HEALTH CARE REPORT CARDS: QUALITY IN THE PUBLIC'S CROSS HAIRS

by Alice G. Gosfield, Esquire

Alice G. Gosfield and Associates, P.C.
2309 Delancey Place
Philadelphia, PA 19103
(215) 735-2384
(215) 735-4778
agosfield@gosfield.com
www.gosfield.com

Published in: "HEALTH LAW HANDBOOK 2000 EDITION", Alice G. Gosfield, Editor [Out of Print]

HEALTH CARE REPORT CARDS: QUALITY IN THE PUBLIC'S CROSS HAIRS

by Alice G. Gosfield[1]

- Health Pages™---the voice of the Health Care Consumer"[2]
- healthgrades.com™ – "the Healthcare Rating Experts"[3], QualityCompass® – "a national database of plan specific performance information featuring the latest HEDIS data from more that 400 health plan products"[4]
- The PBGH California Consumer HealthScope-- "an independent source of information to help you select the best quality health plans, hospitals and medical groups"[5]
- Prudential Healthcare® Report Cards[6]
- US News and World Reports[7]
- Consumer Reports[8].

These are only some of the entities publishing health care report cards, today. Third party purchasers, independent review organizations, business coalitions and even individual hospitals, health plans and provider systems are publishing their own report cards.[9] Public comparative information regarding health plans, hospitals, physicians and even nursing homes is a true phenomenon on the healthcare landscape.

---

1 The author has been Chairman of the Board of Directors of the National Committee for Quality Assurance (NCQA) since 1998, but the opinions expressed here are her own and should not be attributed to NCQA in any way whatsoever.

2 www.thehealthpages.com

3 Ratings by procedure or diagnosis, on more than 5,000 hospitals, on more than 400 health plans nationwide, on more than 17,000 nursing homes (www.healthgrades.com)

4 www.ncqa.org/pages/info/quality%20compass/QC%20Main%20Page.htm

5 www.healthscope.org

6 www.aetnaushc.com/pruhealthcare/Health/Quality/Hedis/hchqh1015.htm

7 "Best HMOs: America's Most Complete Guide", Oct. 5, 1998

8 August, 1999

9 Spath, ed. PROVIDER REPORT CARDS: A Guide for Promoting Health Care Quality to the Public, Health Forum Inc., 1999, Chicago, Illinois. See also Weber, "The empowered consumer," 40 Health Forum Journal 28(Sept/Oct 1997) and HealthNet Report Cards at ifp.healthnet.com/general/ppg_reports.

The impetus for this growth reflects a range of concerns nationwide about quality of care and the extent to which there is or ought to be a real market in health care. Which values do or ought to drive any such market has been debated for years; and that discussion has intensified as the focus on quality has concentrated, too. The methodologies utilized and approaches taken in producing this comparative data bear scrutiny, given their intended and sometimes actual impact. Their effectiveness has been studied and argued. The controversies around them should be understood, especially since state and federal government agencies are now intimately involved in the movement toward greater public accountability for quality in health care. Although the advent of multiple report card sources is so new that there is no case law yet confronting it, it is worth speculating about potential legal issues this trend could portend.

I. POLICY EXPLOSIONS AND A NEW FOCUS

"A vibrant movement to improve the quality of health care has sprung up in the United States. Report cards on health plans, hospitals, medical groups and even individual physicians have appeared on the front pages of newspapers, on television, and on the Internet."[10] Some of this movement stems from the desire to generate a culture of quality because it is intuitively the right thing to do. But at this moment in American health care history experts are engaged in major national policy exercises to explicitly make the case "Why the Quality of US Health Care Must Be Improved".[11] Political aspects of the new attention to quality can be found in the debates regarding Patients' Bills of Rights in relationship to managed care at state and federal levels.

With the undeniable changes in the organization and financing of the health care industry as a whole, managed care and provider reactions to it have crystallized anxieties about quality. Combined with a general increase in consumer activism around health care issues, along with the accessibility and utility of the Internet in disseminating information, the level of interest in the subject is without precedent. Regina Herzlinger of the Harvard Business School has reported that the single most common reason for people to go on the web is for health care information.[12] In 1996, responding to managed care backlash, the President convened an Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Later, the publication by the

---

10 Bodenheimer, "The American Health Care System – The Movement for Improved Quality in Health Care," 340 NEJM 488 (Feb. 11, 1999)

11 Schuster, McGlynn, Brook, Report to the National Coalition on Health Care, Rand Corporation, October, 1997; www.nchc.org/emerge/quality.html

12 Comments made July 19, 1999 at American Association of Health Plans meeting of Chief Executive Officers in Los Angeles.

Institute of Medicine of its report on errors in health care delivery generally[13] fueled attention to the quality debate.[14] The President's swift reaction to the report by ordering a task force to issue yet a further report on patient safety[15] only underscores the increasingly high profile that issues of quality are commanding in the health care debates.

Prior to the most recent focus on safety, the President's Commission recommended a comprehensive national strategy to confront health care quality. In addition to an explicit approach to advancing more standardized quality measurement and reporting, the report called on

> "all sectors of the health care industry [to] support the focused development of quality measures that enhance and improve the ability to evaluate and improve health care...Steps should be taken to ensure that comparative information on health care quality is valid, reliable comprehensible, and widely available in the public domain. . .[Toward that end] a Forum for Health Care Quality Measurement and Reporting should be created in the private sector to improve the effectiveness and efficiency of health care quality measurement and reporting."

To stimulate a market in quality the report both encouraged action by group purchasers and looked toward "strengthening the hand of consumers". Not only should group purchasers offer a choice of plans to their individual members and state and federal governments further opportunities for small employers to participate in larger purchasing pools that make a commitment to individual choice of plans, "All public and private group purchasers should use quality as a factor in selecting the plans they will offer..."[16] Group purchasers should implement strategies to stimulate ongoing improvements in health care quality. On the other side of that equation, "a widespread and ongoing consumer education strategy should be developed to deliver accurate and reliable information about health care quality to consumers and encourage them to consider information on quality when choosing health plans, providers and treatments." That information should be developed to meet the needs of consumers.

In response to the Commission's Report, the Vice President picked up the baton by

---

13 Corrigan, Kohn and Donaldson, ed. TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM, National Academy Press, Washington, D.C. 1999

14 Prager, "Report unleashes furious interest in medical errors", 42 AMNews 1 (December 20, 1999)

15 "Clinton orders task force to issue report on patient safety", 4 BNA Health Care Daily Report 1 (Dec. 8, 1999)

16 Summary of Recommendations, Health Care Quality Commission", July 1998, www.hcqualitycommission.gov/final

issuing still another report when he launched the planning committee to create the Forum recommended by the President's Commission. "The Challenge and Potential for Assuring Quality Health Care for the 21st Century" focused on evidence of quality problems, examples of how quality improvement makes a different, and touted private sector efforts in value-based purchasing and quality improvement.[17]

The Forum has now been created and was incorporated in May, 1999. At this writing it was still in its formative stages, but its mission, fulfilled through its Board and constituent Councils, is to "develop a quality measurement and public reporting strategy that addresses priorities for quality measurement consistent with national aims for quality improvement in health care."[18] Its explicit goals are broad and far reaching within the context of quality measurement and reporting:

- ensure system-wide capacity to evaluate and report on the quality of care;
- promote and inform consumer choice and further consumer understanding and use of quality measures;
- enable providers to use data to improve performance;
- allow meaningful comparisons of health care providers and plans;
- promote competition on the quality of health care services;
- use broad representation to marshal market forces for quality; and
- reduce burdens on providers and health plans by enabling them to collect consistent data that avoids duplication.

But the Forum is not alone in these efforts. The National Committee for Quality Assurance (NCQA), the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), each separately as well as in a joint effort to merge performance measure development efforts (together with the AMA's American Medical Accreditation Program (AMAP)) through the Performance Measurement Coordinating Council, the federal government through multiple vehicles include the Department of Health and Human Services and the former Agency for Health Care Policy and Research (now called the Agency for Healthcare Research and Quality), and private organizations, too, are all engaged in this endeavor in one way or another. Given that there are other organizations pursuing related agendas, the coordination and standardization of multiple efforts will be a real challenge, absent mandates of some sort.

Nonetheless, the urgency of these major policy initiatives has been based on the finding that despite that "at its best, health care in the United States is superb", quality problems are serious and extensive, falling into three major categories: (1) underuse – the failure to provide a health care service when it would have produced a favorable outcome for a patient; (2) overuse -- when a health care service is provided under circumstances in which its potential for harm

---

17 www.ahcpr.gov/qual/21stcena.htm (June 1998)

18 www.qualityforum.org/qfgoals.htm

exceeds the possible benefit; and (3) misuse -- when an appropriate service has been selected but a preventable complication occurs and the patient does not receive the full potential benefit of the service.[19] These judgments cannot be made unless care is measured against some kind of standard. The Institute of Medicine National Roundtable on Health Care Quality came to the following succinct, consensual conclusion based on almost two years of evaluation of evidence:

> The quality of health care can be precisely defined and measured with a degree of scientific accuracy comparable with that of most measures used in clinical medicine. Serious and widespread quality problems exist throughout American medicine. These problems, which may be classified as underuse, overuse or misuse, occur in small and large communities alike, in all parts of the country and with approximately equal frequency in managed care and fee-for-service systems of care. Very large numbers of Americans are harmed as a direct result. Quality of care is the problem, not managed care. Current efforts to improve will not succeed unless we undertake a major systematic effort to overhaul how we deliver health care services, educate and train clinicians, and assess and improve quality.[20]

Against this background of policy exigency what can we say about where we are on comparative public data reporting regarding the quality of health care in the United States?

