion of disparities in health outcomes reflect conditions outside of the health care setting, and health care providers' ability to ameliorate overall health disparities will always be limited by their inability to influence a wide variety of social determinants of health, such as housing, income, and nutrition. At the same time, however, disparities in the quality of health care, the existence of which has been extensively documented, are inherently unfair, and the Institute of Medicine has defined equity as one key component of high-quality health care.<sup>7</sup> High-quality, appropriate health care is also one way to decouple social determinants from adverse health outcomes, and disparities may worsen if there is unequal access to efficacious health care interventions.<sup>8</sup> Efforts devoted to reducing disparities in the quality of health care can thus have a larger impact on health disparities.

### **Pay-for-performance for reducing racial and ethnic disparities**

Pay-for-performance is a relatively new tool for incentivizing quality improvement, and may prove to be a blunt instrument that can affect only a small part of racial and ethnic disparities in care. The evidence base about the effectiveness of pay-for-performance programs is quite limited,<sup>9</sup> and at least one study has found no increase in quality of care among hospitals participating in a pay-for-performance program.<sup>10</sup> At the same time, comparatively little is known about effective methods for reducing disparities in the quality of health care, so pay-for-performance financial incentives may help spur innovative approaches, or may simply result in provider frustration. As a result, it is unclear whether melding pay-for-performance with disparities measures will have the desired effect of reducing disparities in care. The Massachusetts program provides an opportunity to test program designs and assess their impact on disparities reduction. Indeed, given how little is known about the impact of pay-for-performance directed toward the reduction of racial and ethnic disparities, it is incumbent upon MassHealth to proceed in a manner that will facilitate evaluation and adaptation of the program as knowledge is accumulated.

The ability to use pay-for-performance approaches is limited by the availability of accepted, reliable, and valid measures. To date, most quality measures have focused on processes of care rather than patient outcomes. Although process and outcome measures have been stratified to assess disparities, there is currently no widely-accepted set of measures designed specifically to assess racial and ethnic disparities. The National Quality Forum currently has a Technical Advisory Panel on Disparities that is working to develop a disparities measure set for use in ambulatory settings, though this will be of limited use for the current MassHealth hospital-based efforts.

In addition, the effectiveness of pay-for-performance programs for reducing disparities will be affected by the funds available for incentive payments and the cost to providers of conducting the measurement and improvement activities. Both of these can be influenced by the design and implementation of the program in Massachusetts. One approach to minimizing the cost of measurement is to leverage other pre-existing quality and safety requirements in Massachusetts, stratifying those measures by patients' race and ethnicity to inform the pay-for-performance efforts. It would be helpful for the state to provide some technical support to help providers implement new measurement activities.

### **Incentivizing desirable activities**

In addition to its direct effects, the pay-for-performance program can be used to incentivize desirable activities that can help to further reduce disparities and improve the quality of care. For example, incentives that encourage hospitals to expend extra effort on discharge planning for patients with limited English proficiency can result in translated discharge instructions and improved patient understanding, which may improve post-hospitalization care and treatment adherence, reduce readmissions, and improve outcomes. Similarly, from a public health perspective, MassHealth might try to incentivize emergency departments to better connect patients to primary care, as this is an area with documented racial and ethnic disparities. This may be particularly relevant for certain health conditions, such as asthma, where incentives could be designed to encourage hospitals to be more creative in helping asthma patients who visit their emergency departments to connect with a medical home. By stressing preventive measures to minimize repeat visits to the emergency department, such activities could potentially contribute to reductions in racial and ethnic disparities in the disease burden of asthma, such as existing disparities in lost school days and other consequences of poorly managed conditions.

## C. Background on MassHealth Payments and Pay-for-Performance

MassHealth develops an acute hospital annual request for applications (RFA) for contracting with hospitals which describes the requirements for participation in MassHealth for the following contracting year (October 1 to September 30). Every acute general hospital in Massachusetts currently participates in MassHealth, and it is not likely that any would discontinue participation as a result of new pay-for-performance requirements.

The program uses two different payment methodologies: inpatient services are paid on a hospital-specific per discharge basis (the Standard Payment Amount per Discharge, or SPAD), while outpatient services are paid on a hospital-specific per-episode basis (the Payment Amount Per Episode, or PAPE). The SPAD includes all but professional services, which may be billed separately. The PAPE includes all service delivered in one day except for professional and lab services, which may be billed separately.

Annually, MassHealth makes approximately \$450 million in payments for hospital inpatient services, and \$400 million in payments for outpatient services. The 2006 legislation makes a total of \$76.5 million available for rate increases to hospitals in each of three fiscal years, 2007, 2008 and 2009. It is anticipated that \$20 million of this amount will fund the pay-for-performance program – including, but not limited to, the portion related to disparities – for each of fiscal years 2008 and 2009.<sup>11</sup> This constitutes less than two percent of the total acute hospital budget for MassHealth.

The potential population for the pay-for-performance and disparities program includes patients in the primary care clinician plan (PCCP) as well as those with fee-for-service coverage. MassHealth members who are enrolled with one of the four contracting managed care organizations and dual eligibles who are covered by both Medicare and Medicaid are not eligible for inclusion. Mental health services are carved out for PPCP members, and are thus excluded from consideration for the pay-for-performance program.

Given the population they serve, the focus of MassHealth's quality measurement efforts to date has been on maternity care, neonatal and pediatric care, and cultural competence. Typical hospital quality measures that have been used for other pay-for-performance programs are not likely to be useful for the MassHealth population. For example, many programs make use of the National Hospital Quality Measures cardiac care inpatient measures; however, there are few MassHealth admissions for cardiac care.

To date, quality measures the state has used have focused on practices and the structure of care, with measures drawn largely from Appendix G, which has been included in the acute hospital RFA in various forms for more than a decade. Appendix G asks hospitals to report on a wide variety of activities relating to improving care for diverse patients, such as translating patient education materials into a variety of languages, examining quality data by patients' race and ethnicity, and requiring cultural competency training for health care providers.

Data for certain measures could potentially be collected from MassHealth claims data or the birth certificate data reported by hospitals to DPH, especially for maternity measures. Other measures would require reporting from hospitals, and might require chart review to validate the reported data. MassHealth has the ability to change the required measures annually, but is being strongly encouraged by hospitals not to do so, given the complexities and costs of measurement.

