

February 1998



Health Care Quality: From Data to Accountability

During much of this century, Americans have welcomed the technological developments, clinical breakthroughs, and miracle drugs that have produced the most highly regarded health care in the world. Over time, however, the magnitude of national healthcare expenditures has led to questions about whether more always means better and whether patient needs are being met in the best way possible. During the 1970s, rising Medicare costs led to demands for stricter hospital utilization review, in turn prompting concerns about the impact of cost containment on quality.

In the 1970s and 1980s, health services research by John Wennberg and others identified substantial geographic variations in patterns of care, showing that medical decision-making by physicians often depended more on the supply of local resources and on prevailing local practice styles than on science. Other research called into question the appropriateness of up to one-third of all health care interventions, indicating that those procedures either had little impact on patients' health or were potentially harmful to patients.¹

Concerns about quality mounted even higher with the 1986 release by the Health Care Financing Administration (HCFA) of its first provider "report card" of risk-adjusted, hospital-specific data on Medicare mortality rates. Although this report created much controversy and criticism of the methodology used, it did raise awareness and demonstrate significant variations in patient outcomes among hospitals. Congress entered into the evaluative spirit when it authorized and funded Professional Standards Review Organizations to review the quality as well as utilization of Medicare services.

The quality of health care, it appears, has always been inconsistent; it is only recently that awareness of inconsistency has become widespread. This observation runs counter to a popular tendency to associate poor quality with the spread of managed care and its perceived limits on consumer choice. In fact, evidence can suggest that managed care is as good as, worse than, or better than fee-for-service care—depending on which research one turns to.²

Answers to questions about how to define, monitor, and assure health care quality have proven elusive. For more than a decade, various sectors of the industry have pursued an approach based on the concept of accountability—the idea that health plans, insurers, hospitals, physicians, and other providers should take responsibility for their activities by demonstrating the quality and

value of their services. Central to this strategy is the production, collection, and reporting of data designed to measure different aspects of quality and performance.

Today, an abundance of data derived from a wide range of measures is available from multiple sources for multiple audiences. The landscape of health care quality and performance measurement is a patchwork of disparate activities at the national, state, and local levels—some in the public sector, others in the private sector, and still others that represent a collaboration between the two.

But there is little sense of how the data from these various initiatives fit together, what they reveal, and what their limits are. How far do these multiple and diverse approaches help advance the state of the art, and how much do they merely muddy the waters? Do these efforts add up to information that is actually useful to the people who need it? Is there an infrastructure to support the maintenance and dissemination of information? Will current efforts converge on recognizable accountability across the healthcare system?

Like quality, accountability is not a cut-and-dried concept. It involves several specific questions. Who is to be held accountable? By whom? For what and how? In health care, like other industries, numerous "loci" of accountability—parties that can be held accountable or hold others accountable—have been identified.³ "Accountors" may also be "accountees." For example, a hospital may evaluate the activities of its physicians and, in turn, be open to scrutiny by government regulators, contracting health plans and insurers, employers, and the public. Parties may be held accountable in several distinct domains, including professional competence, legal and ethical conduct, financial performance, accessibility, public health promotion, and community benefit.⁴ Different actions, including government sanctions, approval or denial of accreditation applications, and purchasing selections, may be used to establish accountability. Report cards that compare health care providers and plans on specific outcome, process, and service indicators have become a widely used mechanism for establishing accountability. But, without clear systems that identify the parties in accountable relationships, the nature and scope of these relationships, and the procedures to be employed, accountability may well be in the eyes of the beholder.

This paper will discuss quality measurement and reporting activities in three arenas of accountability: professional, market-driven, and public-sector. By

exploring the accomplishments and limitations in each of these areas, it may be possible to develop a better sense of how to invest in future efforts to assure health care quality.

DOMAINS OF ACCOUNTABILITY

There is no single, unified audience for information on health care quality, but rather a variety of audiences with different—and sometimes conflicting—interests and priorities. For example, consumers are interested in information on providers—primarily at the hospital and physician level—that will help them determine where to seek care. Research shows that consumers also want information on how to evaluate tradeoffs among cost, quality, and access under different delivery options.⁵ Policymakers and regulators need information to help them understand how the healthcare system is performing and to inform future legislation and regulation. Purchasers—in both the public and the private sectors—want the greatest possible value for their health-care dollars. Providers—including health systems, plans, hospitals, and physician groups—are using data to demonstrate and improve the quality of care they provide, differentiate themselves to purchasers, and, in some cases, select their contracting partners.

This diversity of needs and interests is reflected in the multiple approaches under way to use health care data to measure, identify, and demonstrate quality. Three approaches will be surveyed in this background paper:

- *The professional approach*—relies on the actions of private-sector accreditation groups, trade associations and health plans, hospitals, and other providers to assure quality. The profession assumes leadership for policing itself and demonstrating quality to parties outside the profession.
- *The market-driven approach*—relies on the use of quality data by healthcare purchasers and consumers in choosing plans and providers. The basic assumption is that quality is a market force on a par—or nearly so—with cost.
- *The public-sector approach*—relies on the regulatory, oversight, and purchasing actions of government at the federal, state, and local levels to assure quality. Traditionally, government activities in healthcare quality assurance have focused on regulation and oversight, but government bodies increasingly are taking advantage of opportunities to use

their purchasing power as an alternative or an adjunct to regulation and oversight.