II. THE REPORT CARD MOVEMENT: DIVERSITY AND COMMON THEMES

That information about quality performance in health care ought be made public is not a new concept. The federal PSRO program which transmuted into the federal Peer Review Organization (PRO) program made data about hospital performance public back in the late 1970s into the mid-1980's.[21] The subject of spirited debate, although it was suspended as a reporting phenomenon, its termination was met with some state initiatives on reporting cost and quality of certain procedures provided in hospitals, notably by the Pennsylvania Health Care Cost Containment Council.[22] Contemporaneously, with the increase in HMO popularity in the late-80's, NCQA launched a pilot report card project in 1994 to give life to the Health Plan Employer Data and Information Set (HEDIS) measures.

---

19 Chassin and Galvin, "The Urgent Need to Improve Health Care Quality", 280 JAMA 1000 (September 16, 1998)

20 Id.

21 See Gosfield, PSROs: THE LAW AND THE HEALTH CONSUMER, Ballinger Publishing Co., Cambridge, MA, 1975.

22 See discussion on hospital report cards, infra.

The HEDIS measurement system began in 1989 as an effort among a coalition of HMOs and four large employers along with a benefits consultant. The purpose was (1) to decrease burden on health plans trying to respond to disparate data requests from purchasers about the plans' performance, (2) to meet purchaser needs for greater comparability among plans to inform their selections, and (3) to pick measures which would in fact lead to quality improvement.[23] The project was taken over by NCQA which published the second iteration of HEDIS in 1993. One of the major refinements in the second version, HEDIS 2.0, was specifications regarding how data was to be reported, to assure consistency among the comparisons which would result.

In 1994, NCQA launched the first national cross-plan report card pilot project to test how the measures would work on a broad basis. Twenty-one plans volunteered to be measured. From this fitful start has emerged the most widely (although not uniformly) accepted national approach to health plan performance measurement in HEDIS 3.0. The current version is the basis for NCQA's QualityCompass®, a proprietary database which accepts performance reports from health plans, compares and publishes them. Health plans have been permitted to choose whether the data they report will be made public, although even if not reported publicly their data informs the comparisons NCQA produces. In light of the recent Commission activities it is significant that NCQA validated in its third annual "State of Managed Care Quality" report that health plans with a track record of public disclosure outperform others and demonstrate improvement across almost all measures. The breadth of this undertaking can be seen in the fact that in its last edition QualityCompass® reported performance information from 247 organizations representing 410 health plans providing information about care provided to nearly 70 million Americans.[24]

The current sixty-plus HEDIS measures have covered eight domains of interest: (1) effectiveness of care; (2) access/availability of care; (3) satisfaction with the experience of care; (4) health plan stability; (5) use of services; (6) cost of care; (7) informed health care choices; and (8) health plan descriptive information. As HEDIS has become more refined, most attention has been focused on effectiveness, access/availability and satisfaction with care. Criticized as too process oriented because of its initial emphasis on preventive measures – rates of mammography screening, diabetic eye exams and immunizations, for example – HEDIS 2000 now addresses five of the top seven leading causes of death, with a new focus on heart disease, asthma and women's health. The measures are selected, modified and retired upon the recommendations of NCQA's Committee on Performance Measurement, a broad-based group of

---

[23] See, Gosfield, GUIDE TO KEY LEGAL ISSUES IN MANAGED CARE QUALITY, Faulkner and Gray, 1996, pp. 203-210, and Spoeri and Ullman, "Measuring and Reporting Managed Care Performance: Lessons Learned and New Initiatives", 127 Annals of Internal Medicine 726 (Oct. 15, 1997)

[24] Press Release, "NCQA's *State of Managed Care Quality* Report, Quality Compass'99 shows simple formula for health care quality: Accountability", NCQA, July 28, 1999.

plan, employer, and consumer representatives and experts in performance measurement.[25]

Although QualityCompass® reports on health plans alone, the general approach has gained momentum and is now being applied in health plans, hospitals and even physician-focused reports. There are controversies, however, surrounding the effectiveness and methodologies of each type of report card. The following discussion highlights some of these issues.

A. Health Plan Report Cards

On the subject of health plan report cards generally, there is no dearth of studies reviewing them and most conclude more study is necessary. One major problem in the theory of consumer targeted report cards is the absence of a real market based on choice among those to whom the data is directed. Forty-seven percent of employees in large companies and 80% in small firms have no choice among health plans.[26] Consequently, even if comparative data is provided, it may have no meaning to its intended recipients. But though consumer usage is questioned, there is increasing use of HEDIS by employers and purchasing coalitions. Still, some argue that although quality within plans may be improved, only items measured by HEDIS are affected.[27] This, however, seems inevitable if we cannot measure everything we do.

Another dilemma for apples to apples comparisons among plans is that although HEDIS offers a readily available source of measurement, some who use it, do not rely on it either alone or without modification in their reporting and comparisons; so the same plan may fare quite differently under different reporting systems. One commentator in comparing hospital report cards versus plan report cards notes that HMO report cards are much more diverse in sponsorship and in content.[28] Multiple studies report variability in results for the same plans reported on by different report cards.

One study compared data from Consumer Reports, Newsweek, US News and World Report, Quality Compass®, GTE Corporation, Consumer's Checkbook, and the California HEDIS Coalition and found that in some instances the same plan scored both the highest and the

---

25 See HEDIS 3.0, NCQA, Washington, D.C., 1997 and Press Release, "NCQA Releases Final HEDIS 2000 Measures; Focus is on Heart Disease, Asthma and Women's Health" NCQA, June 29, 1999

26 See Bodenheimer, supra n.10.

27 Id.

28 Gormley, "Assessing health care report cards", 8 J. Public Administration Research and Theory 325 (July 1998)

lowest scores depending on the report card used.[29] In reporting on their HMO rankings, US News and World Report says that they selected 28 HEDIS measures, which their experts from the National Opinion Research Center concluded were largely responsible for differences in category. They also chose to weight certain factors more than others[30]. Healthgrades.com™ uses only customer satisfaction data and then relies on the Sachs/Scarborough HealthPlus database which is not the same as the HEDIS customer satisfaction instrument.[31] After studying the comparability and methodological issues, researchers have made the following suggestions to improve report cards – some of which are already reflected in the President's Commission's Report:

> Creators of report cards can do several things to improve the usefulness of report cards. First, they can be as explicit as possible about the methodology. We understand that many of the details of report card construction cannot be included, but a more open presentation of the measures and normative judgments used to construct indices and ratings would facilitate comparisons. In this spirit, report card creators should be careful to express general caveats and not give the impression that the ratings are more precise than they are in reality... Second, report card creators should strive to include as many plans as possible...Third, report care authors should cooperate wherever possible to create a common framework for data reporting....[32]

Apart from the methodological issues, there is considerable debate over (1) the significance of customer satisfaction as a measure of quality, (2) the value of process versus outcomes measures, and then the even more difficult question as to (3) whether consumers will use health plan report cards.

On customer satisfaction, commentators have focused on the unique role this type of measurement plays in health plans. Numerous studies, they say, have found patient satisfaction with health care delivery to be related to several positive outcomes. For example, satisfied patients experience less stress, heal faster, complain less, are more likely to return and less likely to sue. Not only are quality and satisfaction improvements important for humanistic reasons,

---

29 Scanlon, Chernew, Sheffler, and Fendrick, "Health Plan Report Cards: Exploring Differences in Plan Ratings", 24 J. on Quality Improvement (JCAHO) 5 (January 1998)

30 See, Comarow, "How we ranked the plans", US News and World Report, Oct. 5, 1998 at 80.

31 www.healthgrades.com/Information/methodology

32 Scanlon et al, supra n. 29 at 15.

they say, they make good business sense.[33] They observe further, however, that traditional reasons for businesses to measure satisfaction generally, including revenue advantages, may actually decrease profitability in a managed care system which rewards decreased usage over increased usage. In addition, many managed care patients have difficulty articulating their expectations of health care service, a common component of satisfaction judgments. In other product and service industries, they note, customer expectations play a dominant role in satisfaction levels.