In a separate initiative, the Division of Health Care Finance and Policy now requires all hospitals in Massachusetts to collect data on patients' race and ethnicity for all inpatient stays, observation unit stays, and emergency department visits. This will be helpful in measurement for the pay-for-performance requirements, as approximately 70% of MassHealth enrollees do not currently provide the optional race and ethnicity data on the MassHealth enrollment form.

In a May 23, 2007 presentation to the Health Care Quality and Cost Council, Tom Dehner, the Acting Medicaid Director for the Commonwealth, outlined the approach to the pay-for-performance program that is currently under consideration, including the disparities-related provisions. Work to date has involved three steps: identifying MassHealth areas of strategic importance, identifying MassHealth quality goals, and selecting the criteria by which measures will be chosen. The presentation described MassHealth's plan to base incentives on five areas, one of which is racial and ethnic disparities. For the first year, the plan includes incentives that reward performance (pay-for-performance) only in areas where data have been collected in the past; it also includes pay-for-reporting for new measures. For disparities, the first year plan includes only measures related to the Culturally and Linguistically Appropriate Services (CLAS) standards, presumably those currently included in Appendix G of the MassHealth RFA. For the second year, the plan includes reporting of clinical measures in four categories relevant to the Medicaid population for hospitals "with sufficient volume of patient race/ethnic mix."<sup>12</sup>

## D. Considerations for Implementing the Program

Three global implementation issues arose throughout the Roundtable's deliberations: short- vs. long-term efforts, infrastructure changes, and what can be measured with available data.

### **Short- vs. long-term efforts**

The Roundtable recognizes the tension between developing an ideal approach to implementation and the need to have a program in place quickly. What is readily measurable in the short term may not be the most helpful, and it may take a longer-term investment in data or measure development to ideally measure disparities in the quality of hospital care in Massachusetts. An incremental approach may be useful in at least two ways:

- The first year of the program may focus on pay-for-reporting rather than pay-for-performance per se, providing financial incentives for obtaining and reporting necessary data and measures rather than for improvement;
- In the longer run, the Roundtable recommends that outcome measures should be included as measures of disparities reduction, as improvement in health outcomes is the ultimate goal of any disparities-reduction effort. However, most current, widely-accepted quality measures focus on processes of care, so it may be necessary to delay the inclusion of outcome measures by one or more years until the validity of a set of outcome measures is established.

The Roundtable cautions, however, that an incremental approach not be used to indefinitely postpone measurement or improvement activities that are more complex or require more time or effort to conduct.

### **Infrastructure changes**

Changes to infrastructure may come before improvements in clinical quality measures. For example, having all discharge instructions translated into the patient's preferred language or ensuring that patients either receive care from a language-concordant provider or via an interpreter require changes to infrastructure, staffing, and activities. It is likely worth financially incentivizing such changes even when it is too early to observe resulting improvements in the quality of care or in health outcomes.

### **Measuring from available data**

Quality measurement requires a significant investment of time and effort from hospitals, and stratifying quality measures by patients' race and ethnicity adds a level of complexity. A recent national survey of Medicaid and SCHIP directors identified limited resources as well as data and technology limitations as challenges to engaging in more performance measurement programs.<sup>13</sup>

As a result, the Roundtable recommends that MassHealth emphasize a balance between what hospitals are asked to report and what could be measured about hospitals without their effort using data from the Division of Health Care Finance and Policy and the Department of Public Health. In addition, the Roundtable recommends that MassHealth, the Division of Health Care Finance and Policy, and the Department of Public Health provide as much data as possible to hospitals about their own performance and that of a de-identified comparison group.

## E. Recommendations

### Issues considered by the Roundtable

The Roundtable set out to consider 12 separate but interrelated issues:

#### Measures

1. Should Medicaid hospital rate increases be contingent solely on inpatient measures, or on both inpatient and outpatient measures?
2. What criteria should be used in measure selection?
3. What measures beyond those specifically mentioned in the legislation should be considered? What measures should the Roundtable recommend to the state?
4. Should the measures in Appendix G of the MassHealth RFA be included in the measure set?
5. Should the state have a list of measures from which hospitals can choose?
6. Should MassHealth use a single composite measure in the rate setting process?

#### Methods

7. Should the state reward the achievement of fixed performance goals, improvement over time, or on a per-patient basis?
8. Should performance be measured in terms of the disparity between “advantaged” and “disadvantaged” groups, or in terms of performance level/level of improvement for the disadvantaged group?
9. Which racial or ethnic groups should be included? What is the minimum sample size? Which racial or ethnic groups should be combined due to sample size considerations?
10. Is risk- or case-mix adjustment for health differences between racial and ethnic groups needed, and if so, when? Should this include some form of socioeconomic risk adjustment?
11. Should the state measure disparities only within the Medicaid population, or among all of a hospitals’ patients?
12. How can the measurement system be designed so that hospitals with large minority patient populations are held accountable but are not disadvantaged by the large number of patients they would need to work with in order to reduce disparities?

During the course of its deliberations, the Roundtable identified three additional issues for consideration:

13. Should disparities measures be publicly reported?
14. How can MassHealth improve its access to data on the race and ethnicity of its members?
15. What strategies could MassHealth employ to expand the measures available for the pay-for-performance program and minimize the burden of measurement on hospitals?

Each of these issues, including major considerations, the Roundtable's recommendation, and the extent of consensus or dissent, is described below.

## **Recommendations on measures**

### **1. Should Medicaid hospital rate increases be contingent solely on inpatient measures, or on both inpatient and outpatient measures?**

#### *Major considerations*

The legislation does not specify the inclusion of inpatient or outpatient measures, and MassHealth has specifically requested that the Roundtable focus on inpatient and emergency department measures, as it will be considering physician outpatient pay-for-performance measures separately in its physician program. In addition, not all hospitals in the state provide the same range of ambulatory services, making the inclusion of outpatient measures in the hospital rate setting program impractical.

#### *Recommendation*

The Roundtable recommends focusing hospital performance incentives solely on measures in the inpatient and emergency department settings.

#### *Consensus/dissent*

This is a unanimous recommendation.