Activities going on in these spheres frequently overlap. For example, the National Committee for Quality Assurance (NCQA), a managed care accreditation group, is involved in several important data initiatives that figure prominently in activities under all three of these models. HCFA's quality measurement and reporting efforts have expanded greatly during the past year as it has begun to take advantage of its purchasing clout. As a result, it is forging more collaborative efforts with employers, consumer groups, and other parties. It has also worked closely with NCQA to develop versions of the widely used Health Plan Employer Data and Information Set (HEDIS) tailored for Medicare and Medicaid.

The structures for establishing accountability reflect different views of who is best suited for assuring health-care quality, a question that ultimately centers on the appropriate role of government. Market proponents argue that the market itself can produce needed information and appropriate responses to assure quality without government regulation. Others (including some market theorists), contending that health care consumers can never have or understand all the information they need to make informed choices, advocate a profession-based accreditation model. Healthcare analyst Michael L. Millenson suggests that the approach developed by the Federal Trade Commission (FTC) during the first term of the Reagan administration could be applied to the healthcare industry. Asked to explore how government and the private sector could work together to make markets function better, the FTC identified several actions: development of standardized measures and tests, education of consumers with respect to these standards, and production of relevant information.⁶ Finally, many people believe that some degree of government oversight or involvement will be required to assure health-care quality, although they disagree on how much. The 1993 Clinton reform plan, for example, outlined a highly regulated and multi-layered system of accountability, to be presided over by a federally appointed body. A proposal sponsored currently by Sen. Joseph I. Lieberman (D-Conn.) and Sen. Jim Jeffords (R-Vt.) takes the view of government as an arbiter and clearinghouse for information on quality. Meanwhile, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry is considering a proposal for a two-tiered approach to healthcare quality, in which a newly created body lodged in the public sector would promote continuous quality improvement activities throughout the industry and another entity

housed in the private sector would concentrate on issues related to the efficacy and effectiveness of different quality measurement and reporting methods.

ACCOUNTABILITY IN A PROFESSIONAL MODE

This approach encompasses the activities of health care accreditation groups and professional associations. In this model, quality standards are developed and applied through voluntary accreditation programs, although often these programs become directly or indirectly mandated by states to satisfy licensing requirements, by HCFA as a condition of participation in Medicare and Medicaid, or by private-sector purchasers.

Accreditation, the award by a recognized independent body of its own “seal of approval” to another organization, is probably the longest-standing form of external healthcare quality assurance. These awards are generally viewed as symbols of quality because they are based on applicants’ ability to meet defined standards. Traditionally, those standards focused on structural assessments of facility resources and capabilities. But changing concepts of quality that emphasize outcomes and process over structure, along with escalating demands for useable quality data and concerns about the lack of standardized and coordinated data collection, are combining to effect changes in accreditation programs.

As a result, the healthcare accreditation industry, like the healthcare industry itself, is undergoing significant change. The proliferation of new and complex vehicles for healthcare delivery have prompted many accrediting organizations to create new accreditation programs, expand the scope of existing ones, and develop new standards for quality.⁷

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is a good example. Created in 1951 as the Joint Commission on Accreditation of Hospitals by the American Hospital Association, the American Medical Association (AMA) and several other physician groups, JCAHO today is an independent, not-for-profit organization that evaluates and accredits more than 18,000 healthcare organizations and programs in the United States. Its hospital accreditation program, launched in 1953, has been the foundation of JCAHO’s activities. But as the healthcare industry has expanded and diversified, so have JCAHO’s accreditation programs, which now also cover health plans, integrated delivery networks, and preferred provider organizations; home care organizations; nursing homes

and other long-term care facilities; behavioral health care organizations; ambulatory care providers; and clinical laboratories.

For several years, JCAHO has worked to make performance measurement a component of its accreditation process, beginning with the development of its Indicator Measurement System (IMS). Initially, JCAHO envisioned the IMS as the linchpin of its hospital performance measurement program. But a series of problems with the IMS forced JCAHO to redraw its plans. Instead, in February 1997, JCAHO launched a program called ORYX, which, according to Deborah Nadzam, Ph.D., JCAHO’s director of indicator measurement, is designed in the short term to get “everyone on the train.” Under ORYX, health care organizations may choose from more than 100 data reporting systems, including the IMS, that have been approved by JCAHO for use in the program. They may also choose which performance measures they will use. Nadzam notes that there is still a great deal of confusion about performances measurement; over time, she adds, JCAHO anticipates that ORYX will become more uniform.

The American Accreditation HealthCare Commission, Inc./URAC, which accredits PPOs, POS plans, and other open-panel plans, also espouses a flexible approach to outcome performance measurement. No single measurement system can be appropriate for all health plans, argues Gary Carneal, the organization’s president, who cites structural differences among plans and other methodological concerns. “This issue,” he says, “reflects the classic debate involving the standardization of measurement indicators versus the need to maintain some flexibility in a diverse marketplace while at the same time maintaining accuracy.”⁸ AAHC/URAC, which was chartered in 1990 as the Utilization Review Accreditation Commission, Inc., and changed its name in 1997, to date has granted about 350 company accreditations and issued 800 site accreditation certificates. It is revising its network accreditation standards to include some outcome performance measurement “to provide benchmarks for comparing plan operations,” Carneal says.