Researchers who have conducted focus groups on consumer choice in health plans have found that consumers seem less interested in or are even suspicious of, information about technical quality and clinical outcomes, which experts think is most important.[34] For these analysts, the dilemma is the following:

> If report cards give people what they want, and they use the information to choose plans and providers, these plans and providers will be rewarded for doing well on aspects of care that are not necessarily related to good medical outcomes. This is cause for concern because it is easier for health plans and providers to give very good service and treatment to the large majority of patients who are relatively healthy than to provide excellent clinical quality for the severely or chronically ill. On the other hand, if report cards emphasize clinical quality, consumers might not use them (although our studies suggest that health plans will still respond by trying to improve their scores).[35]

As health plan report cards have improved, some data regarding their utility suggest they have become more user-friendly and therefore are used. A 1998 study of 1997 plan selection in Washington state found that most of the 98,000 employees who received a report card said they read most or all of the report and spent 30 minutes or more with it. The report was easy to understand and helpful in learning about differences in health care quality, they responded. Counter to early efforts, they chose it as more useful than any other source of quality information, including the state, benefits fairs, health plans, coworkers, friends and family.[36] The researchers attributed much of the improved results to a more standardized approach to customer satisfaction

---

33 Halstead, Casavant and Nixon, "The customer satisfaction dilemma facing managed care organizations", 16 Health Care Strategic Management 18 (June, 1998)

34 Wicks and Meyer, "Making Report Cards Work", 18 Health Affairs 152 (March/April 1999)

35 Id at 154.

36 News Release, "Health Care Report Cards Pass First State Test", www.hms.harvard.edu/news/releases/12298/reportcards.html (Dec. 16, 1998)

data.

The study was part of the Consumer Assessment of Health Plans (CAHPS), a project funded by the federal Agency for Health Care Policy and Research. Begun in 1995, the current iteration has been accepted by NCQA, the federal Medicare program and more than 20 states which survey quality in their Medicaid plans. CAHPS is a combination of the first federally sponsored version of the survey instrument blended with NCQA's Membership Satisfaction Survey.

Some have observed that although consumers seem to embrace satisfaction as a quality marker, it also drives purchaser behavior. "Health care has always been bought as a reputation good."[37] "A health care buyer would have to be marooned with the Skipper and his Little Buddy to not notice the health plan rankings of one flavor or another endlessly aimed at them – from Sachs Group's HMO Honor Roll to CareData's Managed Care Survey. Most such lists -- report cards, they're not -- are based on satisfaction-related issues, not clinical performance."[38]

How customer satisfaction is linked to technical quality in health plans is also closely related to another debate over process versus outcomes measures. "Outcomes" are traditionally meant to indicate what happens to patients as a result of care received. Making sure patients receive a specific service is not the same as determining if they actually got better as a result of the care.

Debate over the significance of these differences has existed as long as healthcare quality has been analyzed .[39] The motivation for an end results approach has been long recognized.

> Almost a century ago, following the death of a patient he and Harvey Cushing had anesthetized, Ernest A Codman, a surgeon at the Massachusetts General Hospital, proposed the use of "end result cards." The cards were to contain the patient's symptoms, treating diagnosis, treatment plan, complications, discharge diagnosis and annual follow-up. For each "surgical treatment lacking perfection", notations were to be entered to distinguish remediable factors involving physician skill and judgement, the institution's facilities organization, and a patient's personal or social conditions form "unconquerable disease" or "accidents and complications over which we have no known control."

---

37 Jon Gabel of KPMG Peat Marwick quoted in Dalzell, "Health Care Report Cards Who's Paying Attention", Managed Care, Feb. 1999; www.managedcaremag.com/archiveMC/9902/9902.whocares.shtml at 3.

38 Id.

39 See, Millenson DEMANDING MEDICAL EXCELLENCE, University of Chicago Press, Chicago, 1998 for an excellent exposition of the history and development of the quality measurement and analysis movement in this country.

> Codman advocated that the results be publicly acknowledged and that studies be directed at prevention. The threatening nature of his ideas and his confrontational approach led to his dismissal from the Massachusetts General Hospital and professional ostracism. Demonstrating intellectual honesty, he followed his own dicta by publishing five years later the end results of patients treated at the private hospital he funded.[40]

Initially focused on what happens to individual patients, today the primary emphasis in end results or outcomes measurement is what happens to populations for which a plan is responsible.

HEDIS 2.0 measures were criticized as too process oriented and not focused enough on whether patients actually got better. Today's version of HEDIS has retired some measures including whether diabetic retinopathy eye exams have been performed in favor of a Comprehensive Diabetes Care measure which looks at various aspects of diabetes care ranging from blood sugar management to eye exams to screening for kidney disease. As a further example of a more outcomes oriented approach the HEDIS 2000 measure on Controlling High Blood Pressure assesses the percentage of members with high blood pressure whose pressure is controlled to below 140/90.

Yet despite the continuing aspiration for outcomes measurement as a core approach to quality, the feasibility of using such measures in a reliable way has been called into serious question. David Eddy, one of the premier quality measurement specialists in the world, has identified five basic problems in focusing on outcomes measurement: (1) probabilism; (2) rarity, (3) delay (4) weak control and (5) confounding.[41] The first is the fact that outcomes do not always occur when a plan does the right thing and can occur even when a plan does the wrong thing. The second is that some of the most important things which we would want to measure – including even breast cancer, for example – occur relatively rarely across a single plan's population. The third is that it takes many years, five to ten years of longitudinal information, to get to survival rates. Weak control reflects that because of how health plans "deliver" care, namely through others, the extent to which a plan can actually control what produces an outcome is questionable. Moreover, in large networks, a single plan may have even less influence over the delivery of care than another factor. Other analysts have focused on the fact that increased network size as a result of an emphasis on consumer choice among physicians decreases the degree of penetration of a physician's practice by a plan, and therefore decreases the plan's ability to influence the physician's behavior.[42] Confounding has to do both with the appropriate

---

40 Dans, "Caveat Doctor: How to Analyze Claims-Based Report Cards" 24 Journal of Quality Improvement 21 (January 1998)

41 Eddy, "Performance Measurement: Problems and Solutions", 17 Health Affairs 7 (July/August 1998).

42 Schoenbaum and Coltin, "Competition on quality in managed care", 10 Int'l J for Quality in Health Care 421 (1998)

level of clinical detail at which the analysis ought to be focused and the fact that definitional problems lie at the core of determining what is being measured. Common clinical concerns, like hypertension, may be expressed in variant measures which produce completely different results.

These inherent problems are further complicated by implementation dilemmas which include inadequate information systems, too many measurers and measures, health plan complexity and funding. "Today's measures tend to be blunt, expensive, incomplete and distorting, and they can easily be inaccurate and misleading."[43] Eddy argues for more rigorously defined, standardized and selected process measures; and he has met with support including at NCQA which is moving more in this direction. Whether those who seek access to performance measurement data will value such a change is a different issue and relates directly to the audiences for plan report cards and whether the message of this data is appropriately received.

As with much in health care these days, the actual impact of plan report cards is debated widely. Employers and purchasers who participated in their spawning generally are supportive of the measurement efforts to date and recognize they are developmental.[44] Smaller purchasers, though, are less likely than larger ones to use health plan report cards. A 1997 Washington Business Group on Health survey found cost, access and member services as priorities one, two and three for purchasers.[45] Satisfaction is therefore important to these purchasers.

The General Accounting Office undertook a study of purchasers' use of report cards and its implications for HCFA in the Medicare program.[46] Studying four major purchasers, the GAO was more sanguine about some of the uses of this data. Purchasers reported that in addition to cost savings, they saw improvements in access to care and health plan services, as well as in employee satisfaction with health plan performance. These positive effects were realized by identifying opportunities to use quality-related data in selecting health plans, monitoring health plan performance, developing quality improvement initiatives with plans and providing information on health plans to their employees.

Those who found the programs successful were far more activist in their uses of this data than merely disseminating evaluative judgments in a static report: They used the data to develop performance targets for plans which were used in contracting with them. They conducted site visits to observe plan behavior and operations. They actively educated their employees about the

---

43 Eddy, supra n. 41 at 15.

44 Meyer, Wicks Rybowski and Perry, "Report on Report Cards", Economic and Social Research Institute in collaboration with the Midwest Business Group on Health," March, 1998, www.esresearch.org/Documents/reportcard.html

45 Dalzell, supra n. 37.

46 GAO, "Health Care Quality: Implications of Purchasers' Experiences for HCFA" GAO/HEHS-98-69 (July 18, 1998)

meaning of the data. They engaged in collaborative and compliance oriented approaches to achieve improvements in the plans. All four purchasers reported that they expected to make greater use of this data over time to achieve even better quality improvement.

The four purchasers forecast additional uses to discriminate among and contract with fewer plans, to determine whether to renew contracts with plans, to translate more performance goals into contractual standards, to present multiple types of data to plans through combined formats and to negotiate rates with and provide financial incentives to employees to choose plans with higher quality rankings.