### **2. What criteria should be used in measure selection?**

#### *Major considerations*

There are comparatively few established measures that apply to the majority of the MassHealth population, so relying on widely accepted measures such as the National Hospital Quality Measures will not completely meet the program's needs. While evidence-based measures are strongly preferable, there is a wide range of views on what could be called "evidence based." In addition, measures need to be practical for the state to implement and feasible for hospitals to produce.

#### *Recommendation*

The Roundtable recommends the following criteria for measure selection:

- a. It is preferable to use measures that have been tried and tested by other national or statewide organizations.
- b. Measures of processes of care should have demonstrated links to health outcomes.
- c. Measures should represent a process or outcome of care that has significant impact on the MassHealth population.
- d. The administrative burden needs to be reasonable for hospitals, and feasibility of measurement is a major consideration. As more hospitals move to electronic health records, and current

electronic health records are improved, this criterion will become somewhat easier to achieve. However, measures requiring chart review pose a significant time and cost burden even in hospitals using advanced electronic health records, and it is likely best to limit chart review to measures that can be based on a sample of patients. To reduce administrative burden and to allow for alignment of various hospital projects and priorities, it is preferable to use measures that are already collected and reported for other purposes (e.g., reporting to CMS or MassHealth) when possible.

- e. Ideally, measures should be known to have considerable variation across hospitals within Massachusetts.
- f. Ideally, measures should have demonstrated significant associations with racial and ethnic disparities in health care either within or outside of Massachusetts.
- g. Measures should focus on processes of care, outcomes of care, and patient experiences with care.
- h. It is preferable to use measures that can be obtained without a significant time lag between an event and its measurement.
- i. Measures should be amenable to improvement.
- j. Measures should be applicable to all or most hospitals in the Commonwealth. For example, while obstetrical care is a major component of the services MassHealth pays for and therefore likely should be included, a measure set focusing exclusively on obstetrical care would not be helpful, since not all hospitals provide these services.
- k. MassHealth should consider examining racial and ethnic disparities in the measures being used for the non-disparities component of the pay-for-performance incentive program.

The Roundtable recognizes that no measure is likely to meet all of these criteria, and that there are explicit tradeoffs to be made among different criteria when selecting specific measures. For example, more clinically rigorous measures might have a stronger evidence base, but may require extensive chart review and therefore be less feasible for hospitals. However, arraying potential measures against this set of criteria can help when selecting specific measures to use for this initiative.

Also, as a practical matter, it is likely that criterion “k” would be the most useful early in the program’s implementation. The Roundtable recommends that in the short run, MassHealth begin by stratifying the measures being used for the main pay-for-performance incentive program by race and ethnicity, and adding to them a selected set of measures from Appendix G (see recommendation #4). In the longer run, a fuller measure set may add to the Commonwealth’s ability to significantly impact the reduction of racial and ethnic disparities.

#### *Consensus/dissent*

This is a unanimous recommendation.

**3. What measures beyond those specifically mentioned in the legislation should be considered? What measures should the Roundtable recommend to the state?**

*Major considerations*

The legislation specifically mentions the use of measures employed by the Hospital Quality Alliance/National Quality Forum and the Boston Public Health Commission. Beyond this, the measures need to be relevant to the MassHealth population, focusing on inpatient and emergency department measures. Many standard quality measures will not have adequate sample size for the MassHealth population, such as those for acute myocardial infarction. Of interest are the top 10 diagnoses for MassHealth fee-for-service and Primary Care Clinician plan patients. These include 6 obstetrical diagnostic related groups (DRGs #629, 373, 372, 371, 370, and 383) as well as chronic obstructive pulmonary disease, simple pneumonia and pleurisy over age 17 with complications, chest pain, and cellulitis over age 17 with complications. All other diagnoses are relevant to 1% or fewer of MassHealth discharges.

Mental health measures do not need to be included, as mental health is a carve out for most of the population covered by the RFA and is not included in the rate increase provisions.

*Recommendation*

Given these considerations, the Roundtable recommends that MassHealth consider the following 5 measure sets in addition to measures from Appendix G:

- *Pediatric asthma.* Existing quality measures for care received in the emergency department should be considered for inclusion. Prior research has shown significant racial and ethnic disparities in the prevalence of asthma, and minority patients miss more school and work days, have poorer health status, and are more likely to receive their asthma care in the emergency department than white asthma patients.<sup>14</sup>
- *Obstetrical care.* Currently, there are no widely-accepted quality of care measures for obstetrical care, but as these are developed, the Roundtable recommends including them as measures in the pay-for-performance incentive program. The Betsey Lehman Center for Patient Safety and Medical Error Reduction at the Department of Public Health is convening an Obstetrics Expert Panel to examine patient safety in obstetrics; the work of this panel is due to be completed in 2007, and may provide guidance on potential obstetrics measures. In addition, the Roundtable recommends that MassHealth consider disparities in breastfeeding rates for newborns at discharge as one measure to include in the pay-for-performance measure set; these data are currently collected by DPH. While this involves a considerable amount of individual preference, the choice to breastfeed may also depend on lactation counseling and other services provided while the new mother is in the hospital, and monitoring this would be helpful from a public health perspective. Prior research has shown significant racial and ethnic disparities in breastfeeding in Massachusetts, particularly for ethnic subgroups, and significant racial and ethnic disparities in birth outcomes in the U.S.

- *Patient safety, adverse events, and serious reportable events.* Many hospitals now have formal reporting systems to capture relevant events. Prior research has shown significant racial and ethnic disparities in some patient safety indicators, but a lower rate of adverse events among minority patients in others.<sup>15</sup> In contrast, “never events” from the Leapfrog Group are unlikely to happen with sufficient frequency to analyze by race and ethnicity.
- *National Hospital Quality Measures.* MassHealth patients will not have an adequate number of discharges to allow the analysis of the acute myocardial infarction and heart failure measures by race and ethnicity. The Roundtable does recommend including the National Hospital Quality Measures pneumonia and Surgical Care Improvement/Surgical Infection Prevention measures in the pay-for-performance/disparities incentive program.
- *Patient experiences with care.* As hospitals transition to using the H-CAHPS® instrument, as required by the Centers for Medicare and Medicaid Services, measures of patient experiences of care that are comparable across hospitals will be available. Prior research has shown significant racial and ethnic disparities in patients’ reports of experiences with care.<sup>16</sup> H-CAHPS® asks patients about their race and ethnicity, creating the potential for survey vendors to stratify responses for different racial and ethnic groups. The Roundtable recommends using a subset of H-CAHPS® composite scores in the pay-for-performance/disparities incentive program.<sup>17</sup>

These recommendations are generally consistent with the MassHealth plans that were presented at the May 23, 2007 meeting of the Health Care Quality and Cost Council.<sup>18</sup> These plans currently call for base requirements of participating in public reporting initiatives around serious reportable events, and basing incentives on four clinical areas, including maternity and newborn care; community acquired pneumonia; surgical infection prevention; and children’s asthma. While the Roundtable’s recommendations call for examining measures of patient experiences with care, that is not included in the plan MassHealth presented.