Yet despite confusion and disagreement on how best to measure performance, the managed care industry has been able to achieve a high level of consensus on HEDIS, the Health Plan Employer Data and Information Set, the most widely used tool for evaluating health plan performance. Launched in the late 1980s as an employer initiative, HEDIS, and the responsibility for maintaining and updating it, now resides with NCQA, the leading accreditor of managed care plans. Cary

Sennett, M.D., Ph.D., NCQA's executive vice president, credits HEDIS with achieving a high level of standardization by initially developing indicators that were feasible and relatively simple for health plans to report and increasing the complexity and sophistication of new measures over time.⁹

NCQA was formed in 1979 by two managed care trade associations, the American Managed Care and Review Association and the Group Health Association of America. (The two groups merged in 1995 to become the American Association of Health Plans.) NCQA became independent in 1990 through a grant from the Robert Wood Johnson Foundation and matching funds from health plans.¹⁰

NCQA develops new measures for HEDIS in collaboration with purchasers, consumers, industry representatives and quality experts. (NCQA calls this a "stakeholder approach" to quality measurement.) It also maintains a database on health plan performance. Its work on HEDIS is separate from its accreditation activities, since HEDIS reporting is not a requirement for NCQA accreditation. However, plans for an integrated accreditation model partially driven by performance measurement are under way, according to NCQA President Margaret E. O'Kane, who anticipates that implementation will begin in July 1999.

Because of its broad view of its role in quality assurance and performance measurement, NCQA has become a major player in the employer-based value purchasing movement and has engaged in many collaborative initiatives with purchasers, health plans, and consumer organizations, most of which are centered around HEDIS. For example, several regional business and purchasing coalitions engage in the publication of HEDIS "report cards," which compare and report plans' performance on specific HEDIS indicators. In California, the Pacific Business Group on Health (PBGH), a preeminent purchasing coalition, joined with the California Public Employees Retirement System to establish the California Cooperative HEDIS Reporting Initiative, which collects, analyzes, and reports plans' HEDIS performance data.

Meanwhile, the AMA, which for many years resisted standardized attempts to evaluate the quality of care provided by physicians, has developed a program for individual physician accreditation. The American Medical Accreditation Program (AMAP), announced in 1996, is designed to free physicians from the multiple data demands and credentialing procedures of health plans and other organizations by establishing a univer-

sally accepted process for certifying physician quality. Work is under way to identify specific clinical performance and patient care indicators for an outcomes component to this program. For now, AMAP requires physicians to participate in a clinical performance evaluation or continuous quality improvement (CQI) initiative.

In general, the incorporation of outcomes-based performance measures into professional accreditation programs is still at an early stage. It is unclear when these programs will begin holding plans and providers accountable for their services on the basis of clinical quality. Nor is it yet clear how this information will be released to broader audiences, such as purchasers, consumers, and policymakers, or how relevant it will be to them in the healthcare choices they make.

THE MARKET-BASED APPROACH TO ACCOUNTABILITY

In this sphere of activity, market demands for comparative information about quality among competing plans and providers reflect purchasing decisions that are based at least partly on quality. Large, private-sector purchasers and regional purchasing coalitions are the driving forces here, and market competition is their mechanism for accountability. Quality may be ascertained either through performance data supplied by plans and providers or through certain proxies for quality, such as accreditation.

Employers are engaging in numerous data collection activities aimed at increasing the value of the healthcare services they purchase. Many of these efforts are focused on the collection of HEDIS data. Some are aimed specifically at identifying high-value plans and providers. Employers may either contract exclusively with those high performers or use financial incentives to steer their employees toward superior plans and providers. In addition, employers and purchasing coalitions throughout the country are engaged in their own initiatives to measure, compare, and promote quality among the plans, hospitals, medical groups and other health care entities with whom they do business.

Employers' demands for information about quality are increasing the pressure on health care plans and providers to invest more heavily in improving their data capabilities as a condition of doing business. This is particularly true among those large purchasers—such as Xerox Corporation, Digital Equipment Corporation, General Motors Corporation, and ARCO, to name a

few—who take a long-term view of health care purchasing, have sufficient market clout to force plans and providers to meet their demands for data, and possess the internal resources necessary to use those data. But these companies are the exception, not the rule, and they are far outnumbered by the thousands of smaller, less powerful employers who still seem to purchase health care almost solely on price.

In addition, a number of employer coalitions have sprung up throughout the country, although “only a handful of groups [are] actively contracting on the basis of value,” according to a report by the National Business Coalition on Health.¹¹ The report notes that coalition activities to measure and improve quality are “slowly progressing,” but adds that this process must accelerate if value-based purchasing is to become an influential force in healthcare markets.