The thrust of "public" accountability, though, is *consumer* information regarding quality; and here, the story is not so clear. The basic predicate for consumer report cards is to inform consumers so they can make informed choices. But some argue that different consumers need different information – the chronically ill approach choice quite differently from the healthy, and "the truth is, most of us don't pay very much attention to the details of the health benefits packages until we are sick."[47] Studies have repeatedly shown that consumers say recommendations from family and friends were most important in influencing their choice of a health plan.[48] Most employees with access to report cards don't really use them. They focus on cost, coverage and keeping the relationship with their doctors.[49]

Employees studied in one Fortune 100 company for the 1994-1995 open enrollment period did not appear to respond strongly to plan performance measures, even when the labeling and dissemination were specifically designed to facilitate their use.[50] The investigators speculated that the counter-intuitive negative correlation could reflect problems with the construction of report cards including if employers have to aggregate data to provide manageable evaluations, those employers also have to place some value on specific plan attributes and in some cases those values may not correspond to employee values. But in other cases

> [t]he ratings may be correlated with plan attributes that are observed and valued by employees, but not captured in the performance ratings. For example, the satisfaction rating, which assumes long waiting times are bad, does not recognize that the preferred physician practices may be those with the longest waiting times. In effect, long waiting times may be correlated with physician quality or at least

---

47 Edgman-Levitan and Gerteis, "measures of quality: What can public reporting accomplish?" 41 Health Forum Journal 36 (Jan/Feb 1998)

48 57% of consumers in this study, Voelker, "Do consumers "get" quality?" 17 Business and Health 14 (1999)

49 Meyer et al, supra n. 44

50 Chernew and Scanlon,"Health Plan Report Cards and Insurance Choice," 35 Inquiry 9 (Spring, 1998)

physician popularity (lines only form at good restaurants).[51]

These analysts however specifically suggested that changes in report cards which were then already underway, could ameliorate these results. In addition, however, they observed that

> It is important to recognize that even if employees are unresponsive to report card information, that information may be valuable to employers when selecting the set of plans to offer. Moreover the collection and reporting of the information may encourage plans to improve their performance.[52]

Yet another assessment of employee use of report card data during the same time frame (1995) in Minnesota, a highly penetrated managed care market, focused on slightly different aspects of the application of report cards in plan choice. "We looked for an influence of the report card on changes in employees' knowledge of health plan benefits, changes in preferences for health plan attributes (namely quality dimensions versus cost dimensions), changes in ratings of available health plans' overall quality, and choice of plans"[53]. The results were just as disappointing in terms of whether the report cards influenced consumer behavior. "We conclude the report card had no discernible effects on employees knowledge, attitudes or choice of health plans. The only impact we found was related to the perception of employees with single coverage on how knowledgeable they felt they were about health plans." Their conclusions about report card design, though, were a little bit different and indicated that technical quality such as long term outcomes may be more important to report and more useful to consumers. They also suggested reevaluation of the then current approach to report cards, suggesting evaluation below the level of the plan to providers, and that hypotheses regarding report cards ought be tested in markets where there is evidence of greater variation in health plan quality than existed in Minnesota at that time.

In terms of what employees consider essential information, in these early studies cost, basic content and quality of providers in the plan were most important. In addition to the specific benefits in each plan, out of pocket costs ranked high as a consumer measure of a plan in a 1997 study.[54] Consumers often find the information made available confusing and too complicated.

There are already changes afoot to deal with these problems. In addition to CAHPS developments already noted as more successful in Washington state, another government

---

51 Id at 19.

52 Id.

53 Knutson et al, "Impact of Report Cards of Employees: A Natural Experiment", 20 Health Care Financing Review 5 (Fall, 1998)

54 Tumlinson et al, "Choosing A Health Plan" What Information Will consumers Use?" 16 Health Affairs 229 (May/June 1997)

supported private entity, the Foundation for Accountability (FACCT) -- has developed a different framework for reporting data which has already been accepted by NCQA for its accreditation reports. In addition, now that NCQA accreditation incorporates certain HEDIS measures into its accreditation decision-making, NCQA accreditation reports will reflect actual performance rather than just whether systems are in place to evaluate quality.

The FACCT model focuses around five areas of concern:

(1) the Basics – delivering the basics of good care – doctor care, rules for getting care, information and service, satisfaction ("Will I be treated respectfully, understand what is said to me and have access to needed services and providers?");
(2) Staying Healthy – helping people avoid illness and stay healthy through preventive care, reduction of health risks, early detection of illness, education ("Will I be able to stay as healthy as possible -- through education, health promotion, preventive services and early detection of disease?");
(3) Getting Better – helping people recover when they're sick or injured through appropriate treatment and follow-up ("If I get sick will I get better and regain normal functioning?");
(4) Living with Illness – helping people with ongoing chronic conditions (such as diabetes or asthma) take care of themselves, control symptoms, avoid complications and maintain daily activities ("If I suffer a chronic condition will I be able to maintain the best possible functioning, minimize undesirable symptoms and learn how to care for myself?");
(5) Changing Needs – caring for people and their families when needs change dramatically because of disability or terminal illness – with comprehensive services, care giver support and hospice care ("As I face death or disability in my family will we be able to cope, minimize pain and suffering and maximize spiritual and family comfort?").[55] When first enunciated, FACCT took the position that HEDIS only focused on the Basics and Staying Healthy and that more work is needed on the other three areas. This process is also underway on multiple fronts and NCQA has already adopted features of FACCT's framework in its accreditation report formatting[56]. Clearly making information more meaningful to consumers is critical if they are to exercise any type of choice based on a health plan report card.

B. Hospital Report Cards

As for hospital report cards there are both similarities and differences in comparing them to health plan report cards. Methodological dilemmas and whether the data are actually used dominate discussions of the much older phenomenon of hospital report cards. Hospital report cards have been published by state agencies, regional business and health care coalitions

---

55 Lansky "Measuring What Matters to the Public", 17 Health Affairs 40 (July/August 1998) and www.facct.org/information.html

56 Press Release, "NCQA unveils new consumer report that will provide a detailed view on HMO Quality", NCQA, July 28, 1998

(Cleveland prime among them) and now by health plans and commercial raters. HCIA and William Mercer provide rankings of U.S. hospitals and US News and World Reports does the same. Healthgrades.com™ uses administrative data from Medicare and the 18 states which make all payor data available and then applies its own statistical prediction model – the typical approach to these report cards -- to determine which facilities exceeded expected mortality rates or performed better than expected[57]. Far less typically, HealthNet, an HMO, publishes a hospital satisfaction report card based on member satisfaction surveys.[58]

In an assessment of hospital, health plan and nursing home report cards, one investigator characterizes hospital report cards as superior to more diffuse health plan cards in that they typically have focused on a clear, important outcome variable – death – and have utilized multivariate statistical models to control for different patient risks (risk adjustment).[59] This opinion is not universal. In addition, all of the report cards he studied are published by state agencies.

Focusing on Pennsylvania, New York, Florida and California -- four of the most populous states — all study death following acute myocardial infraction, coronary artery bypass graft surgery or both. New York and Pennsylvania use clinical data gathered expressly for the purpose of the report cards, while California and Florida rely on administrative claims data. These methodological differences generate their own concerns. Administrative data is cheaper and easier to access but contain limited clinical information. Clinical data is more credible to health care professionals but is more expensive to collect. But while Gormley finds hospital risk adjustment advanced, Iezzoni observes that the predominant proprietary rating systems, one of which is the core data for Pennsylvania, adjust for risk in widely variant ways and therefore can produce confusing results.[60] Going still further, another commentator considers the entire statistically risk adjusted approach to lead to "specious inferences."[61] He criticizes the healthgrades.com™ report cards and other such systems as making it "easy for consumers to compare one hospital to another. Unfortunately it also can totally mislead consumers, thanks to a specious (plausible and attractive but invalid) use of statistics." His concerns about methodology, however, may have little significance themselves, since, like health plan report cards, hospital report cards are, apparently, little used by consumers.

---

57 www.healthgrades.com/information/methodology/HOSPMethodology.cfm

58 ifp.healthnet.com/general/ppg_reports

59 Gormley, supra n. 28 at 329.

60 "Making the grade: A status report on hospital report cards", 30 Health Systems Review 11 (Sept/Oct 1997)

61 MacStravic, "Quality indicators and specious inferences" 17 Hospital Strategic Management 15 (Jun 1999)

In a 1996 study, only twelve percent of respondents in Pennsylvania reported being aware of the Consumer Guide to Coronary Artery Bypass Graft Surgery prior to undergoing that surgery. Of those 56 patients, only eleven said they knew the hospital rating, and the same number said the ratings influenced their choice of provider. Only four knew the correct rating, however. More than half of those surveyed, though, said they were "very" or "somewhat" interested in seeing the guide when its contents were described to them.[62] On the other hand, in New York, researchers found that hospitals with better outcomes experienced higher rates of growth in market share. Emphasizing their focus on *published* data – rather than material used internally for quality improvement alone – these researchers distinguished the New York data from both HCFA's mortality data and the Pennsylvania numbers – both systems where the risk adjustment formulas have been particularly criticized.[63]

In direct contrast with the assessments of health plan report cards, though -- having come a long way from Codman's era[64] -- there is far more acceptance today of the concept that the role of published mortality data has real value for quality improvement within hospitals. The most recent publication of the Pennsylvania data — albeit from 1994-1995 – found that death rates and charges had dropped.[65] With regard to California and New York, current report card efforts are perceived as more credible and meaningful than earlier ones, although not surprisingly, better performing hospitals were more accepting of the data than those who fared less well. Report cards based on clinical data were better accepted than those based on administrative claims data.[66] Other studies of California have focused on the extent to which the data was actually used by quality managers within hospitals. Here the great lag time in receiving data was cited as problematic. In addition, hospital managers want information about processes and not just outcomes of care. Few hospitals undertook meaningful quality improvement based on the data, but "Most of the hospital quality managers we interviewed recognize that report cards are here to stay and believe that both hospitals and consumers are entitled to receive, valid, comparative risk-adjusted outcomes information in a timely manner."[67] Yet other data, particularly about New York, demonstrate that report cards do encourage hospitals to improve their performance,

---

62 "Effect of Surgeon and Hospital "Report Cards", June 1, 1998, www.faxwatch.com/pub/n/html/clinical/3457.asp

63 Mukamel and Mushlin, "Quality of Care Information Makes a Difference", 36 Medical Care 945 (1998)

64 See text at n. 41, supra

65 "Pennsylvania: Bypass Surgery Death Rates, Charges Fall," American Health Line, May 8, 1998, National Journal Group, Inc.