In addition, the Roundtable recommends that MassHealth consider examining measures of access to care, particularly the distribution of a hospitals’ patients by race and ethnicity compared to the racial and ethnic distribution of the population in its catchment area and how this relationship may change over time. Such measures are not intended for use as the basis for payment under the pay-for-performance program. Rather, the Roundtable is concerned about the potential unintended consequences of the new pay-for-performance requirement on racial and ethnic disparities in access to care, as it may create an incentive for some hospitals with large disparities to avoid caring for patients from certain racial and ethnic groups. By monitoring relative changes in access to hospital care over time for the MassHealth population in different geographic areas, the state will be alerted to any increased potential for such adverse effects.

Given the number of children covered by MassHealth, one member recommends pursuing additional measures that are applicable to children by examining the frequency of the top 5 pediatric diagnoses and seeking out established applicable measures. In addition, some Roundtable members recommend including measures of pain control in the emergency department and inpatient settings, since substantial racial and ethnic disparities have been demonstrated in this area in the past.<sup>19</sup>

### *Consensus/dissent*

There is general consensus except in the obstetrical care measures. Certain obstetrical care services are already reported in the MassHealth Appendix G, and some Roundtable members recommend including them as measures of the quality of obstetrical care (cesarean delivery; vaginal birth after cesarean; obstetrical trauma/vaginal delivery without instrument; obstetrical trauma – vaginal delivery with instrument; and birth trauma/injury to neonate). In addition, some Roundtable members recommend the use of the obstetrical measures utilized by the Risk Management Foundation.<sup>20</sup>

## **4. Should the measures in Appendix G of the MassHealth RFA be included in the measure set?**

### *Major considerations*

The state is interested in including measures that reflect the structure, processes, and outcomes of care. There are few measures of structure available that relate to racial and ethnic disparities in care, and many of these are included in Appendix G. In addition, the Appendix G measures pose few measurement and no sample size problems. However, it is not clear that as they are currently structured, the Appendix G measures will provide substantial differentiation of performance between hospitals.

### *Recommendation*

A subset of measures from Appendix G should be included in the measure set. The subset of measures recommended by the Roundtable is shown in Table 1.

The Roundtable strongly recommends that these measures be clarified and operationalized. As they currently stand, the Appendix G measures leave considerable room for interpretation. For example, “Hospital patient data is analyzed by race, ethnicity, and languages spoken” could be interpreted as looking at how many patients in each racial, ethnic, and language group come to a particular hospital, or as examining differences in the quality of care provided by race, ethnicity, and language. Similarly, the standard “Patient education materials are translated in languages reflecting non-English speaking groups served” says nothing about having a minimum level of accuracy and readability for the translated documents, both of which will be crucial to their usability. To be meaningful, all of these items need to be more rigorously specified and need to have objective standards against which hospital practices and performance can be assessed.

The Roundtable believes that it is important for all hospitals to have systems in place to collect high-quality race and ethnicity data from each patient (MassHealth Appendix G Hospital-wide standard #13). Recent requirements issued by the Division of Health Care Finance and Policy and the Boston Public Health Commission, in combination with the new Department of Public Health recommended data collection tool, help ensure that progress is being made in this direction statewide. Quality assurance activities will be important for ensuring the accuracy of race and ethnicity reporting by hospitals.

*Consensus/dissent*

There is general consensus on these measures with the exception of one concern raised by the Massachusetts Hospital Association (MHA). MHA would like to point out that any recommendation to expand current requirements based on Appendix G measures should be consistent with current law or regulations. They note that if the state has not mandated a particular requirement in law, regulation, or policy, then it would be difficult to require this of providers in the pay-for-performance process. Other Roundtable members point out that this is an opportunity for new policy development, so MassHealth may choose to promulgate new requirements.

**Table 1. Recommended Measures from MassHealth RFA Appendix G**

<b>Measures 14, 18, 22, 23, and 24 from the Hospital Wide Standards</b>	<b>Relevance to racial and ethnic disparities</b>
<p>“14. Hospital patient data is analyzed by race, ethnicity, and languages spoken.”</p>	<p>This is related to Interpreter Services Checklist #13 and Data Collection Practices #10 and 11 below. All hospitals in Boston are now required to do this, although the measures to be required have not yet been established.</p>
<p>“18. Patient education materials are translated in languages reflecting non-English speaking groups served.”</p> <p>[NOTE: The Roundtable recommends that this be expanded to include translation of patient education materials, treatment materials, informed consent documents, intake questionnaires, and discharge instructions into relevant languages.]</p>	<p>Receiving written materials in a patient’s preferred language is crucial to comprehension, adherence to treatment, and patient safety.</p>
<p>“22. Interpreter Services has minimum performance standards to assure staff/volunteer competency skills.”</p>	<p>Essential to help reduce disparities caused by language barriers.</p>
<p>“23. Hospital interpreters are members of professional medical interpreter association.”</p>	<p>Essential to help reduce disparities caused by language barriers.</p>
<p>“24. Patient satisfaction surveys are translated for non-English speaking patients.”</p> <p>[NOTE: As a practical matter, most survey vendors can conduct surveys in English and Spanish, so this should be the minimum set of languages offered to patients. Where possible, additional languages are preferred to meet the needs of a specific hospital’s patient population.]</p>	<p>Essential for understanding the experiences of non-English speaking patients.</p>
<b>Measures 13 and 14 from the Interpreter Services Checklist</b>	<b>Relevance to racial and ethnic disparities</b>
<p>“13. Language data is used to analyze core quality measures data.”</p>	<p>Essential to help reduce disparities caused by language barriers.</p>
<p>“14. Interpreter data is used to identify targeted QIPs [quality improvement projects] for inpatient care delivery.”</p>	<p>Essential to help reduce disparities caused by language barriers.</p>