However, several coalitions are actively pursuing “value purchasing” activities. For example, PBGH, which represents 2.5 million covered lives from 33 private- and public-sector purchasers, uses a multi-pronged approach that involves collecting and analyzing health plan performance data to produce report cards for consumers; promoting shared treatment decision-making between providers and consumers; and collecting, analyzing, and reporting data on consumer satisfaction.¹² In addition, PBGH was the first purchasing coalition to impose a condition on contracting plans whereby it would withhold 2 percent of the premium until the plans achieved specific goals for improving customer satisfaction and quality of care. The Alliance, a health insurance purchasing cooperative in Denver, has adopted a similar approach. In Ohio, the employer-driven Cleveland Health Quality Choice (CHQC) program has for several years measured and tracked quality of care provided by area hospitals using risk-adjusted measures of patient satisfaction, mortality, length of stay, hospital complications, and cesarean-section rates. Over time, CHQC has reported improvements in several of these indicators.

Employers involved in value purchasing activities take widely divergent approaches, depending heavily on their influence and on prevailing market conditions. Some work at the hospital level; others deal with plans. Some purchasers confine their scope to consumer satisfaction, which is relatively easy to measure and which, these employers feel, more closely reflects the experience and perceptions of their employees. As mentioned, many purchasers are interested in HEDIS data. Several are now focusing their efforts on the

consumer-oriented outcomes-based measures developed by the Foundation for Accountability (FACCT), a not-for-profit coalition of purchasers and consumer organizations. Some employers are targeting big-ticket conditions and procedures, such as heart disease and bypass surgery, or ones that are linked with workplace productivity, such as depression and asthma.

For plans and providers, the rub is that little of this activity appears to be making an impact on purchasing decisions. Price, according to the experts, still drives the market, and employers have shown that they are willing to switch health plans for small differences in premium. Even in Cleveland, where the widely respected CHQC program has been collecting quality data from hospitals for several years, these efforts appear to have had “less effect on purchasers’ decisions than on hospitals’ concern for their internal practices and their reputations.”¹³ However, the CHQC data appear to have had some effect on the composition of plans’ provider networks.

Some observers point out that reliable data on quality have not been available to employers for long. In addition, employers face numerous challenges in applying outcomes and other quality data to purchasing decisions. Judith H. Hibbard, a professor of health policy at the University of Oregon, found that most purchasers were more likely to consider consumer satisfaction data and accreditation status than outcomes or other clinical quality data as quality determinants. In many cases, employers said they did not feel these data were timely or relevant to their needs. Hibbard also observed that some employers simply did not have the time or inclination to try to figure out how to incorporate these data into complex purchasing decisions. In addition, she noted that the use of performance data varies substantially among purchasers and is changing constantly.¹⁴

It is important to keep in mind that employers are not in business simply to purchase health care. They purchase health care mainly because they feel they have to, and usually only the price of that service has a direct bearing on their ability to do business. This order of priorities not only diminishes the relevance of quality information, which is often difficult to apply in purchasing decisions, but also puts employers at odds with their employees, who bear little of the direct cost of health care.

That “disconnect” in interests is exacerbated by the fact that, when it comes to health care, employers and consumers face different kinds of decisions. Up to 70 percent of all employers offer their employees only one

insurance carrier; that insurer frequently is forced to accommodate consumer demands for greater choice by serving up multiple plans with broad, overlapping networks that include virtually every provider in the local market.¹⁵ Meanwhile, the production of publicly available data has shifted its emphasis from hospitals and physicians to health plans. As a result, most employers have become more focused on measuring quality at the plan level, which is where they make their purchasing decisions. But consumers generally are more interested in information at the provider level, which, despite the restrictions of managed care, may be where more of their choices lie. An initiative by the PBGH and an accreditation group called the Medical Quality Commission attempted to address this conflict by measuring and reporting consumers' perceptions of individual physician groups' performance.

Finally, most employers do not possess the purchasing clout or the internal resources of large companies like Xerox or business coalitions like PBGH. These smaller employers may have little choice but to continue basing their purchasing decisions mainly or even solely on price.

How far employer-based efforts can go in promoting and assuring healthcare quality remains to be seen. An indicator may lie in purchasers' response to impending increases in healthcare premiums, the first in several years.

ACCOUNTABILITY EFFORTS IN THE PUBLIC SECTOR

Traditionally, the public-sector concept of accountability has been based on the regulatory and oversight functions of government at the federal, state, and local levels. These functions have taken on new dimensions during the past half-dozen years, with the creation in some states and localities of data agencies that produce and report comparative data on healthcare quality. The idea is that, armed with reliable data on quality, healthcare purchasers and consumers can make better-informed choices about health plans, hospitals, and physicians. HCFA has also expressed interest in this concept for Medicare.

The federal government's efforts to monitor healthcare quality historically have been linked to its efforts to control healthcare costs, beginning in the 1970s, when rising Medicare costs led to demands for stricter hospitalization review. The shape of Medicare's quality oversight program was largely determined by the

Medicare statute, which specifically bars the federal government from exercising "any supervision or control over the practice of medicine." Because of this restriction, Medicare developed a quality assurance system that relied heavily on peer review by providers, rather than on examination of medical practice by the federal government.¹⁶

In 1970, Experimental Medicare Care Review Organizations (EMCROs), voluntary physician associations, were established under a demonstration program to review services funded by Medicare and Medicaid. The EMCROs became the model for the Professional Standards Review Organizations (PSROs) created by Congress to review not only the utilization but the quality of institutional health care provided under Medicare. The PSROs were federally funded, voluntary, not-for-profit, local organizations of physicians that conducted reviews within specific geographic regions.