66 Romano, et al, "Grading the Graders", 37 Medical Care 295 (1999).

67 Rainwater et al, "The California Hospital Outcomes Project", 24 Journal on Quality Improvement 31 (January 1998)

although all reviewers agree more work needs to be done in this area.[68] And, another assessment of a report card on 88 Missouri hospitals providing obstetrical services found that two years after the initial report card's publication, hospitals that previously had not offered such services as postpartum nursing follow-up care and newborn car seats began to do so and c-sections and ultrasound use dropped about 6% while the occurrence of vaginal births in women who had had c-sections rose 6%.[69]

While the data is, as with health plan report cards, intended to influence purchaser behavior as well, here the connections tend to fall apart. When the Cleveland Clinic pulled out of the Cleveland Health Quality Choice Program, imperiling the entire hospital report card undertaking which had been in effect since the early 90's, they stated the data are not used by insurers or employers, who make their own data requests to hospitals.[70] Yet another study showed that in California, New York, and Pennsylvania purchasers were not even aware of the availability of performance data. Those who were said they did not believe the data were sufficiently reliable or timely; they assumed that the plans with which they did business examined this data themselves; the information was not presented in a useful manner when their needs centered on plan selection as opposed to hospital selection; and they could not use the information for purchasing decisions.[71] Researchers did observe that some purchasers are more evolved on these issues and understand that they can influence health plan behavior based on this type of data, while others do not see their proper role as focused around provider performance.

C. Physician Report Cards

While hospital report cards may prove helpful in improving delivery of care within institutions, the most alluring focus for comparative choice and the one on which most parties agree consumers place the greatest value and employers increasingly seek data is physician report cards. Although far, far more recent as a phenomenon, physician report cards are not unknown. New York and Pennsylvania publish performance rates by surgeon for the procedures they review in the hospital, but the results are the same in terms of acceptance, credibility and effect. Still, physician-focused data has garnered the attention of regulators because of their potential use in Medicare.

The General Accounting Office reviewed the physician report card phenomenon in response to an inquiry from Congressmen Jeffords. The title of their report summarizes the current state of the art: "Physician Performance: Report Cards Under Development but

---

68 Gormely, supra n. 28 at 331.

69 "Report card day for mo caregivers", 51 Trustee 7 (Jan. 1998)

70 Jaklevic, "Hospital Report-Card Model in Peril", Modern Healthcare (January 18, 1999) at 14

71 See n. 60 supra at 15.

Challenges Remain." [72] In addition to noting the work of the Performance Measurement Coordinating Council which includes the AMA's American Medical Accreditation Program (AMAP) to accredit individual physicians, the GAO reported that HCFA is working on a performance measurement system for its Medicare fee-for-service program which is expected to be available in 2001!

The GAO cited all of the general limitations of health plan report cards as intensified when applied to individual physicians. They observed that most data tends to be focused on medical groups, when oriented around physicians at all. Process versus outcomes, rarity of events to measure, sources of data, and delays in reporting data on which change might be based were all noted. In addition, the need for even more collaboration in the design of reports and their publications because of physician anxiety about misuses of data and limited credibility in it were also identified as obstacles in current efforts. Consumer concern for privacy of health care data was also addressed, especially given laws which will limit how such data is managed.

Several noteworthy exercises formed the basis for their conclusions: (1) PBGH developed a Physician Value Check Survey which obtained responses from 31,000 patients; (2) The Business Health Care Action Group (BHCAG) in Minnesota developed a satisfaction survey to its members when they found they could not use HEDIS measures because of state privacy laws impeding access to the data and the fact that they could not identify more than 100 plan enrollees for any of the measures in more than one or two care systems; (3) PacifiCare of California produced a medical group report card – Quality Index -- which included some process measures, service performance and enrollee satisfaction; (4) HealthNet developed its Participating Physician Group Report Card and applies a direct financial incentive to medical groups associated with their performance as measured in a satisfaction survey of the plan's enrollees.

Although the report cards focused on groups, the GAO noted that depending on the size of the group, the data may be of limited utility in individual physician selection by consumers. The use of surveys, they found, may bias the data in favor of those who respond. Comparability was also a problem. Since most physicians in the relevant geographic areas participate in both PacifiCare and HealthNet, the considerable differences in the enrollee satisfaction scores for some groups raise concerns. More collaboration in the development of the processes to produce the data and increased standardization were cited as potential significant improvements.

Unlike the consumer response to the other types of report cards, though, it appears there is keen interest in this data. PacifiCare's medical director says "we have had more hits and downloads on our website for this information than investor information."[73] PacifiCare reports that there was a strong correlation between the number of "best practice" designations a group

---

72 GAO/HEHS-99-178 (Sept 30, 1999)

73 Comments of Gordon Norman, MD, quoted in Dalzell, supra n. 37 at 6.

had and its enrollment increase.[74] PBGH is considering advertising report cards, recognizing outstanding physicians with special awards and using more aggressive efforts generally to stimulate use of the report cards.

Physician reaction has been mixed. Some still question whether the consumers are really paying attention. Credibility is still an issue, especially considering that one group surveyed even under one HMO fared differently in two locations even though they claim to have uniform systems across the group.[75] This concern can also translate into a physician desire to avoid severely ill patients, referring them elsewhere.[76]

In considering the implications of health plan report cards to physicians, issues for physician-level report cards are elucidated. Some issues include disproportionate attention to specific clinical areas of focus including pregnancy-related care, preventive services, asthma, diabetes, behavioral health and selected aspects of oncologic and cardiovascular services. Concern for accuracy and integrity of data reporting ought prompt physicians to examine the capabilities and adequacy of their office-based information system. This overall movement to provider-level reporting ought prompt "revisitation of issues regarding health plan performance reporting — indicator validity, risk adjustment, statistical (and clinical) significance, value to consumers, cost of data collection and reporting and confidentiality."[77] On the other hand "the appeal of profiling and feedback has been recognized by physicians themselves when they are placed at financial risk for the utilization of services. A survey of medical group practices that contract with a health maintenance organization under capitation found that 79% of these groups profile individual utilization rates and 58% report these results to their physicians."[78] The issue is less whether such data can be used to improve and more whether such data will be made public.

So, the state of the art of public reporting of comparative data on health care quality is developmental, with much improvement to date and an undeniable distance to go, if the subjects of reports are likely to take any action based on quality performance data, let alone whether there will be a market impact. Although demonstrated response in the form of active employer, purchaser or consumer choice is equivocal to date, it seems that less direct consequences in quality improvement by plans and providers -- even if they are undertaken only to improve performance scores – can be shown. All

---

74 Larkin, "Doctors starting to feel report cards' impact," AMNews July 26, 1999.

75 Comments of Robert Margolis MD Id.

76 Kaplan, "The Report Card's Role in Health Care Decision Making: Part I", www.medomint.com/resources/mikaplan1297.html

77 Bushick, "health plan report cards", 5 The Medical Journal of Allina (Winter 1995), www.allina.com/Allina_Journal/Winter1996/bushick.html

78 Spoeri and Ullman, supra, n. 23.

misgivings aside, though, Congress does not let the perfect be the enemy of what is available. On that basis, Medicare has leapt into world of consumer choice based on publicly reported performance measurement in a big way.

III. MEDICARE AND QISMC

Performance reporting is part of the Medicare+Choice (M+C) program which Congress created in the Balanced Budget Act of 1997.[79] One of the hallmarks of the new program is to give beneficiaries choice among options which include HMOs, point of service plans, PPOs and fee for service plans.[80] To facilitate that choice information will be made available on the web and through toll free phone lines.

