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Strategic opportunities in the oversight of the U.S. hospital accreditation system

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Abstract

Hospital accreditation and state certification are the means that the Centers for Medicare & Medicaid Services (CMS) employs to meet quality of care requirements for medical care reimbursement. Hospitals can choose to use either a national accrediting agency or a state certification inspection in order to receive Medicare payments. Approximately, 80% of hospitals choose the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The purpose of this paper is to analyze and discuss improvements on the structure of the accreditation process in a Principal–Agent–Supervisor framework with a special emphasis on the oversight by the principal (CMS) of the supervisor (JCAHO).
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1. Introduction

The Institute of Medicine's reports *To Err is Human: Building a Safer Health System* [1] and *Crossing the Quality Chasm: A New Health System for the 21st Century* [2] have directed attention to the organization and delivery of medical care in the United States. Oversight of quality of care standards in U.S. hospitals is done primarily by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a private not-for-profit organization with strong ties to the facilities and networks that it monitors. The lack of public attention that JCAHO has received for their role in the quality of health care delivery is remarkable.

Let us start with a statement on health care that public policy should support short-run goals of improved outcomes, access, and efficiency of care and the long-run goals of creating incentives to develop and adopt innovations that promote quality and contain costs. Studies of hospital regulation tend to focus on cost containment [3]. While there have been recent investigations on the measurement of hospital quality [4–6], very few studies evaluate the effects of regulation on hospital quality. Of those that have, one study found

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that the associations with JCAHO survey results and financial and patient outcomes were almost non-existent [7] and another found that hospitals that used the JCAHO accreditation tended to outperform hospitals that did not use JCAHO in process related measures [8]. A final set of studies, by Moffett and Bohara, found that variation in JCAHO performance areas explained variation in length of hospital stay and patient mortality and that the intensity of JCAHO's impact was greatest at the time of a survey and then quickly dissipated [9,10]. Analysis of the effects of hospital quality of care regulation is based on the principal–agent conceptual model designed to promote effort when effort is not observable. The incentive for hospitals to provide suboptimal processes of patient care, because the effort in the process is not observable, is a moral hazard problem. Because the oversight effort that JCAHO employs is also not observable, there is a second moral hazard in the regulation of hospitals. Evidence on quality effort suggests that gains can be achieved through restructuring policy to more adequately solve the double moral hazard in hospital oversight. The purpose of this paper is to identify structural flaws in the hospital accreditation strategy with respect to promoting high quality of medical care.

2. Hospital quality of care monitoring

2.1. Overview

Health care is a credence good [11], differentiated from a search or experience good. A credence good is one in which the consumer may never be certain of the quality of the good. For a search good, a consumer can discover information about quality before the purchase is made and with experience goods, the quality is revealed after the purchase.

The Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) has the charge of assuring the quality of health care providers related to the Medicare and Medicaid programs. For the Medicare program, the CMS contracts with more than 6000 hospitals. To be eligible to receive Medicare funds, a hospital needs to comply with a set of Conditions of Participation (CoP). CoPs serve as minimum input or minimum safety requirements. The quality requirements under the CoP are verified through accreditation and certification processes. To receive Medicare funds, a hospital must be certified by the state in which the hospital resides. Accreditation can be done through state certification agencies or through a national accreditation survey.

CoPs are comprised of approximately 500 standards of practice. If it is assumed that standards have a clear line of causality with patient outcomes, then better compliance with standards increases the probability that patients will have better health outcomes. In turn, variance in patient outcomes will, in part, be explained by variance in hospital compliance. Thus, measures of compliance with the CMS standards serve as signals of hospital quality. Hospitals have very few ways to create a positive quality signal and are therefore willing to go to great expense to demonstrate strong compliance.

Accreditation is not the only means of medical provider quality regulation in the U.S. Other programs include peer review organizations, performance measurement, patient-safety error reporting. Peer review is provider-to-provider process assessment and designed to be collegial, which helps promote professional rather than public accountability. There are several initiatives that focus on performance measurement guidelines to promote quality effort. The two largest programs are Oryx, managed by JCAHO, and the Veteran Affairs Health System's Performance Measurement System. These initiatives are recent and their effectiveness at promoting quality of care is not yet demonstrated. The structured method of patient-safety error reporting is through the Sentinel Event reporting to JCAHO to develop risk reduction strategies.

The Social Security Act as amended in 1965 granted JCAHO and the American Osteopathic Association (AOA) with the privilege to accredit hospitals for compliance with Medicare CoPs. Both JCAHO and the AOA are private, not-for-profit organizations. CMS was assigned the duty of overseeing the accreditation process and certify new groups that want to become national accrediting bodies. It is important to note that the standards of the accrediting organization are not the same as the standards of the CMS, although accreditation standards are required to be at least as stringent as CMS standards. The specified period between inspections has to be three years or less. The duration and intensity of inspection is verified