In 1983, Medicare adopted the Prospective Payment System for hospitals. Again, efforts to control costs sparked fears about their effect on quality, and in 1986 Congress replaced the PSROs with the Peer Review Organization (PRO) program to monitor the quality of care provided to Medicare beneficiaries and to check for abuses such as premature discharge and early readmission. HCFA developed highly detailed review procedures for the PROs based on examination of medical records of selected cases by trained nurses using quality-related screening criteria, notes Timothy P. Hofer, M.D., of the University of Michigan, Ann Arbor. But this system was viewed as punitive and geared toward the identification of "bad apples." In recent years, the PROs—now known as Quality Improvement Organizations—have become increasingly involved in local quality improvement initiatives with Medicare providers under HCFA's Health Care Quality Improvement Program (HCQIP), which was created to promote continuous improvement of care.

In 1986, when HCFA released its first hospital mortality report rating hospitals in terms of their risk-adjusted mortality rates, the report drew heavy criticism from the industry for serious methodological flaws. In subsequent reports, HCFA worked to correct those flaws and refine its risk-adjustment methodology. These reports were discontinued in 1993 after Bruce Vladeck became HCFA's administrator. Vladeck, formerly with the New York Hospital Fund, felt that the reporting methodology still failed to adjust adequately for the risk factors of hospitals that served indigent populations. He also expressed a desire to expand HCFA's quality

reporting activities beyond mortality rates to include other, more comprehensive measures of quality.¹⁷

Meanwhile, interest in new outcomes measures, risk-adjustment models, and data-collection methods increased throughout the private and public sectors. In 1989, Congress created the Agency for Health Care Policy and Research (AHCPR) within the U.S. Public Health Service. Its mission is to improve the quality, appropriateness, and effectiveness of health care, and to improve access to healthcare services. The agency supports and conducts health services research—including medical effectiveness research—and assessments of health technologies; it also supported for several years the development of clinical practice guidelines. AHCPR's guideline activities on several occasions drew fire from medical specialty groups whose incomes were threatened by the agency's recommendations. In 1996, AHCPR, after surviving several budget cuts and changes in political fortune, abandoned its guideline work in favor of a new program to promote evidence-based medicine. Under this program, AHCPR sponsors 12 Evidence-based Practice Centers in the United States and Canada to review scientific literature on specific medical topics, conduct additional analyses when appropriate, and publish their findings in "evidence reports or technology assessments."¹⁸

Quality measurement and reporting figured heavily in the Clinton health reform proposal of 1993, which outlined an ambitious national quality management program that would have relied on a broad range of performance measures and reporting initiatives to help restructure the delivery system. That proposal made accountability the new slogan for the healthcare industry and called for many levels of performance reporting by the federal government, the states, regional health alliances, plans, and providers. In keeping with the administration's plan to reform healthcare delivery through a combination of managed competition and government regulation, the proposed quality management program was comprehensive and complex. It would have required universal data collection and the creation of a national network of regional health data systems to produce performance report cards.

Details of the proposed National Quality Management Program were never fully fleshed out; many of the issues addressed then remain unresolved. Yet the proposal triggered strong reactions throughout the industry. Some people were angered by what they viewed as a move to increase government regulation and bureaucracy; others were frightened at the prospect

of meeting the proposal's data demands. Whether in support, opposition, or fear, various sectors of the healthcare industry responded to Clinton's promotion of managed competition and accountability by stepping up their own efforts to define and measure quality and report their findings to numerous audiences.

In 1996, continued dramatic changes in the health care system and public skepticism about managed care prompted the appointment of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. The 32-member commission was established to "advise the President on changes occurring in the health care system and, where appropriate, to make recommendations on how best to promote and assure consumer protection and health care quality." In November 1997, the advisory commission unveiled a proposal for a "consumer bill of rights and responsibilities," which included the right for consumers to receive accurate and easily understood information about quality from their plans and providers.

But the advisory commission's final report and recommendations, which are to be submitted to the president by March 30, 1998, are expected to be much more comprehensive and to address issues such as quality measurement, monitoring, and improvement and the role of public and private purchasers and oversight organizations in promoting quality. In the recommendation being considered by the commission to create two complementary bodies on healthcare quality—one lodged in the public sector and the other in the private sector—both entities would include representatives from the public and private sectors. However, the public-sector body would take the lead in promoting and guiding continuous improvement activities and the private-sector body would focus on improving the effectiveness and efficiency of healthcare quality measurement and reporting.

Meanwhile, the Balanced Budget Act of 1997 includes a mandate for HCFA to establish quality requirements for health plans that enroll Medicare and Medicaid beneficiaries. The Quality Improvement System in Managed Care will require participating plans to show proof of improvement in the services they provide and eventually will produce comparative performance report cards of plans for consumers. Although the new quality standards, which are to take effect in 1999, are aimed primarily at managed care plans, a similar system is being developed for fee-for-service care.¹⁹

More congressional action on quality may be in store. The draft Senate bill being circulated by Lieber-

man and Jeffords would establish a Health Quality Council to “provide expertise in the areas of health care quality measurement, the purchase, delivery and regulation of health care, as well as the health needs and requirements of participants and beneficiaries.” With support from AHCPR and in consultation with accreditation groups, employers, providers, health plans, regulators, consumers, and others, the new council would act as both a developer of and a clearinghouse for information on quality standards, criteria, and benchmarks.