Basic issues regarding what consumers need and want have been studied in the commercial sectors as reported above, but special attention has been paid to the potentially different needs of Medicare beneficiaries.[81] In addition to the chronic and more serious health care needs of older Americans, the fact that most will not have the help of employers in making their choices crystallizes some of the deficiencies in report cards to date. Intensifying this dilemma, many of the beneficiaries of this data however, have far less experience with what plan choices even represent than employed populations. About 10% of all Medicare beneficiaries were enrolled in managed care plans in 1996 as contrasted with almost 70% of the commercial population under age sixty five. However, per capita spending on the elderly for health care is about four times that of the commercial population.[82] Today, about 14-15% of the Medicare population is in managed care.[83] The implications for cost are apparent, but an even more interesting phenomenon is that Congress has provided for far greater choice for these relatively inexperienced plan selectors than is found in the general population or among all of the report card exercises reviewed here or in the literature generally. Consider the following premises for this program which is so grounded in theories of market exercise of choice that this factor is incorporated in

---

79 See §1852 of the Social Security Act and 42 CFR 422.111-112; 118; 152, and selected sections of 200 et seq, and 562 et seq. HCFA has enumerated the links between the statute, regulations and QISMC in formal terms. See, "Crosswalk Between the Statute, M+C Regulations and QISMC", www.hcfa.gov/medicare/cross3.htm, September 30, 1998

80 "Despite new emphasis on choice, however Medicare+ Choice remains for the most part an HMO program. Only one provider sponsored organization and one PPO were participating as of July 1999, Grantmakers in Health" COPING WITH MANAGED CARE, Responding to the Needs of the Elderly, Issue Brief No. 2, July 1999, Washington, D.C. at 4.

81 See for example, Hoy, Wicks and Forland, "A Guide to Facilitating Consumer Choice," 15 Health Affairs 9 (Winter 1996); Isaacs, "Consumers' Information Needs: Results of a National Survey, 15 Health Affairs 31 (Winter 1996); Edgman-Levitan and Cleary, "What Information Do Consumers Want and Need?", 15 Health Affairs 42 (Winter 1996); and Lewin and Jones, "Perspective: The Market Comes to Medicare Adding Choice and Protection", 15 Health Affairs 57 (Winter, 1996)

82 Lewin and Jones supra n. 81.

83 GAO Report, supra n. 46 and Grantmakers in Health supra n. 80.

the very name of the program:

> With greater choice has come the expectation that beneficiaries will assume new, more aggressive roles as consumers. The idea is that they will take responsibility for making informed decisions about prices, benefits, providers, service quality, and integration with supplementary and retiree health coverage. The success of this policy change will be determined by beneficiaries' ability to understand their new choices, participate effectively in an annual open enrollment season, and then receive and pay for needed care through their chosen plan.[84]

Given that this population is apprehensive about anything with the word "risk" in it and likely will depend more than others on advice of their physicians, a system which is understandable to their physicians too is also likely to matter. GAO has opined that educational efforts will be even more critical in the Medicare context. Others have suggested that to expect the elderly to manage the complexities of understanding their choices is unrealistic and will require an organized educational strategy that will take five to ten years to produce results. Others argue that formalized "information intermediaries" should be incorporated into the system ranging from trained family members to social services providers, health care professionals and local health officials. The actual open enrollment process for Medicare+ Choice does not begin until 2002, but HCFA has already begun to build the infrastructure for choice.

In considering the implications for HCFA from purchasers' experiences GAO made numerous suggestions about HCFA's undertaking. Prime among the GAO observations was the activist use of data to craft a more comprehensive approach to quality improvement. Current HCFA efforts would indicate that HCFA has heeded that call.

The HCFA Quality Improvement System for Managed Care (QISMC) is a broad based program focusing on patients' rights, operational excellence and a fundamental quality improvement infrastructure. Performance reporting is one piece of this system. Medicare managed care programs are directed to engage in a three pronged approach:

- Operate an internal program of quality assessment and performance improvement that achieves demonstrable improvements in enrollee health, functional status and satisfaction across a broad spectrum of care and services M+C organizations will have considerable discretion to select focus areas addressing specific health care and service needs of their population;
- Collect and report data reflecting performance on standardized measures of health outcomes and enrollee satisfaction and meet such minimum performance levels on these measures as may be established under its contract with HCFA or States;
- Demonstrate compliance with basic requirements for administrative structures and

---

84 Grantmakers in Health, supra n. 80 at 4.

processes that promote quality of care and beneficiary protection.[85]

QISMC incorporates a Quality Assessment and Performance Improvement (QAPI) initiative which requires plans to meet minimum performance levels on standardized quality measures. This is a major development in Medicare generally, and represents such a change for Medicare and managed care plans that the Monitoring Guide states these measures will not actually be monitored until 2001 based on performance levels to be established in 2000.[86] Through a detailed program of conducting performance improvement projects, selecting those projects in accordance with HCFA standards, measuring performance over time, making changes in response to data and reporting on all of this to HCFA, the requirements on MCOs mirror in many ways NCQA accreditation requirements. In fact, some of HCFA's mandates may be met by "deeming" a plan to comply if it is accredited.[87] The relationship between HCFA's requirements and NCQA's (and other accrediting organizations') becomes crucial to those plans which seek NCQA accreditation. HCFA has developed yet another cross-walk comparing NCQA's standards to its requirements.[88] But this article is not about accreditation; it is about report cards. Therefore, we will look at the reporting requirements for plans and the data HCFA is making available to inform beneficiary choice.

> "It is critical to HCFA's mission that it collect and disseminate information that will help beneficiaries choose among MCOs, contribute to better health care through identification of quality improvement opportunities and assist HCFA in carrying out its responsibilities. HCFA makes summary, plan level performance measures available to the public through media that are beneficiary oriented such as the *Medicare Compare*" Internet site and the *Medicare & You* handbook. A subset of HEDIS and CAHPS data is also available in printed form through a toll free line (1-800-MEDICARE)."[89]

There are many questions as to whether Medicare beneficiaries will make use of Internet based information sources. In January, 1999, though, when *Medicare Compare* was launched, more than

---

85 "Implementation of HCFA's Quality Improvement System for Managed Care (QISMC) Interim Standards and Guidelines, Operational Policy Letter #72, HCFA/DHHS, Center for Health Plans and Providers, September 30, 1998, www.hcfa.gov/medicare/opl072.htm

86 See Monitoring Guide, QISMC Domain 1 Quality Assessment and Performance Improvement, www.hcfa.gov/ medicare/managed care at QI 03.

87 §1852(e)(4) of the Social Security Act.

88 See, "Crosswalk Between QISMC Interim Standards and NCQA 1999 Accreditation Standards" www.hcfa/gov/quality/docs/qismc-c2.htm

89 OPL #110, December 22, 1999, www.hcfa.gov/medicare/opl110.htm

175,000 people visited the site.[90] There, searching by zip code and by available Medicare plan, beneficiaries can find comparative mammography rates, use of beta blockers after heart attack, eye exams for members with diabetes, plan members seen by a provider in the past year, primary care doctors who are board certified, specialists who are board certified, providers who stayed in the managed care plan for at least one year, and an overall rating of the managed care plan, based on member surveys.[91] The significance of the data is described along with bar graph percentages compared with aggregated state ratings. For example, on the measure of plan members seen by a provider in the past year, HCFA says the following:

> **Why this measure is important?** This measure shows how well plan members are able to get an appointment and see health care providers. (A provider is anyone with a license from the State to practice medicine. This includes doctors, and in some States, nurse practitioners and physician assistants.) This may help to reduce severe health problems. Regular health care visits may help find health problems early and may result in a greater chance of being cured.
>
> **What does this tell you about a health plan?** If the percentage of plan members seen by a provider within the last year is **HIGH** (closer to 100%) this means the health plan is doing a **GOOD** job of giving its plan members a chance to see a provider when they need one.[92]

Despite requiring plans to report it, for HEDIS 2000, HCFA will not publish the hypertension measure, because HCFA will follow NCQA's new model which allows "first year measures" to be reported to NCQA but not reported publicly to allow fine-tuning of specifications and data collection issues. On the other hand, to assure the credibility of the data, HCFA does require MCOs to undergo an NCQA Compliance Audit. These are audits conducted by third parties who are licensed by NCQA and are certified as competent to conduct HEDIS audits. In addition, underscoring HCFA's strong emphasis on data accuracy, the plan's chief executive officer is required to provide a written attestation as to the validity of the plan-generated data. Any improprieties regarding the data after such an attestation can lead to false claims liability, since this information would be submitted to secure Medicare reimbursement. Final Audit Reports are due by July 30, 2000 and MCOs are responsible for submitting audited data. [93] Final Audit Reports are subject to the Freedom of Information Act.

---

90 Press Release, "NCQA's HEDIS Compliance Audit Required by HCFA For all Medicare Health Plans", www.ncqa.org/pages/communications/news/audrel.html

91 See, www.medicare.gov/comparison/plansearch/QualityResults.asp

92 Id.

93 Full Audit processes are contained in HEDIS 2000, Volume 5, Compliance Audit, Standards, Policies and Procedures published by NCQA.

HCFA is also requiring plans to provide the Medicare Health Outcomes Survey. This is a survey which addresses the functional status of Medicare patients. MCOs, at their expense, are expected to contract with an NCQA certified vendor for administration of these surveys. The survey looks at beneficiary health status over a two year period. Percentages of respondents whose health status improved, declined and remained the same, by plan, will be released publicly in late 2000.