**Table 1. Recommended Measures from MassHealth RFA Appendix G (cont'd)**

<b>Measures 3, 4, 10, 11, 12, and 13 from the Data Collection Practices</b>	<b>Relevance to racial and ethnic disparities</b>
"3. Hospital does data quality checks on Race/ Ethnicity categories."	Necessary to ensure high-quality patient race/ ethnicity data.
"4. Hospital provides training to staff on data collection of race/ethnicity."	Necessary to ensure high-quality patient race/ ethnicity data.
"10. Uses race/ethnicity data for administrative reporting."	Essential to identify disparities in individual hospitals.
"11. Uses race/ethnicity data to analyze quality measures data."	Essential to identify disparities in individual hospitals.
"12. Uses race/ethnicity data to analyze Patient Satisfaction Survey data."	Essential to identify disparities in individual hospitals.
"13. Uses race/ethnicity data to identify quality improvement initiatives."	Essential for improving identified disparities.

## **5. Should the state have a list of measures from which hospitals can choose?**

### *Major considerations*

Any set of measures required by the state will pose different challenges for each hospital. Some hospitals may not offer certain services, or may have too few patients for some measures, and the feasibility and level of effort required to provide data for each measure may vary between hospitals. This would argue for allowing hospitals to choose from a list of measures. On the other hand, allowing hospitals to choose their measures creates an incentive for them to select those on which they are likely to do the best, in order to maximize their rate increases. It also makes it more difficult for the Commonwealth to compare hospitals and to assess improvements in disparities in hospital care statewide.

### *Recommendation*

If the state decides to have a list of measures from which hospitals can choose, the Roundtable recommends that hospitals be required to select all measures in a given group, so hospitals can choose among groups of measures, but not among individual measures. For example, a hospital could choose to include all of the pneumonia measures and none of the asthma measures, or vice versa, but not a subset of the pneumonia and a subset of the asthma measures. In addition, all measures available for hospitals to choose from must be important state health priorities, so no hospital will be selecting a set of measures that is less important.

### *Consensus/dissent*

The Roundtable did not reach consensus on this issue. The Massachusetts Hospital Association and some of the hospitals recommend that hospitals have a list of measures to choose from, while other Roundtable members recommend that all hospitals be required to use the same measures, conditional on their providing the services in question (e.g., no obstetrical measures should be required in hospitals that do not have maternity services). Other members recommend that hospitals be allowed to choose some groups of measures to begin their efforts, but should be required to add groups of measures over time until all hospitals are using all measures. There is consensus on requiring hospitals to select all measures in a given group rather than being able to select individual measures.

## **6. Should MassHealth use a single composite measure in the rate setting process?**

### *Major considerations*

The more measures MassHealth uses to determine rate increases, the more complex the process becomes, as hospitals are likely to do better on some measures than on others within a given set. In one sense, using a single composite measure for rate setting would simplify the payment computation. However, creating a true composite measure is itself a time-consuming and intensive process. In addition, it is difficult to develop an appropriate composite measure without a current reporting system in place, and without having a clearly defined and agreed-upon list of measures to contribute to its development. Uniformly applying a composite measure across all hospitals would require that hospitals not be permitted to select from a list of measures, or that they would be required to select all measures in a given group (see issue #5).

### *Recommendation*

The Roundtable recommends that the development of a composite measure be considered once the Commonwealth has at least one year of experience in collecting measures from hospitals. At that time, the Roundtable recommends that MassHealth engage the services of someone with substantial expertise and experience in developing composite measures to evaluate whether to pursue a composite measure or measures and to develop such measures if recommended.

The Roundtable also considered the use of “perfect care” or “all or nothing” measures, in which a patient would need to have received all care on measures for which he/she is eligible in order for the hospital to be credited with having provided quality care.<sup>21</sup> As one type of composite measure, perfect care scores for a given hospital can be significantly lower than the average of scores on individual measures. The Roundtable has a number of concerns about this methodology, including the need for all measures to be very strong; that equal weight is placed on all of the measures, while some may be more important than others; and that the field has limited experience with using such methodology. As such, the Roundtable does not recommend the use of perfect care measures at this time.

### *Consensus/dissent*

This is a unanimous recommendation.

## Recommendations on methods

### 7. Should the state reward the achievement of fixed performance goals, improvement over time, or on a per-patient basis?

#### *Major considerations*

Fixed performance goals reward historical high achievement, while improvement over time tends to favor those institutions with a history of poorer performance, as there is more room for improvement.<sup>22</sup> While rewarding improvement over time is highly desirable, it is difficult to measure with small denominators (e.g., for multiple racial and ethnic groups), and it either takes longer to do or requires the use of small time intervals for measurement (e.g., quarters).<sup>23</sup> In addition, measuring improvement over time requires a baseline to compare against, making an approach using only this methodology impractical during the first year of the program. A third option is to use a methodology that involves a payment for each patient for whom services are provided that meet designated quality standards. One additional consideration is that it may be more costly or difficult to improve care at higher levels of performance than at lower levels, as the population that would need to be reached may be harder to locate and contact, or may be less likely to agree to a certain plan of care.

#### *Recommendation*

The Roundtable recommends that the state use an approach that incorporates rewards for improvement over time conditional on reaching a minimum acceptable level of achievement. To reward both overall quality and disparities reduction in a consistent manner, the Roundtable recommends both:

#### a. Rewarding quality

For each measure, define a minimum acceptable level of quality (MINq). Also define a maximum theoretical level of quality (MAXq), which may be 100% or may be somewhat less if there is community consensus that 100% is not likely achievable for any provider. Set rewards based on the formula

$$(\text{Hospital achievement} - \text{MINq})/(\text{MAXq}-\text{MINq})$$

for all hospitals achieving at least the minimum acceptable level. For example, if the minimum acceptable level of quality = 50%, the theoretical maximum is 98%, Hospital A achieves 65%, and the bonus at risk for Hospital A (based on MassHealth patient volume) is \$10,000, the reward for Hospital A would be calculated as

$$((65-50)/(98-50))*10,000 = \$3,125,$$

while if Hospital A would achieve 80%, its reward would be calculated as

$$((80-50)/(98-50))*10,000 = \$6,250.$$

Alternatively, the bonus could be prorated based on the percentage reduction in the failure rate (98-65 in the first example) rather than the raw success scores in order to recognize that it may

be more difficult to improve care at higher levels of performance. An additional alternative to the fully proportionate rewards would be to calculate bonuses based on the attainment of a series of intermediate goalposts, with more goalposts yielding better outcomes in terms of improving quality and minimizing any unintended consequences of pay-for-performance.