In recent years, many government entities have become more discriminating and more demanding purchasers of healthcare services for beneficiaries and employees. As a result, the public-sector concept of accountability has evolved to encompass the function of government as a purchaser.

Because of their multiple and developing roles in assuring healthcare quality, government agencies are involved in a wide range of initiatives to develop, test, and apply quality measures and collect and report healthcare data. Many of these activities are collaborative efforts with private sector actors, including providers, plans, employers, researchers, and accreditation organizations. HCFA has taken the lead here.

HCFA’s Health Care Quality Improvement Program is dedicated to assuring high-quality care for Medicare and Medicaid patients by focusing on outcomes measurement and improvement. HCQIP sponsors cooperative projects on measuring and evaluating processes and outcomes of care with HCFA’s PROs and end-stage renal disease networks. More than 700 quality improvement projects were under way during the most recent three-year cycle,²⁰ including the Cardiovascular Cooperative Project, a national, data-based effort to improve care for Medicare patients hospitalized for heart attacks, and a physician office profiling system designed for Medicare.

In Medicaid, a three-state demonstration called the Quality Assurance Reform Initiative tested a CQI framework that included indicators borrowed largely from HEDIS to monitor and improve Medicaid managed care. These indicators were to serve as the basis for targeted quality-of-care studies and subsequent CQI activities.

On the regulatory front, HCFA is proposing to revise its rules for condition of participation in Medicare in four areas: home health, hospital care, hospice care, and end-stage renal disease. These rules would transform the process for Medicare certification,

placing more emphasis on patient care and patients’ experience with care. For example, the proposed home care rule—the only one published so far—would require Medicare home health agencies to use a standard system called the Outcomes and Assessment Information Set (OASIS) to measure quality and patient satisfaction with care. A new proposal would merge OASIS with the Minimum Data Set system used for nursing homes. If approved, these rules may force accreditation groups that have “deemed status” relationships with Medicare and Medicaid—that is, where satisfaction of the organization’s accreditation standards is deemed to satisfy federal requirements—to revise their own standards to meet Medicare’s new conditions of participation.

Most significantly, perhaps, HCFA has started to become a more assertive purchaser of services from risk-based contractors. Although Medicare does not competitively select health plans based on quality, it has raised its contracting requirements in that area through mandatory reporting of HEDIS data and the new Consumer Assessment of Health Plans Survey (CAHPS). The FACCT measures, which HCFA is evaluating in a collaborative study, may eventually become another reporting requirement for Medicare participation. Together, HEDIS, CAHPS, and the FACCT measures would supply HCFA with a three-pronged strategy for holding Medicare contractors to a higher level of accountability through data collection.

In addition, HCFA has played an active role in the development of new HEDIS measures, particularly those measures designed specifically for Medicare and Medicaid. HEDIS 3.0 is the first version of HEDIS that includes Medicare measures; a Medicaid version of HEDIS was issued in February 1996 and is a reporting requirement in many states.

It should be noted that HCFA’s efforts to assure accountability apply to both its managed care and its fee-for-service programs. Although Medicare managed care enrollment is increasing (about 5 million people are signed up with 336 plans nationwide), 87 percent of Medicare beneficiaries still receive care through traditional fee-for-service insurance.²¹ HCFA is investigating the application of HEDIS in fee-for-service settings. In addition, FACCT’s measures are designed for use in both managed care and fee-for-service environments.

Working with NCQA, FACCT, private employers, and others, HCFA hopes to rally purchasers in identifying a universal set of quality measures and methodologies. “HCFA is going to lead the effort among all these

purchasers to converge the list of measures—whether they be procedural or outcomes-focused—and have everyone agree that that’s what they’re going to report,” predicts John Gorman, formerly of HCFA’s Office of Managed Care. The FACCT evaluation provides an example of how HCFA hopes to accomplish this feat. HCFA has encouraged other purchasers to participate in the project, and purchaser interest in participation helped guide site selection.

HCFA’s ambitious agenda may conflict with the incremental, pragmatic approaches pursued by many private-sector purchasers throughout the country. It remains to be seen whether these various pursuits can be successfully dovetailed to the satisfaction of purchasers in both the public and the private sectors.

Like HCFA, state governments are engaged in a number of roles related to measuring, monitoring, and assuring healthcare quality and, in rare cases, using quality as a basis for healthcare purchasing. These activities vary widely by state and for the most part are not coordinated.

Most state Medicaid agencies collect data on utilization, outcomes, consumer satisfaction, and disenrollment; they all conduct chart reviews. The spread of managed care in Medicaid programs has complicated some of these data collection activities, because claims records, a key source for many of these data, are not generated automatically for payment under capitated systems. Nevertheless, public skepticism about managed care and a new emphasis on community-based care have increased pressures on Medicaid agencies to engage in collaborative quality improvement initiatives with health plans, providers, public health agencies, and community organizations in areas such as pediatric immunization and prenatal care.