The core of the Medicare HOS is the SF-36 (36 Item Short Form Health Survey) which is used world-wide to assess health status from the patient's point of view — a development which reflects FACCT concerns enumerated above. Consumers, purchasers and providers use patient-based assessments in four ways: (1) to monitor the health of the general population; (2) to evaluate treatment outcomes and procedures; (3) to monitor and evaluate decision-making in clinical practice; and (4) to provide external performance measures.[94] In its Manual on how to survey, NCQA provides examples of each such application in private and commercial sectors, noting that in comparing the health status of the chronically ill elderly, using the SF-36 it was found that HMO patients fared worse than fee-for-service patients and that the results helped the plans in the four year study improve their outcomes.[95] HCFA is not limited in the uses they may make of such data; and, they are intimately involved in the process by which the HOS is administered, prescribing the content of pre-notification postcards, letters for questionnaire mailings and reminder postcards.

M+C represents a major regulatory initiative from Congress, implemented by HCFA, to create a managed care market predicated in part on comparative data to form the basis for selection by seniors. Access to choice was not requested by seniors but initiated by the industry faced with an increasingly apparent effort of the federal government to shift seniors into managed care mechanisms. The detail imposed in QISMC and the performance reporting mechanisms M+C imposes go well beyond the federal efforts which preceded this new era of increased choice based on comparative public data. Although the diversity of response which Congress may have anticipated from the offerors of these services has not emerged, the developmental nature of the market at issue only underscores the inevitable dynamism in the quality and performance measurement world of federal managed care. Similar initiatives, although not as detailed, are present at the state level as well.

IV. STATE LEVEL REPORT CARDS

State government functions in three ways in managed care markets: (1) as employers they are purchasers which can demand data from the plans which they might choose to offer; (2) as Medicaid agencies they can incorporate federal approaches to comparative performance reporting, as many have; and (3) as regulators they can function as public data clearinghouses and enforcers. States are engaged variously in all three activities. When they function as purchasers they are no different from any other commercial purchasers except for the volume of covered lives they can bring to the table. The issues for

---

94 NCQA, Volume 6, "Medicare Health Outcomes Survey Manual", HEDIS 1999, NCQA, 1999 at 5.

95 Id at 6.

them in seeking and using comparative quality data are not unique.

As Medicaid agencies, they have been assessed by the GAO as having developing skills, which are improving with time. The Medicaid population, though, presents its own challenges in exercising choice. Moreover, little choice is offered to these plan users, so consumer-oriented report cards is a relatively small component of the variety of mechanisms states use to hold plans accountable in Medicaid managed care. Here, however, in terms of data on quality, states have traditionally (to the extent something so new can have traditions yet) hewed to the customer satisfaction model of assessing quality.

In 1997 the GAO looked at Arizona, Pennsylvania, Tennessee and Wisconsin and their efforts to hold plans accountable.[96] Here, as in Medicare, GAO observed that at the time their analysis was conducted there were few benchmarks or standards for utilization or adequacy of care for the affected population. Moreover, in relying on customer satisfaction data,

> Patients typically are not in a position to know what specific care or services they need for a given condition and often cannot assess the appropriateness of the care they receive – or do not receive. In addition, patients new to managed care may confuse differences in the way the system is meant to operate with deficiencies in the care provided. Problems associated with obtaining meaningful patient survey information may be even more pronounced for those in the surveyed population with unique language or cultural needs or who are unaccustomed to receiving routine health care in a structured system. Education and informing prospective and newly enrolled beneficiaries about managed care and helping them learn how to use the system – as some states have done in their medicaid managed care programs – can mitigate these problems.[97]

Although several of the agencies reviewed have the authority to impose financial penalties on plans which do not provide the data required or have inaccuracies in their data, these penalties were rarely imposed. While patient satisfaction surveys and rates of grievances were evaluated by the states, the accountability in Medicaid managed care is not focused on customer choice. The plans selected by the states will succeed or fail based on performance data including subscriber satisfaction, but consumer-targeted report cards is not a major focus since choice is not a significant option for this population.

The most significant state developments in the report card world are state mandated reporting and publication programs. "The most important regulatory incentive is the requirement that plans and

---

96 GAO Report, "Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort", Letter Report, 05/16/97, GAO/HEHS-97-86

97 Id at 8.

providers disclose information about cost, quality and satisfaction to both consumers and purchasers.[98]" This observation was made by the Reforming States Group (RSG), a voluntary association of leaders in health policy in the legislative and executive branches of government, representing in October, 1999, more than 40 states. The group had issued a report in 1997 which anticipated that integrated delivery systems -- hybrid plan and provider systems – would have emerged as the dominant model for health care. While the issues about which regulators were primarily concerned then pertained to categorizing different types of insurance entities or ownership types to focus on identifying the level of risk undertaken by them and assigning oversight commensurate with that risk ("leveling the playing field"), a variety of factors have led to a shift in focus at the state level.

"Consumer concerns" is now seen as the category that is currently exerting the most dramatic influence on state oversight activities. Significant expansion of Medicaid managed care programs has led to more prudent buyer type activities such as those noted by the GAO, with more emphasis on relying on market forces to mold managed care. The regulators who participated in this self-report saw a greater emphasis on quality and access (the consumer concerns noted) as clearly at the forefront of state efforts but predicted that with increased premiums, and any downturn in the economy, this relatively new emphasis would give way to a return to a cost control dominated oversight environment.

The RSG study reports that twenty one states require plans to submit HEDIS data. Sixteen conduct state mandated consumer surveys. Twenty-six have state mandated reports on quality which are provided routinely and another 12 have periodic state quality reports.[99] These numbers were self-reported, however, and do not jibe completely with independent research. For example, Texas is not listed among the states which now has a state mandated HMO report card, yet the Office of Public Insurance Counsel (OPIC) is required to provide such information and issued its first report in 1998.[100] The Texas report however is based exclusively on customer satisfaction surveys utilizing the CAHPS tool, which may explain its omission from the RSG material. The OPIC press release does make it clear that HEDIS measures can also be taken into account by consumers, but these "will soon be available from the Texas Health Care Information Council" which is not the same agency. In addition, not all plans were surveyed. The plans were selected by OPIC based on market share and plan size within relevant service areas. The HMOs reported on account for 90% of Texas commercial enrollment for 1997.

While Texas represents one of the newest entrants into the mandated report card field, Maryland is the oldest. Beginning in 1995, Maryland has required from every HMO in the state that holds a certificate of authority and whose premium volume in Maryland exceeds $1,000,000 to report HEDIS

---

98 Reforming States Group, "Tracking State Oversight of Managed Care" (October, 1999) Milbank Memorial Fund, www.milbank.org/stateoversight/990918soihs.html at 3.

99 Id at Table 4.

100 "HMO Report Card Now Available", www.opic.state.tx.us/pr9-1-98.html

data to the state, which data is then audited for accuracy.[101] Beginning in 1997, with the background assistance of NCQA, that data has been made available in a report card to be used by consumers and purchasers. Where an HMO fails to timely file the required HEDIS report or where the report is substantially incomplete or inaccurate, a penalty of $1,000 per day may be imposed.

Maryland released its third annual report in September, 1999. In 1998 over 140,000 performance reports were distributed to consumers and businesses including 80,000 state employees. The 1999 version included for the first time customer satisfaction data generated by use of the CAHPS survey. In addition to the consumer and state employee report, the state issues a separate, more complex report for employers and benefit managers.[102]

In Florida, which was the first state to require plan accreditation as a condition for doing business in the state, managed care reform legislation mandated reporting of data consistent with the type required for accreditation, to be published no less frequently than every two years. In addition, however, commercial insurers were required to adopt recommendations for preventive pediatric health care which are consistent with the requirements for health checkups for children under the state's Medicaid program with goals of 80% compliance by 1998 and 90% compliance by 1999.[103] A similar approach was taken in New Jersey, one of the newer states to mandate reporting as part of managed care reform. In 1998, the state's Commissioner of Health, reviewing the results on the dozen HMOs and 8 point of service plans[104], took the position that the scores on HEDIS measures were too low and that all plans had to have an improvement strategy in place during 1999. The regulators called for a boost of at least five percentage points in the best scores on preventive health by 2000 in each of the seven health categories the report cards cover.[105]

Connecticut takes an more comprehensive approach (contrary to New Jersey's own assertions) with a statute that gives the Commissioner the ability to not only collect HEDIS data, but to report other factors including any change in the plan's rates over the prior three years, its medical loss ratio or percentage of total premium revenues spent on medical care compared to administrative costs and plan marketing, how it compensates health care providers, the name or source of any established medical protocols and utilization review standards, the status of the organization's reporting requirements, the number of hospital days per thousand enrollees, and the average length of hospital stays for specific

---

101 Title 10, Department of Health and Mental Hygiene, Subtitle 25, Health Care Access and Cost Commission, Chapter 08 Health Maintenance Organization Quality and Performance Evaluation System §§19-1507,-08,-11, Annotated Code of Maryland (7/27/98).

102 "Maryland Commission Releases Report Card on HMO with new Information on Consumer Satisfaction Complaints", www.dhmh.state.md.us/publ-rel/html/hmo-rptcd.htm

103 See Florida Statutes, 641.51(8) and (9)

104 www.state.nj.us/health/hmo/hmoreport.htm

105 Moskowitz, "Jersey plans don't make the grade", 17 Business and Health 38 (Jan. 1999)

practitioners.[106] The Connecticut law provides for penalties of only $100 per day for late or inaccurate or incomplete data, but their report cards include NCQA Accreditation Status, numbers of participating providers in each county, utilization review measures including numbers of requests, denials, appeals, and results on appeal.[107] The report card even includes a work sheet for the consumer to compare on a single page those measures selected for the options they are considering. The consumer is instructed in addition "you will need provider directories, premium or contribution rates, and schedules of benefits for each plan you are considering". The worksheet however, does not include the HEDIS measures or satisfaction measures for comparison. It is primarily oriented around coverages available, and whether the consumer's preferred physician and hospital are in the network.