An alternative method for rewarding quality would involve using the most current methodology employed by CMS at any given time for the Medicare program. This methodology is likely to evolve over time, and such changes may be helpful for informing the design of the MassHealth pay-for-performance initiative. CMS has not yet clarified the methodology it will use when it incorporates pay-for-performance into its hospital payment system beyond its initial demonstration projects.

#### b. Rewarding disparities reduction

Assuming that overall quality is already being rewarded, apply the following methodology to each racial or ethnic group for which the hospital sees an adequate volume of patients. For each measure, define a maximum tolerance for disparities (MAXd). Also define a minimum theoretically achievable level of disparities (MINd), which may be 0% or somewhat greater if there is community consensus that 0% is not likely achievable for any provider. Note that minimum and maximum here are reversed from the quality example.

Assume that achievement for a hospital for a given racial or ethnic group X is measured as (achievement for whites) – (achievement for racial or ethnic group X). Set rewards based on the formula

$$(\text{MAXd} - \text{hospital achievement for group X}) / (\text{MAXd} - \text{MINd}).$$

For example, if the maximum tolerance for disparities is 40% (e.g., whites achieve 80% and African Americans achieve 40%), and the minimum theoretically achievable level of disparities is 5% (e.g., whites achieve 80% and African Americans achieve 75%), Hospital A achieves 20%, and the bonus at risk for Hospital A is \$10,000, the reward for Hospital A would be calculated as

$$(40-20)/(40-5) = \$5,714,$$

While if Hospital A would achieve 10%, its reward would be calculated as

$$(40-10)/(40-5) = \$8,571.$$

Alternatively, the bonus could be prorated based on the percentage reduction in the failure rate rather than the raw success scores in order to recognize that it may be more difficult to improve care at higher levels of performance.

Note that this requires partitioning the reward based on the volume of patients seen in each racial or ethnic group for each hospital. As an example, if Hospital A has 60% of its MassHealth patients who are white, 30% who are Latino, and 10% who are African American, and the hospital's overall bonus for reducing disparities totals \$10,000, the amount applied to the

formula above for Latino patients would be \$7,500 (since  $\frac{3}{4}$  of its minority patients are Latino) and for African Americans \$2,500 (since  $\frac{1}{4}$  of its minority patients are African American).

In addition, the Roundtable recommends that comparisons be made with the most advantaged group as the reference.<sup>24</sup>

*Consensus/dissent*

This is a unanimous recommendation.

**8. Should performance be measured in terms of the disparity between “advantaged” and “disadvantaged” groups, or in terms of performance level/level of improvement for the disadvantaged group?**

*Major considerations*

Disparities can change in many ways over time as overall quality improves. A disadvantaged group may improve over time while disparities remain constant or increase, if improvement happens as or more quickly for advantaged groups. Disparities can potentially decrease over time if quality declines as or more quickly for advantaged groups than for disadvantaged groups. Disparities can also be reduced if quality remains constant for disadvantaged groups while declining for more advantaged groups. The intention is not to sacrifice overall performance in order to improve quality for one group, but rather to improve care for all patients while reducing disparities.

In addition, there may be considerable difficulty, given the anticipated population sizes, showing statistically significant reductions in disparities for small units of analysis, particularly for hospitals with small minority patient populations. There may be, however, sufficient numbers to demonstrate disparity reductions at the state level. This would argue for identifying measures that are known to be sensitive to disparity reduction that can be used at the hospital level, and for the state preparing a public report on the state of racial and ethnic disparities across all hospitals using all available measures (see issue #13).

*Recommendation*

The Roundtable recommends that MassHealth measure both changes in performance level for disadvantaged groups and changes in disparities between advantaged and disadvantaged groups. This will help ensure that the payment formula is consistent with the spirit of the legislation – that is, to diminish disparities in care by raising the quality of care for racial and ethnic minority patients.

*Consensus/dissent*

This is a unanimous recommendation.

**9. Which racial or ethnic groups should be included? What is the minimum sample size?  
Which racial or ethnic groups should be combined due to sample size considerations?**

*Major considerations*

Small sample sizes can quickly become a problem when looking at the subset of patients from any racial or ethnic group who meet the criteria for inclusion in a clinical quality measure – for many combinations of measures and racial/ethnic groups, a given hospital may have too few patients to produce reliable estimates.<sup>25</sup> This may also be true for patient satisfaction surveys, particularly if a hospital’s racial and ethnic minority patient population is small and their survey does not include oversampling by race and ethnicity. The Appendix G measures can be applied to all hospitals regardless of the size of their racial or ethnic minority patient populations.

*Recommendation*

The Roundtable recommends that MassHealth look to the minimum sample size recommended for use with each measure selected for guidance, as the sample size recommendation likely reflects the minimum reliability accepted by the group that first developed the measures. For example, the National Hospital Quality Measures pneumonia measure on smoking cessation, as shown on [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov), requires a minimum sample size of 25 patients for estimation. For measuring disparities, this would require 25 MassHealth patients in each racial or ethnic category to be compared. This approach will ensure comparability with how other organizations, including the Centers for Medicare & Medicaid Services, set minimum sample sizes. Where possible for hospitals with sufficiently large racial and ethnic minority patient populations, the Roundtable recommends that comparisons be made for the smallest possible racial or ethnic groups (e.g. Chinese and Hmong rather than Asian). The Roundtable recommends that hospitals (or MassHealth, for any claims-based measures) be required to produce measures for all racial and ethnic groups for which they meet the minimum sample size requirement.

In addition, the Roundtable recommends that the state request data from each hospital on the distribution of its patient population by race and ethnicity, as well as data on the population of each hospital’s geographic catchment area by race and ethnicity; alternatively, these measures could be produced by DHCFP based on discharge and census data. The Roundtable recommends that the state monitor changes in the comparison between these two population distributions over time to ensure that the pay-for-performance incentives do not result in decreasing access to care for racial and ethnic minority patient populations.