Some state Medicaid agencies are also trying to incorporate quality-based performance indicators and specifications into their contracting strategies. These approaches vary considerably. Several states are using quality determinants to assess potential contractors. For example, Arizona’s Medicaid agency applies a selective contracting evaluation formula that assigns a weight of about 70 percent to quality and access criteria and 30 percent to cost. Other states, such as Massachusetts, Washington, and Oregon, are using performance measurement to manage their Medicaid contracts. For example, Massachusetts holds Medicaid contractors accountable for measurable service improvements that are spelled out in a set of contractual terms and purchasing specifications.²² The quality component of these

terms requires contracting plans to provide member satisfaction data, clinical indicator data from HEDIS, and voluntary disenrollment rates.

In addition, a number of state legislatures have created health data entities that collect and report certain outcomes and other data from healthcare organizations. The scope and responsibilities of these data collection agencies vary. Examples include the Pennsylvania Health Care Cost Containment Council, which publishes comparative quality and cost reports on hospital, physician, and plan services; the Minnesota Health Data Institute, which uses consumer-based surveys to produce detailed plan-specific performance reports; and the Maryland Health Care Access and Cost Commission, which uses HEDIS data, enrollee data, and provider surveys to generate comparative plan performance reports.

Public health agencies are also becoming more active in quality measurement and reporting activities. Some public health agencies are just beginning to build data linkages with managed care plans that can support public health objectives and activities. In addition to the barriers faced by other users of healthcare data, many of these agencies are struggling with severe budget cuts. Still, some efforts have taken shape and most of them are using HEDIS as a blueprint for their data collection activities. Missouri appears to have advanced the furthest in this respect. Providers, plans, purchasers, and public health officials there have collaborated to develop their own Missouri Health Indicator Set for quality assessment. Public health records on births, deaths, hospital discharges, and cancer are being eyed to supply some of the needed data.

Although public health agencies in states like Missouri are starting to make progress in establishing data links that will enable them to monitor community-based public health, it undoubtedly will take several years for these efforts to bear fruit. However, the creation of these data links would benefit managed care organizations, which increasingly are emphasizing community-based care that requires community-based numerator data for quality assessment. These plans in time may begin to invest more resources in establishing data partnerships with public health agencies.

Clearly, public-sector agencies play a significant role in the quality measurement arena. But, like many initiatives in the private sector, these public-sector activities are diverse, driven by multiple agendas and, for the most part, uncoordinated. At the state and local levels, views on healthcare quality and commitments to

data collection vary considerably and are subject to change over time.

At the federal level, important questions remain about what the role of government should be in establishing, monitoring, and reporting on health care accountability. Should government act as a clearinghouse for data on healthcare quality? Should it decide what measures will be used to define quality across various settings? Or should it attempt to forge consensus among the various interest groups by weight of its purchasing power through Medicare?

OVERARCHING ISSUES

Efforts to measure and report healthcare quality invariably confront a wide range of complex issues, including scope, funding, the type of data to be collected, the method of collection, data terms and definitions, timing, risk adjustment, and how the data will be released and to whom. Some of these decisions are highly technical; others are political. How these decisions are made largely depends on who is leading the effort and what its objectives are. According to several observers, it is more important for participants in quality initiatives to achieve consensus on these fundamental issues than it is to achieve technical perfection. “It doesn’t matter what [risk] models you use or what [computer] system you use, as long as all the players agree,” asserts Dwain L. Harper, executive director of the Cleveland Health Quality Choice Program.²³

There is still disagreement on what types of measures are most appropriate for evaluating healthcare quality and whether the state of the art is sufficiently advanced to meet the demands of multiple data users. HEDIS, the FACCT measures, CAHPS, and health status assessment surveys such as the SF-36 are among the more widely used measurement tools. Certainly, a great many more measurement sets are in use; the CONQUEST database maintained by AHCPR has identified more than 1,100 clinical quality measures contained in some 50-odd measurement sets. These measures reflect different views about what dimensions of quality are important to evaluate, what unit of analysis (that is, plan, physician, or hospital) should be used, the feasibility of various data sources, and the information needs of the particular user.

A critical obstacle to resolving data collection issues stems from inadequate investment in sufficiently sophisticated and compatible information systems. NCQA maintains:

The shortcomings of existing sets of performance measures are not so much due to lack of science, imagination, or political will, but to constraints posed by poor information systems—the measures that can be accomplished using today’s systems are necessarily weak and sparse and will remain so until information systems are widely used, and information frameworks are created.²⁴

The importance of investing in information systems is illustrated by the experience of the PBGH and the Medical Quality Commission. The two organizations collaborated on a project to measure consumer-based perceptions of quality in a random survey of 55,000 managed care enrollees, 1,000 from each of 55 participating physician groups. Project directors say that many physician groups had difficulty supplying the enrollment data needed to launch the study, the first of its kind in terms of measuring consumer-rated quality at the group level.²⁵ Similarly, many health plans—large and small—do not have information systems that are sufficiently sophisticated to participate in aggressive data collection initiatives.