As reported by the RSG, which has summarized every state's approach to managed care oversight efforts in its 200 page report, the trend is toward greater disclosure of performance data to the states with varying approaches to how much information regulators make public. There is an undeniable increase in attention to quality as a principal consumer concern, but little information on how much consumers actually are relying on that data. Combined with commensurate increases in hospital and physician data as noted above, overall there is an unprecedented level of quality data produced at the state level. Regulators consistently report, however, being stymied by restrictive federal laws including ERISA and the Balanced Budget Act.[108]

V. LEGAL SPECULATIONS AND PRUDENT RISK MANAGEMENT

The report card phenomenon is new and of varying impact to date. Researchers and state and federal government agencies, however, are undaunted in their efforts to increase the quantity and utility of public comparative data on quality at all levels. There is little case law to date which examines potential liabilities in this arena. Some of the most significant legal issues which may arise from commerce in these data remain unknown at this writing because critical regulations are only available in proposed form. For example, there is considerable debate in quality circles generally about the extent to

---

106 Public Act No. 97-99, Section 4 (a)(4)

107 "A Comparison of Managed Care Organizations in Connecticut", October 1999, State of Connecticut Insurance Department, www.state.ct.us/cid

108 "Although states continue to lead in health policy development and implementation of health reforms, their policymaking and oversight activities are strongly affected by federal law such as the Employee Retirement Income Security Act of 1974 (ERISA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and provisions of the Balanced Budget Agreement (sic) of 1997 (BBA) especially those creating a new health insurance program for children (CHIP) and changing reimbursement under Medicare...All participants agreed that the ongoing tension between federal and state policies will remain an important future influence over the course of oversight. Despite the appearance of a more "balanced federalism" as evidenced in HIPAA, many leaders in state government remain frustrated by the limitations imposed by federal law, and how it is interpreted by the executive branch, on their ability to adopt creative solutions in response to constituents' concerns about access to health care of appropriate quality." See RSG Report, supra n. 98 at 4.

which the new emphasis on patient privacy, particularly in electronically transmitted information under HIPAA's rules on administrative simplification, will thwart availability of data which emanates at is core from individual doctor-patient and provider-patient interactions. At the other end of the spectrum it is without question that false or inaccurate data submitted under M+C will be a basis for false claims liability since the reports are part of a health plan's statements made to secure reimbursement. State insurance fraud codes will likely be another premise for enforcement where those who are required to report information fail to meet the standards imposed. Still, it is not too soon to consider what types of liability could arise and basic risk management techniques which can enhance the validity and safety of health plan report cards.

The more this information is used by employers and the public in making decisions that affect commerce, the higher the stakes for agencies publishing data. Private reporting agencies will have some exposure for the accuracy of the data they provide to others. Whether they followed a developing standard of care in producing and characterizing the data could be a basis for liability for defamation or business tort where a plan or provider is harmed by negative reports.

Report card data aggregates into two principal buckets: (1) customer satisfaction data; and (2) clinical performance data. Each likely leads to different types of liability. Merely reporting levels of customer satisfaction would not seem to create much liability beyond that already addressed in terms of validity of the data in accordance with regulatory requirements. With the increased emphasis at both state and federal levels of externally audited data, the validity of data reported by state and federal agencies will be largely assured. It is the self-publication and other uses of this type of data by plans and providers that would be a greater concern, particularly, in light of the creative causes of action generated by plaintiffs counsel against managed care plans nationally, including false advertising and civil RICO actions.

In *Boyd v. Einstein*[109], a now ancient case which found that a plan could be held liable (although it was not in that case) for the acts of its ostensible agent, the physician, one predicate for liability was the plan's advertisements – "we guarantee the quality of our services." Few would make such a statement in today's world, but it is not hard to imagine a plaintiff's claim predicated on an inducement to select a plan or provider based on overstated or unprovable satisfaction data. For example, were a plan, hospital or physician group to advertise generally a customer satisfaction rate based on selected data which affirmatively excluded negative findings and therefore misled a consumer later harmed while receiving care from the entity selected, creative minds need not tax themselves to craft arguments based on detrimental reliance and fraud in the inducement. The liabilities would seem to rise where the claims are based on clinical outcomes ("95% of our knee replacement patients return to work within three weeks"). Some entities avoid this dilemma by recounting in their advertising findings by a third party ("the state ranked us number 1 in outcomes on CABG surgery for 1998") rather than to make claims of their own, since there will undoubtedly be arguments made about whether any entity publishing its own report cards about its own performance complied with the developing standard of care in report card production.

---

[109] 547 A.2d 1229 (Pa. Super 1988)

Comparative reporting by a plan, hospital or physician group could generate still different types of liabilities. When the New York CABG data became available, it was entertaining to follow hospital advertisements regarding their quality based on the data. Some hospitals characterized their success rates by using selected comparisons, choosing to focus on a more favorably defined specific geographic area to qualify their rankings. As a result, more than one advertisement during that period had different hospitals within similar areas claiming to be number 1 in their results. Here, consumer protection agencies can get involved, and in the past, the Office of Consumer Affairs in New York City has taken plans to task for misleading statements ranging from the number of board certified physicians in their networks, to benefits available for seniors in varying plan products.

Unauthorized use of trademarks or copyrights may emerge as another basis for liability. NCQA has strict standards for what can be said about its findings. Even so, plans, credentials verification organizations, and others whom NCQA reviews, certifies or accredits have made misstatements about their status and been issued cease and desist letters. Other organizations, such as the National Comprehensive Cancer Network, publish national clinical practice guidelines which are copyrighted. Were a plan or provider to claim publicly to follow these guidelines, issues would arise regarding the authorized use of the copyrighted materials and the organization's trademark.

Regardless of the eventual impact and utility of health care report cards, more and more entities and organizations will be publicly reporting data about themselves and others as part of the inevitable attention to stimulating market forces in health care. A range of common sense risk management techniques ought to apply:

- Certainty about the ability to substantiate any characterization of data is important before statements are made publicly. Whether a physician group uses its own outcomes data to generate a favorable case rate from a plan, or a plan publishes data about itself during open enrollment, the truth and verifiability of claims made will be important.
- Avoiding superlatives is always wise. ("We have the best doctors in the region.") Although often considered mere puffery and therefore not actionable when used in marketing, given the increased availability of verified and audited data on results, these types of claims may rise to a higher level of scrutiny. Closer coordination between the marketing departments of plans, providers and physician groups, with legal counsel would seem prudent before publication or release of any such information.
- Reference to third party characterizations is safer than self-generated claims. US News and World Reports rankings are cited by many a health system in billboards and print ads, touting their quality. Where the statements have been made by others, the subsequent publisher is merely reporting what a third party said, whether the content of it is perfectly verifiable or not.
- Disclaimers about the applicability and utility of information, particularly for the public, is also useful, especially where outcomes data are at issue. ("These aggregate results were reported in 1998. Individual experience may vary depending on the patient's condition.")
- Finally, careful review of the entity's liability insurance policy and making sure that the entity's liability carrier is aware of the report card efforts will also be important, depending on the content of the report.

VI. CONCLUSION

The advent of health care report cards commercially and in regulatory schemes is here. From M+C to state report cards to e-commerce, the new emphasis on publicly reported performance in terms of both service and clinical outcomes is part of a generally heightened attention to health care quality. Report card purposes vary: They are part of an overall effort to educate consumers and stimulate a greater sense of responsibility and participation in health care decision-making. Since we cannot improve what we cannot measure they form a critical foundation for better health care. What they report, how they are made public, and who uses them are questions with still developing answers. Despite debate[110] about whether a market is, in fact, being created by data which is intended to bolster choice --- which itself exists in widely varying degrees -- data on quality is being used daily to improve the performance of those who are its subjects, both voluntarily and because of resulting perceived strategic imperatives.

The refinement of health care report cards will reflect the changing demographics of health care service consumption and the population who will use these services.

> In the near future the baby boomers will become the consumers of the health care system and not just its financiers, as we are for the most part today. We are the generation that marched for and against everything. The concept of entitlement was invented for us; and we believe the sun follows us when we walk down the street. We read *Consumer Reports*, and we made the market for Lexus and Infiniti. As patients and health care consumers, we are likely to place enormous value on the quality of the care we get as manifested in data we will demand.[111]

The era of meaningful, useful, publicly reported performance measurement is dawning. The challenges for lawyers and their clients in this context remain to be fully elucidated. The good news is improved health care quality is inevitable as a result.

---

[110] See, Gosfield, Chapter 9, "Back to the Future: Millennial Speculations", in GUIDE TO KEY LEGAL ISSUES IN MANAGED CARE QUALITY, Faulkner and Gray, New York, 1996, pp. 215-230

[111] Id at 229