*Consensus/dissent*

This is a unanimous recommendation.

**10. Is risk- or case-mix adjustment for health differences between racial and ethnic groups needed, and if so, when? Should this include some form of socioeconomic risk adjustment?**

*Major considerations*

Health status differences between racial and ethnic groups are well documented, and there are major socioeconomic differences between racial and ethnic groups. To be most useful, hospital case-mix adjustment should reflect more than education and income, including measures of health literacy, attitudes about health, and lifelong deprivation, among others; however, these measures are not typically available in hospital data. Failing to account for these differences could disadvantage certain hospitals whose minority patient populations pose more clinical challenges or have differing socioeconomic circumstances, and can also set up an incentive for hospitals to choose to care for patients with more favorable profiles. In contrast, an over reliance on risk adjustment can be used to statistically eliminate the appearance of racial and ethnic disparities in care, particularly for measures of processes of care.

*Recommendation*

The Commonwealth should consider some form of risk adjustment for outcome measures based on socioeconomic characteristics and health status, but does not recommend case-mix adjustment for process measures. However, the Roundtable recommends that the development of risk-adjustment and case-mix adjustment methodologies be considered once the Commonwealth has at least one year of experience in collecting measures from hospitals. At that time, the Roundtable recommends that MassHealth engage the services of someone with substantial expertise and experience in developing risk and case-mix adjustment to recommend appropriate strategies. The Roundtable also recommends that MassHealth consult with an expert in risk adjustment before data collection from hospitals begins to ensure that all of the data elements needed to explore risk adjustment options will be available to the state.

*Consensus/dissent*

This is a unanimous recommendation.

**11. Should the state measure disparities only within the Medicaid population, or among all of a hospitals' patients?**

*Major considerations*

There are a considerable number of factors affecting this recommendation. In favor of basing the rate increases on all-payer data are the following: (1) it helps alleviate the problem of small sample sizes; (2) it avoids focusing narrowly on the Medicaid population, thus avoiding incentives to treat Medicaid patients differently from others; (3) it avoids the problems caused by the considerable churning of the Medicaid enrollee population; (4) it avoids the potential for hospitals having multiple reporting requirements for publicly-financed populations (MassHealth, Commonwealth Care, the Uncompensated Care Pool, and the pool of individuals with insurance coverage who receive other health-related financial assistance from the state); (5) it encourages hospitals to redesign systems to focus on overall quality improvement; (6) it encourages alignment between Medicaid performance goals and those of other payers and (7) it encourages a broader perspective on improving public health in Massachusetts. Countering this, basing the rate increases solely on Medicaid data is a unique policy lever designed to focus on improving quality and reducing disparities for Medicaid enrollees. One additional consideration is that decreasing disparities for the MassHealth population can be a lever to increase overall quality and therefore to reduce any gaps in quality between MassHealth enrollees and other patients.

Another approach would be to request both all-payer and Medicaid-specific data, with rate increases based on some combination of these. The CMS/Premier Hospital Quality Incentive Demonstration project provides one example of this strategy – it required the submission of all-payer data, but based rewards solely on the Medicare population.

*Recommendation*

The Roundtable recommends that rate increases be based on all-payer data, while emphasizing measures that are of particular importance for the Medicaid population. In addition, the Roundtable recommends that the Commonwealth conduct a validation study by pooling data from multiple hospitals once two years of data are available. This would enable examination of any differences in disparities in care between the Medicaid population and the all-payer population.

*Consensus/dissent*

There is general consensus. However, some Roundtable members recommend that the Commonwealth require the reporting of all-payer data, but base financial rewards only on Medicaid performance; this would parallel the methodology used in the CMS/Premier Hospital Quality Incentive Demonstration.

**12. How can the measurement system be designed so that hospitals with large minority patient populations are held accountable but are not disadvantaged by the large number of patients they would need to work with in order to reduce disparities?**

*Major considerations*

A level playing field is essential for holding all hospitals in the Commonwealth equally accountable for improving racial and ethnic disparities in care. Designing a system that accomplishes this requires balancing two perspectives. First, in order to achieve similar reductions in disparities, hospitals with larger minority patient populations may have to conduct outreach or change their services for substantially more patients and at greater cost than hospitals with smaller minority patient populations. On the other hand, hospitals that serve small minority populations can have disparities in their quality measures strongly affected by what happens in the process of caring for very few patients. To the extent that minority patients in these hospitals may report lower satisfaction, refuse certain types of treatment, or otherwise be likely to lower a hospital's quality measures, the hospital's performance may be disproportionately affected by a small number of patients.

*Recommendation*

The design of the payment program should account for the size of the minority patient population served by each hospital. One way to accomplish this is to include an adjustment for the volume of minority patients seen for each measure related to individual patients (i.e., excluding the Appendix G measures). This adjustment should include a component for the total number of racial and ethnic minority patients seen and a component for the proportion of the hospital's patient population they comprise.

*Consensus/dissent*

This is a unanimous recommendation.

## Additional recommendations

### 13. Should disparities measures be publicly reported?

#### *Major considerations*

Like pay-for-performance, public reporting for individual hospitals may encourage transparency and improvement, but may also have the unintended effect of encouraging hospitals to avoid caring for patients who may make their publicly-reported rates worse. In the only research study that has examined the impact of public reporting on racial and ethnic disparities in care, Werner and colleagues found that the release of coronary artery bypass graft public report cards was associated with an increased disparity between white versus black and Latino patients.<sup>26</sup> At the same time, public reporting at the state level can serve to increase accountability and track progress toward reducing disparities in Massachusetts over time.

#### *Recommendation*

The Roundtable recommends the development of a public report card to annually assess the current state and trends in racial and ethnic disparities in Massachusetts. This report card would include data for the entire state and for different regions within the state, and would include all of the measures used by MassHealth for the pay-for-performance initiative, but would not include information on individual hospitals' performance. Most individual hospitals are not likely to have enough patients to analyze their data beyond looking at broad racial and ethnic groups (e.g., white, black, Latino). However, by combining data from all hospitals, the state will be able to analyze disparities for the subgroups for whom race and ethnicity data are reported to the Division of Health Care Finance and Policy, and the Roundtable recommends that the state do so. This will require that hospitals submit individual patient-level data to MassHealth using all of the categories required by the Division of Health Care Finance and Policy, even if the individual hospital does not have enough patients in a given category to produce estimates for that group.