Where such systems are in place, they generally cannot be linked. This is a problem in both the public and the private sectors. As mentioned, state and local public health agencies are just beginning to build data linkages with managed care plans to support community-based health assessment and management; these efforts face many financial and logistical barriers. Purchasers, too, have identified similar difficulties. The National Business Coalition on Health says that “the establishment of linkages and networks among data sources” will be critical to supporting value purchasing activities.²⁶

Widespread interest in HEDIS data by employers and HCFA is increasing the pressure on health plans to invest in better information systems. In addition, efforts to develop standardized clinical data sets will help solve data collection and transmission problems. To that end, the Health Insurance Portability and Accountability of Act mandates the setting of standards for electronic transmission of health information for computer-based medical records by August 2000.²⁷

Inability to come to terms with these overarching issues is holding back progress in both the public and private sectors. Yet it is likely that some of these issues will remain moving targets because of constant change in the healthcare industry and the ever-evolving nature of science and technology. New and better measures will always be sought; there is no such thing as a “perfect” risk adjustment model, and it appears that

there will always be room for a bigger, faster, and more powerful computer system. Perhaps with adequate levels of commitment and collaboration, various actors within the healthcare industry may at least work to advance these issues in the same general direction.

ENDNOTES

1. Mary Darby, "Robert Brook: Appropriateness Research Should Inform Health Care," *Report on Medical Guidelines and Outcomes Research*, December 23, 1992, 10.
2. Robert H. Miller and Harold S. Luft, "Does Managed Care Lead to Better or Worse Quality of Care?" *Health Affairs*, 16 (Fall 1997), no. 3:7-25.
3. Ezekiel J. Emanuel and Linda L. Emanuel, "What Is Accountability in Health Care?" *Annals of Internal Medicine*, 124 (January 15, 1996), no. 2:229-239.
4. Emanuel and Emanuel, "Accountability in Health Care."
5. S. Edgman-Levitan and P. D. Cleary, "What Information Do Consumers Want and Need?" *Health Affairs*, 15 (Winter 1996), no. 4:42-56.
6. Michael L. Millenson, "Beyond the Managed Care Backlash: Medicine in the Information Age," Health Priorities Project Policy Report No. 1, Progressive Policy Institute, Washington, D.C., July 1997.
7. "Health Care Quality Protection and Improvement: Activities of Public and Private Quality Oversight Organizations," draft background paper prepared for the Subcommittee on Roles and Responsibilities of Public/Private Purchasers and Quality Oversight Organizations of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, July 16, 1997, 10-11.
8. Testimony of Garry Carneal, president, American Accreditation HealthCare Commission, Inc., before the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Panel on Quality Oversight, July 22, 1997.
9. Charles Marwick, "NCQA: Quality through Evaluation," *Journal of the American Medical Association*, 278 (November 19, 1997), no. 19:1555-6.
10. John Iglehart, "The National Committee for Quality Assurance," *New England Journal of Medicine*, 335 (September 26, 1996), no. 13:995-999.
11. J. Meyer et al., *Employer Coalition Initiatives in Health Care Purchasing*, 2 vols. (Washington, D.C.: Economic and Social Research Institute, 1996).
12. "Promoting, Protecting and Improving Health Care Quality: Activities of Public and Private Group Purchasers," draft background paper prepared for the Subcommittee on Roles and Responsibilities of Public/Private Purchasers and Quality Oversight Organizations of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, June 18, 1997, 9.
13. R. Baxter et al., *A Case Study: Health System Change in Cleveland, Ohio* (Washington, D.C.: Center for Studying Health System Change, 1997), 7-8.
14. Mary Darby, "Will Hospital Report Cards Make the Grade?" The Center for Studying Health System Change, Issue Brief Number 11, July 1997.
15. Mary Darby, "Health Care Costs: Will They Start Rising Rapidly Again?" The Center for Studying Health System Change, Issue Brief Number 10, June 1997.
16. National Academy of Social Insurance, "From a Generation Behind to a Generation Ahead: Transforming Medicare Fee-For-Service" (draft), December 1997, Washington, D.C., 34.
17. Mary Darby, "New HCFA Chief Reconsiders Hospital Mortality Reports," *Report on Medical Guidelines and Outcomes Research*, July 1, 1993, 1-2, 5.
18. Agency for Health Care Policy and Research, "AHCPR Announces 12 Evidence-based Practice Centers," press release, June 25, 1997.
19. Rebecca Voelker, "HCFA Focuses on New Plans for Quality Care," *Journal of the American Medical Association*, 278 (November 19, 1997), no. 19:1559.
20. "Health Care Quality Protection and Improvement," Advisory Commission on Consumer Protection and Quality, 7.
21. "FACCT Measures and HCFA, An Update on the RAND Study," *Accountability Action*, Spring 1997, 10-13.
22. "Promoting, Protecting and Improving Health Care Quality," Advisory Commission on Consumer Protection and Quality, 13.
23. Darby, "Will Hospital Report Cards Make the Grade?"

24. Information Systems Working Group, *A Road Map for Information Systems: Evolving Systems to Support Performance Measurement*, National Committee for Quality Assurance, Washington, D.C., 1997.

25. Mary Darby, "California consumers rate physician groups on quality of care in pioneering survey," *State Health Watch*, 4 (September 1997), no. 9:3, 11.

26. I. Tillman, *Down the Path of Better Returns: Value Based Health Care Purchasing*, National Business Coalition on Health, Washington, D.C., undated.

27. "Proposed Framework for Subcommittee and Policy Issues for Consideration," document prepared for the Subcommittee on a Quality Improvement Environment of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, June 1997, 7.