Disparities for the part of the MassHealth population covered by the pay-for-performance incentives are a comparatively small part of the overall picture of disparities in the state. The pay-for-performance program is necessarily limited in scope, and is likely to have a comparatively small effect on reducing disparities overall in Massachusetts. A larger, concerted effort involving the state, private insurers, and health care providers is likely needed to improve care for racial and ethnic minority patients in Massachusetts and consequently reduce racial and ethnic disparities in the quality of health care. The Roundtable encourages a primary focus on an orientation toward improving public health and reducing disparities that goes beyond a focus on MassHealth reimbursements.

To this end, the Roundtable recommends that the state develop an annual report on health and health care disparities in Massachusetts. Such a report would be based on data reported to MassHealth and DHCFP, later adding data from private payers and other sources, including DPH. Such a report would enable monitoring progress toward reducing disparities statewide on an ongoing basis. This would serve as a state-level parallel to the National Healthcare Disparities Report, drawing from all available data sources to create as complete a picture as possible of disparities in the state.<sup>27</sup>

The Roundtable recommends that all payment programs in the state, including the Connector and private insurers, collaborate to measure and produce this fuller picture of the current state and trends in racial and ethnic disparities statewide. Doing so may require additional action by the state legislature.

In addition, the Roundtable encourages the state to require that each hospital pool multiple years of data to examine disparities for smaller racial and ethnic groups. Data could also be pooled across multiple hospitals that are part of larger hospital systems.

Public reporting for individual hospitals could begin with the Appendix G measures, but the Roundtable recommends that the measures be more clearly operationalized so that all hospitals are providing consistent data to the state. The Roundtable recommends that the issue of public reporting of disparities for individual hospitals be revisited once there is a full year of experience with the pay-for-performance incentive program.

These public reporting efforts are likely to fall within the area of responsibility of either the Health Care Quality and Cost Council or the Disparities Council.

#### *Consensus/dissent*

This is a unanimous recommendation.

### **14. How can MassHealth improve its access to data on the race and ethnicity of its members?**

#### *Major considerations*

Approximately 70% of MassHealth enrollees do not provide the optional race and ethnicity data on the MassHealth enrollment form. The new Division of Health Care Finance and Policy data submission requirements now mandate that all hospitals in the Commonwealth submit race and ethnicity data for every inpatient stay, observation unit stay, and emergency department visit using a standard set of categories. For MassHealth patients who have a hospitalization, this represents an opportunity to obtain race and ethnicity data.

#### *Recommendation*

The Roundtable recommends that MassHealth work with DHCFP to use the race and ethnicity data that are reported to DHCFP on the hospital discharge data in order to improve race and ethnicity information in the MassHealth enrollment database. One member suggested that, in addition, MassHealth share these data with their managed care organizations.

In addition, some racial and ethnic disparities in care are closely tied to language barriers that patients face in receiving health care, and the DPH recommended data collection tool for obtaining race and ethnicity information includes questions on patients' preferred language. The Roundtable recommends that in the future, DHCFP require that patients' preferred language be included in the discharge data hospitals submit. This information should be used to further understand disparities in quality of care and to design incentives under the pay-for-performance and disparities initiative.

*Consensus/dissent*

This is a unanimous recommendation.

**15. What strategies could MassHealth employ to expand the measures available for the pay-for-performance program and minimize the burden of measurement on hospitals?**

*Major considerations*

All hospitals in the state currently report discharge data to DHCFP, and beginning January 1, 2007, all were required to report race and ethnicity data using a standard set of categories. While some quality of care measures cannot be obtained from discharge data, particularly those requiring chart review, the DHCFP data may provide a useful supplement to other measures. In addition, some data are available from DPH, such as birth certificate information, and all DPH programs are now required to collect race and ethnicity data.<sup>28</sup>

*Recommendation*

The Roundtable recommends that MassHealth work with DHCFP to use submitted hospital discharge data to supplement the measures used in the pay-for-performance/disparities reduction program. In addition, the Roundtable recommends that MassHealth work with DPH to develop additional appropriate measures.

*Consensus/dissent*

This is a unanimous recommendation.

## F. Conclusions

Improving the quality of health care for minority patients and reducing racial and ethnic disparities in care is both a social imperative and a difficult task. While the new pay-for-performance initiative in Massachusetts represents a bold step forward in public action to support and incentivize disparities reduction, there is a considerable amount to be learned about how best to design such a program to achieve maximum impact.

At the same time, the fields of both disparities reduction and pay-for-performance are complex and evolving. Measurement of quality and disparities is becoming more sophisticated, with new measures that are reliable, valid, and widely accepted becoming increasingly available. Interventions to reduce disparities are being tried more frequently, and they are more likely to have formal evaluations of their results than in the past. Knowledge about the impact of pay-for-performance, ideal designs for such programs, and their potential role in quality improvement is growing as well.

This points to the need to allow for change over time in the Massachusetts pay-for-performance/ disparities reduction initiative so that the program uses the best available methodology at any given time to maximize the likelihood of its success. At the same time, a fundamental focus on systems change and the infrastructure needed to provide high-quality care – rather than blaming individual providers or staff – will be essential to gaining cooperation and increased attention to reducing disparities.<sup>29</sup> Finally, periodic assessment of the impact of the program to understand whether disparities in the quality of inpatient and emergency department care are improving will be essential.

The 2006 health care reform legislation specified the creation of a permanent Disparities Council to be located within the Executive Office of Health and Human Services. Once the Disparities Council is established, it should be able to provide ongoing guidance to MassHealth in implementing the disparities provisions of the pay-for-performance program and in understanding whether the program is having the desired results for individual hospitals and for the state as a whole.

The new Massachusetts pay-for-performance and disparities reduction initiative is a bold experiment in a field in need of innovative approaches. It is the sincere hope of the Roundtable members that it will result in reductions in racial and ethnic disparities in the quality of health care, and that the knowledge gained from its implementation will contribute to other efforts at the local, state, and federal levels.

## Endnotes

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